Page 1

IN THE CIRCUIT COURT OF UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
EASTERN DIVISION

----------x
LATISA [redacted] as Administratrix
of the estate of MILDRED [redacted]
deceased,

Plaintiff,

vs. CASE NO.
[redacted]

JOHN W. MITCHELL, M.D., and THE
HEART CENTER CARDIOLOGY, P.C.,

Defendants.

----------x

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 Wednesday, November 29, 2017, commencing at 9:00 o'clock a.m., before Tina DeRosa, a Shorthand (Stenotype) Reporter and Notary Public within and for the State of New York.

Page 2

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

PHILIPS BRANCH & HODGES
Attorneys for Plaintiff
105 13th Street
Columbus, Georgia 31901
BY: JASON BRANCH, Esq.

STARNES DAVIS FLORIE LLP
Attorneys for Defendants
Seventh Floor, 100 Brookwood Place
Birmingham, Alabama 35259-8512
BY: MICHAEL K. WRIGHT, Esq.

Page 3

I N D E X

E X H I B I T S

Page 4

B R U C E C H A R A S H, 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 MR. WRIGHT:

Q Good morning, Dr. Charash. Am I pronouncing your name correctly?

A Yes, sir.

Q All right. We met prior to the deposition. As you know my name is Mike Wright and I represent the Defendants in this case.

I want to kind of not take up too much of your time unnecessarily. Tell me when you were first contacted in connection with this case and feel free to refer to anything that you need to?

A Yes. I brought a copy of all my invoices that I have submitted in this case.

Q All right.

A And the first invoice I have is from March 4, 2015. I can't tell you exactly when I received the file, but it most likely would have been somewhere in February of 2015.

Q And the source of that contact would

Page 5

have been what?
A It could have been a phone call or an e-mail or in some cases I just get a file with a letter to review. I just don't recall and I don't have saved e-mails so I don't know.
THE REPORTER: Excuse me. I need to go off the record.
(Whereupon, a short recess was taken.)
(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:
(Compilation of invoices were marked as Exhibit No. 1 for identification, as of this date.)
Q So to catch us up, Dr. Charash, you've handed me a compilation of invoices on the case which I have marked with a sticker as Exhibit 1, and I think you told me before we had the machine malfunction that you thought you would have been contacted somewhere in the vicinity of February of 2015?
A Correct.
Q All right. And you did not recall the

Page 6

source of that contact, whether phone, letter or e-mail; is that accurate?
A Equally true.
Q All right. Now, can you tell me who it was by whatever media you were contacted, who it was that contacted you?
A No. I just have no memory of the contact.
Q All right. And you have no record of it?
A Correct.
Q So you don't know whether it was Jason or someone from his firm or someone acting on behalf of the firm that might not have been employed by the firm.
Am I right about all of that?
A Well, I think it was someone from his firm. I don't know whether or not, and again because I do receive cases in various ways, Mr. Branch may have called me. Mr. Branch may have written me a letter, an associate or an employee of Mr. Branch may have made the contact. I don't recall.
Q Have you worked with him or his firm previously?

Page 7

A I have.
Q On how many occasions?
A I don't know, a handful. Three, four, five maybe.
Q Have you ever testified in court for them?
A I don't recall. Have I?
MR. BRANCH: No.
A I don't think so.
Q All right. Have you given depositions previously?
A I think once. I don't recall the case.
Q All right. Do you know how Jason or his firm first, I'm talking about prior to this case, came to know of your availability to review medical/legal cases and to testify?
A No.
Q How long or, excuse me, over what period of time have you been doing work with him?
A With who?
Q Jason or his firm.
A Mr. Branch's firm, I don't know, five, six years perhaps. I don't recall.
Q All right. And all together how many

Page 8

cases do you think you have had?
A Maybe three.
Q All right. Are those included on any list that you have provided in connection with this case?
A I don't think so.
Q Do you have an updated list that is more recent than the one that was provided with the Rule 26 information we received on you in this case?
A No, I do not.
Q What would it take in terms of an effort on your part to update your list?
A It is pretty updated.
Q Well, if it doesn't include the three cases you have had with them for the past --
A Those lists are testimony lists.
Q Maybe I misunderstood that you had given at least one deposition for him?
A I may have. I don't remember.
With all due respect, I just want to be clear, I am not trying to be difficult with you. I truly just don't remember.
I have reviewed in my career 900 medical malpractice cases over a period of 30 years, but over the same period of time I may have

Page 9

interacted with 50,000 patients and the way my memory works I need something to trigger it. So I'm not trying to be disrespectful or evasive. I just don't recall.

Q I am only asking the questions the only way I know how.

A No. No. I'm just telling you I just don't remember. I'm sure Mr. Branch's firm can provide more updated information than I can.

Q Okay. Maybe we'll ask him about that at a later point.

So in connection with this case what is your first substantive memory of any communication?

A I only remember our recent meeting on Monday to discuss my final opinions. I mean I know I consulted with Mr. Branch about my report. I know I have discussed the information as it became available. I know that as I reviewed the depositions of the Defendants we had discussions, but quite frankly I don't have a recollection of dates or what we said and because my opinions are based on the sum of all the information it's difficult for me to parse back when I had partial information.

Page 10

Q Was the lawsuit already filed by the time that you were contacted or had it yet to be filed?

A I don't know.

Q Have you been provided with a copy of the Complaint?

A I don't know. I don't have it. So I --

Q What have you brought here today?

A Most of my records were sent to me electronically. So I could not print it all out. We could forward you a disk afterward.

I brought with me my written report. I brought the Georgia death certificate report. Provided to me on Monday when Mr. Branch came to my home is a handwritten note from Tim Parker concerning the catheterization schedule.

And then I have a series of medical records from Dr. Mitchell's office and then I have the depositions of Dr. Mitchell and Mr. Parker.

Q All right. Now, when you say a series of medical records from Dr. Mitchell's office, are you referring to what you understand to be his complete office chart or are those excerpts?

A I have his complete office chart. I don't know if I printed out the entire office chart.

Page 11

Q Okay. Are these document that you printed yourself or that were provided to you?

A No, totally printed. Everything was sent to me by Dropbox.

Q Right.

A Or by e-mail.

Q Well, the note regarding the phone calls that you just showed you said was provided to you on Monday. Was that an e-mail or was that --

A No. We met in person.

Q That's what I understood.

A And we discussed the case.

Q Anything else provided to you by Jason as of Monday that you did not have prior to Monday?

MR. BRANCH: Just to clarify, when I handed it to him Monday we were in a meeting. It was easier for me to hand me a copy. It's a copy of the chart that you all provided with you all's Bates stamps on there.

MR. WRIGHT: Yes.

MR. BRANCH: So you were saying is there anything you hadn't been provided before.

Page 12

Q Well, I thought he testified that he saw that for the first time on Monday. Am I mistaken about that?

A Well, I guess it was highlighted to me on Monday. I probably had seen it, but it became a point of our conversation.

Q It wasn't something that you had discussed specifically prior to Monday; is that fair?

A Probably.

Q All right. Now, the materials that you have reviewed in connection with this case I think you just told me included what you understand to be the complete chart of Dr. Mitchell, his deposition, Mr. Parker's deposition, and what else?

A I think it's in my report. Let me see what I reviewed. The depositions of Dr. Mitchell and Parker. Dr. Mitchell's records and The Heart Center. The records of Dr. Solt. East Alabama Medical Center. The multiple reports of testing that Ms. [redacted] underwent.

Q Those would be part of the East Alabama records; would they not?

A Yes. I think that's it.

Q Okay. Now, other than this report

Page 13

that we have received have you had any other substantive written communications with Mr. Branch or his firm about the case?
A No.
Q Any drafts of the report that were revised or anything of that sort?
A No.
Q Who wrote the report?
A It was a combination effort. I had a thorough conversation about my opinions with Mr. Branch. He then provided me a draft in Word documents.
I don't recall to what degree I would have personalized the report or whether or not his draft effectively -- for the most part of the draft was very effective in outlining the opinions that I expressed.
Q But he wrote it and you confirmed that it comported with the opinions you had expressed?
A Yes. And I may have made some individualization to it, but I cannot recall.
Q Are you aware of any other experts in the field of cardiology who are involved in this case?
A No.

Page 14

Q Retained by Mr. Branch or his firm?
A No.
Q So you haven't been shown any other reports that might be pretty much identical to your report?
A Correct.
Q Or even different from your report. You haven't seen any other reports is what I'm understanding.
A Correct.
Q All right. You as I understand are a cardiologist; is that correct?
A Yes.
Q You are not an interventional cardiologist; are you?
A Correct.
Q You've never performed an interventional procedures; have you?
A Correct.
Q You are also not a cardiovascular surgeon?
A Correct.
Q Not a, if there is the difference, I think there is, a cardiothoracic surgeon?
A Correct.

Page 15

Q And not a pathologist and not a pulmonologist?
A All correct.
Q Those are all specialties that are distinct from your practice; is that fair?
A That's not completely fair.
Q Well, I don't want to be unfair.
A There's a lot of overlap. There are doctors who perform procedures, open heart surgeons or interventional cardiologists. They wear two hats. I wear one of those hats with them. One hat, this is a fair metaphor using hats.
Q I understand.
A Is the actual procedural involvement they engaged in, engaging in the catheterization, the mechanics of doing it and the mechanics of doing angioplasty or any other form of invasive work, to that degree I am not qualified to make comment. But the other hat that they wear common to me is decision-making about a patient's clinical status and how to utilize potentially invasive procedures. To that degree we have absolute day-to-day common practice.
Q The ultimate decision on whether to perform an interventional procedure, the nature of

Page 16

that procedure and the extent of it ultimately rests with the interventional cardiologists; doesn't it?
A To the degree that if an interventional cardiologist was unable to or unwilling to do a procedure there is the option of getting another one.
Q Right. But it would be an interventional cardiologist who would decide whether it need to be done ultimately, how it should be done, if it should be done and what areas should be treated, if any?
A Again, to a degree in consultation. Now, again, Dr. Mitchell wore both hats.
Q These both hats, we're talking about specialties and subspecialties; right?
A What I'm saying is that most people that get referred for catheterization are referred from non-interventional doctors because there are more clinical cardiologists than there are interventional cardiologists and interventional cardiologists are doing interventions which means they are having less patient time.
So the majority of people who get referred for a cardiac catheterization and potential management invasively are referred from doctors like

Page 17

myself.
Dr. Mitchell also served even though is an interventional doctor in the position of a clinical doctor. I'm only going to offer opinions in that clinical arena.
Q I understand. And just so we're clear and I really didn't mean to make this too difficult of an exercise for you or for me, the subspecialties that I outlined are areas of expertise in areas of practice that you do not have and that you do not follow?
A Correct.
Q Okay. Now, with regard to Ms. [redacted] the patient involved in this case, do you understand that she had some significant comorbidities?
A Yes.
Q What was her weight?
A By memory I don't know. I could look it up.
Q I don't think there would be any dispute.
A She was obese.
Q She was morbidly obese; wasn't she.
A Yes, but I don't recall.
Q She had, I don't think we'll have any

Page 18

dispute about this, coronary artery disease clearly; did she not?
A Yes.
Q She had a prior PCI with a stent placement. I believe initially was it the left circumflex?
A The first procedure was in 2007 before she saw Dr. Mitchell.
Q Right. West Georgia?
A Yes.
Q And then had she had -- excuse me. Did she also suffer from chronic hypertension, systemic hypertension?
A Yes.
Q Diabetes mellitus?
A Yes.
Q Obstructive sleep apnea for which she was prescribed the CPAP therapy?
A Yes.
Q Hyperthyroidism?
A Yes.
Q Dyslipidemia?
A Yes.
Q She was noted in several places to be a person with a sedentary lifestyle; was she not?

Page 19

A Correct.
Q And it may be my mistake. I'm reading this as different from stent placement, but did she have angioplasty of the obtuse marginal coronary artery and proximal mid-right coronary artery prior to her bypass grafting in 2009?
A Yes.
Q Okay. And is that different from stent placement?
A An angioplasty is using a balloon or a device to open up an artery. A stent is just the spring you leave behind to keep the artery open.
Q Okay.
A So an angioplasty/stent procedure was performed in two arteries. Eventually because of their shutdown she underwent a bypass.
Q Right. Three vessels bypass; was it not?
A Yes.
Q Now, do you know anything about the decision-making she had relative to the timing of the scheduling of that bypass surgery. Was there anything significant to you about that?
A Again I don't know if I understand what you're asking me. I know the timing of the

Page 20

procedure, but I don't know what you're asking me.
Q When was it done?
A Her bypass operation was performed on January 12, 2011.
Q 2011?
A Yes.
Q Okay.
A Or 2010.
Q 2010 was it not?
A Yes. I wrote my ten poorly.
Q 2010?
A Right.
Q All right. Now, I also saw on some studies that she had a tricuspid valve disorder which was I think thought to be not uncommon for her age; is that correct?
A Yes. She had mild tricuspid regurgitation.
Q And she suffered also from peripheral vascular disease; did she not?
A Yes.
Q Okay. Any other significant comorbidities that she had that I have not asked you about that you know of?
A No.

Page 21

Q All right. Talk to me for just a minute about your charges for doing this kind of work, Dr. Charash. What do you charge for reviewing records presently?

A Since 2015 my rates have been $450 an hour for review of records and $500 an hour for testimony time.

For trial it's purely based on how many hours of work I miss on a 9:00 to 5:00 schedule. So if I were to fly down for travel after work hours to testify the next morning and come back for the night I would only miss eight hours of work, so I charge $4,000.

Q Okay.

A For a deposition it's 500 an hour with a two-hour minimum unless I'm told in advance that the deposition will be short.

Q All right. And you showed me your invoices. I'm going to hand them back to you. I did not do any calculations myself.

How many hours would you say you have in the case up to the point of today's exercise?

