1	MICHAEL JONES, Individually	IN THE
2	and as Personal Representative	CIRCUIT COURT
3	of the Estate of FRANK JONES	FOR
4	Plaintiff	BALTIMORE CITY
5	vs.	Case No. 24-C-12-006505
6	UNIVERSITY OF MARYLAND MEDICAL	
7	SYSTEM CORPORATION, d/b/a	
8	UNIVERSITY OF MARYLAND MEDICAL	
9	CENTER	
10	Defendant	
11	_____/	
12		
13		

The Videoconference Deposition of BRUCE CHARASH, M.D. was held on Tuesday, January 7, 2014, commencing at 1:20 p.m., at the Offices of Gore Brothers Reporting & Video, 28 Allegheny Avenue, Towson, Maryland 21204, before Bracha Goldberger, Notary Public.

REPORTED BY: Bracha Goldberger

APPEARANCES:

ON BEHALF OF THE PLAINTIFFS:
ROBERT E. JOYCE, ESQUIRE
The Suder Law Firm, P.A.
210 East Lexington Street, Suite 100
Baltimore, Maryland 21202
Telephone: (410) 727-8177

ON BEHALF OF THE DEFENDANT:
APRIL J. HITZELBERGER, ESQUIRE
Waranch & Brown, LLC
1301 York Road, Suite 300
Lutherville, Maryland 21093
Telephone: (410) 821-3500
Facsimile: (410) 821-3501
Email: ahitzelberger@waranch-brown.com

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Deposition of Bruce Charash, M.D.

January 7, 2014

PROCEEDINGS,

Whereupon,

BRUCE CHARASH, M.D.

was called as a witness and having been duly sworn by the Notary Public, was examined and testified as follows:

EXAMINATION BY MS. HITZELBERGER:

Q. Good afternoon, Dr. Charash.
Am I pronouncing that correctly?
A. Yes.
Q. Okay.
My name is April Hitzelberger. I represent the defendant in this case, the University of Maryland Medical System.
I understand that you have had your deposition taken before?
A. Yes.
Q. Okay.
If I ask you a question that you don't understand, please let me know; I'll be happy to rephrase it to the best of my ability.

If you answer the question, I'll assume that you understood it, and I will hold you to that answer.
Is that okay?
A. Well, with one exception.
Q. Sure.
What's that?
A. One exception is, and it's likely to happen, but in life, sometimes we've all had moments where we think we understand a question, and we don't, and we answer a different question. Now, that happens to everyone.
I doubt that something like that will happen that would have any consequence, but I -- if I answer, it means I think I understand your question, but it's possible I don't, and you don't realize it.
Q. I understand your point, that's taken. But, if you recognize that my question is unintelligible, or if I misstate the medical records in this case, or the medicine in general, please let me know.
Okay?
A. Of course.

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Q. All right.
You understand that you have been designated as an expert, to offer opinions against the defendant in this case, the University of Maryland?
A. Well, actually, I'm giving more causation opinions than standard of care. So, I'm not really testifying against anybody.
Q. Do --
A. But, to that degree, I am retained by the plaintiff in this case.
Q. You will not be offering any standard of care opinions in this case.
Is that correct?
A. Correct.
Q. Okay.
Have you received a copy of your deposition notice, or the amended notice to take your deposition in this case?
A. I have it here.
Q. Have you had a chance to review it?
A. Of course.

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Q. And, did you bring any documents with you today that are responsive to the requests in the deposition notice?
A. Yes.
Q. What have you brought?
A. A photocopy of my CV, and a copy of two lists, one of trial testimony and appearances, and one of deposition testimonies for the last five years.
I don't think -- I don't have any billing records in the case; I'm certain Mr. Joyce does. You can get it from him.
And, you know, in terms of notes, I wrote a chart, which I will show, a pretty color -- I don't think you can see it. It's -- charts, which is my timeline, which I am happy to turn in.
Also, throughout the depositions, and everything, in the chart I have tabs on many pages, and a lot of it is highlighted in different colors.
It's important to know if you ever see this, that there is no color coding. It's just randomly changes colors. It helps me -- in some pages multiple

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colors because it helps me see different answers quicker. But, there is no coding to red, yellow, blue, green highlighting.
And, I sometimes write in the margins, and I sometimes write on the post-its. I have it all here.
Also, I -- you know, I couldn't bring all the records. They were sent to me electronically, and I have only printed a fraction of the over 700 pages of medical documents.
I brought here an index of the medical documents that I have reviewed, plus the depositions.
Q. Okay.
Just to go back for a minute. The margins that you have may or may not have writing, and the post-it notes that may or may not have writing, does that contain substantive opinions, or is it more factual?
A. Most of it, almost all of it is factual; repeating what is on the page, so I can identify what I wanted on the page.
I doubt that I have, looking through here,

