

Page 1

1 IN THE CIRCUIT COURT OF UNITED STATES DISTRICT COURT  
 2 FOR THE MIDDLE DISTRICT OF ALABAMA  
 3 EASTERN DIVISION  
 4 -----x  
 5 LATISA [REDACTED] as Administratrix  
 6 of the estate of MILDRED [REDACTED]  
 7 deceased,  
 8 Plaintiff,  
 9 vs. CASE NO. [REDACTED]  
 10 JOHN W. MITCHELL, M.D., and THE  
 11 HEART CENTER CARDIOLOGY, P.C.,  
 12 Defendants.  
 13 -----x  
 14 DEPOSITION of BRUCE CHARASH, M.D., taken by  
 15 Defendants at the offices of Fink & Carney Reporting  
 16 and Video Services, 39 West 37th Street, Sixth Floor,  
 17 New York, New York 10018, on Wednesday, November 29,  
 18 2017, commencing at 9:00 o'clock a.m., before Tina  
 19 DeRosa, a Shorthand (Stenotype) Reporter and Notary  
 20 Public within and for the State of New York.  
 21  
 22  
 23  
 24  
 25

Page 3

I N D E X

3 Witness: Page  
 4 Bruce Charash, M.D.  
 5  
 6 Examination By: Mr Wright 4  
 7  
 8 E X H I B I T S  
 9  
 10 Exhibit Description Page  
 11 For Id.  
 12 Exhibit 1 Compilation of invoices 5  
 13  
 14  
 15  
 16  
 17  
 18  
 19  
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 21  
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 23  
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Page 2

1 A P P E A R A N C E S:  
 2  
 3 PHILIPS BRANCH & HODGES  
 4 Attorneys for Plaintiff  
 5 105 13th Street  
 6 Columbus, Georgia 31901  
 7 BY: JASON BRANCH, Esq.  
 8  
 9 STARNES DAVIS FLORIE LLP  
 10 Attorneys for Defendants  
 11 Seventh Floor, 100 Brookwood Place  
 12 Birmingham, Alabama 35259-8512  
 13 BY: MICHAEL K. WRIGHT, Esq.  
 14  
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1 BRUCE CHARASH, M.D., called as a  
 2 witness, having been first duly sworn by Tina  
 3 DeRosa, a Notary Public within and for the  
 4 State of New York, was examined and testified  
 5 as follows:  
 6 EXAMINATION  
 7 BY MR. WRIGHT:  
 8 Q Good morning, Dr. Charash. Am I  
 9 pronouncing your name correctly?  
 10 A Yes, sir.  
 11 Q All right. We met prior to the  
 12 deposition. As you know my name is Mike Wright and  
 13 I represent the Defendants in this case.  
 14 I want to kind of not take up too much  
 15 of your time unnecessarily. Tell me when you were  
 16 first contacted in connection with this case and  
 17 feel free to refer to anything that you need to?  
 18 A Yes. I brought a copy of all my  
 19 invoices that I have submitted in this case.  
 20 Q All right.  
 21 A And the first invoice I have is from  
 22 March 4, 2015. I can't tell you exactly when I  
 23 received the file, but it most likely would have  
 24 been somewhere in February of 2015.  
 25 Q And the source of that contact would

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1 have been what?  
 2 A It could have been a phone call or an  
 3 e-mail or in some cases I just get a file with a  
 4 letter to review. I just don't recall and I don't  
 5 have saved e-mails so I don't know.  
 6 THE REPORTER: Excuse me. I  
 7 need to go off the record.  
 8 (Whereupon, a short recess was  
 9 taken. )  
 10 (The deposition resumed with all  
 11 parties present.)  
 12 BRUCE CHARASH, M.D., resumed  
 13 and testified further as follows:  
 14 (Compilation of invoices were  
 15 marked as Exhibit No. 1 for  
 16 identification, as of this date.)  
 17 Q So to catch us up, Dr. Charash, you've  
 18 handed me a compilation of invoices on the case  
 19 which I have marked with a sticker as Exhibit 1, and  
 20 I think you told me before we had the machine  
 21 malfunction that you thought you would have been  
 22 contacted somewhere in the vicinity of February of  
 23 2015?  
 24 A Correct.  
 25 Q All right. And you did not recall the

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1 source of that contact, whether phone, letter or  
 2 e-mail; is that accurate?  
 3 A Equally true.  
 4 Q All right. Now, can you tell me who  
 5 it was by whatever media you were contacted, who it  
 6 was that contacted you?  
 7 A No. I just have no memory of the  
 8 contact.  
 9 Q All right. And you have no record of  
 10 it?  
 11 A Correct.  
 12 Q So you don't know whether it was Jason  
 13 or someone from his firm or someone acting on behalf  
 14 of the firm that might not have been employed by the  
 15 firm.  
 16 Am I right about all of that?  
 17 A Well, I think it was someone from his  
 18 firm. I don't know whether or not, and again  
 19 because I do receive cases in various ways,  
 20 Mr. Branch may have called me. Mr. Branch may have  
 21 written me a letter, an associate or an employee of  
 22 Mr. Branch may have made the contact. I don't  
 23 recall.  
 24 Q Have you worked with him or his firm  
 25 previously?

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1 A I have.  
 2 Q On how many occasions?  
 3 A I don't know, a handful. Three, four,  
 4 five maybe.  
 5 Q Have you ever testified in court for  
 6 them?  
 7 A I don't recall. Have I?  
 8 MR. BRANCH: No.  
 9 A I don't think so.  
 10 Q All right. Have you given depositions  
 11 previously?  
 12 A I think once. I don't recall the  
 13 case.  
 14 Q All right. Do you know how Jason or  
 15 his firm first, I'm talking about prior to this  
 16 case, came to know of your availability to review  
 17 medical/legal cases and to testify?  
 18 A No.  
 19 Q How long or, excuse me, over what  
 20 period of time have you been doing work with him?  
 21 A With who?  
 22 Q Jason or his firm.  
 23 A Mr. Branch's firm, I don't know, five,  
 24 six years perhaps. I don't recall.  
 25 Q All right. And all together how many

Page 8

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

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1 interacted with 50,000 patients and the way my  
 2 memory works I need something to trigger it. So I'm  
 3 not trying to be disrespectful or evasive. I just  
 4 don't recall.  
 5 Q I am only asking the questions the  
 6 only way I know how.  
 7 A No. No. I'm just telling you I just  
 8 don't remember. I'm sure Mr. Branch's firm can  
 9 provide more updated information than I can.  
 10 Q Okay. Maybe we'll ask him about that  
 11 at a later point.  
 12 So in connection with this case what  
 13 is your first substantive memory of any  
 14 communication?  
 15 A I only remember our recent meeting on  
 16 Monday to discuss my final opinions. I mean I know  
 17 I consulted with Mr. Branch about my report. I know  
 18 I have discussed the information as it became  
 19 available. I know that as I reviewed the  
 20 depositions of the Defendants we had discussions,  
 21 but quite frankly I don't have a recollection of  
 22 dates or what we said and because my opinions are  
 23 based on the sum of all the information it's  
 24 difficult for me to parse back when I had partial  
 25 information.

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1 Q Was the lawsuit already filed by the  
 2 time that you were contacted or had it yet to be  
 3 filed?  
 4 A I don't know.  
 5 Q Have you been provided with a copy of  
 6 the Complaint?  
 7 A I don't know. I don't have it. So I  
 8 --  
 9 Q What have you brought here today?  
 10 A Most of my records were sent to me  
 11 electronically. So I could not print it all out.  
 12 We could forward you a disk afterward.  
 13 I brought with me my written report.  
 14 I brought the Georgia death certificate report.  
 15 Provided to me on Monday when Mr. Branch came to my  
 16 home is a handwritten note from Tim Parker  
 17 concerning the catheterization schedule.  
 18 And then I have a series of medical  
 19 records from Dr. Mitchell's office and then I have  
 20 the depositions of Dr. Mitchell and Mr. Parker.  
 21 Q All right. Now, when you say a series  
 22 of medical records from Dr. Mitchell's office, are  
 23 you referring to what you understand to be his  
 24 complete office chart or are those excerpts?  
 25 A I have his complete office chart. I

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1 don't know if I printed out the entire office chart.  
 2 Q Okay. Are these document that you  
 3 printed yourself or that were provided to you?  
 4 A No, totally printed. Everything was  
 5 sent to me by Dropbox.  
 6 Q Right.  
 7 A Or by e-mail.  
 8 Q Well, the note regarding the phone  
 9 calls that you just showed you said was provided to  
 10 you on Monday. Was that an e-mail or was that --  
 11 A No. We met in person.  
 12 Q That's what I understood.  
 13 A And we discussed the case.  
 14 Q Anything else provided to you by Jason  
 15 as of Monday that you did not have prior to Monday?  
 16 MR. BRANCH: Just to clarify,  
 17 when I handed it to him Monday we were  
 18 in a meeting. It was easier for me to  
 19 hand me a copy. It's a copy of the  
 20 chart that you all provided with you  
 21 all's Bates stamps on there.  
 22 MR. WRIGHT: Yes.  
 23 MR. BRANCH: So you were saying  
 24 is there anything you hadn't been  
 25 provided before.

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1 Q Well, I thought he testified that he  
 2 saw that for the first time on Monday. Am I  
 3 mistaken about that?  
 4 A Well, I guess it was highlighted to me  
 5 on Monday. I probably had seen it, but it became a  
 6 point of our conversation.  
 7 Q It wasn't something that you had  
 8 discussed specifically prior to Monday; is that  
 9 fair?  
 10 A Probably.  
 11 Q All right. Now, the materials that  
 12 you have reviewed in connection with this case I  
 13 think you just told me included what you understand  
 14 to be the complete chart of Dr. Mitchell, his  
 15 deposition, Mr. Parker's deposition, and what else?  
 16 A I think it's in my report. Let me see  
 17 what I reviewed. The depositions of Dr. Mitchell  
 18 and Parker. Dr. Mitchell's records and The Heart  
 19 Center. The records of Dr. Solt. East Alabama  
 20 Medical Center. The multiple reports of testing  
 21 that Ms. [REDACTED] underwent.  
 22 Q Those would be part of the East  
 23 Alabama records; would they not?  
 24 A Yes. I think that's it.  
 25 Q Okay. Now, other than this report

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1 that we have received have you had any other  
 2 substantive written communications with Mr. Branch  
 3 or his firm about the case?  
 4 A No.  
 5 Q Any drafts of the report that were  
 6 revised or anything of that sort?  
 7 A No.  
 8 Q Who wrote the report?  
 9 A It was a combination effort. I had a  
 10 thorough conversation about my opinions with Mr.  
 11 Branch. He then provided me a draft in Word  
 12 documents.  
 13 I don't recall to what degree I would  
 14 have personalized the report or whether or not his  
 15 draft effectively -- for the most part of the draft  
 16 was very effective in outlining the opinions that I  
 17 expressed.  
 18 Q But he wrote it and you confirmed that  
 19 it comported with the opinions you had expressed?  
 20 A Yes. And I may have made some  
 21 individualization to it, but I cannot recall.  
 22 Q Are you aware of any other experts in  
 23 the field of cardiology who are involved in this  
 24 case?  
 25 A No.