A Well, there are reflected in these invoices up until October 9th six and a half hours and there will be another two and a half to three

Page 22

hours for our meeting and my preparation.

Q Okay. And then whatever time you and I are spending today is charged at $500 an hour with at least a two-hour minimum?

A Right. Which that invoice will be forwarded to you.

Q But the charge for trial as I understand it is essentially $4,000 a day for each day that you would be away from your work?

A Correct. But if, for example, Mr. Branch wanted me down to meet at 6:00 p.m. and I had to leave for the airport at 2:00 p.m., then I would charge for three hours of work.

It's all based on how many hours during workdays from 9:00 to 5:00 the trial consumes.

Q Of your time?

A Yes, of my missing work, how many 9:00 to 5:00 hours I miss.

Q Now, what would you tell me is the amount or the approximate amount of income that you have earned doing this type of work over, say, the last five years?

A Five years?

Q Sure.

Page 23

A I think it's probably averaged $60,000 a year, so it could be $300,000.

Q And from the time that, over the time that you have been doing this work have you made over a million dollars?

A Probably. You know, again, I'm asked this all the time.

Q I understand.

A But probably.

Q How many cases would you say you've, you alluded to this earlier. I think you said over 900 cases you have taken on for review?

A Yes.

Q Can you be more specific?

A No.

Q All right. Did you think it's probably by now as we sit here in late '17 closer to a thousand?

A No. I had in previous years given estimates and then as time went by I inflated those estimates because I thought it was better to over estimate than to under estimate.

So I would think that it would be under 950. Maybe under 930. I have not kept track, but I would say it's closer to 900 than it is to

Page 24

950.

Q You average giving depositions 20 or more a year; don't you?

A In recent years. But over the course of my career it's averaged 11 a year.

Q How many depositions have you given this year since we are almost to December?

A Probably my 14th. Maybe 15. I don't know.

Q When did you last testify before today?

A In deposition or trial?

Q Either one.

A Yesterday in trial.

Q Where was that?

A In Syracuse, New York.

Q Okay. And that was a medical negligence case?

A Yes, it was.

Q You were retained on behalf of the plaintiff?

A Yes, I was.

Q What was the name of that case?

A Merrill, M-E-R-R-I-L-L.

Q Against who?

Page 25

A A Dr. Caputo, C-A-P-U-T-O.
Q And Dr. Caputo was a cardiologist?
A An interventional cardiologist.
Q Was it a death case?
A Yes, it was.
Q Were you speaking to issues of interventional cardiology in that case?
A Only to areas of common overlap. I was speaking to what I believe his missing life-threatening problems on the angiogram images and we showed the angiogram to the jury and showed them what I found.
Q Do you perform catheterizations?
A I do not.
Q Have you ever performed a catheterization?
A Not outside my training in 1985, fellowship.
Q All right. You do not do diagnostic catheterizations, nor do you do interventional procedures; is that fair?
A Correct. But I have probably read over 20,000 angiograms in my career of my own patients.
Q You do conduct stress test or do you?

Page 26

A I do stress tests and stress echocardiograms in my office.
Q How many times have you testified at trial all together?
A Probably 230 times to 240 times in 30 years.
Q And the total number of depositions you would say you have given?
A 330 times.
Q Is that an estimate?
A Yes.
Q Okay. You provided us with some information that looks like you had given, let's see, according to what we were supplied in terms of your list between May of 2013 and March 7th of 2017, so a bit less than two years you had testified in 77 depositions?
A I'm sorry, over what period of time?
Q May 22nd of 2013.
A Yes.
Q Through and including March the 7th of 2017. So that would be, excuse me, four years, a little less than four years?
A You have to take off three because the first case appears as No. 4.

Page 27

Q I did. The last case appears as No. 80, so that's 77?
A Very good. Then you're accurate.
Q Okay. And those are just depositions?
A Yes.
Q According to the list?
A Yes.
Q And for trial testimony from approximately the same period?
A Four years.
Q Right. July through March, July of '13 through March of '17 it's 56 trial appearances; is that right?
A Yes.
Q Okay. And were all of these on behalf of the plaintiff?
A No. I don't distinguish plaintiff, defense. I have pretty much reasonably estimated that over 95 percent of my testimony for deposition and trial are for plaintiff and under five percent are for defense.
Q But the reality is in recent years it's a hundred percent plaintiff and zero for defense; isn't it?
A I wouldn't say in recent years. I did

Page 28

a trial for defense in New Jersey.
Q When was that?
A A few months ago in the summer.
Q What was the cause?
A I don't remember. I would have to pull out the records. But it is over 95 percent for plaintiff even though 15 percent of what I review come from defense firms for a number of reasons, kind of structural reasons less than five percent of my testimony is for defense.
Q If it was over the summer since this list stopped, this trial and deposition list stopped in March of 2017 it would not be on either of these lists; is that fair?
A True. I'm sure I could get you an updated list.
Q Right. I wish you would.
A Of course.
Q You can just convey to Jason and he will get it to me.
A Of course.
Q But I will be honest with you I was not able to find every deposition that you had given on the list, but the ones I was able to find I did not find any on behalf of the defendant.

Page 29

A Well, again, more than 95 percent of them are plaintiff. It's going to be much harder to find one.
Q All right. Well, when we say more than 95, in fairness would it be 99 percent?
A No. Probably 96, 97.
Q All right. When are you next scheduled to testify after today?
A I have a deposition scheduled somewhere in December here.
Q Here to be taken at this court reporting office?
A At this court reporting office, yes.
Q They are excellent court reporters. I'm not suggesting anything but just making a point about your familiarity with them. Is this a preference of yours?
A I have no input as to where the deposition is held.
Q Well, actually we were told you would prefer to do it here.
A I just suggested it as a place. I say it could be anywhere in Midtown. I's not the one that makes the decision.
Q I understand.

Page 30

A But I recommend this as a user friendly place, but I have been deposed in other places.
Q Sure.
A I am never the one who makes the decision, but I do recommend them as comfortable location.
Q You have testified here many times and you have familiarity with them?
A Yes. And it's easy for me to get here. So, therefore, if it was more remote I would have to discuss charging for travel time because if it was way downtown then I'm going to miss more work. I don't charge for travel to here.
Q Sure. And in making a presumption with respect to the handling of the transcript and things of that sort, your experience and familiarity with this court reporting firm is such that you have confidence in their abilities to get you what you need to sign off on?
A I'm not even sure I understand what that means.
Q Well, you sign your depositions; don't you?
A Not in all cases. Sometimes I waive.

Page 31

Q Okay.
A What I'm just saying is I have never had a bad experience at a court reporting agency anywhere else, but because this is very easy for me to travel to and because I know they are as reliable as anybody else I usually say this is a good location. And I advise lawyers who pick more remote locations that there is going to have to be a charge for my travel.
Q I'm not taking any issue with any of that. I was just trying to understand your familiarity with these people who do very excellent work.
A I'm very familiar because a lot of lawyers elect to come here.
Q All right. So moving forward, I apologize if this is repetitious, didn't make a note of it and if you answered it I don't remember, but did you tell me how many depositions -- maybe you said 330. Is that what you said?
A I did.
Q And then the number of trial appearances was what?
A 230.
Q 230.

Page 32

All right. So in the materials you brought here today I didn't see or hear you make any reference to any specific medical literature and may I take it that you have not done any specific medical literature research in this case. Rather you are testifying on the basis of your training, education, and experience; is that accurate?
A It is.
Q All right. And you do not intend to do any medical literature research relative to the issues involved in this case?
A Correct.
Q Okay. Now, another way of stating the same thing that is while I certainly respect your education, training, and experience, Dr. Charash, you are not pointing to any specific passage from the medical literature to buttress, relying on it to buttress or illustrate the points that you are making?
A Yes. And I would add to the fact that there cannot be a literature that would address this directly because there are no comparative studies of delaying someone's procedure to see if they die. I mean, so.
MR. WRIGHT: Well, I move to

Page 33

exclude that.
Q My question simply is you are not relying on any medical literature to illustrate, buttress or make a point. Rather you are relying on your own education, training, and experience in expressing the opinions you are giving me here today. Is that accurate?
A Yes, but it also includes a cumulative career of reading literature.
Q And I'm not suggesting otherwise. I'm trying to be specific as opposed to generalities.
A Then we are on the same page.
Q Now, you have, you have testified many times relative to defining the standard of care for cardiologists; haven't you?
A Yes.
Q And do you stand by the testimony that the standard of care for a practicing cardiologist consists of a range of reasonable and acceptable different diagnostic or treatment options depending on the circumstances presented by the patient. Do you stand by that?
A Well, if there is a range within the standard of care. Sometimes the standard of care doesn't have alternatives. Often it does. So when

Page 34

it does, yes, I stand by that.
Q All right. And to follow-up on that then, often as you just said there will be more than one acceptable or reasonable approach to the evaluation or treatment of a patient. That's true; isn't it?
A Yes.
Q Do you agree with me that so long as a physician is following a recognized and acceptable school of thought in his evaluation and treatment of a patient then by definition he or she is practicing within the standard of care?
A In general.
Q Sure.
A But if there is more than one option there is a duty to explain to the patient and let them have vital input into the option.
Q That's not what I asked you. I asked you do you agree that so long as a physician follows, and I will put it this way to make it easier for you.
Indeed, have you not testified that so long as a physician follows a recognized and acceptable school of thought and school of practice in his evaluation or treatment of a patient is he

Page 35

practicing within the standard of care. Do you agree with that or not?
A Okay. And I can't answer the question limited to a simple yes or no. Only from the point that it's not my language to say following a school of thought because school of thought sounds like it's a general ideology.
If the doctor picks an appropriate option within the standard of care then they are within the standard of care.
Q Fair enough.
A But saying following a school of thought sounds like a philosophy that isn't accounting for individual --
Q You certainly agree that in making treatment decisions for a patient a physician should call upon his or her education, training, and experience to meet the standard of care just as I think you have said you are doing here today; is that right?
A Of course.
Q All right. Has it been your experience that while there is much scientific agreement on a number of points in the field of cardiology there is also a great deal of controversy

Page 36

in the practice of cardiology on many other points?
A You would have to be more specific. There are always areas that require further definition.
I think there is more commonality than controversy, but we are always pushing the boundaries of new information and there become issues that require further investigation to understand the appropriate use.
Q You have had occasion where you have disagreed with colleagues in the past even though you and the colleague within whom you disagree have certainly the best of intentions for a patient?
A Yes.
Q And the mere fact that one cardiologist may prefer a specific method of treatment or workup of the patient whereas another equally qualified cardiologist may prefer a different method does not mean that either of them is practicing below the standard of care; does it?
A Well, you would have to be specific.
Q In general --
A Just because there is a disagreement doesn't prove one is outside the standard of care.
Q That's what I am getting at.

Page 37

Do we agree that the practice of medicine and, in particular, the practice of cardiology is not an exact science?
A Sometimes it is and sometimes it isn't. Parts of is are exact science, parts of it are not.
Q What do you mean by that?
A There are exact science to a great deal to the practice of cardiology.
Q Exact science?
A Yes. We do tests with known predictive values.
Q Wait a minute. You said predictive values?
A That's science.
Q It's not exact science; is it?
A It is exact science. If you are defining exact science as absolute certainty of outcome that's not what science is.
Q I very well know that. I want to make sure you and I agree on that point.
A So there are parts of cardiology that are an exact science and there are parts that are not.
Q All right. Do you agree with me that

Page 38

clinical judgment is an important part of every medical decision or made by a cardiologist for a patient?
A Sometimes there is no option other than one so judgement doesn't play a role, but as long as we agree that judgment is embracing decisions that are within the standard of care, yes.
Q All right. Do you agree that despite the best care and treatment by a physician there are unfortunate outcomes for patients more times than we would ever like to see?
A Well, I agree that practicing medicine within the standard of care at the highest levels cannot guarantee a good outcome. And one case that has a bad outcome is discouraging.
Q So I think you have testified before that a physician should not be held to a standard of guaranteeing the results of his efforts to workup, diagnose or treat the patient. Do you stand by that?
A Of course I do.
Q And do you feel that a physician should be judged on his care and treatment with regard to the facts and circumstances known to him at the time that he exercised judgment for the

Page 39

patient rather than in retrospect and hindsight on the basis of outcome?
A Yes, of course. Although retrospect and hindsight are critical in determining causation.
Q You come to the case, and I'm not saying this critically of you, but just as a matter of fact, you come to this case with the benefit of hindsight; don't you?
A Yes.
Q Have you had circumstances where you feel that even though your judgment, your evaluation, your care and treatment of a patient was reasonable and within the standard of care you nevertheless have been mistaken or incorrect in an assessment of a patient?
A I cannot answer the question the way you phrase it as a simple yes, no.
Q So there has never been a time that you feel you have made a mistake even though you were within the standard of care?
A Again, I cannot answer the question the way you phrase it limited to a simple yes, no.
Q Why?
A Because I'm not to sure what you mean by a mistake. For example, I have admitted patients

Page 40

to the hospital with very atypical chest pain and I have told them that based on the information available it sounds like it probably will not be cardiac, but the risk of it being cardiac is too great to ignore.
I have had patients undergo a stress test, they pass and I'm waiting for the nuclear and I say this is encouraging and I might say I think it's probably not your heart, but I followed procedure and then I discovered it was the heart.
Was I wrong, no. I was right that it was probably not the heart pretest, but the test proved me that it was cardiac.
Now, I don't call that a mistake because medicine is about procedure. Do patients sometimes die with all the appropriate care, of course. But if you're saying have I made a mistake, I'm not too sure what you mean by that.
Generally there is a reasonable range of procedural options to try and diagnose a patient. I have certainly at times told patients I thought they probably did or probably did not have heart disease and the outcome was different, but that wasn't a mistake. That was reasonable prediction with the information, but following through with the

Page 41

right testing comes up with the answer.
So I don't think I was wrong when I told the patient that I thought it was probably not his heart because it probably wasn't his heart, but then the testing proved it was.
Q So it probably was his heart and I'm not critical of you for the judgement, but what I'm trying to say is, and I don't know why we are having such a difficult time with this, Dr. Charash, the reality is that physicians have to make judgments and they can make reasonable judgements that are within the standard of care which might later be proven to be incorrect?
A I don't know what that means. I really don't.
Q All right. Fair enough. If you don't know what that means we'll move on.
A You could have had a bad outcome.
Q I haven't asked you a question right now, Dr. Charash.
MR. BRANCH: He tried to answer the question that you asked and you should let him finish.
MR. WRIGHT: Okay. Well, I want him to be responsive to the question.