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anything that is commentary. It's all just writing what was -- it's really just writing down. I don't think there is anything in here that's commentary.
In the depositions, again, it's more of the same. Just bringing out things I wanted to discuss.
Q. And, the timeline that you have, is there a technician at the office there that could fax a copy of the timeline to us?
A. I have no idea. I could ask. Just a second.
Q. Sure. Thank you.
A. Meanwhile, why don't you work on getting a fax number in case you do want me to fax it.
Q. You read my mind. Thank you.
(A short break was taken.)
BY MS. HITZELBERGER:
Q. Have you received any correspondence from plaintiff's counsel in this case, written correspondence, or e-mail correspondence?
A. The records were originally e-mailed to me, but there was nothing substantive in it. And again, I

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don't think I have that.
Q. Any other written correspondence?
A. No. Again, this was all sent to me electronically.
Q. When were you first contacted by the plaintiff's counsel in this case?
A. Oh, good heavens. It wasn't that long ago. And, again, I do apologize, but I don't know, because I don't have a billing record. I don't know. Mr. Joyce will know, but it wasn't very long ago.
Q. Would you be able to determine that date based on the e-mail that you received in closing the records?
A. Probably I would be able to determine, because I don't think I saved that e-mail by the date I downloaded it into my desktop.
Q. Could you look for that information, and provide that to Mr. Joyce?
A. Of course. Although he would probably know the date I was contacted without that part.
Q. Have you worked with Mr. Joyce on prior

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medical malpractice cases?
A. Yes.
Q. On approximately how many occasions?
A. Two, maybe three about, if I remember right.
Q. Were either of those cases dealing with issue that are pertinent to this case?
A. No.
Q. Have you worked with any other attorneys from the Suder law firm before this case, and excluding those two additional cases you just discussed?
A. No. Again, I think I have done two or three cases for this Suder firm for Mr. Joyce.
Q. Returning to when you were first contacted, I understand we are going to try and ascertain that date, but do you believe it was within the last two months, if you know?
A. I'm not a hundred percent sure. The problem is I really -- for me to kind of correlate that kind of timeline without something written, I don't remember. But, it was not very long ago.
Certainly in the last half year, maybe in

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the last few months. But, I don't want to make a mistake, and give you a date, and be wrong.
It was relatively recently. For all I know, it was much more recently than that. I just don't remember.
Q. What medical records have you reviewed in this case?
A. I reviewed the records from the University of Maryland Medical Center, admission of January 5 through January 17. I reviewed previous record from University of Maryland, April 17, '95.
I reviewed records from the Shock Trauma at Maryland, from April 14 to 18, 2003. Records from same place, May 7, '03 to September 18, '03.
More Maryland records from October 2, '03, to October 5, '03. October 16, '03, to October 23, '03. November 28, '06 to December 1, '06.
Let me just see. And, finally -- I think that's it.
Q. Following the deposition, could you provide the index to Mr. Joyce, so that we could get a copy of

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it?
A. Of course. Oh, sorry. There is more. I do apologize. I couldn't find this.
Obviously, I should have said this first, but I have reviewed the Bon Secours, that's B-O-N, space, S-E-C-U-O-U-R-S, records from October 31, '08, to January 15, '09. And, a Saint Agnes hospitalization from April 14, 2003, or a presentation to the emergency room.
Q. Are you relying on any of the medical records prior to January of 2009, for your opinions in this case?
A. I don't think any of the previous records impact on my opinions in this case.
Q. Okay.
A. When you say rely on, I'm relying on -- I mean, that's kind of a difficult to answer question, because I have reviewed everything.
But, there is nothing in his previous records, from his different fractures, and dog bite, that change my opinions today.

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So, I don't know what you mean by relied on. If I said I did rely on it, it could sound like I didn't read them.
Q. What --
A. I wouldn't want to give that false --
Q. What depositions have you reviewed in this case?
A. Three depositions.
I reviewed the depositions of -- and, they are all experts for the defense. Dr. Platia, P-L-A-T-I-A, Dr. Cohen, part one of his deposition. I was informed he had part two of his deposition today. And, Dr. Batipps, B-A-T-I-P-P-S. And, if I mispronounce names, I apologize.
Q. Outside of reviewing the depositions and the medical records in this case, what did you do to prepare for your deposition today?
A. Just re-review the depositions and medical records.
Q. Did you have any --
A. And, I did create -- I wrote this chart up

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last night, if that is part of your question.
Q. We still have not received the charts, so I'll come back to that.
Did you have any teleconferences or meetings?
A. Pardon me?
When you say you haven't received it, are you saying you didn't go through the facts, or no one has brought it in yet?
MR. JOYCE: No one has brought it in yet.
BY MS. HITZELBERGER:
Q. No one has brought it in yet. They said they would check the fax machine --
A. Okay.
Q. -- and bring it in.
A. Okay.
Because it certainly is there in the fax machine.
Q. Did you have any teleconferences or in-person meetings with Mr. Joyce, prior to your deposition today?

