IN THE CIRCUIT COURT FOR BALTIMORE COUNTY, MARYLAND

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KATHERINE MARIE PETTWAY, et al.,

Plaintiffs,

v. Civil No. 03-C-16-004803

HASSAN KASSAMALI, M.D., et al.,

Defendants.

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DEPOSITION of BRUCE CHARASH, M.D., taken by Defendants at the offices of Fink & Carney Reporting and Video Services, 39 West 37th Street, Sixth Floor, New York, New York 10018, on Friday, January 27, 2017, commencing at 10:00 o'clock a.m., before Tina DeRosa, a Shorthand (Stenotype) Reporter and Notary Public within and for the State of New York.

APPEARANCES:

SNYDER & SNYDER
Attorneys for Plaintiffs
1829 Reisterstown Road, Suite 100
Baltimore, Maryland 21208
BY: SCOTT A. SNYDER, Esq.

KASLICK & PRETE, LLC
Attorneys for Defendants Hassan Kassamali, M.D. and Hassan Kassamali, M.D., P.A.
117 West Patrick Street, Suite 201
Frederick, Maryland 21701
BY: MARY ELIZABETH KASLICK, Esq.

BRUCE CHARASH, M.D., called as a witness, having been first duly sworn by Tina DeRosa, a Notary Public within and for the State of New York, was examined and testified as follows:

EXAMINATION

BY MS. KASLICK:

Q Doctor, would you state your full name for the record, please?

A Bruce Charash.

Q And your current professional address?

A 205 East 63rd Street, New York, New York 10065.

Q Is that an office building?

A It's an apartment building with an office.

Q And what's the name of your practice?

A Just my name. I'm an unincorporated business.

Q And how long have you had the office on East 63rd?

A Since early 2015. Before that I

was practicing on Long Island.

Q And do any other physicians practice with you at that 205 East 63rd address?

A No. I'm in solo practice, always have been. Well, I had a period of time where I worked with another doctor, but in solo practice.

Q Do you see patients in the hospital anymore?

A Yes.

Q How frequently do you do that?

A About ten percent of my professional time is hospital versus 90 percent office or at least of my clinical time.

Q What hospital?

A Lenox Hill Hospital.

Q Do you have privileges at any other hospital?

A No.

Q When was the last time you had privileges at any hospital besides Lenox Hill?

A Well, I had privileges at New York Presbyterian from February 1, 2005 through July 1, 2006, and I had privileges at Mount Sinai

Hospital in New York from May 5, 2007 through December 12 -- sorry, May, 2007 through December, 2012.

Q What led you to get privileges at New York Presbyterian?

A I had been at Lenox Hill from '91 to 2005. In 2004 half of the Cardiology Department, mostly the interventional group, the majority left to Columbia to start a new program there. Even though I'm not an interventional cardiologist, these were my closest professional friends. So they asked me to come with them and I did. But after a year and a half there I realized most of my patients preferred to go to Lenox Hill and I decided to go for private practice.

For that year and a half I was on the medical school faculty of Columbia, but then I decided it was time to go into practice so I went back to Lenox Hill.

Q Did you resign your privileges at New York Presbyterian?

A Yes. I just told them I was not going to apply to renew.

Q Then you said you had privileges at Mount Sinai from 2007 to 2012; is that correct?

A Correct.

Q What prompted you to get privileges there?

A Largely because it was concerning that Lenox Hill was going to go bankrupt and in fact they were on the verge of closing. My closest friend in hospital administration was at the time the President of Mount Sinai and he encouraged me to get privileges and there was every reason to believe the State was going to close Lenox Hill, but when North Shore Hospital-Long Island Jewish purchased Lenox Hill into their network the hospital was saved with much more resources added to it.

So I eventually let my privileges expire and did not renew at Sinai.

Q Why did you think the state was going to close Lenox Hill?

A Because Lenox Hill had enormous debt. They were beginning to sell property to cover their operating expenses and the state was

not going to bail them out and because it's such a prominent Upper East Side hospital on some level and they had closed St. Vincent's downtown it was pretty clear they were going to close Lenox Hill unless some financial solution came about.

Q And did you voluntarily resign your privileges at Mount Sinai?

A Well, again you don't require to resign from any hospital because you must renew your application on an annual or every two year basis. So when they sent me my new application I told them I was not going to renew my privileges and they accepted.

Q Do physicians ever resign their privileges from hospitals?

A You can, but the point is you can passively not renew them.

Q I understand.

A So I didn't need to resign. I just didn't renew.

Q All right. So my question is -- my question was did you resign your privileges, no, but you allowed them to elapse; correct?

A Right.

Q All right.

A Just basically a passive way of just not continuing.

Q Has there ever been a time since you went into private practice that more than ten percent of your professional clinical time was spent in a hospital setting?

A Well, again, from 1987 through 2006, 90 percent of my clinical time was in the hospital and ten percent of my time was in a hospital -- in an office. And then from 2006 forward it flipped. Ninety percent office, ten percent hospital.

Q And what happened in 2006 to flip it?

A I went into private practice as opposed to working for hospitals or medical schools.

Q So when you went into private practice did your practice immediately go to 90 percent clinical time or did it evolve over a period of time?

A Well, over a period of months, but

it rapidly accelerated to primary office based.

Q When you were doing 90 percent of your time in hospital based practice what did your practice involve?

A I'm not sure what you're asking. Are you talking the 90 percent of what the hospital practice was or the ten percent that was office at the time?

Q What the hospital practice was when you were doing 90 percent.

A The majority of the time I was running a cardiac intensive care unit of 15 beds, a cardiac step-down unit of 37 beds, the emergency room chest pain center which was four beds, the cardiac arrest team of the hospital. So those were my main responsibilities.

Q That was at Lenox Hill?

A Yes. And at New York Hospital it was similar, but instead of being the chief I was the assistant chief.

Q So as chief of cardiac -- what was your title actually at Lenox Hill?

A Chief of the cardiac care unit.

Q Okay. And when you were doing 90

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percent of your time at Lenox Hill as chief of the cardiac unit, how much of that time was administrative?

A Under five percent.

Q So when you said you ran those departments, what did you mean by running them?

A I was responsible for -- it was basically a very early version of being a hospitalist.

Every patient that was admitted to my unit fell under my immediate supervision. Now, some of them, but a minority, were my personal patients. But cardiologists who admitted patients to these units, had me there day-to-day rounding on all their patients.

The functional benefit was that I was on-site most of the time during the day when these doctors were in their office so it was a very symbiotic relationship. But I was given the authority by the hospital to have oversight of all patient care.

Over the years at Lenox Hill, 14 years, there were specific occasions where I had to step in because I thought a doctor was not

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adhering to the standards of practice and I was able to override them for the patient's care. We did it without the patient being aware of that controversy, but I had that authority and exercised it.

For the rest of the time I would call up doctors and tell them that their patient was deteriorating and they would trust me to manage it.

Q So, and I'm just trying to get an understanding of how that worked, when you were overseeing the care of patients who were not your patients at Lenox Hill, were you actually writing notes on those patients or overseeing it, but not getting into the actual medical record of the patient by entering records?