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1 Q Retained by Mr. Branch or his firm?  
 2 A No.  
 3 Q So you haven't been shown any other  
 4 reports that might be pretty much identical to your  
 5 report?  
 6 A Correct.  
 7 Q Or even different from your report.  
 8 You haven't seen any other reports is what I'm  
 9 understanding.  
 10 A Correct.  
 11 Q All right. You as I understand are a  
 12 cardiologist; is that correct?  
 13 A Yes.  
 14 Q You are not an interventional  
 15 cardiologist; are you?  
 16 A Correct.  
 17 Q You've never performed an  
 18 interventional procedures; have you?  
 19 A Correct.  
 20 Q You are also not a cardiovascular  
 21 surgeon?  
 22 A Correct.  
 23 Q Not a, if there is the difference, I  
 24 think there is, a cardiothoracic surgeon?  
 25 A Correct.

Page 15

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

Page 16

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

Page 17

1 myself.

2 Dr. Mitchell also served even though

3 is an interventional doctor in the position of a

4 clinical doctor. I'm only going to offer opinions

5 in that clinical arena.

6 Q I understand. And just so we're clear

7 and I really didn't mean to make this too difficult

8 of an exercise for you or for me, the subspecialties

9 that I outlined are areas of expertise in areas of

10 practice that you do not have and that you do not

11 follow?

12 A Correct.

13 Q Okay. Now, with regard to Ms. [REDACTED]

14 the patient involved in this case, do you understand

15 that she had some significant comorbidities?

16 A Yes.

17 Q What was her weight?

18 A By memory I don't know. I could look

19 it up.

20 Q I don't think there would be any

21 dispute.

22 A She was obese.

23 Q She was morbidly obese; wasn't she.

24 A Yes, but I don't recall.

25 Q She had, I don't think we'll have any

Page 18

1 dispute about this, coronary artery disease clearly;

2 did she not?

3 A Yes.

4 Q She had a prior PCI with a stent

5 placement. I believe initially was it the left

6 circumflex?

7 A The first procedure was in 2007 before

8 she saw Dr. Mitchell.

9 Q Right. West Georgia?

10 A Yes.

11 Q And then had she had -- excuse me.

12 Did she also suffer from chronic hypertension,

13 systemic hypertension?

14 A Yes.

15 Q Diabetes mellitus?

16 A Yes.

17 Q Obstructive sleep apnea for which she

18 was prescribed the CPAP therapy?

19 A Yes.

20 Q Hyperthyroidism?

21 A Yes.

22 Q Dyslipidemia?

23 A Yes.

24 Q She was noted in several places to be

25 a person with a sedentary lifestyle; was she not?

Page 19

1 A Correct.

2 Q And it may be my mistake. I'm reading

3 this as different from stent placement, but did she

4 have angioplasty of the obtuse marginal coronary

5 artery and proximal mid-right coronary artery prior

6 to her bypass grafting in 2009?

7 A Yes.

8 Q Okay. And is that different from

9 stent placement?

10 A An angioplasty is using a balloon or a

11 device to open up an artery. A stent is just the

12 spring you leave behind to keep the artery open.

13 Q Okay.

14 A So an angioplasty/stent procedure was

15 performed in two arteries. Eventually because of

16 their shutdown she underwent a bypass.

17 Q Right. Three vessels bypass; was it

18 not?

19 A Yes.

20 Q Now, do you know anything about the

21 decision-making she had relative to the timing of

22 the scheduling of that bypass surgery. Was there

23 anything significant to you about that?

24 A Again I don't know if I understand

25 what you're asking me. I know the timing of the

Page 20

1 procedure, but I don't know what you're asking me.

2 Q When was it done?

3 A Her bypass operation was performed on

4 January 12, 2011.

5 Q 2011?

6 A Yes.

7 Q Okay.

8 A Or 2010.

9 Q 2010 was it not?

10 A Yes. I wrote my ten poorly.

11 Q 2010?

12 A Right.

13 Q All right. Now, I also saw on some

14 studies that she had a tricuspid valve disorder

15 which was I think thought to be not uncommon for her

16 age; is that correct?

17 A Yes. She had mild tricuspid

18 regurgitation.

19 Q And she suffered also from peripheral

20 vascular disease; did she not?

21 A Yes.

22 Q Okay. Any other significant

23 comorbidities that she had that I have not asked you

24 about that you know of?

25 A No.

Page 21

1 Q All right. Talk to me for just a  
 2 minute about your charges for doing this kind of  
 3 work, Dr. Charash. What do you charge for reviewing  
 4 records presently?  
 5 A Since 2015 my rates have been \$450 an  
 6 hour for review of records and \$500 an hour for  
 7 testimony time.  
 8 For trial it's purely based on how  
 9 many hours of work I miss on a 9:00 to 5:00  
 10 schedule. So if I were to fly down for travel after  
 11 work hours to testify the next morning and come back  
 12 for the night I would only miss eight hours of work,  
 13 so I charge \$4,000.  
 14 Q Okay.  
 15 A For a deposition it's 500 an hour with  
 16 a two-hour minimum unless I'm told in advance that  
 17 the deposition will be short.  
 18 Q All right. And you showed me your  
 19 invoices. I'm going to hand them back to you. I  
 20 did not do any calculations myself.  
 21 How many hours would you say you have  
 22 in the case up to the point of today's exercise?  
 23 A Well, there are reflected in these  
 24 invoices up until October 9th six and a half hours  
 25 and there will be another two and a half to three

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1 hours for our meeting and my preparation.  
 2 Q Okay. And then whatever time you and  
 3 I are spending today is charged at \$500 an hour with  
 4 at least a two-hour minimum?  
 5 A Right. Which that invoice will be  
 6 forwarded to you.  
 7 Q But the charge for trial as I  
 8 understand it is essentially \$4,000 a day for each  
 9 day that you would be away from your work?  
 10 A Correct. But if, for example,  
 11 Mr. Branch wanted me down to meet at 6:00 p.m. and I  
 12 had to leave for the airport at 2:00 p.m., then I  
 13 would charge for three hours of work.  
 14 It's all based on how many hours  
 15 during workdays from 9:00 to 5:00 the trial  
 16 consumes.  
 17 Q Of your time?  
 18 A Yes, of my missing work, how many 9:00  
 19 to 5:00 hours I miss.  
 20 Q Now, what would you tell me is the  
 21 amount or the approximate amount of income that you  
 22 have earned doing this type of work over, say, the  
 23 last five years?  
 24 A Five years?  
 25 Q Sure.

Page 23

1 A I think it's probably averaged \$60,000  
 2 a year, so it could be \$300,000.  
 3 Q And from the time that, over the time  
 4 that you have been doing this work have you made  
 5 over a million dollars?  
 6 A Probably. You know, again, I'm asked  
 7 this all the time.  
 8 Q I understand.  
 9 A But probably.  
 10 Q How many cases would you say you've,  
 11 you alluded to this earlier. I think you said over  
 12 900 cases you have taken on for review?  
 13 A Yes.  
 14 Q Can you be more specific?  
 15 A No.  
 16 Q All right. Did you think it's  
 17 probably by now as we sit here in late '17 closer to  
 18 a thousand?  
 19 A No. I had in previous years given  
 20 estimates and then as time went by I inflated those  
 21 estimates because I thought it was better to over  
 22 estimate than to under estimate.  
 23 So I would think that it would be  
 24 under 950. Maybe under 930. I have not kept track,  
 25 but I would say it's closer to 900 than it is to

Page 24

1 950.  
 2 Q You average giving depositions 20 or  
 3 more a year; don't you?  
 4 A In recent years. But over the course  
 5 of my career it's averaged 11 a year.  
 6 Q How many depositions have you given  
 7 this year since we are almost to December?  
 8 A Probably my 14th. Maybe 15. I don't  
 9 know.  
 10 Q When did you last testify before  
 11 today?  
 12 A In deposition or trial?  
 13 Q Either one.  
 14 A Yesterday in trial.  
 15 Q Where was that?  
 16 A In Syracuse, New York.  
 17 Q Okay. And that was a medical  
 18 negligence case?  
 19 A Yes, it was.  
 20 Q You were retained on behalf of the  
 21 plaintiff?  
 22 A Yes, I was.  
 23 Q What was the name of that case?  
 24 A Merrill, M-E-R-R-I-L-L.  
 25 Q Against who?

Page 25

1 A A Dr. Caputo, C-A-P-U-T-O.  
 2 Q And Dr. Caputo was a cardiologist?  
 3 A An interventional cardiologist.  
 4 Q Was it a death case?  
 5 A Yes, it was.  
 6 Q Were you speaking to issues of  
 7 interventional cardiology in that case?  
 8 A Only to areas of common overlap. I  
 9 was speaking to what I believe his missing  
 10 life-threatening problems on the angiogram images  
 11 and we showed the angiogram to the jury and showed  
 12 them what I found.  
 13 Q Do you perform catheterizations?  
 14 A I do not.  
 15 Q Have you ever performed a  
 16 catheterization?  
 17 A Not outside my training in 1985,  
 18 fellowship.  
 19 Q All right. You do not do diagnostic  
 20 catheterizations, nor do you do interventional  
 21 procedures; is that fair?  
 22 A Correct. But I have probably read  
 23 over 20,000 angiograms in my career of my own  
 24 patients.  
 25 Q You do conduct stress test or do you?