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A. No. Just phone discussions.
Q. When were those discussions?
A. Well, the most recent one was last night. We spoke for five minutes before today, when I called him to say that I couldn't find parking.
And, when we originally reviewed the case, not that long ago.
Q. I'm just now looking over a copy of your timeline.
Could you please explain to me what this is?
A. It's a timeline of the critical events from the patient's code, which are the events in question in this case, leading to the patient's death.
I -- this chart demonstrates to me why the theory of the defense is completely at odds with basic medicine.
I mean, it requires an explanation when we get into the discussion, but the defense theory is just not physiologically possible.
Q. The defense theory of death; is that what are you talking about?

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A. Yes. I -- Dr. -- I mean, in all fairness, Dr. -- is it Batipps? I don't want to mis-say his name.
Q. Batipps.
A. Batipps.
Q. Batipps.
A. Batipps. He's the neurologist for the defense.
Correct?
Dr. Batipps made some declarations that are also highly unreasonable. And, I mean, Dr. Cohen did, as well.
Oddly enough, the cardiologist, Dr. Platia, didn't really say very much in his deposition. He squeezed the least amount of content into the most amount of words I have seen in a long time in a deposition.
But, there is a defense theory that a seizure can't lead to sudden death. And, Dr. Batipps, Batipps, pardon me -- almost obsessively kept talking about prolonged multiple seizures leading to death,

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with fast heart rates, all of this.
He is missing the entire point that that's not the only mechanism by which seizures can lead to death. And, certainly, anyone is suggesting that this was a prolonged seizure event.
He kept defending against that. He was a straw man. He was defending against a straw man, against something that no one would even suggest.
The reality is that when you have a seizure, I think virtually every person in medicine, as well as most people who have seen movies, know that a person during a seizure can obstruct their airway with their tongue, which is why protecting airway occurs frequently during seizure activity.
And, I believe that a man with a facial neck infection, with the most aggressive organism known to man, with evidence that he was getting clinically worse in the hospital, has a seizure, it is not an implausible medical consideration, that the seizure could lead to a airway obstruction in a person who is more vulnerable due to the nature of their infections,

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and that's what could cause an arrest.
This has nothing to do with the nature of the electrical activity of the brain causing the heart to stop, which was primarily the only thing that Dr. Batipps was defending.
And, that's nothing to do with this case. This patient had a seizure because of airway obstruction. I mean, had a seizure, and because of airway obstruction, had a code.
Q. Dr. Charash, are -- do you have any postgraduate training in neurology?
A. No.
Q. You are not board certified as a neurology?
A. I think that's apparent, but I have never represented myself to, and my resume doesn't have it.
Q. And, you are also not board certified otolaryngology?
A. That is correct.
Q. If we can turn to your CV, which we have marked as exhibit two, could you briefly describe to me your postgraduate medical training?

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A. I graduated Cornell Medical School 1981. From '81 to '84, I did internship and residency at Mount Sinai Hospital in New York in the field of internal medicine. In 1984 -- '81 to '84.
In '84, I took and passed the national boards to begin a board certified internist. From '84 to '87, I trained in cardiology in subspecialty training, called a fellowship, at the New York Hospital in New York.
Likewise, in 1987, I took and passed the boards of cardiology, becoming a board certified cardiologist.
From '87 to 1991, I was hired by Cornell Medical School as an assistant professor of medicine, and as the assistant chief of the cardiac intensive care unit.
From 1991 to 2005, I was the chief of the cardiac care unit at Lenox Hill Hospital in New York, as well as a clinical associate professor of medicine at NYU Medical School.
From February 1st, 2005, until July 1st,

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2006, I was an employee full-time of Columbia Medical School, where I was an assistant professor of clinical medicine.
And then, I voluntarily left that program, July 1st, 2006, to go into private practice, which is the situation I find myself still today.
I have admitting privileges at Lenox Hill Hospital, and I'm still a clinical associate professor of medicine at NYU.
Q. Have you ever worked as an internist?
A. Yes. I still do.
Q. What percentage of your current practice is devoted to internal medicine, as opposed to cardiology?
A. The best way I can break that down is to describe the demographics of my practice.
Fifty percent of my practice are patients that have come to me only for cardiology issues, and they have their own primary care provider.
Twenty-five percent of my practice are patients who came to me for cardiology issues, and then asked me to become their primary care provider.