A Well, this is before electronic charts, but daily when I would see them I would write a daily CC director note for all the patients in the cardiac care unit, 15 beds, I would write orders frequently.

On the step-down unit I would round on the patients, too, but I would only write notes if an intervention was required and

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I would write orders regularly and most of the time with the understanding explicitly of the doctor what I was doing, of their private attending.

Q And you were employed by Lenox Hill or whatever corporate entity it was that had Lenox Hill at the time?

A Yes.

Q Have you ever been sued yourself for medical malpractice?

A Once.

Q How long ago was that?

A 1989.

Q And what was the allegation against you?

A There were no allegations against me.

Q Was the action filed in New York State?

A Yes.

Q What hospital were you practicing at the time.

A It was a case called Friedman versus New York Hospital. Every doctor and

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nurse whose name was identified in the chart was sued, but when I was deposed in my discovery deposition -- pardon me one second.

MS. KASLICK: Let's go off the record.

(Discussion off the record.)

A When my discovery deposition was taken it was clear that I was not involved in the patient's care and management at any point in time related to the issues of the case and I was dropped.

Q What were the issues of the case?

A No idea. I wasn't involved in the patient's care. I admitted him from the emergency room. His problems occurred well after my management and once the discovery demonstrated that I was not even with any point of contact the issues were I was dropped.

Q Was he admitted as a cardiac patient from the emergency room?

A Yes.

Q Do you know what that patient's cause of death was?

A Good Lord, I don't remember

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anything about it because I had nothing to do with his management after he left the cardiac care unit and the issues were specifically related to management after I ever saw him again.

And as I said there was no criticism of me, no expert was hired about my care, and I had no point of contact with any of the issues in the Complaint. The only reason I know it is in my discovery deposition it was made clear I saw the patient well before any of the problems came up.

Q Have you ever been employed by any other hospital or university or medical school besides your employment by Lenox Hill?

A Yes. I mean my resume speaks to that. I was originally hired by Mount Sinai Hospital as an intern and a resident.

I was hired by Cornell Medical School and New York Hospital as a fellow and then as a young attending from 1991 to 2000 -- sorry, 1987 to 1991 I was hired by Cornell Medical School as a full-time Assistant Professor of Medicine. From '91 to 2005 Lenox

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Hill was my employer.

From 2005 to July 1, 2006 Columbia Medical School was my employer and then I'm self-employed.

Q Have any of the entities for whom you worked ever been sued for care that related to care that you rendered?

A No.

Q I have a curriculum vitae, but I don't know if it's the most up to date one.

Did you bring one with you?

A Yes.

MS. KASLICK: Let's go ahead and have the court reporter mark it as Exhibit No. 2, please.

(Curriculum vitae was marked as Deposition Exhibit No. 2 for identification, as of this date.)

BY MS. KASLICK:

Q I'll hand it back to you, Doctor.

Does Exhibit No. 2 have any publications on it that relate to the testimony that you're going to be giving in this case?

A There is no literature. I

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published a small amount in my early training and none of it relates to this case.

Q Are you relying upon any literature or studies or other writings with respect to your opinions in this case?

A No, I will not.

Q How much do you charge for your involvement as a medical/legal expert?

A My rates increased in 2015 to $450 an hour for review and $500 an hour for testimony.

For depositions it's a two-hour minimum unless it's agreed upon in advance that it will going to be short and for trial I charge $4,000 a day for the 9:00 to 5:00 hours of work I miss due to the trial. If it's a local trial in New York I'll charge for a half a day if I can go back to work.

Q So when you say two-hour minimum for depositions, that would be at the rate at $500 an hour?

A Yes. So it's basically a thousand dollars to start a deposition, but if I'm told in advance that it's a follow-up deposition that

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will take a short period of time I don't have to block out time from my calendar.

Q Can you give me an estimate of how many times you have been deposed over the last 12 months?

A Probably 14 times.

Q Have you given testimony in trial over the last 12 months?

A Probably nine, ten times, I believe.

Q Have any of those instances been in the State of Maryland?

A Yes.

Q When was the last time you testified in the State of Maryland at trial?

A I'm having a hard time remembering exactly when, but I would say that my last trial testimony was somewhere around October in, it might have been Baltimore, but I'm not sure.

MR. SNYDER: October what year?

A I'm sorry, 2015. I apologize. 2016. It was three, four months ago I was in Maryland. I don't remember which county.

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Q What attorney were you working with in that cause?

A I'm not sure. You know, it's kind of strange, but my memory is very powerful on a certain level. But I need something to trigger my memory. I compartmentalize. So I just don't remember. My list will show it, so it's there. I just don't remember.

Q What were the issues in that particular case?

A No idea. Again, and if I'm given the name of the case I'll remember a little bit, but if I am given one piece of information to trigger my memory I'll remember everything about it. I need a key to unlock my memory.

Q All right. When we take a break we will get the list and we can go back on that.

Was that the only time in the last year or so or over the last calendar year that you testified in Maryland in a case?

A No. I have probably done at least two or three trial testimonies, but I truly just don't remember the number of times. That's why I need these written reminders. I don't

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remember.

Q And that would have been at a rate of $4,000 for a day?

A Yes, for a trial it would be.

Q Have you ever worked with Mr. Snyder or his firm in any other cases?

A No. This is the first time we have been involved in a case together and today is the first time I have ever met him.

Q Do you know how much you made year, last year as a medical/legal expert approximately?

A I don't know how much I made last year. I'm going to determine that for taxes, but that's not coming up for a couple months.

Q How about the year before?

MR. SNYDER: Objection.

A I mean I'm happy to answer it.

MR. SNYDER: You can answer it.

A Okay. Fine. I just wanted to know whether it was allowed.

Q Sure. If there is something, believe me before we get to the point where

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counsel would be trying to instruct you not to answer I'll ask you to leave the room and we will have a discussion, but I don't think we are going to get to that in this particular case.

A Fine. I just want to know the rules.

Q Sure.

A I probably made about 65 or $70,000 in 2015.

Q Have there been years where you have made over that?

A Yes.

Q And when was the last time you made over that amount as a medical/legal expert?

A In the early 2000's, probably around 2003 or four. It was the peak amount of work I did time and number of cases and income, but around that period of time I started my non-profit and I voluntarily reduced the number of cases I took. And there have been ups and downs in the number of testimonies I have given and income, but it's been, last year was higher than the year before, but not much.

Q What was that peak in 2003, 2004?

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A I don't know. I don't remember what the amount of the money was. I'm not sure of the exact year, but it's about when I was at the most number of cases that were coming up for various testimony.

Q How many files do you currently have open for medical/legal cases?

A I would think somewhere between 20 and 25, but some of them are clearly old cases and I've discovered over the years that I'm not always told when a case resolves.

So I don't know how many of them are active. I would probably think around half of them are probably still active, but I don't know for sure.

Q Is there an average of how many you accept for review per year?

A Well, there is an average over 30 years and that number has had changes and again it increased and then decreased.

Q Well, how about over the last ten years can you give me an average?

A Sure. Probably averaged 20 cases a year.

Q Are you listed in any expert witness services?