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

Page 27

1 Q I did. The last case appears as No.  
 2 80, so that's 77?  
 3 A Very good. Then you're accurate.  
 4 Q Okay. And those are just depositions?  
 5 A Yes.  
 6 Q According to the list?  
 7 A Yes.  
 8 Q And for trial testimony from  
 9 approximately the same period?  
 10 A Four years.  
 11 Q Right. July through March, July of  
 12 '13 through March of '17 it's 56 trial appearances;  
 13 is that right?  
 14 A Yes.  
 15 Q Okay. And were all of these on behalf  
 16 of the plaintiff?  
 17 A No. I don't distinguish plaintiff,  
 18 defense. I have pretty much reasonably estimated  
 19 that over 95 percent of my testimony for deposition  
 20 and trial are for plaintiff and under five percent  
 21 are for defense.  
 22 Q But the reality is in recent years  
 23 it's a hundred percent plaintiff and zero for  
 24 defense; isn't it?  
 25 A I wouldn't say in recent years. I did

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

Page 29

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

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

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

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

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1 exclude that.

2 Q My question simply is you are not

3 relying on any medical literature to illustrate,

4 buttress or make a point. Rather you are relying on

5 your own education, training, and experience in

6 expressing the opinions you are giving me here

7 today. Is that accurate?

8 A Yes, but it also includes a cumulative

9 career of reading literature.

10 Q And I'm not suggesting otherwise. I'm

11 trying to be specific as opposed to generalities.

12 A Then we are on the same page.

13 Q Now, you have, you have testified many

14 times relative to defining the standard of care for

15 cardiologists; haven't you?

16 A Yes.

17 Q And do you stand by the testimony that

18 the standard of care for a practicing cardiologist

19 consists of a range of reasonable and acceptable

20 different diagnostic or treatment options depending

21 on the circumstances presented by the patient. Do

22 you stand by that?

23 A Well, if there is a range within the

24 standard of care. Sometimes the standard of care

25 doesn't have alternatives. Often it does. So when

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1 it does, yes, I stand by that.

2 Q All right. And to follow-up on that

3 then, often as you just said there will be more than

4 one acceptable or reasonable approach to the

5 evaluation or treatment of a patient. That's true;

6 isn't it?

7 A Yes.

8 Q Do you agree with me that so long as a

9 physician is following a recognized and acceptable

10 school of thought in his evaluation and treatment of

11 a patient then by definition he or she is practicing

12 within the standard of care?

13 A In general.

14 Q Sure.

15 A But if there is more than one option

16 there is a duty to explain to the patient and let

17 them have vital input into the option.

18 Q That's not what I asked you. I asked

19 you do you agree that so long as a physician

20 follows, and I will put it this way to make it

21 easier for you.

22 Indeed, have you not testified that so

23 long as a physician follows a recognized and

24 acceptable school of thought and school of practice

25 in his evaluation or treatment of a patient is he

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1 practicing within the standard of care. Do you

2 agree with that or not?

3 A Okay. And I can't answer the question

4 limited to a simple yes or no. Only from the point

5 that it's not my language to say following a school

6 of thought because school of thought sounds like

7 it's a general ideology.

8 If the doctor picks an appropriate

9 option within the standard of care then they are

10 within the standard of care.

11 Q Fair enough.

12 A But saying following a school of

13 thought sounds like a philosophy that isn't

14 accounting for individual --

15 Q You certainly agree that in making

16 treatment decisions for a patient a physician should

17 call upon his or her education, training, and

18 experience to meet the standard of care just as I

19 think you have said you are doing here today; is

20 that right?

21 A Of course.

22 Q All right. Has it been your

23 experience that while there is much scientific

24 agreement on a number of points in the field of

25 cardiology there is also a great deal of controversy

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1 in the practice of cardiology on many other points?

2 A You would have to be more specific.

3 There are always areas that require further

4 definition.

5 I think there is more commonality than

6 controversy, but we are always pushing the

7 boundaries of new information and there become

8 issues that require further investigation to

9 understand the appropriate use.

10 Q You have had occasion where you have

11 disagreed with colleagues in the past even though

12 you and the colleague within whom you disagree have

13 certainly the best of intentions for a patient?

14 A Yes.

15 Q And the mere fact that one

16 cardiologist may prefer a specific method of

17 treatment or workup of the patient whereas another

18 equally qualified cardiologist may prefer a

19 different method does not mean that either of them

20 is practicing below the standard of care; does it?

21 A Well, you would have to be specific.

22 Q In general --

23 A Just because there is a disagreement

24 doesn't prove one is outside the standard of care.

25 Q That's what I am getting at.

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1 Do we agree that the practice of  
 2 medicine and, in particular, the practice of  
 3 cardiology is not an exact science?  
 4 A Sometimes it is and sometimes it  
 5 isn't. Parts of is are exact science, parts of it  
 6 are not.  
 7 Q What do you mean by that?  
 8 A There are exact science to a great  
 9 deal to the practice of cardiology.  
 10 Q Exact science?  
 11 A Yes. We do tests with known  
 12 predictive values.  
 13 Q Wait a minute. You said predictive  
 14 values?  
 15 A That's science.  
 16 Q It's not exact science; is it?  
 17 A It is exact science. If you are  
 18 defining exact science as absolute certainty of  
 19 outcome that's not what science is.  
 20 Q I very well know that. I want to make  
 21 sure you and I agree on that point.  
 22 A So there are parts of cardiology that  
 23 are an exact science and there are parts that are  
 24 not.  
 25 Q All right. Do you agree with me that

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

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

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

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

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

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

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1 Q And you have admitted that physicians  
 2 can exercise reasonable judgment even though those  
 3 judgments are later shown to be incorrect and  
 4 because those judgments were reasonable at the time  
 5 they were exercised that physician practiced within  
 6 the standard of care. You have testified to that;  
 7 haven't you?  
 8 A No, not with the way you're saying  
 9 that. I have testified with reasonable judgment  
 10 there can be bad outcomes.  
 11 I don't think I can recall a time that  
 12 I would have phrased the way you are because the way  
 13 you are phrasing it makes no sense to me.  
 14 (Discussion off the record.)  
 15 (A short recess was taken at  
 16 this time.)  
 17 (The deposition resumed with all  
 18 parties present.)  
 19 BRUCE CHARASH, M.D., resumed,  
 20 and testified further as follows:  
 21 BY MR. WRIGHT:  
 22 Q Moving along then, Dr. Charash, have  
 23 you, yourself, ever had the misfortune of being  
 24 named as a defendant in a medical malpractice claim?  
 25 A Yes, once.

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

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

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

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

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

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1 A Well, her stress test was December  
 2 7th. She was catheterized a week later on the 14th.  
 3 Q Right.  
 4 A And basically a month later she  
 5 underwent her bypass.  
 6 Q Okay. So the revascularization in  
 7 that case was roughly six weeks from the time of the  
 8 positive stress test; was it not?  
 9 A Well, actually closer to five weeks,  
 10 but that said --  
 11 Q Fair enough.  
 12 A -- her symptoms did not appear highly  
 13 unstable and once they had the roadmap of the  
 14 angiogram to see her coronary anatomy then a  
 15 decision could be made about the need for speed.  
 16 Q Okay. And as you said because she was  
 17 not having continuous symptomatology the timing as  
 18 far as the revascularization is appropriate as far  
 19 as you're concerned?  
 20 A Well, I think that I would have to  
 21 have testimony of the surgeon as to why they waited  
 22 that long and what the medical circumstances were,  
 23 so I have incomplete information.  
 24 There is no benefit to waiting unless  
 25 there is a benefit to waiting. So, for example, if

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

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

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1 Q All right. When she came on October  
 2 the 30th of 2014 do you understand that her  
 3 presentation there was basically a follow-up visit  
 4 for an established patient?  
 5 A Well, she came in as a symptom driven  
 6 visit of an established patient.  
 7 Q How long had it been since she had  
 8 been there previously?  
 9 A I don't remember.  
 10 Q When was the last time she saw Dr.  
 11 Solt prior to that visit?  
 12 A I don't remember.  
 13 Q Let me ask you this. Would it refresh  
 14 your recollection that she was last seen by Dr.  
 15 Mitchell the previous year in August or September of  
 16 2013?  
 17 A It doesn't refresh my recollection,  
 18 but I accept it.  
 19 Q Okay. And when she came in do you  
 20 understand that she was not complaining of any  
 21 active symptoms that day?  
 22 A Which visit?  
 23 Q Fair enough. October the 30th, 2014.  
 24 A Correct.  
 25 Q Now, her past medical history was

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1 reviewed and recorded in the chart; was it not?  
 2 A Yes.  
 3 Q And she gave by history that she had  
 4 been experiencing some chest pain, some tightness  
 5 which tended to occur more often at night; right?  
 6 A Yes.  
 7 Q And that with exertion she had fatigue  
 8 and severe dyspnea which is shortness of breath; am  
 9 I right about that?  
 10 A Yes.  
 11 Q All right. Now, did you understand  
 12 that either from the testimony or the record or both  
 13 that she was not complaining of having these  
 14 symptoms every night?  
 15 A It's not documented.  
 16 Q I'm asking you did you understand from  
 17 the testimony or the record that she was not having  
 18 these symptoms every night. Either you did or you  
 19 didn't.  
 20 A Again, only from the testimony; not  
 21 from the note.  
 22 Q All right. The symptoms that she  
 23 described particularly what occurred if it was not  
 24 occurring every night and would tend to occur more  
 25 often at night are not typical for angina; aren't

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

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

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1 A Yes.

2 Q All right. Did you understand that --

3 well, I know you did that by this time she was of

4 course a few years from her surgery, her open heart

5 surgery and he documented that?

6 A Yes.

7 Q So the plan was to go ahead and get a

8 stress echocardiogram, which you are not critical of

9 that I know?

10 A Correct.

11 Q All right. Can decreased oxygen lead

12 to shortness of breath and tightness in the chest?

13 A I'm sorry, I don't think I understand

14 your question.

15 Q I apologize. It was poorly worded.

16 If a patient is experiencing

17 desaturations can that lead to shortness of breath

18 and chest tightness?

19 A It could although it would depend on

20 what the nature of the desaturation, but if your

21 oxygen level drops low enough, sure.