Page 42

MR. BRANCH: He is trying his best to respond to your question.
MR. WRIGHT: I think he is trying at something. I'm not sure that last exercise was his best effort to answer the question.
Q Let me just ask you this. Can we agree that a physician and in particular a cardiologist can exercise a reasonable judgment which might later be proven to be incorrect, but given the reasonableness of his judgment that would not mean he breached the standard of care at the time that he exercised the judgement. Can we agree with that?
A I cannot answer the question the way you phrase it limited to a simple yes, no.
Q All right.
A Because every time you say exercises reasonable judgment, but made a mistake.
Q I didn't say mistake. I said incorrect.
A Well, I don't know how reasonable judgement could be incorrect.
Q Fair enough.
A You could get a bad outcome with

Page 43

reasonable decisions, I agree to that. But when you say they could do reasonable judgment that proved to be incorrect those are incompatible statements.
Q No, they're not.
A Well, then I don't understand your question.
Q Did you not just describe to me a situation where you made hypothetically a reasonable judgement that a patient's condition was not cardiac and subsequently it was determined that the patient's problems were cardiac in nature?
A Yes, but that wasn't a mistake because I --
Q I didn't use the word mistake.
A Then it wasn't wrong. I don't think it was wrong to say that pretesting I thought it was probably not going to be heart, but because the threat of heart disease was so great they needed to go through the procedure which proved it to be cardiac. That's not being wrong.
Q Now, you have been through this hundreds of times, haven't you, Doctor. This exercise on this kind of a question hundreds of times; haven't you?
A Yes.

Page 44

Q And you have admitted that physicians can exercise reasonable judgment even though those judgments are later shown to be incorrect and because those judgments were reasonable at the time they were exercised that physician practiced within the standard of care. You have testified to that; haven't you?
A No, not with the way you're saying that. I have testified with reasonable judgment there can be bad outcomes.
I don't think I can recall a time that I would have phrased the way you are because the way you are phrasing it makes no sense to me.
(Discussion off the record.)
(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 MR. WRIGHT:
Q Moving along then, Dr. Charash, have you, yourself, ever had the misfortune of being named as a defendant in a medical malpractice claim?
A Yes, once.

Page 45

Q And that, I think I read a little bit about that. That was long ago.
A Yes. And I was dropped when my deposition revealed that I had nothing to do with the patient's care.
Q All right. We have discussed I believe and I hope to your satisfaction all of Ms. [redacted] comorbidities; have we not?
A Yes.
Q And you understand that she had a history with Dr. Mitchell, your report said it dated back to 2008, but it might actually have dated back to 2007 or do you know?
A I'm not sure.
Q Okay. But in any event, in a general sense and not line and verse can you give us an overview of your impression of her experience with Dr. Mitchell prior to October 30th of 2014?
A What are you asking, to summarize the entirety of her medical course with him?
Q Is there anything that is of significance to you in her medical course with him beyond the simple statements that are made in your report?
A Well, I think that one element that

Page 46

isn't explicit although it's contained in the report is that if you look at the pattern Dr. Mitchell was aware that Ms. [redacted] was a patient with coronary disease that progressed and at different times needed diagnostic testing and then interventions. I think he was dutiful that, that regard.
After her intervention in 2007 she came back to him and if you look at the record on April 18, '08 she had a positive stress test and four days later he catheterized her.
If you look to December 7, '09 when she had a positive stress test related to complaints he performed a catheterization seven days later on December 14th.
When she returned in 2011 with symptoms that required a stress test she was found to have a positive stress test on April 6, 2011 and was catheterized on April 18th which was 12 days later.
Now, having reviewed the records I could not find evidence of her having rest discomfort during any of those visits, although some of them were relatively low activity provoked. But the point is that he catheterized her, you know, ranging from four to 12 days after the abnormal

Page 47

stress test.
So to me when she presented yet again with an abnormal stress test on November 4, 2014 at a time where she presented with discomfort at night, and I know there is going to be the jury to decide as to whether Dr. Mitchell --
Q Go ahead with your substance. You don't have to say that. We all understand that. Just go ahead.
A Well, I mean Dr. Mitchell said she had pain while lying down, although that's not established.
Clearly if there are other fact witness that know about when she had pain that might be important to know. But the point is that she was clearly having rest pain. That's as unstable as you get.
Yet in the previous examples she had been catheterized in a relatively timely manner and this time it stands out as very unusual that with a positive stress test, knowing that she has had a history of recurrent interventions and knowing that the only way to manage her is to maintain the integrity of her coronary arteries and that time provides no benefit and knowing that she came in

Page 48

with an unstable presentation it is somewhat astonishing that her catheterization was pushed forward to a month.
Now, there are aspects of Dr. Mitchell's testimony that are concerning to me, although not well-defined.
Q All right.
A Do you want me to continue or not?
Q Since it sounds like you are -- my question I was trying to limit it to the period prior to October 30, 2014. I apologize if that wasn't clear.
From having read your report and having listened to you here today it sounds to me like you have summarized the significant issues as you see them prior to October 30th of 2014; is that fair?
A Yes.
Q Okay. And what I'm hearing you say is that you see that fairly typically if there was a positive stress test within one week to two weeks after the stress test she was catheterized as you have outlined?
A Well, I actually specifically said from four to 12 days.

Page 49

Q Well, isn't that within one to two weeks. I mean the last time I checked 14 days was two weeks. So I'm counting 12 days is within two weeks, but more than one.
A I just think that being specific is better than shrouding it in generalization.
Q Okay.
A Four to 12 days he cathed her on the three previous times.
Q And you were also referring to this -- what was your understanding of the sequence for her intervention in 2007 relative to when she may have had an abnormal stress test?
A I don't know.
Q Okay. Or the sequence for her, you do understand, I didn't hear you mention it, but you do understand that she was actually referred for open heart surgery. That is coronary artery bypass grafting surgery as we discussed. That was performed in January of 2010; correct?
A Yes.
Q And what is your understanding of the sequence there relative to when she may have had an abnormal stress test her catheterization and then the surgery?

Page 50

A Well, her stress test was December 7th. She was catheterized a week later on the 14th.
Q Right.
A And basically a month later she underwent her bypass.
Q Okay. So the revascularization in that case was roughly six weeks from the time of the positive stress test; was it not?
A Well, actually closer to five weeks, but that said --
Q Fair enough.
A -- her symptoms did not appear highly unstable and once they had the roadmap of the angiogram to see her coronary anatomy then a decision could be made about the need for speed.
Q Okay. And as you said because she was not having continuous symptomatology the timing as far as the revascularization is appropriate as far as you're concerned?
A Well, I think that I would have to have testimony of the surgeon as to why they waited that long and what the medical circumstances were, so I have incomplete information.
There is no benefit to waiting unless there is a benefit to waiting. So, for example, if

Page 51

her kidneys reacted to contrast which I don't have record of and there was a medical reason to delay that may have changed the balance, but I don't have enough testimony.
But as of 2009 she was not presenting with rest symptoms and they catheterized her and saw the blockages and none of them seemed to be acute or urgently threatening.
Q Now, you made the comment earlier that Dr. Mitchell, I think you were referring to the October 30th presentation to his office, that Dr. Mitchell says she was having symptoms or pain when she was, quote, laying down, end quote.
Is that something you took from his testimony or is that something that is recorded in his record?
A No. His record only says pain at night. He doesn't fulfill his duty to explain it and, you know, in his deposition he basically acts like there is a medical shorthand he has for what it means. But when you are a doctor writing a note you have a duty to write a note that's clear to any other health care provider that must rely on your note.
He basically wrote down that she had

Page 52

pain at nighttime. And he even drew a conclusion that it was probably twice a week because he didn't write every day. He made unsubstantiated conclusions that make no sense.
MR. WRIGHT: I'm going to move to exclude as nonresponsive.
Q Did he record either by his testimony or in his record that she had this pain when she was laying down. I'm just asking that question.
A It's only in his testimony, not in his record.
Q All right. And are you conversant with specifically what he said about that in his testimony?
A Yes.
Q What did he say according to your memory?
A Well, I have the records here.
Q By the records you mean the deposition?
A Yes. He basically said that if he wrote at nighttime he assumed that it meant while lying in bed.
Q Okay.
A But of course that's a leap.

Page 53

Q All right. When she came on October the 30th of 2014 do you understand that her presentation there was basically a follow-up visit for an established patient?
A Well, she came in as a symptom driven visit of an established patient.
Q How long had it been since she had been there previously?
A I don't remember.
Q When was the last time she saw Dr. Solt prior to that visit?
A I don't remember.
Q Let me ask you this. Would it refresh your recollection that she was last seen by Dr. Mitchell the previous year in August or September of 2013?
A It doesn't refresh my recollection, but I accept it.
Q Okay. And when she came in do you understand that she was not complaining of any active symptoms that day?
A Which visit?
Q Fair enough. October the 30th, 2014.
A Correct.
Q Now, her past medical history was

Page 54

reviewed and recorded in the chart; was it not?
A Yes.
Q And she gave by history that she had been experiencing some chest pain, some tightness which tended to occur more often at night; right?
A Yes.
Q And that with exertion she had fatigue and severe dyspnea which is shortness of breath; am I right about that?
A Yes.
Q All right. Now, did you understand that either from the testimony or the record or both that she was not complaining of having these symptoms every night?
A It's not documented.
Q I'm asking you did you understand from the testimony or the record that she was not having these symptoms every night. Either you did or you didn't.
A Again, only from the testimony; not from the note.
Q All right. The symptoms that she described particularly what occurred if it was not occurring every night and would tend to occur more often at night are not typical for angina; aren't

Page 55

they?
A Of course they are. They would be typical for unstable angina. By the way, according to this note, she had symptoms not only at night, just more often at night.
Q I think that's what I said. Tends to occur more often at night.
A Right, but that means they didn't occur only at night.
Q I didn't suggest that they only occurred at night.
A So there are two aspects to assessing a symptom. One is how cardiac does the symptom sound based on the patient's construct. The other is if it is cardiac is it stable or unstable. So exertional predictable angina might sound very cardiac, but it sounds stable. If somebody is having unstable angina then there is a complete lack of predictability of when they have it and recurrent rest pain occurs.
So this is a woman who has known coronary disease, known recurrences who is complaining of tightness that's occurring, appears at rest, although that is not well-defined, more often at night, but clearly not only at night and

Page 56

she has severe shortness of breath with activity.
Given her known risk factor you would have to say this has enough cardiac concern you need to stress test her obviously, but also if it is cardiac it's highly unstable cardiac disease because it appears to be occurring at rest as opposed to the other episodes that did not seem to have the same level of as emergency.
MR. WRIGHT: Move to exclude as nonresponsive.
Q Did he note that she was noncompliant with her CPAP for her obstructive sleep apnea?
A Yes.
Q And did you see that there was notations even back in 2013 that she had been noncompliant with her CPAP?
A Yes.
Q All right. Now, given the, and I think we can agree since -- well, you may not be looking at it anymore. There is a typographical error that says and no sleep apnea on the second page of his report, although clearly he documented that she had obstructive sleep apnea on that page as well as the first page. You understand that; don't you?

Page 57

A Yes.
Q All right. Did you understand that -- well, I know you did that by this time she was of course a few years from her surgery, her open heart surgery and he documented that?
A Yes.
Q So the plan was to go ahead and get a stress echocardiogram, which you are not critical of that I know?
A Correct.
Q All right. Can decreased oxygen lead to shortness of breath and tightness in the chest?
A I'm sorry, I don't think I understand your question.
Q I apologize. It was poorly worded. If a patient is experiencing desaturations can that lead to shortness of breath and chest tightness?
A It could although it would depend on what the nature of the desaturation, but if your oxygen level drops low enough, sure.
Q All right. Did you understand that she was not complaining of chest pain with exertion?
A Right. She was limited by shortness of breath.

Page 58

Q No, I didn't ask you that. I asked you did you understand that she was not complaining of exertional chest pain and that's true; isn't it?
A Partially true. We don't have enough real definition of her symptoms, but it appears that her symptoms were primarily at rest and her activity was limited by severe breathing problems.
Q With exertion she had fatigue and dyspnea, but there was no history reported of exertional chest pain; was there?
A That's correct.
Q All right. Now, this record says and I'm really just pinpointing this for reference in the transcript, Dr. Charash, that she was five feet, six. Her weight was 265 and her BMI which stands for body mass index was 42.8; doesn't it?
A Yes.
Q And that by definition is morbid obesity?
A Yes.
Q All right. So the echo, the stress echo was scheduled for November the 4th according to the record and performed on that day; is that your understanding?
A Yes.