A I don't know, but not with my permission if I am. I will not allow my name to be used by anybody. I will not solicit or advertise on any level. I never have and I never will.

Q Have you ever received a case where even without your permission you found out that you were listed with a service?

A No, but I would not -- if I did find out I would act upon that.

Q What's the non-profit that you formed?

A It's called Doc to Dock. And it's spelled D-O-C, for doctor, then T-O, D-O-C-K. Doctors to the docks.

Q Not Doctors to the Dock, Doc to Dock?

A Right.

Q And what is that. What is its mission?

A Every day in the U.S. our country sends to landfill approximately 7,000 tons of

unused medical supplies or reusable medical equipment. We collect it on a national basis. I organized this. We keep warehouses and a specific inventory and then we go to Africa and now to countries outside of Africa in great need to determine what they need to function and send them for free a 40-foot container with the supplies needed to jump start health care.

For example, we sent six containers to the second biggest city in the Congo in 2011 and within a month maternal mortality dropped by 90 percent in the city.

So it's a highly productive and successful mission because we're taking things sterile, unused syringes, unexpired to IV lines to everything and we are taking our surplus, as I always say we are converting surplus to survival.

Q What year did that form?

A We incorporated in early 2006 and sent our first container by the end of that year and the number of containers have increased expedientially in the first ten years.

Q Is it a New York State

incorporated non-profit?

A No. It was New York State. I'm sorry, I didn't know if the non-profit was Delaware based, but this was New York State. We incorporated in New York.

Q And do you have a Board position or an officer position in that non-profit at this point?

A Well, for the first eight years I was Chairman of the Board. Now I'm just a Board member. And for some of the years I functionally served as the Chief Executive Officer, but eventually had it self sufficient without me.

My primary job now is to help raise money and to direct care, although I have gone on 18 missions to Africa to train and to restart health care.

Q When you were serving as the Chief Executive Officer was that on a pro bono basis?

A Of course. Actually not. I had to donate a salary technically, but I donated back to the corporation. The Board required me to draw a salary for the position, but it was

all funneled back in.

Q That is the only reason I ask because I'm aware from non-profit work that CEO generally is a paid position.

A Yes, but I mean I didn't take home a check. I just gave it back in.

Q Did you remember the years that you functioned as the CEO or how long you functioned as the CEO?

A Well, from 2006 even though we were barely operational probably until 2010, '11. I don't remember the year.

Q When you were functioning as the CEO how much time were you devoting to that?

A Virtually all my weekends and lots of evening time. I hired a person who was basically running the company answering to me, but I was named CEO.

Q The work that you do as a medical/legal expert, is that work that you're paid for individually as opposed to going into some kind of corporation?

A Correct. All of my income comes to me as a non-incorporated entity.

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Q Besides your clinical practice, your work with that particular non-profit, your work as a medical/legal expert, is there anything else that you do on a professional basis that aren't covered within those categories?

A No. I mean I'm involved in several other non-profit works, but they are not at this point significant amounts of my time.

Q Are they medically related?

A Yes. One of them is I'm a founding member of a non-profit called Lodestone. We purchased several hundreds of acres in a pristine elevated valley in the Colorado Rockies. The valley is actually 10,000 feet elevated and we're using it as a base camp for post-traumatic stress therapy for Vets using wilderness therapy.

We have a highly structured program with the top at risk professionals in the VA. We are doing men and women's groups and we're studying it and we're trying to come up with a predictor as to who would benefit best from that form of therapy. So it's been

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operational now for six months.

Q And are you on the Board of that?

A Yes.

Q Do you have any other position besides being a Board member?

A No.

Q Any other involvement in medically related non-profits that we haven't hit yet?

A No.

Q I ask that because I thought you said there were a few more.

A There's one more, but it's just not -- it's called Alma, A-L-M-A, Sana, S-A-N-A.

Q What is that?

A It's a non-profit that has found a low tech solution to a significant problem in many of the most underserved aspects of Africa and South America. There is poor, if any, medical documentation. So even when vaccine programs are introduced into a region there is no clear documentation as to whether or not a baby or infant has received a vaccine.

So our low tech solution has been, and I have been on the Board since 2015, is to

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we produce these rubber bracelets with symbols on them that are baby size and the mothers and you actually punch stamp the symbol for the vaccine given so it allows the child to wear a document of what vaccines they've received and what they need.

Q Any others?

A No.

Q Are you on the Board of Alma Sana?

A Yes.

Q Do you have any other position with them?

A No.

Q Can you tell me how many hours per week you on average are practicing in your office?

A Sure. Probably 35 hours.

Q And approximately how much time are you in hospital work per week?

A Three to four hours.

Q Is that rounding on your own patients or some other aspect of clinical work?

A Both. I round on my own patients and some weekends I cross cover other practices.

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I'm called to do consultations.

Q I think you told me earlier you have never been an interventionist -- interventionist; correct?

A Yes. Actually, I think it is called interventionalist, but yes.

Q I probably got it right the first time.

A Yes.

Q Doctor, the patients who you see in your office, are they all there as cardiac patients?

A No.

Q Under what other category would you place them if not cardiac?

A If you will give me the liberty to explain the breakdown of my practice it will be clearer and it's simple.

Fifty percent of my patients are heart patients who came to me primarily for heart disease management and they retain their own primary care doctor.

Twenty-five percent of my patients came to me for heart disease who had a primary

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care doctor, but over the course of the years asked if I would take over as primary care and cardiologist, and 25 percent of my practice are patients who came to me without a preexisting cardiac concern or complaint, just to be primary care, but over the years, heart disease is 50 percent of internal medicine, I took over for many of them heart disease.

So I'm the primary care doctor of half my practice. Three-quarters of my practice were cardiac patients who came to me for cardiac issues.

Q Of the 25 percent who came to you seeking a primary care physician, but did not seek you out because of any heart concern, I'm trying to understand the statistic you give me. Is that translating into 50 percent of that 25 percent eventually having some kind of heart related issue that you have dealt with?

A Yes or will, yes.

Q Or will.

When did you come up with those statistics or how did you come up with those statistics?

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A It's just been my overall recognition of my out-patient practice for the last ten years. Actually, those statistics applied to my practice even before I left the employ of hospitals because I did have an out-patient practice and it was probably in the range of ten to 20 years ago I started allowing noncardiac patients to see me for primary care, but I keep it to about a quarter of my practice.

Q Are you still Board-certified in internal medicine?

A Yes. I am grandfathered in so I don't require recertification.

Q When were you first notified by Mr. Snyder's firm with respect to reviewing this case?

A I think you have the invoices I brought with me.

Q I don't.

A Here they are and this gives me the timeline. So I was first contacted in March of 2016.

Q Let me see those invoices then and we'll have them marked; okay?

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A Yes.

(Invoices were marked as Deposition Exhibit No. 3 for identification, as of this date.)

Q Doctor, I'm going to hand you what's been marked as Exhibit No. 3.

A Yes.

Q Those appear to be two invoices related to work you have done on this case; is that correct?

A Yes. It does not include an invoice to be submitted for the review of the family member depositions, preparation for this deposition, and pre-deposition meeting which will probably be four more hours.