22 Q All right. Did you understand that

23 she was not complaining of chest pain with exertion?

24 A Right. She was limited by shortness

25 of breath.

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1 Q No, I didn't ask you that. I asked

2 you did you understand that she was not complaining

3 of exertional chest pain and that's true; isn't it?

4 A Partially true. We don't have enough

5 real definition of her symptoms, but it appears that

6 her symptoms were primarily at rest and her activity

7 was limited by severe breathing problems.

8 Q With exertion she had fatigue and

9 dyspnea, but there was no history reported of

10 exertional chest pain; was there?

11 A That's correct.

12 Q All right. Now, this record says and

13 I'm really just pinpointing this for reference in

14 the transcript, Dr. Charash, that she was five feet,

15 six. Her weight was 265 and her BMI which stands

16 for body mass index was 42.8; doesn't it?

17 A Yes.

18 Q And that by definition is morbid

19 obesity?

20 A Yes.

21 Q All right. So the echo, the stress

22 echo was scheduled for November the 4th according to

23 the record and performed on that day; is that your

24 understanding?

25 A Yes.

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1 Q And do you also understand that was

2 performed at the East Alabama Medical Center

3 facility where they do that under the supervision of

4 a physician, not Dr. Mitchell?

5 A Yes.

6 Q Okay. Do you also understand that

7 during the course of that stress echo there were no

8 problems reported to Dr. Mitchell or anyone else in

9 terms of any kind of acute problems that she may

10 have experienced during the procedure?

11 A Correct.

12 Q Okay. Have you, yourself, and the

13 things that you listed I did not hear you say that

14 you had actually reviewed the stress echo films;

15 have you?

16 A I don't believe so.

17 Q Okay. You have reviewed the report

18 and I sort of took from reading your report that

19 your opinions relative to the stress echo were based

20 on the report itself; is that fair?

21 A Yes. And no one has challenged the

22 validity of it.

23 Q The validity of the report?

24 A Yes.

25 Q So as far as you are concerned you

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1 take the report at face value as an accurate report;

2 is that fair?

3 A Yes.

4 Q All right. Now, just looking at the

5 report we see that Dr. Mitchell records that she had

6 positive and it says S segment. Our understanding

7 is that that's a typographical error and it should

8 be ST segment changes with infusion. Is that how

9 you read it?

10 A Yes.

11 Q Okay. She had typical angina with

12 infusion which was described as some chest

13 discomfort with the infusion of the Dobutamine

14 and/or the Atropine; is that right?

15 A Yes.

16 Q All right. Her baseline

17 echocardiogram showed a normal left ventricular

18 size, normal left ventricular systolic

19 contractility, and an ejection fraction at

20 60 percent; correct?

21 A Yes.

22 Q And that is a normal ejection

23 fraction; isn't it?

24 A Yes.

25 Q Okay. Mild tricuspid regurgitation

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

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

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

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

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1 Q All right. Is it also true that  
 2 abnormal septal wall motion is commonly seen in  
 3 patients who have had bypass surgery, that is  
 4 coronary arterial bypass grafting?  
 5 A Permanent wall motion abnormalities  
 6 are seen, but not reversing wall motion  
 7 abnormalities.  
 8 Q Well, what I'm asking is in a patient  
 9 like her who has had CABG surgery previously it  
 10 would be common to see septal wall motion  
 11 abnormality; wouldn't it?  
 12 A It would be common to see a permanent  
 13 septal wall abnormality. Some people develop it,  
 14 others didn't. But it would not be an abnormality  
 15 that would appear during exercise and be gone at  
 16 rest.  
 17 So a reversing abnormality would not  
 18 be part of a bypass. But if it was permanently not  
 19 moving during exercise and rest then you might argue  
 20 that was a consequence of the surgery.  
 21 Q Well, doesn't that depend upon the  
 22 degree of which the surgery itself affects the  
 23 septal wall motion?  
 24 A No.  
 25 Q Why do you say that?

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

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1 There are patients that have wall motion  
 2 abnormalities --  
 3 Q As a generality it is frequent to see  
 4 abnormal wall motion in patients who have undergone  
 5 CABG surgery; isn't it?  
 6 A I can't answer the question the way  
 7 you phrase it as a simple yes, no.  
 8 Q Fair enough. If you don't know that's  
 9 fine.  
 10 A No. I didn't say I don't know.  
 11 Q Well, then answer it if you do know.  
 12 A No. I said I can't answer the  
 13 question the way you phrased it limited to a simple  
 14 yes, no. That's different than saying I can't  
 15 answer it.  
 16 Q Well, I'm going by what you just said  
 17 which was you can't answer it.  
 18 A I said I can't answer it limited to a  
 19 simple yes, no, but you cut me off before I said  
 20 that.  
 21 Q I don't think I did.  
 22 A Good Lord.  
 23 Q Are you finished?  
 24 A Excuse me?  
 25 Q Are you finished with what you wanted

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

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

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1 very low?  
 2 A No.  
 3 Q They have not shown that?  
 4 A No.  
 5 Q Okay. Have the studies shown that  
 6 repeat revascularization is not significantly  
 7 associated with improved survival in these patients,  
 8 those being those who have a prior history of CABG  
 9 surgery?  
 10 A It depends on what the clinical  
 11 situation is. If a person has -- you could have a  
 12 person who has an asymptomatic abnormal stress test.  
 13 You can have a person who has a symptomatic  
 14 presentation and you can have a person who has  
 15 unstable angina.  
 16 You can't just make a generalization.  
 17 It depends on the patient. If you have a patient  
 18 with recurrent pain at rest with evidence of  
 19 ischemia on a catheterization they are facing  
 20 imminent risk of sudden death.  
 21 Q Do you agree that decisions to proceed  
 22 with revascularization are based on the clinical  
 23 status of the patient rather than the result of the  
 24 catheterization test?  
 25 A It's based on all. It's based on the

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

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

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1 earlier that you have read Mr. Parker's deposition  
 2 testimony?  
 3 A Yes.  
 4 Q Do you understand that he received a  
 5 handwritten note from Dr. Mitchell telling him that  
 6 her stress echo was positive and that she needed a  
 7 left heart catheterization and that he should call  
 8 her to schedule that?  
 9 A Yes.  
 10 Q All right. And that's what he did?  
 11 A Yes.  
 12 Q All right. Now, did you understand  
 13 from Mr. Parker's testimony that Ms. [REDACTED] told him  
 14 that she wanted to wait until after Thanksgiving to  
 15 schedule the procedure and that she was not  
 16 experiencing any cardiac symptoms after he  
 17 questioned her about that?  
 18 A Well, I'm aware that he testified that  
 19 she wanted it after Thanksgiving in his testimony,  
 20 although it's not documented. But equally so he  
 21 testified that he asked her about whether she had  
 22 symptoms the day he called.  
 23 He was not representing himself to  
 24 taking a history of more than are you feeling well  
 25 today from his testimony, and he's certainly not

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

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1 MR. BRANCH: The implication of  
 2 that is offensive.  
 3 MR. WRIGHT: Well, I apologize,  
 4 but I think you should apologize as  
 5 well. I don't mean it offensively. I  
 6 wish you would not make gestures while  
 7 the witness is testifying approving or  
 8 disapproving of his testimony.  
 9 THE WITNESS: I can't see Mr.  
 10 Branch --  
 11 MR. BRANCH: My gestures are not  
 12 approving or disapproving of anything.  
 13 MR. WRIGHT: You were nodding  
 14 your head so it seemed to me like you  
 15 were giving him an encouraging gesture  
 16 to the witness to testify.  
 17 THE WITNESS: Can we get any  
 18 more childish than what you are doing  
 19 now. Can we just get to this case and  
 20 focus?  
 21 BY MR. WRIGHT:  
 22 Q I think we are pretty much focused on  
 23 this case, Dr. Charash.  
 24 A Very good.  
 25 Q And, you know, you can call all the

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

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1 A No, but it's not clear if he was  
 2 asking her since she already presented with a  
 3 pattern of discomfort whether he was talking about  
 4 something that was different than her current  
 5 pattern.  
 6 Frankly, if a person should come in  
 7 with a symptom then she should already be in because  
 8 she had the symptom.  
 9 Q Well, I'm not sure who is being  
 10 childish or what now, Dr. Charash, but had this lady  
 11 had previous catheterizations, previous percutaneous  
 12 interventions, had she been to the emergency room  
 13 previously with symptoms, and come to clinics  
 14 previously with symptoms. All of that had occurred  
 15 in her history; had it not?  
 16 A Right. And each time she was given a  
 17 plan by her health care provider which she believed  
 18 in good faith was a safe plan.  
 19 In this case she was turfed to a later  
 20 date for a catheterization which is one of the  
 21 central complaints I have and as a result she can't  
 22 independently know that her doctors made a mistake.  
 23 MR. WRIGHT: I move to exclude  
 24 that as nonresponsive.  
 25 Q Try to confine your answers directly

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1 to the question, Dr. Charash, and this will go a lot  
 2 more smoothly for both of us I think.  
 3 You understand that she according to  
 4 Mr. Parker said she wanted to wait until after  
 5 Thanksgiving. B, that she was not experiencing any  
 6 cardiac symptoms and, C, that he told her that if  
 7 she developed chest pain, shortness of breath or  
 8 anything out of the ordinary to call the clinic or  
 9 to go to the emergency room.  
 10 Is all of that your understanding of  
 11 his testimony?  
 12 A I think that is mischaracterizing her  
 13 testimony.  
 14 Q In what way.  
 15 A I think his testimony was that she  
 16 didn't have pain at the time of his call that day.  
 17 No. 2, he wasn't clear about what the  
 18 specific warning sign would be to come in, nor was  
 19 he qualified to even give such instructions.  
 20 Q Did he say exactly in his testimony  
 21 what I related to you?  
 22 A I don't know.  
 23 Q All right. Do you take issue with his  
 24 testimony that he told her that if she had chest  
 25 pain, shortness of breath or anything out of the

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1 ordinary she should contact the clinic or go to the  
 2 emergency room?  
 3 A Major issue. When he says out of the  
 4 ordinary that could imply outside of the pattern  
 5 that she presented with.  
 6 Q You misunderstood my question.  
 7 Do you take issue with his testimony  
 8 that he said that to her?  
 9 A I think that is for the jury to  
 10 decide.  
 11 Q Well, I understand that, but I'm  
 12 trying to understand --  
 13 A Well, I'm not weighing in on the  
 14 validity. That's for the jury to decide.  
 15 Q You are misunderstanding the question.  
 16 Did he testify to that or not?  
 17 A I said yes, he did.  
 18 Q All right. This stress echo by  
 19 definition would place her at intermediate risk for  
 20 a coronary event; wouldn't it?  
 21 A Only independent of her symptoms. So  
 22 if this was a routine stress echo that was done for  
 23 surveillance purposes without symptoms it would make  
 24 it intermediate.  
 25 Q All right.