Page 59

Q And do you also understand that was performed at the East Alabama Medical Center facility where they do that under the supervision of a physician, not Dr. Mitchell?
A Yes.
Q Okay. Do you also understand that during the course of that stress echo there were no problems reported to Dr. Mitchell or anyone else in terms of any kind of acute problems that she may have experienced during the procedure?
A Correct.
Q Okay. Have you, yourself, and the things that you listed I did not hear you say that you had actually reviewed the stress echo films; have you?
A I don't believe so.
Q Okay. You have reviewed the report and I sort of took from reading your report that your opinions relative to the stress echo were based on the report itself; is that fair?
A Yes. And no one has challenged the validity of it.
Q The validity of the report?
A Yes.
Q So as far as you are concerned you

Page 60

take the report at face value as an accurate report; is that fair?
A Yes.
Q All right. Now, just looking at the report we see that Dr. Mitchell records that she had positive and it says S segment. Our understanding is that that's a typographical error and it should be ST segment changes with infusion. Is that how you read it?
A Yes.
Q Okay. She had typical angina with infusion which was described as some chest discomfort with the infusion of the Dobutamine and/or the Atropine; is that right?
A Yes.
Q All right. Her baseline echocardiogram showed a normal left ventricular size, normal left ventricular systolic contractility, and an ejection fraction at 60 percent; correct?
A Yes.
Q And that is a normal ejection fraction; isn't it?
A Yes.
Q Okay. Mild tricuspid regurgitation

Page 61

and mild pulmonic insufficiency, are those findings consistent with age in a patient like this?
A Yes.
Q Then he says after peak doses of Dobutamine the septum fails to thicken appropriately.
Now, as to the ST depressions, can ST depressions be caused in a patient who has chronic hypertension?
A Possibly.
Q If a patient has a right bundle branch block which is an underlying electrical abnormality, is it recognized that this can render ST changes less diagnostic and nonspecific for ischemia?
A No.
Q That's not recognized?
A Not a right bundle branch block. A left, yes.
Q Not a right?
A Correct.
Q Okay. Does the literature recognize that a resting ejection fraction of greater than 50 percent gives a patient a very high chance of survival over the next year without intervention?
A Yes, all things being equal. But if

Page 62

somebody has acute coronary disease the plumbing is going to kill them even if the pump is healthy. But for any given patient matched up it's better to have a normal ejection fraction.
Q Well, I think the point being that even in patients with coronary artery disease a resting ejection fraction greater than 50 percent gives the patient a very high chance of survival over the next year without intervention.
Is that true or not true according to Dr. Charash?
A It depends on the context of the sentence and it depends on the discussion being held. That sentence can be true and also cannot be true depending on the context.
As a general proposition all patients being equal a good ejection fraction is a good prognosticator. If someone is having unstable angina there is no protection against death because your ejection fraction is good.
Q While she did have some hypokinesia, her left ventricular function was normal; wasn't it?
A Yes.
Q And that is the context in which I am asking you the question.

Page 63

In that scenario a resting ejection fraction of greater than 50 percent gives that patient a very high chance of survival over the next year without intervention. Is that true or not true?
A Which patient?
Q A patient with mild hypokinesia.
A Are you saying -- I still don't understand because you're just talking about just the ejection fraction and just the ejection fraction is a great prognosticator.
Q Okay.
A You are not going to die from the ejection fraction. But it depends on what else is wrong with the patient. So an out of context general statement is pointless.
Q Well, I'm not trying to make an out of context general statement. I'm trying to put it all together.
We agree that insofar as her left ventricular function, the size of it and the functionality of the left ventricle was concerned that was a good prognostic indicator?
A Yes.
Q Okay.

Page 64

A It was a good prognostic indicator when she had her other angioplasties and bypass surgery.
Q I understand.
Now, is it also true that while she had the induced wall abnormality in the septum the apex appeared normal?
A Yes.
Q And that is also a good prognostic indicator because it suggests that the LAD is patent; doesn't it?
A Not necessarily. The septum is part of the LAD. In general when you see wall motion abnormalities induced by a chemical stress test it can tell you that there is ischemia.
If there is massive global reduction of function during stress that would be an independent bad thing. But if you have a limited amount of ischemia it doesn't provide enough information to know about the short-term prognosis.
Q Well, to be clear the normal appearing apex implies patency of the LAD because that area is served by distribution coming from the LAD; isn't that true?
A Generally, yes.

Page 65

Q All right. Is it also true that abnormal septal wall motion is commonly seen in patients who have had bypass surgery, that is coronary arterial bypass grafting?
A Permanent wall motion abnormalities are seen, but not reversing wall motion abnormalities.
Q Well, what I'm asking is in a patient like her who has had CABG surgery previously it would be common to see septal wall motion abnormality; wouldn't it?
A It would be common to see a permanent septal wall abnormality. Some people develop it, others didn't. But it would not be an abnormality that would appear during exercise and be gone at rest.
So a reversing abnormality would not be part of a bypass. But if it was permanently not moving during exercise and rest then you might argue that was a consequence of the surgery.
Q Well, doesn't that depend upon the degree of which the surgery itself affects the septal wall motion?
A No.
Q Why do you say that?

Page 66

A Because it doesn't. It only matters whether the septal wall is permanently damaged or not.
Q You might not be able to detect the degree of wall motion abnormality except on stress if it's not substantial; isn't that true?
A I disagree. If the wall is damaged it will be there at rest and exercise.
If it isn't damaged then the fact that it changes its function during exercise is as predictive as we have to ischemia and that's how the stress test was reported. It wasn't reported a negative stress test typical bypass patient.
Q Is it also true that areas of wall abnormality, not just the septum, are commonly seen in patients following CABG surgery?
A I can't answer your question because of the vagueness.
Some people have had damage to the heart before or during surgery. Other haven't.
Q Well --
A I don't know what you mean by common. I don't know what you mean --
Q Frequently.
A Well, you are just being general.

Page 67

There are patients that have wall motion abnormalities --
Q As a generality it is frequent to see abnormal wall motion in patients who have undergone CABG surgery; isn't it?
A I can't answer the question the way you phrase it as a simple yes, no.
Q Fair enough. If you don't know that's fine.
A No. I didn't say I don't know.
Q Well, then answer it if you do know.
A No. I said I can't answer the question the way you phrased it limited to a simple yes, no. That's different than saying I can't answer it.
Q Well, I'm going by what you just said which was you can't answer it.
A I said I can't answer it limited to a simple yes, no, but you cut me off before I said that.
Q I don't think I did.
A Good Lord.
Q Are you finished?
A Excuse me?
Q Are you finished with what you wanted

Page 68

to say?
A I said I could not answer your question the way you phrase it limited to a simple yes, no.
Q Is it true or untrue or let me put it this way. Is it recognized in the practice of cardiology that areas of wall abnormality are commonly seen in patients who have a history of CABG surgery prior to a catheterization?
A I cannot answer the question the way you phrase it limited to a simple yes, no because you're not explaining to me what you mean by frequently.
Q Well, we'll just go with your definition of that term since you are the expert.
A Patients who have suffered pre-bypass damage or intraoperative damage will likely show wall motion abnormalities after the bypass.
Patients who have had a bypass without preexisting wall motion damage will not show wall motion abnormalities.
If you want to try to come up with what percentage of patients who have had bypass surgery have had preexisting heart attacks, I'm sure that number is available, but I don't know what you

Page 69

would consider frequent.
Q We are just going by your definition of frequent, Dr. Charash.
A Well, frequent is a term of relative comparison to something else.
Q Are you aware of any studies that have shown that for patients with abnormal stress echo tests who had prior CABG surgery referral for coronary angiography, in other words, catheterization is low?
A Not if there is a reversing wall motion abnormality which is why this patient was referred for a catheterization.
If there was a fixed wall motion abnormality that did not change and if the patient were asymptomatic, then you would not act on a singular fixed defect of the septum. But here's a patient having symptoms at rest who has a reversing wall motion abnormality during exercise.
That reversing abnormality is not an expectation from surgery and is exactly the reason why she was being referred for a catheterization.
Q Have the studies shown that the survival benefit from repeat revascularization for patients who have undergone prior CABG surgery is

Page 70

very low?
A No.
Q They have not shown that?
A No.
Q Okay. Have the studies shown that repeat revascularization is not significantly associated with improved survival in these patients, those being those who have a prior history of CABG surgery?
A It depends on what the clinical situation is. If a person has -- you could have a person who has an asymptomatic abnormal stress test. You can have a person who has a symptomatic presentation and you can have a person who has unstable angina.
You can't just make a generalization. It depends on the patient. If you have a patient with recurrent pain at rest with evidence of ischemia on a catheterization they are facing imminent risk of sudden death.
Q Do you agree that decisions to proceed with revascularization are based on the clinical status of the patient rather than the result of the catheterization test?
A It's based on all. It's based on the

Page 71

sum of all the information. You rely on the clinical status, the noninvasive testing, and the invasive.
Q But your testimony is that in your experience there is no study showing that the survival benefit from revascularization is very low in patients who have a history of a prior CABG surgery?
A With just that information I can't imagine what you are talking about. You would need a more specific targeted population for a study and it would depend on the reason for revascularization.
If you are just throwing out there this vague criteria it makes no sense and I couldn't comment.
Q Are you aware of any studies or literature that stands for the proposition that within the practice of cardiology for patients that have had prior CABG surgery and who have a subsequent positive stress echo referral for catheterization within 180 days of the stress echo is a recognized method of practice?
A No. I have no idea what you are referring to.
Q You've never heard of that?

Page 72

A No, but I would have to see the context and the population.
If a patient, for example, had an asymptomatic surveillance stress test that showed ischemia that might provide one direction.
If a person is having repeated episodes of rest discomfort that's new in onset with the clear established history of advancing disease that's a different patient.
Q This patient had without question a positive stress echo?
A Yes. Everyone agrees.
Q Right. And her catheterization procedure was scheduled and rescheduled clearly within certainly less than 180 days of the time that she had the stress echo. Just the calendar tells us that; doesn't it?
A Yes.
Q All right. Now, after he made the interpretation of the stress echocardiogram Dr. Mitchell had his medical assistant, Mr. Parker, call her to schedule the catheterization and you have referred to that fact in your report; have you not?
A Yes.
Q All right. And I think you told me

Page 73

earlier that you have read Mr. Parker's deposition testimony?
A Yes.
Q Do you understand that he received a handwritten note from Dr. Mitchell telling him that her stress echo was positive and that she needed a left heart catheterization and that he should call her to schedule that?
A Yes.
Q All right. And that's what he did?
A Yes.
Q All right. Now, did you understand from Mr. Parker's testimony that Ms. [redacted] told him that she wanted to wait until after Thanksgiving to schedule the procedure and that she was not experiencing any cardiac symptoms after he questioned her about that?
A Well, I'm aware that he testified that she wanted it after Thanksgiving in his testimony, although it's not documented. But equally so he testified that he asked her about whether she had symptoms the day he called.
He was not representing himself to taking a history of more than are you feeling well today from his testimony, and he's certainly not

Page 74

qualified to take a medical history about the pattern and nature of chest pain, whether or not she was having it at that moment or that day.
Q My question to you, sir, simply is do you understand that he asked her whether she was experiencing any chest pain, shortness of breath or cardiac symptoms and she said that she was not?
A Well, again, you have to qualify it. He testified that he meant that day, not overall, right. Is very clear about that.
Q Do you need Jason to approve --
MR. BRANCH: I mean that's what he said. I mean you asked him if that's his recollection of what he said.
MR. WRIGHT: I don't know why you are nodding your head up and down as if -- with all due respect, I wish you would stay out of it and let him answer the question.
MR. BRANCH: It's in his report he wrote.
MR. WRIGHT: I know what's in his report, but you wrote his report which might be the same thing as you nodding your head during his deposition.

Page 75

MR. BRANCH: The implication of that is offensive.
MR. WRIGHT: Well, I apologize, but I think you should apologize as well. I don't mean it offensively. I wish you would not make gestures while the witness is testifying approving or disapproving of his testimony.
THE WITNESS: I can't see Mr. Branch --
MR. BRANCH: My gestures are not approving or disapproving of anything.
MR. WRIGHT: You were nodding your head so it seemed to me like you were giving him an encouraging gesture to the witness to testify.
THE WITNESS: Can we get any more childish than what you are doing now. Can we just get to this case and focus?
BY MR. WRIGHT:
Q I think we are pretty much focused on this case, Dr. Charash.
A Very good.
Q And, you know, you can call all the

Page 76

names you want to of me.
A I'm not calling you names. I'm just saying this behavior at this moment is childish. I'm not characterizing you. I'm characterizing this conversation is childish.
Q Well, maybe the inability to answer a question directly and with intellectual honesty could be characterized in a certain way that you may not appreciate, so why don't we just move forward.
A Well, I stand by my answer.
Q I stand by my questions as well.
A Great.
Q I think the simple question that I was asking you was did you understand that she told him she was not experiencing any cardiac symptoms?
A And I have answered that.
Q Yes.
Did you also understand that he testified that if she developed any chest pain, shortness of breath or anything out of the ordinary she should contact the clinic or go to the emergency room if those symptoms occurred after hours?
A I read that testimony.
Q All right. And you have nothing to dispute that; do you?

Page 77

A No, but it's not clear if he was asking her since she already presented with a pattern of discomfort whether he was talking about something that was different than her current pattern.

Frankly, if a person should come in with a symptom then she should already be in because she had the symptom.

Q Well, I'm not sure who is being childish or what now, Dr. Charash, but had this lady had previous catheterizations, previous percutaneous interventions, had she been to the emergency room previously with symptoms, and come to clinics previously with symptoms. All of that had occurred in her history; had it not?

A Right. And each time she was given a plan by her health care provider which she believed in good faith was a safe plan.

In this case she was turfed to a later date for a catheterization which is one of the central complaints I have and as a result she can't independently know that her doctors made a mistake.

MR. WRIGHT: I move to exclude that as nonresponsive.

Q Try to confine your answers directly

Page 78

to the question, Dr. Charash, and this will go a lot more smoothly for both of us I think.

You understand that she according to Mr. Parker said she wanted to wait until after Thanksgiving. B, that she was not experiencing any cardiac symptoms and, C, that he told her that if she developed chest pain, shortness of breath or anything out of the ordinary to call the clinic or to go to the emergency room.