Q When was the pre-deposition meeting?

A Phone discussion. It was, what's today, Friday. It was earlier this week.

Q You said that all of those things would be four more hours.

Can you break down the time for me what you spent on each of those things that you haven't billed for yet?

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A Well, the family depositions was an hour for all of them. The phone call was probably another hour, and two hours was more detailed re-review of this to prepare for the deposition specifically.

Q Now, besides what's documented in the two invoices that are collectively marked as Exhibit No. 3 and those additional four hours that you have told me about, have you spent any other time with respect to your work in this case?

A No. I mean I have probably spent more time thinking about it, you know, like last night I was thinking about it, but I don't bill for times when I'm watching TV and thinking about what I'm going to say today, but I have contemplated the case.

Q But no other billed time or billable time; right?

A Correct, of course.

Q And what were you provided in March of 2016?

A The relevant medical records concerning Robert Margotta, but not any

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discovery deposition testimony.

Q And did you bring those relevant medical records?

A Of course? I have them here. This includes --

Q Well, before you say what it includes, have you received any other medical records besides those that are sitting in front of you here at the deposition?

A No.

Q Have you asked for any other medical records besides those?

A No.

Q Okay. Did you receive any kind of index with those medical records?

A No.

Q So we're going to have the group marked as Exhibit No. 4 and I'll tell you specifically because I notice that you have highlighted and made notes within those medical records.

A And let me just say something just for your benefit.

Q Are you going to tell me that the

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colors didn't have anything to do with --

A There is no color coding and everything that I wrote down, just so you know in advance, is simply cataloguing what's on that page. There is no commentary. All for you available, but I don't write anything more than just highlighting what's on that page that I might want to bring up.

MS. KASLICK: And we are going to have them marked as a group Exhibit No. 4.

(Medical records were marked as Deposition Exhibit No. 4 for identification, as of this date.)

BY MS. KASLICK:

Q All right. Besides Exhibit No. 4 and the depositions that you have mentioned, have you received anything else with respect to your work in this case?

A No.

Q Okay. Could you read off for our court reporter, please, the depositions that you have in front of us, who the deponents are?

A Of course. I have the deposition

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of Dr. Kassamali, K-A-S-S-A-M-A-L-I. Then Katherine Pettway, P-E-T-T-W-A-Y. Janet Mardaga, Matthew Mardaga, and Robert Mardaga.

Q With respect to the depositions of the Plaintiffs in this case, did you make any notations in those depositions?

A The Plaintiff only?

Q Yes.

A No.

Q Plaintiffs.

A Nothing in the Plaintiffs', only in the Defendant.

Q Okay. So let's have your copy of Dr. Kassamali's deposition marked as Exhibit No. 5 because I understand that you did make notations in that; correct?

A Yes.

(Deposition of Hassan Kassamali, M.D. was marked as Deposition Exhibit No. 5 for identification, as of this date.)

Q Did you receive any correspondence or e-mails from Plaintiffs' counsel or his office?

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A We probably had some e-mails concerning scheduling the deposition, but I don't save e-mails unless they are substantive.

I have a cover letter that was sent to me for the receipt of the family member depositions which is here.

I usually keep the most current letterhead for the purposes of knowing whose file it is and this letter simply outlines the depositions that I received from the family members.

Q Is there a date on the letter?

A No. That's weird. But it obviously had to be --

Q After their depositions?

A After their depositions which were all in December, so right before Christmas. I don't remember what date it came to me.

Q You signed a certificate of qualified expert and a report in this particular case. Did you bring those with you here today?

A No. I completely forget that I had. That, you know, trigger memory problem I have.

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Q Did you review them in preparation for your deposition?

A Not recently.

Q Other than the notes that you have made that are either on Post-its that are attached to the materials in front of you or directly onto the pages of materials in front of you, have you made any other notes with respect to your review in this case?

A No.

Q Doctor, can you tell me the date or the dates you believe Dr. Kassamali first violated the standards of care in this case?

A Sure. I just want to reorganize my timeline.

Dr. Kassamali deviated from the standard of care on September 10, 2015 and then again extending into October 8, 2015.

Q Okay. I'm going to try to get you to focus on that time the first violation of standards of care or violations of the standards of care; all right?

A Yes.

Q So you told me the first time Dr.

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Kassamali violated the standards of care would have been September 10, 2015; is that correct?

A Yes, it is.

Q All right. Tell me, if you could list for me how you feel he violated the standards of care on that particular date I would appreciate it.

A Of course.

Q Okay.

A He took an inadequate history of current illness and by doing so failed to recognize that Mr. Mardaga had more of an unstable cardiac condition, and by doing so resulted in a lack of an urgent to emergent evaluation of his problems and failure to after the workup -- well, as of that date, inadequate history and failure to recognize the relative instability of Mr. Mardaga's condition.

Q Okay. Any other way, I'll get into that, is there any other way on that particular date that you felt that he violated the standards of care?

A Well, I mean if I'm not thinking it right now I mean as it dovetails into the

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other problems, but, no, he failed to recognize through an inadequate history, through an inadequate evaluation the risk faced by his patient.

Q Okay. You said that he took an inadequate history of the current illness?

A Yes.

Q Can you tell me what he did not do that would have made it an adequate history?

A Of course. And this is probably one of his more substantial deviations. When a person develops chest pain that may well be from the heart, anginal chest pain, the single most important requirement of a doctor is to understand through the history how stable or unstable that syndrome is and stability versus instability extends to a number of factors one of which is what level of activity if it's not occurring at rest which clearly rest symptoms are a signature of unstable disease, but knowing the physical threshold by which a patient gets symptoms is crucial in understanding the danger to the patient.

For example, if a patient reports

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their first episode of chest pain occurring while running full speed up a hill which they don't normally do and I have had patients call with that. I've had patients say that say twice in the last month when they ran up a hill they decided to give their full effort and got chest pain I can be assured that maximum or near maximum activity of physical effort was required to provoke it.

But in medicine the term exertional means anything not sitting down basically. So if you walk to the bathroom and get chest pain that is exertional angina, but at low threshold which makes it dangerous and unstable. New onset chest pain is presumed to be unstable until you can prove otherwise.

So we work on the assumption that if someone has new pain we worry that there is something reactive going on. It's not always the case, but you start with that posture.

Also, he recognized there were new Q waves in the anterior leads which raises a concern that this patient may well have had a recent heart attack and this could be

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post-myocardial infarction angina.

Further, he should have recognized that this patient's probable recent heart attack occurred without the patient noticing it. He didn't go to the emergency room.

Now, this patient is a diabetic. Diabetics frequently through damage to their nerve awareness, nerve conduction don't feel pain at all or the same way as somebody who isn't.

So a person who had a potential recent heart attack, yet didn't know it and by the way, of course you don't know if it occurred anywhere in the last five years, but the fact is that he didn't go to a hospital which means he has to assume that Mr. Mardaga may well have a defective pain awareness. Clearly if he did have a heart attack, when he had it he didn't know he had it.

So that means that whatever he does experience may well be the tip of an iceberg and he has to go through that lens as well.