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1 A But in the context of her symptomatic  
 2 presentation it puts her at extreme short-term risk  
 3 for sudden death.  
 4 Q I want to be sure I understand what  
 5 you're saying. The stress echo itself aside from  
 6 the history of symptoms that she gave would place  
 7 her at intermediate risk, and your testimony is that  
 8 taking this stress echo and coupling it with the  
 9 history of symptoms that she had given places her at  
 10 a greater risk.  
 11 Am I understanding you correctly?  
 12 A Of course.  
 13 Q And, therefore, in the event that she  
 14 were not symptomatic she would be at intermediate  
 15 risk, but because of the history of symptoms you say  
 16 she is at greater risk?  
 17 A Of course.  
 18 Q All right. You don't have any  
 19 evidence that would dispute Mr. Parker's report in  
 20 his testimony that she said she was having no  
 21 symptoms at that time; do you?  
 22 A No.  
 23 Q Okay. And you understand that given  
 24 the discussion between the two of them the  
 25 catheterization was scheduled for December the 5th

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

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1 consequence to that error.  
 2 Q All right.  
 3 A She needed an earlier catheterization  
 4 and needed to be told why, but if she had been  
 5 catheterized in retrospect on that first date she  
 6 would be alive and well today.  
 7 Q Well, we don't know whether she would  
 8 be alive and well today?  
 9 A Well, yes, we know with reasonable  
 10 medical certainty. No one is in the absolute  
 11 medical certainty business, but we can say  
 12 reasonable medical certainty.  
 13 Q There is no such thing as reasonable  
 14 medical certainty with all due respect.  
 15 A I have no idea what you are talking  
 16 about. That's a term that is used all the time.  
 17 Q It's a legal term that is a fiction;  
 18 isn't it?  
 19 A No.  
 20 Q It is either certain or not?  
 21 A No. You could say probably she would  
 22 be alive.  
 23 Q That is different than certainty?  
 24 A Reasonable certainty.  
 25 Q I don't know what reasonable certainty

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

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

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

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

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

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

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1 A What?

2 Q We're in a hurry.

3 A This is two hours into the deposition.

4 We are entitled to a five or ten minute break.

5 Q I'm fine with that.

6 (Whereupon, a short recess was

7 taken. )

8 (The deposition resumed with all

9 parties present.)

10 BRUCE CHARASH, M.D., resumed and

11 testified further as follows:

12 BY MR. WRIGHT:

13 Q Look, I know this is stressful, but

14 I'm just trying to do a job here.

15 A I know.

16 Q So let's just do our best.

17 A But in all fairness I know you want

18 certain questions limited, but I thought you wanted

19 this as an opportunity to hear the full breadth of

20 my opinions and in good faith I am just trying to

21 provide.

22 I thought that's what you needed to

23 know and I'm not trying to play games here, but I

24 mean there are a large breadth of opinions. You

25 have been asking me some narrow focused questions

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1 with very specific narrow focused answers and I'm

2 happy to do it all day long, but I just want to make

3 sure that I do have an opportunity today to express

4 all of the opinions that I have formed.

5 Q Well, all you have to do is just

6 answer my questions and when I am done we are done

7 unless Jason has something he wants to put on the

8 record.

9 A Okay.

10 Q And we'll see how it plays out later

11 if it's not to your satisfaction today.

12 All right. Let's kind of, I want to

13 go back to something that we spoke about just prior

14 to the break, Dr. Charash, and with regard to the

15 notations of Mr. Parker's calls to Ms. [REDACTED] the

16 document that you referred to.

17 I'm just going to ask you it this way.

18 Just assume for purposes of this question that

19 Mr. Parker wrote that she had refused or declined

20 Dr. Westermeir when he called her on or about the

21 4th of December.

22 Given that assumption that I'm asking

23 you to make, you would not have any evidence that

24 you could point to that would contradict that; am I

25 right?

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1 A Other than my presumption that the

2 note contradicts it, yes.

3 Q Well, I'm saying if you assume that he

4 wrote it on the 4th, if you make that assumption you

5 don't even have that perception.

6 A Well, again that's for the jury to

7 sort out, not me. I can only talk about the

8 evidence. Mr. Parker testified to what he testified

9 to. That's for the jury to decide.

10 Q That was going to be my next question.

11 You clearly understand that his testimony was that

12 she declined Dr. Westermeir during that initial

13 telephone conversation?

14 A Yes.

15 Q I said initial, but I meant the

16 December 4th telephone conversation. No issue there

17 in terms of what he testified to; am I right?

18 A You're just repeating yourself.

19 That's what he testified to.

20 Q All right. Now, I think then where we

21 are in this chronology is that you understand from

22 both his testimony and Dr. Mitchell's that Dr.

23 Mitchell was not going to be available to perform

24 the cath himself on December the 12th?

25 A Correct.

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1 Q Okay. And we don't have any evidence

2 as we discussed relative to December the 5th. We

3 also don't have any evidence of any harm or any

4 untoward event occurring between the December 4th

5 conversation and December 12th when the

6 catheterization was next scheduled?

7 A Nothing that we know about.

8 Q That's what I meant.

9 A She certainly was alive.

10 Q Right. And then on or just prior to

11 December the 12th do you understand from the records

12 and from Mr. Parker's testimony that he again

13 telephoned Ms. [REDACTED] to explain to her that Dr.

14 Mitchell was not going to be available on the 12th?

15 A Yes.

16 Q And do you understand that he

17 testified that -- he told her Dr. Westermeir was

18 available to do her procedure?

19 A That's what he said.

20 Q Right. And do you understand that he

21 testified that he again questioned Ms. [REDACTED]

22 specifically regarding any symptoms that she was

23 having?

24 A That day he said.

25 Q And that she denied any active

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1 symptoms including shortness of breath, chest pain  
 2 or the need for nitroglycerine?  
 3 A On or about the time of that phone  
 4 call, yes.  
 5 Q Okay.  
 6 A He did not take a history. Nor was he  
 7 qualified to.  
 8 Q And do you understand that he  
 9 according to his testimony that he again instructed  
 10 her to immediately contact the clinic or present to  
 11 the emergency room should she have any kind of  
 12 symptomatology?  
 13 A That's his testimony.  
 14 Q Okay. And do you understand that  
 15 according to Mr. Parker's testimony she declined Dr.  
 16 Westermeir again?  
 17 A According to his testimony, yes.  
 18 Q And that she told Mr. Parker she would  
 19 prefer to reschedule it after the Christmas holiday?  
 20 A That's what he said.  
 21 Q Okay. And so it was scheduled next  
 22 for January the 12th of 2015?  
 23 A Yes.  
 24 Q Which would be after the Christmas and  
 25 New Year's holidays?

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1 A Yes.  
 2 Q Obviously. All right. Now, do you  
 3 have any understanding of when, if at all, Ms. [REDACTED]  
 4 was presenting to her primary care physician Dr.  
 5 Solt in and about the timeframe after October the  
 6 30th?  
 7 A I don't recall.  
 8 Q Okay. Do you know that she went to  
 9 see Dr. Solt the day after her echocardiogram?  
 10 A I think so, yes.  
 11 Q The 5th of November?  
 12 A Yes.  
 13 Q And do you understand that she had no  
 14 complaint of chest pain or chest discomfort or  
 15 dyspnea or any symptoms referable to her chest or  
 16 her heart on that presentation?  
 17 A At that moment, yes.  
 18 Q The next day. She was complaining of  
 19 lower abdominal pressure and, well, I think  
 20 ultimately a urinary tract infection was diagnosed.  
 21 Do you recall that?  
 22 A Yes.  
 23 Q All right. And he prescribed  
 24 antibiotics for that and told her to come back if  
 25 she is not improving or if she had any problems;

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1 right?  
 2 A Yes.  
 3 Q To follow-up as needed?  
 4 A Yes.  
 5 Q Okay. And were you aware that on  
 6 December the 12th, the day that she had been  
 7 scheduled for this catheterization, she again  
 8 presented to Dr. Solt with symptoms consistent with  
 9 either a bladder spasm or urinary tract infection?  
 10 A Yes.  
 11 Q Again she made no complaint to him of  
 12 any shortness of breath, chest pain or any symptoms  
 13 referable to her heart?  
 14 A Yes.  
 15 Q Okay. And I know you know that Dr.  
 16 Solt was aware that she was being seen by Dr.  
 17 Mitchell?  
 18 A Yes.  
 19 Q All right. Now, did you notice that  
 20 there was a call to Dr. Solt's office from Ms. [REDACTED]  
 21 on November the 7th wanting all of here routine  
 22 medications to be renewed?  
 23 A Yes.  
 24 Q In other words, asking that they call  
 25 the CVS pharmacy to renew her regular medications?

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

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1 Q All right. And I'll just ask you this  
 2 since you seem to have a general understanding of  
 3 pharmacy practices, but probably know nothing in  
 4 particular about this branch of the CVS pharmacy  
 5 down in Alabama.  
 6 Do you allow that as an end of the  
 7 year type of exercise CVS was contacting Dr.  
 8 Mitchell's office for a routine renewal of her  
 9 prescription as opposed to some request from the  
 10 patient to have it renewed?  
 11 MR. BRANCH: Is the question  
 12 does he allow that as a possibility?  
 13 Q Yes. Do you allow for that?  
 14 A Of course.  
 15 Q All right. And do you have any  
 16 information as to whether she ever picked up a  
 17 refill of her nitroglycerine in December?  
 18 A I have not seen pharmacy records so I  
 19 don't know.  
 20 Q Okay. But clearly we don't have any  
 21 evidence of her calling the office requesting that  
 22 it be renewed or calling the clinic complaining of  
 23 any symptoms and we know she did not present to an  
 24 emergency room.  
 25 All that's true; isn't it?