Is all of that your understanding of his testimony?

A I think that is mischaracterizing her testimony.

Q In what way.

A I think his testimony was that she didn't have pain at the time of his call that day.

No. 2, he wasn't clear about what the specific warning sign would be to come in, nor was he qualified to even give such instructions.

Q Did he say exactly in his testimony what I related to you?

A I don't know.

Q All right. Do you take issue with his testimony that he told her that if she had chest pain, shortness of breath or anything out of the

Page 79

ordinary she should contact the clinic or go to the emergency room?

A Major issue. When he says out of the ordinary that could imply outside of the pattern that she presented with.

Q You misunderstood my question.

Do you take issue with his testimony that he said that to her?

A I think that is for the jury to decide.

Q Well, I understand that, but I'm trying to understand --

A Well, I'm not weighing in on the validity. That's for the jury to decide.

Q You are misunderstanding the question. Did he testify to that or not?

A I said yes, he did.

Q All right. This stress echo by definition would place her at intermediate risk for a coronary event; wouldn't it?

A Only independent of her symptoms. So if this was a routine stress echo that was done for surveillance purposes without symptoms it would make it intermediate.

Q All right.

Page 80

A But in the context of her symptomatic presentation it puts her at extreme short-term risk for sudden death.

Q I want to be sure I understand what you're saying. The stress echo itself aside from the history of symptoms that she gave would place her at intermediate risk, and your testimony is that taking this stress echo and coupling it with the history of symptoms that she had given places her at a greater risk.

Am I understanding you correctly?

A Of course.

Q And, therefore, in the event that she were not symptomatic she would be at intermediate risk, but because of the history of symptoms you say she is at greater risk?

A Of course.

Q All right. You don't have any evidence that would dispute Mr. Parker's report in his testimony that she said she was having no symptoms at that time; do you?

A No.

Q Okay. And you understand that given the discussion between the two of them the catheterization was scheduled for December the 5th

Page 81

which would be certainly after the Thanksgiving holidays; correct?
A Yes.
Q In reality there was nothing that occurred between November the 7th when the phone call was made by Mr. Parker and December the 5th that was adverse to the patient. That's true; isn't it?
A Well, not that we know of. She didn't die, but we don't know if there was any damage to her heart.
Q Well, let me ask you this. As far as you are concerned had the cath been done on December the 5th given what we know about the case and assuming reasonable decisions would have followed that there would be no issue, you would be satisfied; wouldn't you?
A Right. She would be alive.
Well, no, I would say the standard of care was violated by the delay in the procedure, but if she survived without adverse consequences then there would be no damages associated with the deviation.
You know, people might make a mistake, but if nothing bad happens then there is no

Page 82

consequence to that error.
Q All right.
A She needed an earlier catheterization and needed to be told why, but if she had been catheterized in retrospect on that first date she would be alive and well today.
Q Well, we don't know whether she would be alive and well today?
A Well, yes, we know with reasonable medical certainty. No one is in the absolute medical certainty business, but we can say reasonable medical certainty.
Q There is no such thing as reasonable medical certainty with all due respect.
A I have no idea what you are talking about. That's a term that is used all the time.
Q It's a legal term that is a fiction; isn't it?
A No.
Q It is either certain or not?
A No. You could say probably she would be alive.
Q That is different than certainty?
A Reasonable certainty.
Q I don't know what reasonable certainty

Page 83

means. That makes no sense to me.
A Okay.
Q But where we are in this discussion is that any distinction between doing the cath up to December 5th or not was inconsequential because we know that she had no untoward event; is that fair?
A We assume she had no untoward event.
Q There is no evidence of it?
A Correct.
Q All right. Now, as you know the testimony in this case is just prior to the 5th, so on the 2nd or the 3rd Dr. Mitchell took a leave of absence for some health care issues that he was having.
Do you understand that in connection with that he made arrangements for a Board-certified cardiologist who is known to him and who had privileges at the East Alabama Medical Center cath lab to cover his practice until he could return to work. You understand that?
A Yes.
Q And that was Dr. Westermeir?
A Yes.
Q Okay. Clearly doctors are not immune from needing to be away from their work from time to

Page 84

time; are they?
A No, but there are very significant questions raised by that.
Q I'm going to ask that question again. I would like a direct answer.
Doctors are not immune from needing to take time away whether it's for vacation or a death in the family or even health care issues of their own. That's true; isn't it?
A Correct.
Q And the standard of care recognizes that when they are scheduled to be away it's proper for a colleague to cover their patients. That's true as well; isn't it?
A Yes.
Q In fact, that's precisely how on call schedules work, but no doctor is on duty 24 hours a day, seven days a week; are they?
A Correct.
Q But at least in this case there is no dispute from you that Dr. Mitchell arranged for a Board-certified cardiologist to stand in for him and take care of his patients while he was away?
A Correct.
Q All right. And while we are still on

Page 85

that subject, the standard of care does not require him to call every patient and review every chart. He wouldn't even be able to leave if he had to do that; would he?
A No, but the standard of care does require him to let the covering doctor know about patients who are due for procedures and those with higher risk.
Q Well, the covering doctor would have the schedule of the catheterizations to be performed; wouldn't they?
A Perhaps.
Q With the patient information?
A Perhaps.
Q Okay. While we're on the subject, doctors are entitled to their privacy like all patients are. There is no rule or ethical code or requirement that a physician is bound to explain personal health care issues to his patient population; is there?
A Well, only to the degree that if their medical condition impaired their cognitive function that would have to be explained. If their judgment was impaired because of a problem that could impact decision-making they do have a duty to let their

Page 86

patients know they there may have been with a cognitive problem.
Q You don't have any evidence of that in this case; do you?
A I have no idea what his problem was.
Q All right.
A But he clearly said he was aware of a problem in November and by December he left. If he had a problem that affected his cognition that would be very important to know.
Q Dr. Westermeir was an experienced, trained and capable cardiologist who could perform Ms. [redacted] catheterization and make decisions about what, if any, additional steps would be recommended. You don't take issue with that; do you?
A No. And if he was told about her I would hope to think he would have done the right thing.
Q Do you understand that because of Dr. Mitchell's leave of absence Mr. Parker called Ms. [redacted] somewhere around maybe the 3rd or the 4th of December about her December 5th catheterization?
A Yes.
Q And in the context of that discussion he told her that Dr. Westermeir would be available

Page 87

to perform it because Dr. Mitchell was away.
Do you understand that from Mr. Parker's testimony?
A I understand that that's his testimony.
Q Right. Do you have anything to contradict that, any evidence to contradict that?
A Well, one thing.
Q What?
A His note where he wrote that patient declined Dr. Westermeir is not written under the December 5th call or the December 22st call. I can't make sure what date is, the December 12th call. So he wrote it after. So his record kind of looks the opposite.
Q Looks the opposite of him having told her that Dr. Westermeir was available?
A Correct.
Q Okay.
A Because it looks like she declined Dr. Westermeir for the January 12th visit.
Q To be perfectly honest, Dr. Charash, I can't remember whether he was asked in his deposition or not, but if his testimony was that he wrote that on that chart after or if his testimony

Page 88

would be that he wrote that on that chart after the initial call and that the other dates were filled in later when those calls were made, you would have nothing to dispute that; would you?
A I will let the jury determine that.
Q I'm just saying you would have no evidence to contradict that from your position; would you?
A I cannot weigh in on factual matters for the jury to decide. I can say that his documentation suggests otherwise.
Q Well, that's weighing in.
A Also, I am critical of a fact that he should not be in a position to be whiting out dates under the signature of Dr. Mitchell.
Q You're not being responsive to my question, Doctor.
A I just want to make sure, though, that at the end of this deposition if there are areas that are significant and you didn't bring them up --
Q We are not to that yet, so why don't you just let me ask the question without you making a speech every time.
A All right. I need a short break.
Q Well, make it short.

Page 89

A What?
Q We're in a hurry.
A This is two hours into the deposition. We are entitled to a five or ten minute break.
Q I'm fine with that.
(Whereupon, a short recess was taken.)
(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 MR. WRIGHT:
Q Look, I know this is stressful, but I'm just trying to do a job here.
A I know.
Q So let's just do our best.
A But in all fairness I know you want certain questions limited, but I thought you wanted this as an opportunity to hear the full breadth of my opinions and in good faith I am just trying to provide.
I thought that's what you needed to know and I'm not trying to play games here, but I mean there are a large breadth of opinions. You have been asking me some narrow focused questions

Page 90

with very specific narrow focused answers and I'm happy to do it all day long, but I just want to make sure that I do have an opportunity today to express all of the opinions that I have formed.
Q Well, all you have to do is just answer my questions and when I am done we are done unless Jason has something he wants to put on the record.
A Okay.
Q And we'll see how it plays out later if it's not to your satisfaction today.
All right. Let's kind of, I want to go back to something that we spoke about just prior to the break, Dr. Charash, and with regard to the notations of Mr. Parker's calls to Ms. [redacted] the document that you referred to.
I'm just going to ask you it this way. Just assume for purposes of this question that Mr. Parker wrote that she had refused or declined Dr. Westermeir when he called her on or about the 4th of December.
Given that assumption that I'm asking you to make, you would not have any evidence that you could point to that would contradict that; am I right?

Page 91

A Other than my presumption that the note contradicts it, yes.
Q Well, I'm saying if you assume that he wrote it on the 4th, if you make that assumption you don't even have that perception.
A Well, again that's for the jury to sort out, not me. I can only talk about the evidence. Mr. Parker testified to what he testified to. That's for the jury to decide.
Q That was going to be my next question. You clearly understand that his testimony was that she declined Dr. Westermeir during that initial telephone conversation?
A Yes.
Q I said initial, but I meant the December 4th telephone conversation. No issue there in terms of what he testified to; am I right?
A You're just repeating yourself. That's what he testified to.
Q All right. Now, I think then where we are in this chronology is that you understand from both his testimony and Dr. Mitchell's that Dr. Mitchell was not going to be available to perform the cath himself on December the 12th?
A Correct.

Page 92

Q Okay. And we don't have any evidence as we discussed relative to December the 5th. We also don't have any evidence of any harm or any untoward event occurring between the December 4th conversation and December 12th when the catheterization was next scheduled?
A Nothing that we know about.
Q That's what I meant.
A She certainly was alive.
Q Right. And then on or just prior to December the 12th do you understand from the records and from Mr. Parker's testimony that he again telephoned Ms. [redacted] to explain to her that Dr. Mitchell was not going to be available on the 12th?
A Yes.
Q And do you understand that he testified that -- he told her Dr. Westermeir was available to do her procedure?
A That's what he said.
Q Right. And do you understand that he testified that he again questioned Ms. [redacted] specifically regarding any symptoms that she was having?
A That day he said.
Q And that she denied any active

Page 93

symptoms including shortness of breath, chest pain or the need for nitroglycerine?
A On or about the time of that phone call, yes.
Q Okay.
A He did not take a history. Nor was he qualified to.
Q And do you understand that he according to his testimony that he again instructed her to immediately contact the clinic or present to the emergency room should she have any kind of symptomatology?
A That's his testimony.
Q Okay. And do you understand that according to Mr. Parker's testimony she declined Dr. Westermeir again?
A According to his testimony, yes.
Q And that she told Mr. Parker she would prefer to reschedule it after the Christmas holiday?
A That's what he said.
Q Okay. And so it was scheduled next for January the 12th of 2015?
A Yes.
Q Which would be after the Christmas and New Year's holidays?

Page 94

A Yes.
Q Obviously. All right. Now, do you have any understanding of when, if at all, Ms. [redacted] was presenting to her primary care physician Dr. Solt in and about the timeframe after October the 30th?
A I don't recall.
Q Okay. Do you know that she went to see Dr. Solt the day after her echocardiogram?
A I think so, yes.
Q The 5th of November?
A Yes.
Q And do you understand that she had no complaint of chest pain or chest discomfort or dyspnea or any symptoms referrable to her chest or her heart on that presentation?
A At that moment, yes.
Q The next day. She was complaining of lower abdominal pressure and, well, I think ultimately a urinary tract infection was diagnosed. Do you recall that?
A Yes.
Q All right. And he prescribed antibiotics for that and told her to come back if she is not improving or if she had any problems;

Page 95

right?
A Yes.
Q To follow-up as needed?
A Yes.
Q Okay. And were you aware that on December the 12th, the day that she had been scheduled for this catheterization, she again presented to Dr. Solt with symptoms consistent with either a bladder spasm or urinary tract infection?
A Yes.
Q Again she made no complaint to him of any shortness of breath, chest pain or any symptoms referrable to her heart?
A Yes.
Q Okay. And I know you know that Dr. Solt was aware that she was being seen by Dr. Mitchell?
A Yes.
Q All right. Now, did you notice that there was a call to Dr. Solt's office from Ms. [redacted] on November the 7th wanting all of here routine medications to be renewed?
A Yes.
Q In other words, asking that they call the CVS pharmacy to renew her regular medications?

Page 96

A Of course.
Q All right. And do you understand that this was in and about the timeframe for renewal of her regular prescription for the nitroglycerine?
A Yes.
Q Do you know anything about the practices of CVS to follow-up with prescribing physicians for either annual or six-month renewals of maintenance type or PRN type medications that are prescribed on a routine basis for patients?
A I think it depends on how the prescriptions are written. Some can be written for a year, some can be written for six months.
Q Right.
A If you are past the prescription period they are duty bound to call the doctor, but if it's prescribed for a year which is permissible they don't need to.
Q Do you have any indication of a call by Ms. [redacted] to the clinic in December prior to her death of a complaint of active chest pain?
A I don't recall any.
Q Okay. And there is none documented; is there?
A Correct.

Page 97

Q All right. And I'll just ask you this since you seem to have a general understanding of pharmacy practices, but probably know nothing in particular about this branch of the CVS pharmacy down in Alabama.