In no way does he try and evaluate

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whether the patient had some symptom that he might had dismissed as not being cardiac, that he might have thought was bad heartburn. But the point is he had new onset chest pain, a heart attack that occurred in the past five years that he can't time.

But in clinical cardiology if you see new Q waves and someone is having chest pain now this certainly raises the specter of this being post-infarction angina, and again you can't prove it, but you must act on that as being the overriding threat and being time sensitive and aware is a significant thing to do.

Finally, he did not determine the activity threshold by which this patient had chest pain. I told Mr. Snyder on the phone when I read this note actually after his deposition because it wasn't discussed and after the family deposition where it wasn't asked, he wrote down here that Mr. Mardaga got dull substernal chest pain along with shortness of breath which would resolve within a few minutes of resting. It was very noticeable when he was working in the yard

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and mowing his lawn, especially during hot weather.

That statement indicates A, that there has been more than one episode of pain because it was very noticeable during working in his yard, but he doesn't really give any insight as to other episodes, how many there may have been, what kind of pattern they were.

But the single most glaring absence in his note which I asked Mr. Snyder to talk to the family and although this is not in evidence this is the reply I got, there are three kind of lawnmowers. There's a lawnmower that you manually push. There are self-propelled lawnmowers where the effort to push it is minimal and there are sit on lawnmowers where you ride them. Further, if you are pushing a lawnmower you could be pushing it on flat lawn or uphill. A self-propelling lawnmower with still be having effort up a hill.

So I asked Mr. Snyder or I told him that as a clinical cardiologist the clinical question that would be required at the time that I would have needed to know from Mr. Mardaga was

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what kind of lawnmower did he have and what kind of terrain was he mowing the lawn since mowing the lawn was clearly the most provocative trigger to his chest pain.

Q What was the answer?

A Well, Dr. Kassamali said he used -- the answer is his lawnmower was a sit on lawnmower and if that's the lawnmower that they owned that he sat on it you can't consider even in the heat to be significant activity.

And Dr. Kassamali just did not make any efforts to distinguish that. So if he developed chest pain at his worst example just sitting on his lawnmower regardless of the heat that would not be considered anything more than mild activity. It certainly would make it much more provocative that this is low threshold angina and life-threatening.

Q What that the extent of Mr. Mardaga's activity when the chest pain came on in the yard?

A Well, it's not clear in the note of Dr. Kassamali because when he said yard work and mowing the lawn and he sats especially in

hot weather so he suggests that there have been multiple episodes working outside not even in hot weather and he completely failed -- I mean cannot get chest pain mowing the lawn and yard work especially in hot weather. He didn't say once in hot weather. He talks about that being the most prominent.

He does not in any metric evaluate what threshold of activity provoked this chest pain, but based on the fact that Mr. Mardaga owned a sit on lawnmower clearly takes us out of the realm of maximum or even near maximum activity.

Again, the doctor clearly indicates that there were episodes at less activity than that because he says especially during this activity.

Q Did Mr. Mardaga have unstable angina when he saw Dr. Kassamali on that September date?

A Well, the answer is yes, but qualified. We don't have enough information to actually determine what level of instability it was.

What we can determine from this history is not that it was unstable in the traditional sense of rest pain, but we can determine that Mr. Mardaga was likely to be having chest pain at reasonably low levels of activity during day-to-day activity because there is no demonstration of maximum or near maximum.

What we can determine is the following findings of Mr. Mardaga as of this visit. One, his pain is not occurring at maximum activity and certainly seems like it may be significantly less.

Two, multiple episodes, but they're not described.

Three, potentially, and there is no way to prove or disprove post-MI angina. You must work on that assumption because if you can't know you have to worry that it was a recent MI.

Four, a diabetic with defective pain awareness because he didn't know he had that heart attack that he sees on the Q waves.

So given those factors he needed

to be treated as if this was unstable. It wasn't the most extreme version of unstable angina which would be recurrent pain at rest, but there is a giant spectrum between pain at maximum activity reproducible only at that maximum activity versus pain occurring at lower levels of activity.

Q What did you mean when you said he had unstable angina, but not in the traditional sense. What is the traditional sense of unstable angina?

A Well, the traditional would be thinking of pain at rest would be a clear metric of unstable angina. But here's the distinction. Low threshold angina may not be unstable, but it's equally life-threatening because the lower the activity threshold the more danger you are in.

Q But in this particular case do you think using the accepted definitions of angina that Mr. Mardaga had unstable angina at the time of the September visit?

A It's indeterminate because he doesn't describe the other episodes, what level

of activity they occur. He doesn't describe the number of episodes, their frequency. He talks about duration being minutes or recovering in minutes, but he doesn't actually discover the duration of the chest pain in his note. He doesn't discuss the spectrum of symptoms that he had.

When you say he would get dull substernal chest pain that was very noticeable while working in yard, mowing the lawn, especially during hot weather clearly he is indicating other episodes not at that threshold.

Q When you look at the case retrospectively do you believe to a reasonable degree of medical probability that Mr. Mardaga had unstable angina at that point?

A My conclusion would be he had life-threatening angina.

Q Would your conclusion be that he had unstable angina?

A I cannot conclude it because I don't have enough information to make that conclusion. All I can say is that it clearly states he was getting chest pain at not high

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levels of exertion.

And with the untimed heart attack and it being an unrecognized heart attack you would have to conclude that the symptoms he is feeling are not the complete spectrum of his ischemia. Because if he didn't know he had a heart attack and he is a diabetic that portends the most likely scenario that he is having silent ischemia.

It's known even in healthy people from multiple ambulatory studies who feel symptoms of angina that a majority of them there are multiple episodes of silent ischemia during their day-to-day life. In a diabetic who had a heart attack and didn't know it you must work on the assumption that he is vulnerable to much more ischemia than you are aware of and what he aware of is worrisome.

So the way I would characterize Mr. Mardaga with the limited information is that he is getting angina at less than maximum activity, he has a defective pain syndrome and it doesn't matter how you define it he needs urgent management because time is his enemy.

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Q The new Q waves, is there any other explanation for the Q waves that were seen on the EKG that was done in September, any other explanation besides a myocardial infarction?

A Yes. There are potential ways to get Q waves due to physical shifts of the heart, its size, but after his stress test demonstrated anterior wall ischemia it made those Q waves much more likely to have been due to some insult of the heart.

It's always possible, but the problem is you must treat him as if that is the case. And we're not talking about treating him differently than he needs to be treated. We're not adding tests because of the Q waves. What I'm saying is this information means that you can't sit on him. That time is an essential critical factor here and that doesn't hurt the patient to do it earlier.

Whether you think it's unstable angina or at thresholds that are too low for comfort for him to resume his life with the Q waves you must treat him as if that is what's occurring because we are only talking about

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doing things more quickly, not about doing new things to him because of the Q wave.

Q What is the definition of unstable angina?

A Well, technically it would mean that angina is being provoked not solely based on the amount of work you're doing with a stable plaque, but based on potentially dynamic plaque with either clot or spasm or inflammation. But again low threshold angina can be stable, but it's life-threatening nonetheless. So he's somewhere in there. I just don't know where he is because we have a lack of information.