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1 A Yes.  
 2 Q Now, with her history and with the  
 3 instructions that Mr. Parker said that he would have  
 4 given her as well as knowing that she had presented  
 5 herself to an emergency room previously when she  
 6 felt the need to do so, you would certainly expect  
 7 her to call the clinic or go to the emergency room  
 8 if she was having any symptoms; wouldn't you?  
 9 MR. BRANCH: Object to the form.  
 10 A I can't answer the question limited to  
 11 a simple yes, no. She presented to Dr. Mitchell  
 12 with pain at rest more often in the evening and he  
 13 did not hospitalize her. As a result it would  
 14 depend on what level of pain she would assume would  
 15 require to go in.  
 16 If Dr. Mitchell did not believe that  
 17 she needed to be hospitalized based on the pattern  
 18 of pain by which she presented to him then naturally  
 19 she would assume if that was a continuing pattern it  
 20 would not be a requirement to go to the emergency  
 21 room.  
 22 Q Well, I wasn't limiting my question to  
 23 the emergency room. You would expect her to call  
 24 the clinic or go to the emergency room given the  
 25 instructions that she received assuming Mr. Parker

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1 described those instructions accurately?  
 2 A Well, Mr. Parker is not qualified to  
 3 give a patient instructions. He's not a healthcare  
 4 provider.  
 5 Q That's not the basis of my question.  
 6 A The instructions are not clear because  
 7 she had a pattern of pain that the doctor knew  
 8 about.  
 9 So I would not expect her to call or  
 10 go to the emergency room unless something changed  
 11 from the pattern she was having.  
 12 Q So even with an instruction whether it  
 13 was from Mr. Parker or anybody else that she should  
 14 call the clinic or go to the emergency room if she  
 15 had any symptoms of chest pain or shortness of  
 16 breath your testimony is you would not expect her to  
 17 do that?  
 18 A Correct.  
 19 Q Okay.  
 20 A It would not make any sense in the  
 21 context of Dr. Mitchell knowing what her pattern was  
 22 saying go home.  
 23 Q Okay. In any event, we know that she  
 24 did not make a call to the clinic or go to the  
 25 emergency room during this timeframe; did she?

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1 A Correct.  
 2 Q All right. Now, I understand your  
 3 testimony in this case, but I want to ask this  
 4 question. If it were a recognized method of  
 5 practice under the standard of care for this  
 6 patient, Ms. [REDACTED] with her history of coronary  
 7 artery disease, with her history of this prior CABG  
 8 surgery and her positive stress echo test to have  
 9 her catheterization scheduled within 180 days of  
 10 that stress echo, that is the practice that was  
 11 followed in this case just going by the dates; isn't  
 12 it?  
 13 A I cannot answer the question because  
 14 that is intrinsically negligence if her pain was at  
 15 rest and as a result that practice might be  
 16 reasonable in a patient who has a routine positive  
 17 stress test without symptoms or a person who is  
 18 having symptoms at maximum activity where you can  
 19 tell them to not approach it, but it is primary  
 20 negligence not to immediately act if a person is  
 21 having symptoms at rest.  
 22 So are you saying that this practice  
 23 has a structural negligence to it. That regardless  
 24 of a patient's symptoms 180 days is acceptable.  
 25 That's a deviation in the standard of care. 180

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1 days is not acceptable in a patient having rest  
 2 pain.  
 3 MR. WRIGHT: Move to exclude as  
 4 nonresponsive.  
 5 Q All right. Whether you agree with  
 6 that practice or not, if it were a recognized method  
 7 of practice under the standard of care that a  
 8 patient like Ms. [REDACTED] with her history of the  
 9 coronary artery disease, the prior CABG surgery and  
 10 her positive stress echo test could have her cath  
 11 scheduled within 180 days of that stress echo, that  
 12 is, in fact, the practice that was followed here;  
 13 wasn't it?  
 14 A I disagree because you can't have a  
 15 practice for all patients. It's intrinsically  
 16 negligent --  
 17 Q You're not answering my question.  
 18 A Well, then you are making a circular  
 19 argument. You're saying if they want to do  
 20 negligence --  
 21 Q I'm not saying anything about  
 22 negligence. I'm saying if it was a recognized  
 23 method under the standard of care which is not  
 24 negligence, Dr. Charash.  
 25 A It isn't a recognized standard of care

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1 practice if someone is having rest pain to say you  
 2 can apply the same approach to a patient who is rock  
 3 stable to a patient who is unstable. So you can't  
 4 make that statement.  
 5 Q If she was asymptomatic as she told  
 6 Mr. Parker that she was according to his testimony  
 7 that would be one recognized method under the  
 8 standard of care for a patient like this; wouldn't  
 9 it?  
 10 A No. You would have to have someone  
 11 who knows how to take a history, not to ask about  
 12 that day or that moment, but about her global  
 13 pattern.  
 14 Mr. Parker was not qualified to take a  
 15 history that would satisfy the need to know whether  
 16 she was stable or unstable. It appears from his own  
 17 testimony that he asked highly focused questions  
 18 about limited timeframes of pain.  
 19 He was not qualified to take the  
 20 history. He was not qualified to change the cath  
 21 date without a physician's supervision. He was not  
 22 qualified to white out the date with Dr. Mitchell.  
 23 Q Come on, come on. Answer the  
 24 questions.  
 25 A I'm answering them all.

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1 Q Quit going onto something that I  
 2 haven't asked you.  
 3 A He was not qualified to do this.  
 4 Q I didn't ask you about his  
 5 qualifications.  
 6 A Well, his history was not acceptable.  
 7 Q I didn't ask you that.  
 8 I said if the patient was asymptomatic  
 9 as she stated that she was according to what he  
 10 said, do you acknowledge that under the standard of  
 11 care she could have her catheterization scheduled  
 12 within 180 days?  
 13 A Absolutely not.  
 14 Q All right. At least you will  
 15 acknowledge because it's undeniable looking at the  
 16 calendar that all of the scheduling and rescheduling  
 17 of her catheterization occurred within less than 180  
 18 days from the date of her stress echo. That's a  
 19 true statement; isn't it?  
 20 A That is a true statement.  
 21 Q All right. And if the literature were  
 22 to show that that is a recognized practice that is  
 23 followed by many cardiologists in this country for  
 24 patients with positive stress echos and a prior  
 25 history of CABG surgery, indeed that is the practice

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1 that was followed in this case just looking at the  
 2 calendar?  
 3 A If the literature includes unstable  
 4 symptoms. If the literature is about asymptomatic  
 5 patients or patients who have predictable chest pain  
 6 at maximum activity that would comply with the  
 7 standard of care. But you are not going to find a  
 8 literature that gives a blanket statement that  
 9 disregards the patient's presenting symptoms.  
 10 Q You cannot say what would have been  
 11 seen, if anything, on a catheterization had she had  
 12 one done prior to her death; can you?  
 13 A Well, I can say that within reasonable  
 14 medical probability or certainty she would have had  
 15 a blockage that would have needed fixing and that's  
 16 the blockage that caused her pain and her death, but  
 17 I can't identify where it was.  
 18 Q That's entirely speculative on your  
 19 part; isn't it?  
 20 A No. It's a medical opinion based on  
 21 reasonable medical certainty.  
 22 Q There's no science that allows you to  
 23 predict that; is there?  
 24 A I disagree with you. You have a  
 25 patient who had pain at rest who is known to have

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1 recurrent coronary disease who failed a stress test,  
 2 who is having shortness of breath with limited  
 3 activity and who died over a short period of time.  
 4 Using retrospect and prospect you can  
 5 draw a medical conclusion that with reasonable  
 6 medical certainty she died from her acute coronary  
 7 disease that wasn't fixed.  
 8 Q You cannot say what, if any, artery  
 9 may have been involved; can you?  
 10 A I don't know which specific artery was  
 11 involved.  
 12 Q Or the nature of any blockage if there  
 13 was any?  
 14 A Well, there certainly was a blockage  
 15 critical enough to cause pain at rest.  
 16 Q Well, chest pain occurs even in  
 17 patients who do not have clinically significant  
 18 blockage following CABG procedures and prior  
 19 interventions; doesn't it?  
 20 A True. You can have non-coronary pain,  
 21 but you could also say that a package ticking at an  
 22 airport could be an alarm clock. It doesn't mean  
 23 you ignore it because it could be an alarm clock.  
 24 MR. WRIGHT: Move to exclude.  
 25 Q Let me ask you this. Have you ever

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1 been disqualified by any court for offering  
 2 testimony beyond your area of expertise?  
 3 A Not to my knowledge.  
 4 Q When we were talking about these  
 5 comorbidities that Ms. [REDACTED] had, she had in Dr.  
 6 Solt's records, we see she had a history of low  
 7 potassium; don't we?  
 8 A Yes.  
 9 Q Electrolyte imbalances are known to  
 10 produce sudden death by fatal arrhythmias; aren't  
 11 they?  
 12 A They can cause or contribute.  
 13 Q Diet in low potassium intake in  
 14 elderly patients with multiple comorbidities is a  
 15 known cause of sudden death independent of coronary  
 16 artery disease; isn't it?  
 17 A It's very rare in a patient who is not  
 18 taking a diuretic or who is not suffering from a  
 19 primary kidney disorder.  
 20 Q She was taking a diuretic; wasn't she?  
 21 A Yes.  
 22 Q You cannot eliminate that as a cause  
 23 for her death in this case on any evidence we have  
 24 in her medical chart?  
 25 A I can't eliminate that as a

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1 contributing factor, but of course part of my  
 2 opinion is, and this is essential, that Mr. Parker  
 3 was not in a position to make decisions about  
 4 changing cath dates and she needed to be evaluated.  
 5 Q I understand that. I'm talking about  
 6 something completely different.  
 7 A Well, that would have included blood  
 8 tests if she showed up for -- the standard of care  
 9 required the moment there was going to be a delay in  
 10 the cath which already the date was too far out to  
 11 have her come in for --  
 12 Q My question is simply --  
 13 A Let me answer the question. You can  
 14 object all you want, but I'm going to finish.  
 15 Q No. I'm going to interrupt you.  
 16 A My answer is going to be --  
 17 MR. BRANCH: He is not finished.  
 18 MR. WRIGHT: I asked him whether  
 19 he could eliminate --  
 20 MR. BRANCH: Let him finish his  
 21 answer.  
 22 MR. WRIGHT: -- an electrolyte  
 23 imbalance as a cause of sudden death  
 24 independent of coronary artery disease.  
 25 A I think it's unlikely.