Do you allow that as an end of the year type of exercise CVS was contacting Dr. Mitchell's office for a routine renewal of her prescription as opposed to some request from the patient to have it renewed?

MR. BRANCH: Is the question does he allow that as a possibility?

Q Yes. Do you allow for that?

A Of course.

Q All right. And do you have any information as to whether she ever picked up a refill of her nitroglycerine in December?

A I have not seen pharmacy records so I don't know.

Q Okay. But clearly we don't have any evidence of her calling the office requesting that it be renewed or calling the clinic complaining of any symptoms and we know she did not present to an emergency room.

All that's true; isn't it?

Page 98

A Yes.

Q Now, with her history and with the instructions that Mr. Parker said that he would have given her as well as knowing that she had presented herself to an emergency room previously when she felt the need to do so, you would certainly expect her to call the clinic or go to the emergency room if she was having any symptoms; wouldn't you?

MR. BRANCH: Object to the form.

A I can't answer the question limited to a simple yes, no. She presented to Dr. Mitchell with pain at rest more often in the evening and he did not hospitalize her. As a result it would depend on what level of pain she would assume would require to go in.

If Dr. Mitchell did not believe that she needed to be hospitalized based on the pattern of pain by which she presented to him then naturally she would assume if that was a continuing pattern it would not be a requirement to go to the emergency room.

Q Well, I wasn't limiting my question to the emergency room. You would expect her to call the clinic or go to the emergency room given the instructions that she received assuming Mr. Parker described those instructions accurately?

Page 99

A Well, Mr. Parker is not qualified to give a patient instructions. He's not a healthcare provider.

Q That's not the basis of my question.

A The instructions are not clear because she had a pattern of pain that the doctor knew about.

So I would not expect her to call or go to the emergency room unless something changed from the pattern she was having.

Q So even with an instruction whether it was from Mr. Parker or anybody else that she should call the clinic or go to the emergency room if she had any symptoms of chest pain or shortness of breath your testimony is you would not expect her to do that?

A Correct.

Q Okay.

A It would not make any sense in the context of Dr. Mitchell knowing what her pattern was saying go home.

Q Okay. In any event, we know that she did not make a call to the clinic or go to the emergency room during this timeframe; did she?

Page 100

A Correct.

Q All right. Now, I understand your testimony in this case, but I want to ask this question. If it were a recognized method of practice under the standard of care for this patient, Ms. [redacted] with her history of coronary artery disease, with her history of this prior CABG surgery and her positive stress echo test to have her catheterization scheduled within 180 days of that stress echo, that is the practice that was followed in this case just going by the dates; isn't it?

A I cannot answer the question because that is intrinsically negligence if her pain was at rest and as a result that practice might be reasonable in a patient who has a routine positive stress test without symptoms or a person who is having symptoms at maximum activity where you can tell them to not approach it, but it is primary negligence not to immediately act if a person is having symptoms at rest.

So are you saying that this practice has a structural negligence to it. That regardless of a patient's symptoms 180 days is acceptable. That's a deviation in the standard of care. 180

Page 101

days is not acceptable in a patient having rest pain.

MR. WRIGHT: Move to exclude as nonresponsive.

Q All right. Whether you agree with that practice or not, if it were a recognized method of practice under the standard of care that a patient like Ms. [redacted] with her history of the coronary artery disease, the prior CABG surgery and her positive stress echo test could have her cath scheduled within 180 days of that stress echo, that is, in fact, the practice that was followed here; wasn't it?

A I disagree because you can't have a practice for all patients. It's intrinsically negligent --

Q You're not answering my question.

A Well, then you are making a circular argument. You're saying if they want to do negligence --

Q I'm not saying anything about negligence. I'm saying if it was a recognized method under the standard of care which is not negligence, Dr. Charash.

A It isn't a recognized standard of care

Page 102

practice if someone is having rest pain to say you can apply the same approach to a patient who is rock stable to a patient who is unstable. So you can't make that statement.

Q If she was asymptomatic as she told Mr. Parker that she was according to his testimony that would be one recognized method under the standard of care for a patient like this; wouldn't it?

A No. You would have to have someone who knows how to take a history, not to ask about that day or that moment, but about her global pattern.

Mr. Parker was not qualified to take a history that would satisfy the need to know whether she was stable or unstable. It appears from his own testimony that he asked highly focused questions about limited timeframes of pain.

He was not qualified to take the history. He was not qualified to change the cath date without a physician's supervision. He was not qualified to white out the date with Dr. Mitchell.

Q Come on, come on. Answer the questions.

A I'm answering them all.

Page 103

Q Quit going onto something that I haven't asked you.

A He was not qualified to do this.

Q I didn't ask you about his qualifications.

A Well, his history was not acceptable.

Q I didn't ask you that.

I said if the patient was asymptomatic as she stated that she was according to what he said, do you acknowledge that under the standard of care she could have her catheterization scheduled within 180 days?

A Absolutely not.

Q All right. At least you will acknowledge because it's undeniable looking at the calendar that all of the scheduling and rescheduling of her catheterization occurred within less than 180 days from the date of her stress echo. That's a true statement; isn't it?

A That is a true statement.

Q All right. And if the literature were to show that that is a recognized practice that is followed by many cardiologists in this country for patients with positive stress echos and a prior history of CABG surgery, indeed that is the practice

Page 104

that was followed in this case just looking at the calendar?

A If the literature includes unstable symptoms. If the literature is about asymptomatic patients or patients who have predictable chest pain at maximum activity that would comply with the standard of care. But you are not going to find a literature that gives a blanket statement that disregards the patient's presenting symptoms.

Q You cannot say what would have been seen, if anything, on a catheterization had she had one done prior to her death; can you?

A Well, I can say that within reasonable medical probability or certainty she would have had a blockage that would have needed fixing and that's the blockage that caused her pain and her death, but I can't identify where it was.

Q That's entirely speculative on your part; isn't it?

A No. It's a medical opinion based on reasonable medical certainty.

Q There's no science that allows you to predict that; is there?

A I disagree with you. You have a patient who had pain at rest who is known to have

Page 105

recurrent coronary disease who failed a stress test, who is having shortness of breath with limited activity and who died over a short period of time.

Using retrospect and prospect you can draw a medical conclusion that with reasonable medical certainty she died from her acute coronary disease that wasn't fixed.

Q You cannot say what, if any, artery may have been involved; can you?

A I don't know which specific artery was involved.

Q Or the nature of any blockage if there was any?

A Well, there certainly was a blockage critical enough to cause pain at rest.

Q Well, chest pain occurs even in patients who do not have clinically significant blockage following CABG procedures and prior interventions; doesn't it?

A True. You can have non-coronary pain, but you could also say that a package ticking at an airport could be an alarm clock. It doesn't mean you ignore it because it could be an alarm clock.

MR. WRIGHT: Move to exclude.

Q Let me ask you this. Have you ever

Page 106

been disqualified by any court for offering testimony beyond your area of expertise?

A Not to my knowledge.

Q When we were talking about these comorbidities that Ms. [redacted] had, she had in Dr. Solt's records, we see she had a history of low potassium; don't we?

A Yes.

Q Electrolyte imbalances are known to produce sudden death by fatal arrhythmias; aren't they?

A They can cause or contribute.

Q Diet in low potassium intake in elderly patients with multiple comorbidities is a known cause of sudden death independent of coronary artery disease; isn't it?

A It's very rare in a patient who is not taking a diuretic or who is not suffering from a primary kidney disorder.

Q She was taking a diuretic; wasn't she?

A Yes.

Q You cannot eliminate that as a cause for her death in this case on any evidence we have in her medical chart?

A I can't eliminate that as a

Page 107

contributing factor, but of course part of my opinion is, and this is essential, that Mr. Parker was not in a position to make decisions about changing cath dates and she needed to be evaluated.

Q I understand that. I'm talking about something completely different.

A Well, that would have included blood tests if she showed up for -- the standard of care required the moment there was going to be a delay in the cath which already the date was too far out to have her come in for --

Q My question is simply --

A Let me answer the question. You can object all you want, but I'm going to finish.

Q No. I'm going to interrupt you.

A My answer is going to be --

MR. BRANCH: He is not finished.

MR. WRIGHT: I asked him whether he could eliminate --

MR. BRANCH: Let him finish his answer.

MR. WRIGHT: -- an electrolyte imbalance as a cause of sudden death independent of coronary artery disease.

A I think it's unlikely.

Page 108

Q But you can't eliminate it on the basis of anything we have in this record.

A I can't eliminate it with 100 percent certainty. It's not a reasonable possibility, but it's a possibility.

Q If it occurred the clinical picture could look exactly the same as we have here; couldn't it?

A It could.

Q All right. You cannot dispute that she was a patient that was at risk for a fatal arrhythmia independent of her coexisting heart disease; can you?

A I disagree because a person who has a normal ejection fraction who gets hypokalemia it has to be very profound for them to suffer a primary arrhythmia.

Whereas a person with an acute coronary syndrome as their potassium level drops, if it did drop would increase their proclivity to an ischemically induced sudden death.

And it's highly unlikely, but not impossible that a primary electrolyte disorder caused her death. But it is almost certain that she had acute coronary syndrome and that would be the

Page 109

main contributing factor towards her death.
Q Even if she did not have an acute coronary syndrome given her history and her risk factors for an electrolyte imbalance particularly associated with a low potassium level in an elderly patient who is on routine diuretics, you cannot point to any science that would eliminate that as a cause for her death in this case based on the facts that we have?
A Are you saying with 100 percent certainty?
Q I'm saying with any degree of certainty.
A Oh, I think you can with some degree of certainty.
Dr. Solt who knew this patient probably better than anybody wrote down cardiovascular disease and myocardial infarction. They give you as a consequence of and alternatives and she never mentioned low potassium. This patient never demonstrated a life-threateningly low potassium level.
So it's extremely unlikely. With reasonable medical certainty that was not her cause of death. If you're asking whether anything is

Page 110

possible, anything is possible.
Q An electrolyte imbalance can come on suddenly and produce a fatal arrhythmia particularly in an elderly patient who his on a diuretic?
A Again, it's rare with a normal EF.
Q Can it happen?
A It's possible.
Q Now, do you agree that there is a strong association between obstructive sleep apnea and cardiovascular events including fatal arrhythmia and sudden cardiac death?
A Not as a general statement. It depends A, on the magnitude of the sleep apnea. Her sleep study actually showed that she had mild sleep apnea if you look at it. It wasn't profound.
No. 2, if you have unstable coronary disease sleep apnea becomes more dangerous because of the underlying coronary disease. But ultimately her sleep study was not very profoundly abnormal.
Q Is it well recognized that the risk of sudden death is vastly increased among patients who have obstructive sleep apnea and who are not compliant with CPAP?
A Not vastly increased and it depends of the magnitude. If the patient had mild sleep apnea

Page 111

there would be very little correlation.
Q Is the risk increased?
A A little bit.
Q Sudden death associated with sleep apnea independent of coronary artery disease comes on suddenly; doesn't it?
A It can, yes.
Q Frequently it occurs at night; doesn't it?
A That's generally when it would.
Q Right. Do you understand that Ms. [redacted] was found unresponsive having passed away suddenly?
A Yes.
Q The same findings that are frequently seen in patients who suffer fatal arrhythmias due to obstructive sleep apnea independent of cardiac disease; true?
A It's a way it could present from sleep apnea. But again she also on her echocardiograms never showed evidence of pulmonary hypertension which means that she did not have a reason for shortness of breath in the daytime due to sleep apnea.
Her sleep apnea was not causing right

Page 112

ventricular enlargement or pulmonary hypertension. She had only mild tricuspid regurgitation and her sleep study showed mild sleep apnea. So the likelihood that she could suffer a primary death from obstructive sleep apnea in the absence of a CPAP mask is very low.
Q She does not have to have pulmonary hypertension or core pulmonale to suffer sudden death from obstructive sleep apnea; does she?
A No. But Dr. Mitchell wrote off her shortness of breath with activity due to her obstructive sleep apnea and you do need to have pulmonary hypertension for it to affect your daytime activities and in that regard he was dead wrong.
Q Did she pass away overnight?
A Yes.
Q With respect to sudden death during nighttime, she does not have to have pulmonary hypertension chronically for that to occur if she is noncompliant with her CPAP?
A True. But again Dr. Solt who knew that patient better than anybody did not write down death due to obstructive sleep apnea, but wrote coronary disease and she was right. Overwhelmingly that's the cause of death.

Page 113

Q Nothing was done to prove a myocardial infarction; was there?
A Not with absolute certainty.
Q Not with any certainty?
A Reasonable certainty.
Q What?
A That she died in the middle of the night in the setting of having had rest pain while awaiting a catheterization. Of all people who die in their sleep in her age group you would say that 70 percent nationally of people who die in their sleep of her age group regardless of conditions are coronary.
With her risk factors, her known history of recurrent disease, her presentation with chest pain mainly at night, her flunking a stress test indicating there was ischemia and while awaiting a cardiac catheterization died. The odds are 95 to 99 percent likely that she died from her coronary disease.
Q There is no study that says that as compared to the risk that she would have from her being noncompliant with her CPAP?
A I disagree.
Q What's the study?

Page 114

A It's the statistics of what people die of. Looking at the medical context we don't study people by letting them die. But in the context of this case to make an argument that this wasn't coronary disease is ridiculously, you know, over defending this case. This patient's death certificate --
Q I don't really need you to characterize the hypothesis that I put to you, Doctor. I just need for you to answer my questions and your answers will be whatever they are without editorial comment, if you please.
A She did not die from sleep apnea with reasonable medical certainty.
Q All right. If she had the circumstances about her death would appear exactly the same way as they, in fact, were; wouldn't they?
A Yes.
Q All right. And there is not any test or any study that was done or that probably could be done short of an autopsy to rule out death associated with obstructive sleep apnea or an electrolyte imbalance; true?
A There was no autopsy.
Q Right. Is my statement correct?