Again, we have no idea about the pattern, how many episode of chest pain he had and these are things that a cardiologist is required to document. And the fact that this cardiologist did not define how much work he was actually doing to mow his lawn means that he did not do his job because he can't even document what the workload was when he did have angina. And if indeed it occurred while sitting on a lawnmower that does not become exertional angina.

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Q Give me an example of the language that you believe was required by the standards of care in order to report in this record the exertional effort that was required to provoke the angina.

A The way you do that is to describe specifically what his activities were at the time he had it.

Writing that a person got chest pain while mowing their lawn in warm or hot weather is not information.

Q I'm asking you to give me an example of the kind of information that you would expect to have included in a note in this kind of scenario.

A I would say Mr. Mardaga developed chest pain while sitting on a lawnmower after ten minutes of riding or after doing this in the garden.

Q Like what. I know it doesn't have to be specific to this case because you don't know what the activity was, but so I can have an understanding of how detailed the description should be.

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A Enough to provide another health care provider a reasonable understanding of the amount of work involved in an activity.

Q So if it's lawn work give me examples of the minimum description you would expect there to be.

A You're too broad. I'm just saying you would have to define both the activity he physically did leading up to the chest pain. Whatever he was doing you document it to give an idea of the workload. There is a big difference between writing a note say patient pushing a manual lawnmower up a hill in hot weather got chest pain versus sitting on a automated lawnmower driving it in hot weather got chest pain and you describe the activity. If he was cutting down branches was he building up a sweat. You could hedge your bushes with great effort or with slow activity. You need to get an idea of the workload.

That's not provided here. In fact, it suggests the opposite. If you read that note it sounds like he is pushing a lawnmower in the hot weather working himself

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out. And, in fact, it's the opposite, he wasn't doing that at all, but your client didn't bother to provide it.

Your client also clearly denotes, implies directly that there were other episodes of chest pain. And if the worst was while mowing the lawn which we now know was sitting on a lawnmower what were the other episodes. Just a broad stroke to have an idea of how many episodes he has been feeling. What are the range of activities that provoked it, not just the lawnmower, but the others. He doesn't provide that.

What he does provide are highly concerning issues of a potential recent heart attack. A patient who doesn't know he had the heart attack if he had it which is a life-threatening problem because he doesn't feel things well. And as we know a threshold of chest pain that is not as dramatic as he wants to pretend it was. And like I said --

Q Who wants to pretend it was?

A Dr. Kassamali. Because in his own deposition he testified that this patient had

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chest pain during strenuous activity. There is no evidence that he was involved in strenuous activity. The information suggests the otherwise, that it wasn't so strenuous.

That's his testimony. He doesn't write strenuous in his note and he doesn't describe the other episodes and he doesn't account for the Q waves in terms of the implications that I have well discussed today and, like I said, the reason why that information is important is because it would determine the timeframe by which you act, not simply the choices you make. So he got a stress test.

And, by the way, and this wasn't discussed in his deposition, but it's very interesting to recognize that in 2010 this patient was sent for an exercise stress test. An exercise stress test is important in terms of determining what workload provokes the ischemia. So when you exercise you get a metric of how much work it did. But in 2015 he ordered a chemical stress test.

Now, chemical stress tests are

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done for people who are either too impaired to exercise like somebody with the need for a hip operation who can't walk on a treadmill with an orthopedic limitation or for patients who are at too great a risk to exercise and legitimately aortic valve stenosis is dangerous to exercise.

So his choice of a chemical stress test has two implications. That test did not provide any metric of how much work it took to provoke ischemia, but it did provoke large ischemia. But that stress test, the fact that he chose a chemical stress test certainly indicates which I would agree with is that exercise even at low levels could be dangerous for this patient with presumed coronary disease and aortic valve disease.

Q So I take it you agree that, I understand you disagree with the timing, but I take it that you agree that between a chemical and an exercise induced stress test that the safer more reasonable approach was the one taken by Dr. Kassamali in opting for the chemical stress test?

A Yes. But the only reason why it's

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safer is concern that a person might be in danger at reasonable activity levels.

Q I understand, but you agree that the chemical stress test was the appropriate way of doing a stress test?

A Yes. And the chemical stress test proved the point.

Q Okay.

A However, when he got the echocardiogram and saw that this patient had severe aortic stenosis he is going to require a catheterization anyway because chest pain with aortic stenosis is an absolute indication for aortic valve replacement and he would need a coronary angiogram anyway. But that said the stress test provides some information.

Q It was not unreasonable to get the chemical stress test. You just believe that the timing was unreasonable with respect to that particular test; correct?

A Well, that is one of my opinions.

Q I know, but that's the one I am asking you about at this point.

A Yes.

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Q Now, let's get back to September. So when the doctor saw and evaluated Mr. Mardaga in September of 2015 what did the standard of care require him to do upon completion of his evaluation on that date?

MR. SNYDER: What's the date?

MS. KASLICK: September of 2015 when he came in for his office visit.

A That would be September 10th. On September 10, 2015 --

MS. KASLICK: 0The one that we were talking about, that first visit.

A I'm in the middle of my answer.

Q I just wanted to make it clear to Mr. Snyder which one we are talking about.

A The standard of care required him to tell Mr. Mardaga that based on his physical exam his aortic stenosis was probably worse.

To tell him that given the circumstance of his valve disease and potential coronary disease and potential recent heart

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attack that it was near certain that he was going to need surgery, but not absolutely certain and that he needed an expedited workup within 48 hours. To keep his activity limited to the slowest day-to-day, assuming by the way that he is not getting chest pain walking around his house in which case he would have to be hospitalized. But if he doesn't get symptoms walking around his house, he could do that, but nothing more than that. Get his echo near immediately, within 42 hours or 72 hours at most get a stress test and then hospitalize him shortly after that for valve replacement surgery -- for an angiogram leading to open heart surgery.

Q Hold on. Let me evaluate, let me ask you some clarification with respect to that.

You made mention of getting an echo and getting the stress test?

A Right. Although the echo would have obviated the need for a stress test, but I don't object to the stress test.

Q All right. Do they have to be done in a particular order in order to comply

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with the standards of care?

A Yes. You would never get a stress test before an echo because you want to know the structure of the heart. Quite frankly the echocardiogram showing an aortic valve that was 0.8 centimeter squared which is severe would make it too dangerous to exercise him which further indicates it's too dangerous for him to walk around the house too much.

So basically, if you factor in the potential new heart attack and the potential for post-MI angina after that echo you would hospitalize him. But if you within a very short period get a stress test and admit him that's okay.

Q Okay. That's where I wanted to go back to your response because you said 48 to 72 hours. First you said 48 hours and then you said 48 to 72 hours and I wasn't sure whether you were talking to 48 to 72 hours with respect to the echo or not.

A Okay. I'm saying both tests should be done within that period. I was accounting for the fact that a Friday you could

wait to Monday if he takes it easy. That's only true, the only thing that would not have him to be admitted to the hospital immediately would be absolutely certainty that he is comfortable with no symptoms or potential symptom walking around the house at the bare minimum of day-to-day activities. If anything suggested that he had chest pain at a low level he would have to be hospitalized.