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1 Q But you can't eliminate it on the  
 2 basis of anything we have in this record.  
 3 A I can't eliminate it with 100 percent  
 4 certainty. It's not a reasonable possibility, but  
 5 it's a possibility.  
 6 Q If it occurred the clinical picture  
 7 could look exactly the same as we have here;  
 8 couldn't it?  
 9 A It could.  
 10 Q All right. You cannot dispute that  
 11 she was a patient that was at risk for a fatal  
 12 arrhythmia independent of her coexisting heart  
 13 disease; can you?  
 14 A I disagree because a person who has a  
 15 normal ejection fraction who gets hypokalemia it has  
 16 to be very profound for them to suffer a primary  
 17 arrhythmia.  
 18 Whereas a person with an acute  
 19 coronary syndrome as their potassium level drops, if  
 20 it did drop would increase their proclivity to an  
 21 ischemically induced sudden death.  
 22 And it's highly unlikely, but not  
 23 impossible that a primary electrolyte disorder  
 24 caused her death. But it is almost certain that she  
 25 had acute coronary syndrome and that would be the

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

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

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1 there would be very little correlation.  
 2 Q Is the risk increased?  
 3 A A little bit.  
 4 Q Sudden death associated with sleep  
 5 apnea independent of coronary artery disease comes  
 6 on suddenly; doesn't it?  
 7 A It can, yes.  
 8 Q Frequently it occurs at night; doesn't  
 9 it?  
 10 A That's generally when it would.  
 11 Q Right. Do you understand that  
 12 Ms. [REDACTED] was found unresponsive having passed away  
 13 suddenly?  
 14 A Yes.  
 15 Q The same findings that are frequently  
 16 seen in patients who suffer fatal arrhythmias due to  
 17 obstructive sleep apnea independent of cardiac  
 18 disease; true?  
 19 A It's a way it could present from sleep  
 20 apnea. But again she also on her echocardiograms  
 21 never showed evidence of pulmonary hypertension  
 22 which means that she did not have a reason for  
 23 shortness of breath in the daytime due to sleep  
 24 apnea.  
 25 Her sleep apnea was not causing right

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

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1 Q Nothing was done to prove a myocardial  
 2 infarction; was there?  
 3 A Not with absolute certainty.  
 4 Q Not with any certainty?  
 5 A Reasonable certainty.  
 6 Q What?  
 7 A That she died in the middle of the  
 8 night in the setting of having had rest pain while  
 9 awaiting a catheterization. Of all people who die  
 10 in their sleep in her age group you would say that  
 11 70 percent nationally of people who die in their  
 12 sleep of her age group regardless of conditions are  
 13 coronary.  
 14 With her risk factors, her known  
 15 history of recurrent disease, her presentation with  
 16 chest pain mainly at night, her flunking a stress  
 17 test indicating there was ischemia and while  
 18 awaiting a cardiac catheterization died. The odds  
 19 are 95 to 99 percent likely that she died from her  
 20 coronary disease.  
 21 Q There is no study that says that as  
 22 compared to the risk that she would have from her  
 23 being noncompliant with her CPAP?  
 24 A I disagree.  
 25 Q What's the study?

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

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

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

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

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1 Q Right. And that is the same process,  
 2 the same kind of process that causes vascular  
 3 disease in diabetic patients that can cause venous  
 4 thromboembolism; isn't it?  
 5 A Yes.  
 6 Q She had proven peripheral vascular  
 7 disease which in and of itself it's a risk factor  
 8 for pulmonary embolism; isn't it?  
 9 A Yes.  
 10 Q So both of those, really all of that  
 11 places her at risk for a pulmonary thromboembolism;  
 12 doesn't it?  
 13 A Puts her at increased risk from the  
 14 general population.  
 15 Q Right. Now, are you aware that it is  
 16 reported that there is a higher prevalence of acute  
 17 pulmonary embolism among patients with obstructive  
 18 sleep apnea?  
 19 A Mild increase, very mild and it's  
 20 dependent on whether or not there is right  
 21 ventricular dysfunction.  
 22 In those patients with sleep apnea who  
 23 have normal right ventricular function there is no  
 24 increase in pulmonary emboli.  
 25 Q Actually combined with diabetes and

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1 her other risk factors there is a significant and  
 2 independent association between OSA and pulmonary  
 3 embolus; isn't there?  
 4 A Not if you have mild sleep apnea and  
 5 you are without right ventricular or pulmonary  
 6 hypertension, there isn't. But if you do have  
 7 severe sleep apnea and have a failing right heart  
 8 that does increase the risk.  
 9 Q Well, clearly she had the other risk  
 10 factors for pulmonary thromboembolism that we  
 11 discussed?  
 12 A Yes.  
 13 Q Pulmonary embolism is frequently of  
 14 sudden onset; isn't it?  
 15 A Yes.  
 16 Q Do you understand that it's the third  
 17 leading cause of death in this country?  
 18 A It may be.  
 19 Q Do you understand that it frequently  
 20 occurs at night during sleep?  
 21 A It can. I didn't know how frequently.  
 22 Q Do you understand that it is most  
 23 frequently diagnosed at autopsy as opposed to any  
 24 other way?  
 25 A Well, most people who have it

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

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1 Q But stroke is known to produce sudden  
 2 death in some patients?  
 3 A It is very rare, but it can occur.  
 4 Q And that is embolic, ischemic or  
 5 hemorrhagic, it can occur; can't it?  
 6 A Correct.  
 7 Q She had risk factors of diabetes,  
 8 hypertension, age, being of the female gender and  
 9 her global vascular, peripheral vascular disease all  
 10 placing her at risk to develop a stroke; true?  
 11 A Yes.  
 12 Q Did she have a small aneurysm in her  
 13 carotid artery?  
 14 A Yes.  
 15 Q Does that increase her risk for a  
 16 fatal stroke?  
 17 A It would increase her risk for a  
 18 stroke.  
 19 Q And of course the sedentary lifestyle  
 20 is another risk factor that is recognized?  
 21 A Very mild risk factor.  
 22 Q It's a risk factor that is included  
 23 with the others that we mentioned; isn't it?  
 24 A Not significantly.  
 25 Q Well, I'm not arguing with you about

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1 anything other than is it a recognized risk factor.  
 2 Either you say it is or it isn't.  
 3 A It's a negligible risk factor.  
 4 Q So it's a risk factor?  
 5 A It's not a major risk factor.  
 6 Q You are saying in and of itself you  
 7 don't think it would be much of a risk factor?  
 8 A No.  
 9 Q It is a risk factor in combination  
 10 with the other things that she had, though, isn't  
 11 it?  
 12 A To a degree, yes.  
 13 Q All right. Acute stroke is known to  
 14 disturb the central autonomic control  
 15 causing cardiac arrhythmias and sudden death; isn't  
 16 it?  
 17 A Very rare. It is very rare to have  
 18 sudden death from a stroke.  
 19 The overwhelming majority of people  
 20 who have strokes, even with massive intracranial  
 21 bleeds don't die suddenly.  
 22 Q Rare or not my statement is correct?  
 23 A It's possible.  
 24 Q Interference with brain stem function  
 25 associated with stroke -- is associated with stroke

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

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

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

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

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1 A That's unrelated to the risk of  
 2 abdominal aneurysm.  
 3 Q I agree with you, but it shows that  
 4 because of her peripheral vascular disease she was  
 5 at risk to develop aneurysms; doesn't it?  
 6 A Yes, of course.  
 7 Q All right. Are you aware that  
 8 abdominal aortic aneurysm is often associated with a  
 9 history of atherosclerosis and cardiovascular  
 10 disease?  
 11 A Yes.  
 12 Q She had that; didn't she?  
 13 A Yes.  
 14 Q Are you aware that both obstructive  
 15 and restrictive spirometric patterns have been  
 16 associated with an increased risk of abdominal  
 17 aortic aneurysm?  
 18 A I don't understand your question.  
 19 Q That patients with obstructive  
 20 spirometric patterns have been associated with an  
 21 increased incidence of abdominal aortic aneurysm?  
 22 A I'm not sure what you mean by  
 23 spirometric patterns. Spirometric patterns of what?  
 24 Q Breathing.  
 25 A I'm not aware of that.

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1 Q Okay. Peripheral vascular disease is  
 2 a known risk factor for abdominal aortic aneurysm;  
 3 isn't it?  
 4 A Yes.  
 5 Q Hypertension is associated with  
 6 abdominal aortic aneurysm in the medical literature;  
 7 isn't it?  
 8 A Yes.  
 9 Q Are you aware that in patients with  
 10 obstructive sleep apnea abdominal aortic aneurysm is  
 11 highly prevalent?  
 12 A It's not highly prevalent, but if they  
 13 have pulmonary hypertension and right ventricular  
 14 dysfunction it might be more prevalent.  
 15 Q Is abdominal aortic aneurysm rupture  
 16 frequently of a sudden onset with extremely high  
 17 mortality when it occurs?  
 18 A Yes.  
 19 Q And is it something that is frequently  
 20 diagnosed at autopsy and a known cause of sudden  
 21 death in older patients?  
 22 A Well, it's a very rare cause of sudden  
 23 death, but it is a potential cause.  
 24 Q And by my question about it being  
 25 frequently diagnosed at autopsy I'm asking you if

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1 you have the understanding that when not clinically  
 2 suspected as of the time of death it is something  
 3 that has been frequently diagnosed at autopsy?  
 4 A It can be found on autopsy, although  
 5 patients often when they are discovered dead have  
 6 abdominal bloating from the massive bleeding in  
 7 their abdomen.  
 8 Q We have discussed a number of  
 9 potential causes of death for Ms. [REDACTED] all of  
 10 which -- for all of which she had specific risk  
 11 factors, and while I understand your testimony and  
 12 your opinions in this case there is not any fact or  
 13 any scientific basis that you can point to in this  
 14 particular case that would distinguish your opinion  
 15 about the cause of her death from one of these other  
 16 causes that would have been fatal for her in any  
 17 event and would not have been prevented by an  
 18 earlier catheterization?  
 19 A I disagree. We can't establish with  
 20 absolute certainty her death, but clinically can  
 21 distinguish the relative likelihood of what caused  
 22 her death.  
 23 That is done every day. And in this  
 24 case a woman who had pain at rest, failed a stress  
 25 test with known recurrent coronary disease who died

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1 while waiting to be catheterized, overwhelmingly the  
 2 scientific reason why she died was due to her  
 3 coronary disease.  
 4 Now, it doesn't mean you can say with  
 5 absolute certainty that other causes weren't there.  
 6 But if the metric were we need 100 percent certainty  
 7 that we can't do. But we can say that it's over 95  
 8 percent likely it's coronary and that leaves room in  
 9 the very distant minority for other causes of death,  
 10 but they are highly unlikely, each one of them in  
 11 the context of the clinical case.  
 12 Clinical diagnosis is a legitimate  
 13 form of diagnosis for cause of the death and it was  
 14 exercised by the primary care doctor.  
 15 Q In addition, to be complete, she was  
 16 also a lady who had risk factors for fatal  
 17 arrhythmia independent of her heart disease; didn't  
 18 she?  
 19 A No.  
 20 Q She was also a lady who had risk  
 21 factors for pulmonary thromboembolus independent of  
 22 her heart disease?  
 23 A Yes, she did.  
 24 Q And risk factors for stroke  
 25 independent of her heart disease?