Page 115

A Yes.
Q Okay.
A So, therefore, the opinions are not with absolute certainty, but reasonable certainty.
Q The point is there was no test or study done that would distinguish the cause of death stated on the death certificate from the two causes of death that I have hypothesized to you; is there?
A But there is clinical evidence for it. When a person dies and doesn't have an autopsy, you come up with a clinical diagnosis as to what they died from based on their recent medical history and medical circumstance.
And given this patient's medical circumstance for all the reasons I have given the odds are over 95 percent likely that she died from a coronary event.
Q There is no study that says that; is there?
A There is no study about this patient.
Q It's just a simple question. There is not a study that you can point to that says that; is there?
A I disagree with you. There are studies that talk about the statistical likelihood

Page 116

of sudden death being coronary and then you could extrapolate into that the specifics of a case. That is scientific. This isn't random. She could have been killed by blowfish poisoning.
Q Let's not be absurd.
A Well, it's just as absurd from what you are saying.
Q No. She actually had as you have testified risk factors for the development of an electrolyte imbalance that is known to produce sudden death by fatal arrhythmia. You've already testified to that.
A But she had never demonstrated a potassium drop to even approach that.
Q Simply because it wasn't measured prior to her death doesn't change the fact that she had risk factors for it; does it?
A She didn't have risk factors for profound dropping because she was in a study state on her medicines and her potassium was not at a level that would induce sudden death.
Q She clearly had risk factors associated with obstructive sleep apnea which were increased by her non-compliance with the CPAP, that is true; isn't it?

Page 117

A Well, I disagree because she had mild sleep apnea and the likelihood of death with mild sleep apnea is low, but not impossible and it depends on what your standard is.
Q The point being that clinically the findings would be the same as we had in this case if death were due to either of these modality?
A That is the fourth time you have asked me that exact same question and I said yes.
Q Okay. Now, let me ask you this. We talked about her morbid obesity and her chronic heart disease and what do you understand her age was at time of her death?
A Seventy-one.
Q Yes. And she had -- I think that's right, yes. She had limited mobility associated with sedentary lifestyle; did she not?
A Yes.
Q It is recognized that that puts her at an increased risk for venous thromboembolism?
A Yes.
Q Particularly in a patient that also had diabetes; true?
A Yes. She is higher risk than the average person.

Page 118

Q Right. And that is the same process, the same kind of process that causes vascular disease in diabetic patients that can cause venous thromboembolism; isn't it?
A Yes.
Q She had proven peripheral vascular disease which in and of itself it's a risk factor for pulmonary embolism; isn't it?
A Yes.
Q So both of those, really all of that places her at risk for a pulmonary thromboembolism; doesn't it?
A Puts her at increased risk from the general population.
Q Right. Now, are you aware that it is reported that there is a higher prevalence of acute pulmonary embolism among patients with obstructive sleep apnea?
A Mild increase, very mild and it's dependent on whether or not there is right ventricular dysfunction.
In those patients with sleep apnea who have normal right ventricular function there is no increase in pulmonary emboli.
Q Actually combined with diabetes and

Page 119

her other risk factors there is a significant and independent association between OSA and pulmonary embolus; isn't there?
A Not if you have mild sleep apnea and you are without right ventricular or pulmonary hypertension, there isn't. But if you do have severe sleep apnea and have a failing right heart that does increase the risk.
Q Well, clearly she had the other risk factors for pulmonary thromboembolism that we discussed?
A Yes.
Q Pulmonary embolism is frequently of sudden onset; isn't it?
A Yes.
Q Do you understand that it's the third leading cause of death in this country?
A It may be.
Q Do you understand that it frequently occurs at night during sleep?
A It can. I didn't know how frequently.
Q Do you understand that it is most frequently diagnosed at autopsy as opposed to any other way?
A Well, most people who have it

Page 120

diagnosed while they are alive get treated for it, so they don't die from it. So the most likely reason for death from a pulmonary embolism that was not diagnosed in life would be autopsy.
Q Right. And that cannot be ruled out in this case; can it?
A It cannot be ruled out with absolute certainty, but with reasonable certainty it would be extraordinarily low on the list, but anything is possible.
Q The circumstances of her death that are known that she passed away in her sleep are the same as would be expected for a patient with her comorbidities who developed a fatal pulmonary thromboembolus; aren't they?
A Correct.
Q Is stroke a leading cause of death in this country?
A It is, but it's rarely the cause of death. Most strokes are non-fatal and then you die days later. It is very rare to die in your sleep from a stroke. It's not impossible, but the overwhelming majority of people who die from strokes and over 95 percent of them die after being hospitalized with signs of a stroke.

Page 121

Q But stroke is known to produce sudden death in some patients?
A It is very rare, but it can occur.
Q And that is embolic, ischemic or hemorrhagic, it can occur; can't it?
A Correct.
Q She had risk factors of diabetes, hypertension, age, being of the female gender and her global vascular, peripheral vascular disease all placing her at risk to develop a stroke; true?
A Yes.
Q Did she have a small aneurysm in her carotid artery?
A Yes.
Q Does that increase her risk for a fatal stroke?
A It would increase her risk for a stroke.
Q And of course the sedentary lifestyle is another risk factor that is recognized?
A Very mild risk factor.
Q It's a risk factor that is included with the others that we mentioned; isn't it?
A Not significantly.
Q Well, I'm not arguing with you about

Page 122

anything other than is it a recognized risk factor. Either you say it is or it isn't.
A It's a negligible risk factor.
Q So it's a risk factor?
A It's not a major risk factor.
Q You are saying in and of itself you don't think it would be much of a risk factor?
A No.
Q It is a risk factor in combination with the other things that she had, though, isn't it?
A To a degree, yes.
Q All right. Acute stroke is known to disturb the central autonomic control causing cardiac arrhythmias and sudden death; isn't it?
A Very rare. It is very rare to have sudden death from a stroke.
The overwhelming majority of people who have strokes, even with massive intracranial bleeds don't die suddenly.
Q Rare or not my statement is correct?
A It's possible.
Q Interference with brain stem function associated with stroke -- is associated with stroke

Page 123

and sudden death; isn't it?
A It's possible, but very rare to be a primary cause of sudden death. But nothing is impossible.
Q Did she have based on this record a history of chronic urinary tract infections?
A Yes.
Q Do you have an understanding of the terminology fulminant urosepsis?
A Yes, but that doesn't cause sudden death. People are symptomatic. There's a rapid decline over a period of hours or days, but there is no such thing I go to bed feeling well and die of sepsis in my sleep. That does not exist.
Q I have read that urosepsis can strike and kill shockingly fast according to the literature.
A Yes, hours, but not without a prodrome of symptoms.
Q It can invade -- it's an infection that invades the bloodstream and can even invade the cerebral spinal fluid when it is fulminant; true?
A Correct. But it never starts -- it's not possible to go to bed not feeling sick and die in your sleep from that.

Page 124

Q How do we know that does not apply to her?
A There was no evidence that she was complaining of symptoms of fever, chills, sweats, weakness and unraveling. So there's nothing there to support that.
Q And it may be that the testimony is otherwise, but there is no evidence to say that did not occur either; is there?
A Sure. There is no evidence --
Q As of right now?
A Right. It's possible that she had 48 hours of high fevers, shaking and chills and ignored it. Anything is possible and so is blowfish poisoning because you are getting that absurd.
Q I'm not talking about blowfish poisoning.
A I am because I think it's just as likely as urosepsis.
Q She was at risk to develop fulminant urosepsis, wasn't she, by virtue of her age, female gender and chronic urinary tract infection.
Is that true or not true?
A She was at risk for that.
Q Okay. I'm not going to make a remark

Page 125

about your blowfish.
A Why. You didn't know what she ate that night, do you?
Q Well, I'm not going to argue with you about that, Doctor.
She was at risk to develop, being intellectually honest, she was at risk for developing a fulminant urosepsis; wasn't she?
A Not in the clinical context of the story that we know so far.
Q Are seniors at the greatest risk for that?
A Everyone as you get older is at greater risk for the consequence of sepsis.
Q Are older women in particular at high risk for urosepsis with a history of chronic urinary tract infections and diabetes?
A Even among people with diabetes and frequent urinary infections, it is very rare among that population to develop urosepsis, but they can.
Q With her comorbidities including her diabetes she is also at significant risk for abdominal aortic aneurysm rupture; isn't she?
A Well, there was no evidence of an abdominal aortic aneurysm. She was frequently

Page 126

examined. No one felt a pulsatile mass. So that's again getting to the same level of likelihood of blowfish poisoning.
Q Are you just going to be cute like that for the this?
A I'm not being cute. You're throwing out anything that can kill a person.
Q No, I'm not. I'm throwing out things that Ms. [redacted] had risk factors for.
A There was no evidence of an abdominal aneurysm and she was being evaluated by a cardiologist and a primary care doctor. Had been catheterized, meaning she had procedures through her vascular. No one ever found an aneurysm. The likelihood of her having an aneurysm is as close to irrelevant as possible.
Q Did she ever have an arteriogram that evaluated her aorta?
A Not that I'm aware of, but she had catheters advanced up through her abdominal aorta and if she had an aneurysm that would have been detected of fluoroscopy.
Q Did she have, I think we talked about the fact that she had an aneurysm at one of her carotid arteries?

Page 127

A That's unrelated to the risk of abdominal aneurysm.
Q I agree with you, but it shows that because of her peripheral vascular disease she was at risk to develop aneurysms; doesn't it?
A Yes, of course.
Q All right. Are you aware that abdominal aortic aneurysm is often associated with a history of arthrosclerosis and cardiovascular disease?
A Yes.
Q She had that; didn't she?
A Yes.
Q Are you aware that both obstructive and restrictive spirometric patterns have been associated with an increased risk of abdominal aortic aneurysm?
A I don't understand your question.
Q That patients with obstructive spirometric patterns have been associated with an increased incidence of abdominal aortic aneurysm?
A I'm not sure what you mean by spirometric patterns. Spirometric patterns of what?
Q Breathing.
A I'm not aware of that.

Page 128

Q Okay. Peripheral vascular disease is a known risk factor for abdominal aortic aneurysm; isn't it?
A Yes.
Q Hypertension is associated with abdominal aortic aneurysm in the medical literature; isn't it?
A Yes.
Q Are you aware that in patients with obstructive sleep apnea abdominal aortic aneurysm is highly prevalent?
A It's not highly prevalent, but if they have pulmonary hypertension and right ventricular dysfunction it might be more prevalent.
Q Is abdominal aortic aneurysm rupture frequently of a sudden onset with extremely high mortality when it occurs?
A Yes.
Q And is it something that is frequently diagnosed at autopsy and a known cause of sudden death in older patients?
A Well, it's a very rare cause of sudden death, but it is a potential cause.
Q And by my question about it being frequently diagnosed at autopsy I'm asking you if

Page 129

you have the understanding that when not clinically suspected as of the time of death it is something that has been frequently diagnosed at autopsy?

A It can be found on autopsy, although patients often when they are discovered dead have abdominal bloating from the massive bleeding in their abdomen.

Q We have discussed a number of potential causes of death for Ms. [redacted] all of which -- for all of which she had specific risk factors, and while I understand your testimony and your opinions in this case there is not any fact or any scientific basis that you can point to in this particular case that would distinguish your opinion about the cause of her death from one of these other causes that would have been fatal for her in any event and would not have been prevented by an earlier catheterization?

A I disagree. We can't establish with absolute certainty her death, but clinically can distinguish the relative likelihood of what caused her death.

That is done every day. And in this case a woman who had pain at rest, failed a stress test with known recurrent coronary disease who died

Page 130

while waiting to be catheterized, overwhelmingly the scientific reason why she died was due to her coronary disease.

Now, it doesn't mean you can say with absolute certainty that other causes weren't there. But if the metric were we need 100 percent certainty that we can't do. But we can say that it's over 95 percent likely it's coronary and that leaves room in the very distant minority for other causes of death, but they are highly unlikely, each one of them in the context of the clinical case.

Clinical diagnosis is a legitimate form of diagnosis for cause of the death and it was exercised by the primary care doctor.

Q In addition, to be complete, she was also a lady who had risk factors for fatal arrhythmia independent of her heart disease; didn't she?

A No.

Q She was also a lady who had risk factors for pulmonary thromboembolus independent of her heart disease?

A Yes, she did.

Q And risk factors for stroke independent of her heart disease?

Page 131

A They are just -- if the benchmark is what's the most likely cause of her death, if that's the standard.

Q Just answer my question.

A I have been answering your questions and saying that there are all possible.

Q The point is, and I understand that your preference of cause of death is that it is in your opinion regarding cause of death is that it was a cardiac cause?

A Not just me. It's Dr. Solt's who knew her better than any of us.

MR. WRIGHT: Move to exclude.

Q I'm just talking about your opinion.

A I have a basis for my opinion. It's not just an opinion. I have a foundation for my opinion, sir.

Q Well, if she had sudden death due to a cause unrelated to outcome from an earlier catheterization we have established in our discussion today that the clinical picture would be exactly the same; haven't we?

A That's why we can't say with absolute certainty and we can only say with reasonable certainty.

Page 132

Q And the point would be if she died from something else that would be 100 percent the cause whether you can know it with certainty or not; true?

A Right. But we are talking about reasonable medical probability.

Q And that has to be based on science; doesn't it?

A Science is clinical information. Otherwise, then you could say -- she did not get an autopsy because it wasn't needed. It wasn't needed because her primary care doctor, Dr. Solt, recognized in the clinical context of the patient who died on the precipice of getting a catheterization who presented with recurrent chest pain, with a history of recurrent coronary disease, who failed a stress test that the overwhelming likelihood was coronary.

It doesn't mean that it's impossible to be something else, but it means that it's not credibly -- it's not credible to take any of your diagnosis and say that they even remotely approach the likelihood of a coronary death. But of course anything is possible including blowfish poisoning.