Q Okay. Let me ask you this. Why in light of what you reference as the violations of the standards of care at that September, 2015 visit was this not an emergent situation for that further testing evaluation as opposed to an urgent situation?

A Because I don't have the information about the spectrum of his chest pain. I have no idea what the other episodes of chest pain were occurring. When, how often, what levels of activity.

He only highlighted the most extreme example which we now know was sitting on a self-propelled lawnmower that he sat on. We don't know what the levels of activity were of

the other pain.

It's certainly strong potential that he needed to be hospitalized right from that office visit depending on what the pain was. And with the new onset heart attack you would not be faulted for sending him to the emergency room anyway, but it would depend on his pain.

(A short recess was taken at this time.)

(The deposition resumed with all parties present.)

B R U C E C H A R A S H, M.D., resumed, and testified further as follows:

BY MS. KASLICK:

Q Doctor, I believe your testimony was that within 48 to 72 hours Dr. Kassamali would have had to have accomplished the testing that he eventually did with the echo and the chemical stress test, and if that had been done within that time period do you have an opinion as to what the next step would have been reasonably?

A Yes.

Q What?

A Based on the distinction I've already made about more information about his symptoms, the more you are reassured the more it can wait, but within 48 hours admit him for catheterization.

Q Okay.

A And remain in for surgery.

Q Let me make sure I understand this. If testing had been done on an out-patient basis within the 48 to 72 hours and the testing I'm talking about is 0the testing that was actually ordered by Dr. Kassamali, after that are you saying that catheterization within 48 hours of completing that testing would have been required for the standards of care?

MR. SNYDER: Objection.

A Yes.

Q Okay.

A That's assuming he was on the more stable side of how low threshold his angina was. But time is his enemy. He has aortic stenosis and potentially significant coronary artery

disease, potential recent heart attack.

The standard of care would have permitted him being admitted directly from the office on the September 10, 2015 visit. If his symptoms were more defined and more worrisome it would have required it.

If his symptoms were less worrisome the standard of care would have permitted him to have out-patient testing within 72 hours and then within 48 hours later admit him to the hospital for catheterization and repair.

Q But even if the symptoms were less worrisome the timeframe could not have been more than 72 hours to complete that testing?

A Correct. Based on three reasons. The Q waves suggesting an unrecognized heart attack as an out-patient and that means the failure to have appropriate symptoms. Two, his aortic stenosis which compounds the coronary disease and is life-threatening and, three, based on the history that clearly his chest pain was not being provoked by heavy exertion.

There is no way to discern from

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his note there was indeed heavy exertion going on given that he primarily talks about mowing the lawn and this was a lawnmower he sat on. And his clear recollection that that was the most extreme pain which means we have no idea about the threshold before it. And given any question about this man's threshold of pain time is only his enemy.

His aortic stenosis once it was documented on his echocardiogram to be as severe as it was meant that he absolutely was going to have surgery no matter what they found and on cath, no matter what they found. And as a result there is no benefit to this patient waiting and only threat.

Q Okay.

A So the timeframe I have given you is the latest you could do assuming that what I'm worried about his anginal threshold, whatever that range is at best it had to be done quickly, at worst it had to be done urgently.

Q What actually caused his death in this case?

A He died of sudden cardiac death.

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Q But do you have an opinion based upon a reasonable degree of medical probability as what the actual mechanism was that caused his sudden cardiac death?

A Most likely an arrhythmia from his coronary disease and aortic stenosis.

Q And how was it that an arrhythmia was caused by his coronary artery disease and his stenosis?

A Well, coronary disease is the most frequent trigger for sudden death, but that threshold is lowered because left ventricle is under tremendous pressure with aortic stenosis.

That means the wall tension is significantly higher. That means the myocardial oxygen demand is always higher. It also means with those higher pressures that coronary artery delivery is reduced even with healthy arteries. So the magnitude of threat from any level of coronary disease is dramatically enhanced when you have severe aortic stenosis.

Q You said that no matter what the cath found Mr. Mardaga was going to need surgery. What surgery was he going to need?

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A An aortic valve replacement with or without bypass surgery depending on the arteries.

Q On an urgent or emergent basis?

A Urgent or emergent depending on the facts that are not known.

Q Well, is there enough information from the testing itself to discern whether it should be done, an I mean the aortic valve replacement on an urgent or emergent basis?

A No. Basically it should be done within a week if the symptoms are on the better side of what we know and he should have been hospitalized immediately if it was on the worse side of facts that we don't know, but we don't know.

Q So when you said on the better side of the facts that we don't know what does the better side mean at the point after he had had the echo and the medical stress test?

A Well, with the echo and the stress test showing the large amount of ischemia and the ischemia being in the area where the Q waves developed indicating he probably has post-MI

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angina I already said he had to be admitted within 48 hours.

Now, if he is having any difficulty with his walking around the house, and again I gave you the timeline of test, he should have been admitted right from the echo or right from the stress test. But if he is actually walking around at the minimum of day-to-day activities with absolutely no hint of a symptom 48 hours after that test he should have had the cath scheduled and brought in.

Q Any other ways in which you feel that Dr. Kassamali violated the standards of care?

A Well, to the degree that, this will be for the jury to determine, but to the degree he did not inform the patient that he had a potential recent heart attack, to the degree that he did not inform the patient that the aortic stenosis is an independently life-threatening disease that requires surgery, to the degree he didn't provide him with any of the information he needed to have an urgent procedure he was deviating from the standard of

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care.

Although in terms of direct action he did not accelerate this to the appropriate level and this patient would have been alive if he went for surgery.

Q Any other ways in which he violated the standards of care?

A No.

Q Is there a threshold at which aortic stenosis is required to be surgically addressed?

A Well, it's not a simple answer, but a normal aortic valve the functional surface area is about two and a half centimeters squared. When it falls under two centimeters we consider that clinical aortic stenosis, but generally the closer you get to one centimeter squared the more concerning it is.

When it's under one centimeter squared it universally means the person is going to need surgery. Now, in certain cases you could delay that for a little time if they are totally stable. We used to look at symptoms of chest pain, shortness of breath or loss of

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consciousness as the absolute trigger once the aortic valve reached a centimeter and he was having chest pain with an aortic valve under one centimeter, but in relatively active patients who are not extremely old or extremely young we now recognized that when you fall under a centimeter squared it takes very little to require urgent surgery. But there is a range in that area.

But once someone has chest pain, a potential recent new heart attack and their valve is 0.8 centimeters squared that's absolutely going to be a need for surgery.

Q Is that true even if the chest pain is consistent with unstable angina as it would be for stable angina?

A Yes. You're going to have to remove that valve.

Q And I meant to say that in reverse. That's true with stable angina, right, in your opinion?

A Yes.

Q You said you would have to remove that valve. Earlier you said under some

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circumstances you could delay a little bit. What's the little bit?

A It depends on the person's activity level. If somebody is elderly, more infirmed and you don't want to operate you could watch and wait to try and optimize it. But generally most aortic valves, 99 percent of them that are .8 centimeter squared are going to be operated on if the patient is otherwise healthy.