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1 A They are just -- if the benchmark is  
 2 what's the most likely cause of her death, if that's  
 3 the standard.  
 4 Q Just answer my question.  
 5 A I have been answering your questions  
 6 and saying that there are all possible.  
 7 Q The point is, and I understand that  
 8 your preference of cause of death is that it is in  
 9 your opinion regarding cause of death is that it was  
 10 a cardiac cause?  
 11 A Not just me. It's Dr. Solt's who knew  
 12 her better than any of us.  
 13 MR. WRIGHT: Move to exclude.  
 14 Q I'm just talking about your opinion.  
 15 A I have a basis for my opinion. It's  
 16 not just an opinion. I have a foundation for my  
 17 opinion, sir.  
 18 Q Well, if she had sudden death due to a  
 19 cause unrelated to outcome from an earlier  
 20 catheterization we have established in our  
 21 discussion today that the clinical picture would be  
 22 exactly the same; haven't we?  
 23 A That's why we can't say with absolute  
 24 certainty and we can only say with reasonable  
 25 certainty.

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1 Q And the point would be if she died  
 2 from something else that would be 100 percent the  
 3 cause whether you can know it with certainty or not;  
 4 true?  
 5 A Right. But we are talking about  
 6 reasonable medical probability.  
 7 Q And that has to be based on science;  
 8 doesn't it?  
 9 A Science is clinical information.  
 10 Otherwise, then you could say -- she did not get an  
 11 autopsy because it wasn't needed. It wasn't needed  
 12 because her primary care doctor, Dr. Solt,  
 13 recognized in the clinical context of the patient  
 14 who died on the precipice of getting a  
 15 catheterization who presented with recurrent chest  
 16 pain, with a history of recurrent coronary disease,  
 17 who failed a stress test that the overwhelming  
 18 likelihood was coronary.  
 19 It doesn't mean that it's impossible  
 20 to be something else, but it means that it's not  
 21 credibly -- it's not credible to take any of your  
 22 diagnosis and say that they even remotely approach  
 23 the likelihood of a coronary death. But of course  
 24 anything is possible including blowfish poisoning.  
 25 Q It would be speculative and it is

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1 speculative without an autopsy to state that this  
 2 was a death due to myocardial infarction when she  
 3 had all these other risk factors?  
 4 A No, it's not speculation. It's  
 5 reasonable likelihood. It's only speculating if you  
 6 are holding it to a standard of 100 percent  
 7 certainty. But it's not speculation to draw the  
 8 overwhelming most likely cause of death.  
 9 This statement doesn't say it is  
 10 impossible for her to have died from something else.  
 11 It's just saying overwhelmingly we know what killed  
 12 her, but we don't know with 100 percent certainty.  
 13 But if the legal standard required  
 14 100 percent certainty then I would concede that I  
 15 can't be 100 percent certain. But I can be  
 16 reasonably certain that all the other diagnosis are  
 17 pale in comparison to the probability that a woman  
 18 who died waiting for a cath with her history, her  
 19 symptoms, her symptoms more at night and she died at  
 20 night, her death was coronary, you can say that with  
 21 reasonable certainty, but not absolute certainty.  
 22 Speculation could only be raised if I were to say I  
 23 know with 100 hundred percent certainty.  
 24 Q Every one of those factors fits fatal  
 25 arrhythmia due to electrolyte imbalance, fatal

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1 arrhythmia associated with noncompliance with the  
 2 CPAP, nighttime, pulmonary thromboembolus, stroke  
 3 and even abdominal aortic aneurysm, doesn't it?  
 4 MR. BRANCH: Objection. Asked  
 5 and answered.  
 6 Q Every one of those factors fit equally  
 7 with those causes as well; don't they?  
 8 A They fit in terms of methodology of  
 9 her death, but not with equal likelihood.  
 10 THE WITNESS: Pardon me. I need  
 11 a short break.  
 12 MR. WRIGHT: Okay. I'm about to  
 13 wrap up.  
 14 (A short recess was taken at  
 15 this time.)  
 16 (The deposition resumed with all  
 17 parties present.)  
 18 B R U C E C H A R A S H, M.D., resumed,  
 19 and testified further as follows:  
 20 BY MR. WRIGHT:  
 21 Q Now, earlier you made some reference  
 22 to the scheduling changes on the whiting out of the  
 23 date and the rescheduling by Mr. Parker for each of  
 24 these rescheduled dates.  
 25 Do you recall that?

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1 A Yes.  
 2 Q And you understand that the only thing  
 3 that he did relative to those orders was change the  
 4 date to facilitate getting her on the schedule for  
 5 the date selected?  
 6 A It's more than that.  
 7 Q It's not more than that.  
 8 A No, it is more than that because he  
 9 implied that Dr. Mitchell signed off on that date  
 10 which he didn't.  
 11 He was not in a position to change  
 12 dates without consulting a physician. This patient  
 13 needed an interval follow-up. If this patient even  
 14 did tell him that she didn't want the doctor, he was  
 15 duty bound to have the doctor talk to her to discuss  
 16 the risks and benefits and to have her come in.  
 17 He was not qualified to explain to her  
 18 the threat she faced. He was not a health care  
 19 professional in a position to take an history, to  
 20 change dates unilaterally. To make it look like Dr.  
 21 Mitchell signed off on those dates and not to  
 22 consult the doctor if she refused. He had no clue  
 23 about the risk-benefit ratio. He had no ability to  
 24 transmit that to the patient about the threat and he  
 25 didn't bring her in to be seen by the doctor.

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1 His approach is egregiously  
 2 unacceptable. To white out a date from a signed  
 3 note and change the date is a gross deviation in the  
 4 standard of care and to not consult a doctor is a  
 5 gross deviation.  
 6 Q You're obviously, I asked you a number  
 7 of things earlier about areas of practice that you  
 8 are not involved in and one of the things that you  
 9 are not is a medical assistant. Not taking anything  
 10 away from the position that you do occupy, but  
 11 that's a true statement; isn't it?  
 12 A Yes, but I do know about the limits of  
 13 what a non-physician can do.  
 14 Q Let me just ask you this. Do you  
 15 allow, and I'm asking you this with respect to a  
 16 cardiologist, okay, not as a medical assistant. Do  
 17 you allow that if the patient were stable without  
 18 symptoms and preferred to have her catheterization  
 19 scheduled after the holidays a reasonable  
 20 cardiologist within the standard of care could  
 21 acquiesce with that request?  
 22 A I would need to know about that  
 23 change, what the date is and the reason. I would  
 24 need to know if there was a clinical reason. I  
 25 would need to explain to the patient the risks and

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

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

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

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

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

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

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

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

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

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

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

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

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1 A Never.

2 Q Ever voluntarily given up -- excuse

3 me, even involuntarily given up any hospital

4 privileges or your license to practice medicine?

5 A Never.

6 Q Have you ever been to Alabama?

7 A Yes.

8 Q For professional or social?

9 A Tourism.

10 Q Okay.

11 A My wife and I once did a trip through

12 the south, went to Natchez, Mississippi, drove

13 through Mississippi, Alabama. We kind of did a

14 whole southern tour. We love the south.

15 Q I think I am basically done. I just

16 want to leave with this and that is are we clear

17 there is not any issue that's important to you that

18 we haven't touched on about this case, that we

19 haven't touched on in our question and answer

20 session today?

21 A Yes.

22 MR. WRIGHT: Okay. That's all.

23 Thank you.

24 MR. BRANCH: The only thing I

25 would add is and I can't remember what

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1 we talked about for five hours.

2 THE WITNESS: It's three and a

3 half hours, but that's okay.

4 MR. WRIGHT: I don't think it's

5 five.

6 MR. BRANCH: But his report

7 obviously states all of his opinions and

8 they discuss whichever one of those or

9 all of those at Mr. Wright's choice, so.

10 THE REPORTER: Do you want the

11 witness to read?

12 THE WITNESS: I waive.

13 (Whereupon, at 12:40 o'clock

14 p.m., the deposition was concluded.)

15

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1 CERTIFICATE

2 STATE OF NEW YORK )

3 ) ss.

4 COUNTY OF NEW YORK )

5 I, TINA DeROSA, a Shorthand

6 (Stenotype) Reporter and Notary

7 Public of the State of New York, do

8 hereby certify that the foregoing

9 Deposition, of the witness, BRUCE

10 CHARASH, M.D., taken at the time and

11 place aforesaid, is a true and

12 correct transcription of my

13 shorthand notes and reading and

14 signing was waived.

15 I further certify that I am

16 neither counsel for nor related to

17 any party to said action, nor in any

18 wise interested in the result or

19 outcome thereof.

20 IN WITNESS WHEREOF, I have

21 hereunto set my hand this 4th day of

22 December, 2017.

23

24 \_\_\_\_\_

25 TINA DeROSA

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