Q It would be speculative and it is

Page 133

speculative without an autopsy to state that this was a death due to myocardial infarction when she had all these other risk factors?

A No, it's not speculation. It's reasonable likelihood. It's only speculating if you are holding it to a standard of 100 percent certainty. But it's not speculation to draw the overwhelming most likely cause of death.

This statement doesn't say it is impossible for her to have died from something else. It's just saying overwhelmingly we know what killed her, but we don't know with 100 percent certainty.

But if the legal standard required 100 percent certainty then I would concede that I can't be 100 percent certain. But I can be reasonably certain that all the other diagnosis are pale in comparison to the probability that a woman who died waiting for a cath with her history, her symptoms, her symptoms more at night and she died at night, her death was coronary, you can say that with reasonable certainty, but not absolute certainty. Speculation could only be raised if I were to say I know with 100 hundred percent certainty.

Q Every one of those factors fits fatal arrhythmia due to electrolyte imbalance, fatal

Page 134

arrhythmia associated with noncompliance with the CPAP, nighttime, pulmonary thromboembolus, stroke and even abdominal aortic aneurysm, doesn't it?

MR. BRANCH: Objection. Asked and answered.

Q Every one of those factors fit equally with those causes as well; don't they?

A They fit in terms of methodology of her death, but not with equal likelihood.

THE WITNESS: Pardon me. I need a short break.

MR. WRIGHT: Okay. I'm about to wrap up.

(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 MR. WRIGHT:

Q Now, earlier you made some reference to the scheduling changes on the whiting out of the date and the rescheduling by Mr. Parker for each of these rescheduled dates.

Do you recall that?

Page 135

A Yes.

Q And you understand that the only thing that he did relative to those orders was change the date to facilitate getting her on the schedule for the date selected?

A It's more than that.

Q It's not more than that.

A No, it is more than that because he implied that Dr. Mitchell signed off on that date which he didn't.

He was not in a position to change dates without consulting a physician. This patient needed an interval follow-up. If this patient even did tell him that she didn't want the doctor, he was duty bound to have the doctor talk to her to discuss the risks and benefits and to have her come in.

He was not qualified to explain to her the threat she faced. He was not a health care professional in a position to take an history, to change dates unilaterally. To make it look like Dr. Mitchell signed off on those dates and not to consult the doctor if she refused. He had no clue about the risk-benefit ratio. He had no ability to transmit that to the patient about the threat and he didn't bring her in to be seen by the doctor.

Page 136

His approach is egregiously unacceptable. To white out a date from a signed note and change the date is a gross deviation in the standard of care and to not consult a doctor is a gross deviation.

Q You're obviously, I asked you a number of things earlier about areas of practice that you are not involved in and one of the things that you are not is a medical assistant. Not taking anything away from the position that you do occupy, but that's a true statement; isn't it?

A Yes, but I do know about the limits of what a non-physician can do.

Q Let me just ask you this. Do you allow, and I'm asking you this with respect to a cardiologist, okay, not as a medical assistant. Do you allow that if the patient were stable without symptoms and preferred to have her catheterization scheduled after the holidays a reasonable cardiologist within the standard of care could acquiesce with that request?

A I would need to know about that change, what the date is and the reason. I would need to know if there was a clinical reason. I would need to explain to the patient the risks and

Page 137

benefits of delay.
I would want to take a thorough history about her intercurrent symptoms, not what Tim Parker did, and that way I would have an understanding as to the reasonableness of a delay.
Q All right. And if the patient were to say that she was not experiencing any symptomatology and had not experienced symptomatology as of the date of the stress echo forward, would you allow that a reasonable cardiologist could schedule her catheterization in accordance with her wishes along the timeline that we have in this case?
MR. BRANCH: Are we assuming the same presentation on the 30th and the symptomatology?
Q Yes, I'm saying everything.
A Absolutely not. She needed to be catheterized within a few days of her stress test as Dr. Mitchell had done before.
I raise the issue if Dr. Mitchell was impaired then he needed to let his patients know that if it affect his judgment.
Q Are you aware of literature that holds that even with a catheterization in patients like Ms. [redacted] who have had coronary artery bypass

Page 138

grafting, revascularization previously, that even with catheterization there is no improved survival?
A I disagree.
Q Okay.
A I think if a patient is unstable there is a clear improvement in survival.
Q If she is not having symptoms she would not be considered unstable; would she?
A I disagree. She had unstable symptoms at the time of her presentation and-- unstable coronary symptoms can have phases of symptom-free and then come back with an aggressive storm.
Her presentation demanded an earlier response to her catheterization and the date set was too late and every delay was egregious and she died while waiting to have her life saved without knowing the grave nature of her problem.
Q If she were symptom -- if she were asymptomatic following -- by the way, did you understand that at the conclusion of her stress echo her symptoms normalized?
A Yes, but the stress echo pushed her heart to a limit she was incapable of doing on her own. It induced the same symptoms of chest pain that she was feeling spontaneously and of course it

Page 139

resolved. She was forced to do a marathon that she normally couldn't do so of course it normalized.
But it is further validated because she did have chest pain that her symptoms at rest were coronary and urgent and unstable.
Q And do you acknowledge that a patient who might be considered as a patient with potential unstable angina, but who over the course of the following weeks demonstrated stabilization of symptoms would be considered at an intermediate risk for a cardiac event within the following year, particularly given her normal left ventricular function?
A No. If she present unstable, you can have periods where the symptoms lessen and they come back with a vengeance and there has been no history taken of her symptoms over the course of the weeks after her leaving.
Mr. Parker specifically testified that he was only asking about now. He did not ask about the night before. He did not ask about two nights before.
Q Was he asked those questions?
A He stated I think affirmatively that he was asked about that day. I think that was his

Page 140

statement. He brought that up.
Q So the point would be I guess, for me at least, that if the conversation or if, in fact, the patient's symptomatology was nonexistent, that she was asymptomatic for this period of time she could be classified as an intermediate risk?
A No. She was high risk because she presented with multiple rest symptoms at night and multiple rest symptoms is unstable and a future pattern can change, but there still could be a thrombotic lesion waiting to clamp down like a spring trap.
Q How many stents had she had previously?
A I don't remember the number.
Q We can figure it out, but it was several; wasn't it?
A Yes.
Q And the three-vessel bypass?
A Yes.
Q And I think we discussed earlier that patients who have undergone that many procedures in their chest and on their heart can have and frequently do have non-coronary pain even at rest?
A True. But she had an abnormal stress

Page 141

test which induced chest pain that she was complaining of. And she was scheduled for a cath for that very reason.
Q I'm not taking issue with that. But the fact of the matter is those patients can have a stable situation even with an abnormal stress test if it's not producing symptoms?
A If they have a pattern of stable pain, yes.
Q Okay.
A But if they are having rest pain, no.
Q And a pattern of stable pain allows for the possibility that pain can develop infrequently and then can be normal?
A I don't understand the question. If they come in with an unstable pattern they are unstable until the day they are fixed and every day you are playing dice with their life.
MR. WRIGHT: Move to exclude as nonresponsive.
Q She was not coming in with any active symptomatology even on the 30th of October; was she?
A Not at the moment.
Q Right.
A She had more symptoms that night. It

Page 142

wasn't nighttime.
Q You said she had more symptoms that the night of the 30th?
A No. Her complaints were more symptoms at night, although she clearly had some symptoms not at night so if she was seen in the daytime statistically it would be less likely she would be having a symptom at that moment.
Q Did she describe herself as so-so?
A Yes.
Q All right. And do you understand that the questioning regarding her symptoms at night or that the information regarding her symptoms occurring at night, but not every night, was developed through questioning from Dr. Mitchell and his nurse practitioner?
A Yes.
Q And I apologize, I know this is repetitious, but you and I are clear that according to the testimony of Tim Parker he was never informed of any symptomatology that she was having from the date of the stress test forward; is that fair?
A True, but he wasn't qualified to ask or know.
Q Do you know how long he had worked in

Page 143

that practice as a medical assistant contacting patients and setting up these schedules?
A No.
Q You understand it was a pretty good period of time?
A It doesn't make a difference. He is not qualified to take an interval medical history with issues of life or death consequence.
Q He is qualified to know and understand when a patient is complaining of chest pain or shortness of breath; isn't he?
A I disagree because he clearly asked narrow questions of this patient and that shows a complete lack of understanding.
Q And of course Ms. [redacted] herself had a history of having experienced things that caused her to go to an emergency room or go to a clinic?
A Yes. And when you present to your doctor with rest pain and the doctor says you can go home and get a stress test and be cathed in a month, you are being told by your doctor that this is not high risk and that this pattern is acceptable.
Q All right. Have you given me all of your opinions with regard to Dr. Mitchell's care and the causation issues in this case?

Page 144

A Well, I think they are all in my report. I think I raised the issue of Dr. Mitchell's medical condition in November and even though it has not been disclosed, if it was a condition that affected his ability to make medical decisions, if he was under the influence of drugs or alcohol that would be a significant factor in terms of both the mistake of delaying how long the cath was, the failure to sign this patient out to his covering doctor. Or if he had any meningitis. But if he have some medical condition that affected his ability, his mentation, that is a very significant finding in terms of what happened here.
Q But you didn't have any evidence of any of that; do you?
A No.
Q All right.
A And, by the way, the delay in the cath knowing she had rest pain as a minimum even if he made the mistake of saying I'm going to do you a cath in a month, he was required to see her at least weekly to see if her pattern had changed or to insure he had phone calls to be aware of her symptoms which he didn't do.
Instead it was Tim Parker who called

Page 145

who doesn't know what he's doing.
MR. WRIGHT: I move to exclude his argumentative nonresponsive and beyond the scope of the pleadings.
MR. BRANCH: It was in response to your question about his opinions. He has told you what you have asked him about and he has and he has a detailed report that have all of his opinions in it and he was just answering your broad question.
A Anyway, that's all of my opinions.
Q All right. Now, just a few other generalized questions and I think we'll be finished.
A Good.
Q Have you ever promoted or advertised your availability to provide consultations and testimony in any media?
A Never have.
Q Are you affiliated with or associated with any organization or have you ever been that secures or connects or refers expert witnesses to attorneys?
A I have no relationship with any, although I think at times I have discovered lawyers

Page 146

reached me through services that find doctors, but I have no relationship. I would not permit them to use my name in advertising and there is just no relationship.
Q Have you ever been contacted by any expert witness service and referred a case?
A I think I have discovered in retrospect that I thought I was being called by a law firm and it ends up being an intermediary, but I didn't know it at the time.
Q What were the names of those firms?
A I don't recall the names of the firms.
Q Have you ever spoken to or addressed any trial lawyers or plaintiff type group regarding the provision of expert testimony in medical/legal cases?
A No.
Q Or promoted yourself in any manner, whether it was a letter or anything like that?
A Never.
Q And you have no idea how Mr. Branch from down in Georgia initially found you?
A Correct. Often it's word of mouth through other lawyers, but I don't have any understanding.

Page 147

Q Right. Well, do you understand that you are within the American Trial Lawyers, that is the plaintiff group network for expert witnesses?
A I have no idea. I didn't even know that existed.
Q How many -- let me do it this way. For this number of cases in which you have been deposed and testified at trial as well as taken on for review, is there any state in the country from which you have not received a case?
A Ten states at least. But I would have to get a map.
Q Yes. I'm trying to do this the easiest way rather than have you run off 40 states.
A Well, I'll try. I don't think I have reviewed any case from North or South Dakota, Idaho, Iowa. Well, maybe Iowa. Alaska, Hawaii, Utah. I mean there are ten states. I have given you six of the ten. I don't recall.
Q Okay.
A And at least ten of those other states I have reviewed one case over 30 years.
Q You know why I am asking you that question. I have seen in some prior testimony that you have given similar answers.

Page 148

A That I reviewed cases from lawyers in as many as 40 states, but the overwhelming majority come from a handful and the majority of the other states have been one or two cases over 30 years.
Q Okay. But your best judgment is you have taken on for review within this multitude of cases they have come from 40 states or so?
A The multitude have come from five states and then occasional cases from others.
Q All right. Do you currently hold privileges to admit to a hospital?
A Yes, Lenox Hill Hospital. It's on my CV.
Q All right. And have you ever had, I don't have any reason to think your answer to these questions would be yes, but I need to ask them anyway.
Have you ever had any action taken against any hospital privileges that you have held at any hospital?
A Never.
Q Ever had any disciplinary procedures or grievances, I'm not counting that lawsuit filed against you, by any regulatory board, licensure board or hospital?

Page 149

A Never.
Q Ever voluntarily given up -- excuse me, even involuntarily given up any hospital privileges or your license to practice medicine?
A Never.
Q Have you ever been to Alabama?
A Yes.
Q For professional or social?
A Tourism.
Q Okay.
A My wife and I once did a trip through the south, went to Natchez, Mississippi, drove through Mississippi, Alabama. We kind of did a whole southern tour. We love the south.
Q I think I am basically done. I just want to leave with this and that is are we clear there is not any issue that's important to you that we haven't touched on about this case, that we haven't touched on in our question and answer session today?
A Yes.
MR. WRIGHT: Okay. That's all. Thank you.
MR. BRANCH: The only thing I would add is and I can't remember what

Page 150

we talked about for five hours.
THE WITNESS: It's three and a half hours, but that's okay.
MR. WRIGHT: I don't think it's five.
MR. BRANCH: But his report obviously states all of his opinions and they discuss whichever one of those or all of those at Mr. Wright's choice, so.
THE REPORTER: Do you want the witness to read?
THE WITNESS: I waive.
(Whereupon, at 12:40 o'clock p.m., the deposition was concluded.)

Page 151

C E R T I F I C A T E

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 and reading and signing was waived.

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 4th day of December, 2017.

_____
TINA DeROSA