But again if somebody found it actually on an echo, say you go to a doctor, you're 60 and he hears a murmur and you feel well and they get an echo and you have a .8 centimeter valve I would instruct the patient and the standard of care would require you to state look, you can't do extreme activity. It's too dangerous. If your life requires it you need your valve replaced now. If you have a sedentary life you are almost certainly going to need your valve replaced soon, but you could plan for it.

Q Within what timeframe?

A Months as long as they are not active. But if they have symptoms immediately

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meaning within days.

Q Have you been asked to offer an opinion with respect to what Mr. Mardaga's life expectancy would have been if, in fact, there had not been violations of the standards of care as you have suggested?

A Yes.

Q What is it?

A It would have been near normal by life tables and that requires an explanation.

A 60 year old American male will have a life table number for the average life expectancy. Let's assume it's between 20 and 25 years. I don't know the number, but it will be between 20 and 25 years. Once you make it to 60 the average life expectancy is in the young 80's. Let's work with 20 years.

That 20-year life expectancy is the peak of a bell curve, the average patient. You don't start with healthy patients and start deducting based on illness. If you look at the bell curve which focuses on 20 more years or whatever the number may be, there are three group of patients in that bell curve.

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Group 1 are completely healthy 60 year olds with no medical problems, in good shape and they are on the side of the bell curve that will go significantly longer than 20 years. That's the population most likely to make it into their late 80's, into their 90's or even over a hundred. In fact, today in the United States there are 62,000 Americans that are a hundred years old or older and that number is going to double in 20 years. He is not in Group 1. He's not going to go well beyond the average population.

Group 3 patients are the worst end of the bell curve. 60 year olds with massive end organ failure, malignancies or degenerative disease that have a grim five-year prognosis. And that's the poor end of the bell curve.

The center of the bell curve represent the population of patients who have chronic medical conditions that need management. That's the average 60 year old. High cholesterol, diabetes, coronary disease, valve disease. All of his problems were manageable. None of them were immediately life-threatening.

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And, yes, aortic valve surgery is a big deal and if he got a mechanical valve he would need anticoagulation, but in terms of seriously jeopardizing his average life table life expectancy his other organs were working. He had no major end organ failure. So his prognosis would have actually been the average, average because he is the average, average, a man with medical problems that need careful attention. And the fact that he had resources to be seen by appropriate health care providers and have the appropriate treatments meant he would have been reflected by the average.

Q I think you said at the beginning of that response that he would have near normal life expectancy by the life tables and I think by the end of the response my understanding of what you're saying is that he would have the number that is reflected on the life tables.

A Right. Plus or minus three to five years because no one can be that exact. So I would say at worst he would be five years less than the average for the life tables, but he probably would be somewhere in between.

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Q What conditions have an impact on that answer?

A Postoperative course.

Q That's all?

A Well, yeah, whether he gets other organ failure, how he does. That would be the main one.

Q Any others?

A No.

Q Any other issues you have been asked to address by Mr. Snyder?

A No.

MS. KASLICK: Okay. I don't have anything else. Thank you.

MR. SNYDER: I have no questions.

MS. KASLICK: And, Doctor, would you like to read and sign?

THE WITNESS: Yes.

MS. KASLICK: All right. Just for the record before we go off marked as 1A and 1B, 1A is trial list provided by the doctor and 1B is the deposition list provided by

Charash, M.D.

the doctor.

(Trial list was marked as Deposition Exhibit No. 1A for identification, as of this date.)

(Deposition list was marked as Deposition Exhibit No. 1B for identification, as of this date.)

BY MS. KASLICK:

Q And before you go, Doctor, I just want a clarification on the list itself.

Is Column C the name of one of the parties in each of the cases?

A If you look at the top it says case. That's the name of the plaintiff.

Q The name of the plaintiff?

A Regardless of what side I'm on.

Q All right. The list itself does not distinguish then whether you were testifying for the plaintiff or the defendant; correct?

A Yes.

Q Have you ever testified in the State of Maryland for a defendant physician or health care provider?

A No.

Charash, M.D.

Q In what states have you testified at trial on behalf of a defendant doctor or health care provider?

A New York, Florida, Illinois, Massachusetts.

Q Okay. I'm going to hand you 1A and I'm going to harken you back to the beginning of the deposition. You said that there had been a case in Maryland you believe that you testified in last year. I think I can probably figure it out which one. Is that the Wais Vogelstein case?

A Yes.

MS. KASLICK: Okay. All right. I don't have anything further. Thank you.

MR. SNYDER: No questions.

MS. KASLICK: I would like an E-Tran, please. And you know what, Doctor, I'm going to need Tina to at least make copies.

THE WITNESS: She'll send them back to me.

MS. KASLICK: And send them back to me. So I'll need PDF with the exhibits. And make sure they are in color, okay because the your highlighting is in color.

MR. SNYDER: Condensed E-Tran by e-mail, PDF.

(Whereupon, at 11:58 o'clock a.m., the deposition was concluded.)

CAPTION

The Deposition of BRUCE CHARASH, M.D., taken in the matter, on the date, and at the time and place set out on the title page hereof.

It was requested that the deposition be taken by the reporter and that same be reduced to typewritten form.

The Deponent will read and sign the transcript of said deposition.

CERTIFICATE

STATE OF_____:
COUNTY/CITY OF_____:

Before me, this day, personally appeared BRUCE CHARASH, M.D., who, being duly sworn, states that the foregoing transcript of his/her Deposition, taken in the matter, on the date, and at the time and place set out on the title page hereof, constitutes a true and accurate transcript of said deposition.

_____
BRUCE CHARASH, M.D.

SUBSCRIBED and SWORN to before me this_____

day of _____, 2017, in the jurisdiction aforesaid.

_____ _____
My Commission Expires Notary Public

DEPOSITION ERRATA SHEET

RE:
FILE NO.
CASE CAPTION: KATHERINE MARIE PETTWAY, et al. vs.
HASSAN KASSAMALI, M.D., et al.
DEPONENT: BRUCE CHARASH, M.D.
DEPOSITION DATE: JANUARY 27, 2017

To the Reporter:
I have read the entire transcript of my Deposition taken in the captioned matter or the same has been read to me. I request for the following changes be entered upon the record for the reasons indicated.
I have signed my name to the Errata Sheet and the appropriate Certificate and authorize you to attach both to the original transcript.

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SIGNATURE:_____ DATE:_____
BRUCE CHARASH, M.D.

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EXHIBITS

CERTIFICATE

STATE OF NEW YORK)
) ss.
COUNTY OF NEW YORK)

I, TINA DeROSA, a Shorthand (Stenotype) Reporter and Notary Public of the State of New York, do hereby certify that the foregoing Deposition, of the witness, BRUCE CHARASH, M.D., taken at the time and place aforesaid, is a true and correct transcription of my shorthand notes.

I further certify that I am neither counsel for nor related to any party to said action, nor in any wise interested in the result or outcome thereof.

IN WITNESS WHEREOF, I have hereunto set my hand this 3rd day of February, 2017.

_____
TINA DeROSA