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And, twenty-five percent of my practice are patients who came to me only as a primary care provider, without any initial heart disease to bring them to me.

While I was chief of the cardiac care unit at Lenox Hill for fourteen years, and while I was the assistant chief at Cornell for another four years, so for a total of seventeen years, a great deal of the medical decision making in critical care medicine, even for the heart, are nonmedical issues.

We took care of seizures, and fevers, and renal failure, liver failure, and hematologic problems.

So, it's very hard to quantify how much of my entire medical practice has been internal medicine. But, internal medicine is a giant part of critical care medicine, regardless of the reason why someone is in critical care.

Q. Is there a separate board certification for critical care medicine currently?

A. There is, and actually when that board was being created, I was grandfathered in to be eligible to

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take the boards because of my -- the nature of my training, I was a year of critical care at my job, but I never opted to take it.

I have no idea if I am still considered board eligible. I was when they started these boards, but I would not -- yes. I just was too busy to worry about taking those boards.

Q. Are you licensed to practice in any state other than -- excuse me -- in any state other than New York?

A. No. Never have been.

Q. And, your first employment position after your postgraduate training, as the assistant attending physician in 1986, was that the same type of breakdown that you just described, in terms of internal -- a combination of internal medicine and cardiology?

A. I'm not sure I understood your question.

Q. Why don't you describe for me what you did as the assistant attending physician in 1986, which was for New York Hospital Cornell Medical Center.

You worked there until 1991?

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A. First of all, I think in 1986 to 1987, I was considered an instructor in medicine. That should be what's on my CV. And, that was my third year of fellowship, but we were given the title of instructor in the department of medicine.

And then, I became an assistant attending physician at Cornell Medical School in 1987. I hope that's reflected on my resume.

Q. I'm trying to figure out --

A. It was not --

Q. What was your clinical practice, if any, during those years? I'm looking at page one of your resume, three quarters of the way down, assistant attending physician.

A. Okay.

That should say 1987, though.

Page one?

Q. Yes. Perhaps I have a different version than you?

A. No. Maybe -- you know what? You are right, I'm sorry. That's the hospital title, as opposed to

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the academic. I'm sorry. My own error. I apologize.

We were an assistant attending physician in '86. I was an instructor at Cornell Medical School, not an assistant professor. That's where I got confused.

From 1986, which was a final year of training, it was a fellowship year, but it was also a year of being on the faculty. It was a hybrid year. It was in 1986.

Cardiology fellowships only had to be two years, so if you opted for a third year, which I did, which focused on critical care, we were given hospital appointments, but we were still fellows, because we did an optional third year.

And, at that time, I was running an intensive care unit with two other people. And, I was, every third month, the attending on record in the cardiac care unit, dealing with all sorts of medical problems, as well as cardiac.

During other months, I did clinical research, or I was the attending on the stepdown floor.

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Again, dealing with a wide array of problems.
But, from those days forward, I always had a practice, my own practice, outpatient. Which is, back in those days, my outpatient practice was only twenty percent, and most of my time, eighty percent, was hospital.
Back then, most of my patients who came to me for outpatient management were cardiology. It was really only in the last ten, fifteen years that I started seeing internal medicine patients.
Q. Thank you. That's what I was trying to understand.
What was your reason for leaving the position of chief of cardiac care unit at Lenox Hill Hospital in 2005?
A. It's a little complicated, but the bottom line was that it's a very intensive job being an intensive care unit director, and it's a younger person's job, generally.
With that said, it was kind of a camelot moment my clinical life, because my closest friend,

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personal and professionally, were the interventional unit at Lenox Hill then.
And, they were nationally famous. We had some of the most exciting medicine going on, probably the most important research trials in cardiology. We were getting patients from all over the world.
My interaction with them was really kind of spectacular. In fact, they are the ones who brought me to Lenox Hill from Cornell.
And then, in 2004, July 2004, fifty people from Lenox Hill went to Columbia. The interventional department just left and went to Columbia.
And, at that point, Lenox Hill was being transformed from the preeminent interventional center in the Northeast to a good community hospital.
And, at that point, I didn't want to remain chief of the cardiac care unit, because the only reason why I was willing to put up with that kind of job was this interaction we had.
So, I followed them to Columbia. Columbia had their own chief of the cardiac care unit; they

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weren't looking for one.
So, I went into the faculty practice. But, after a year-and-a-half at Columbia, I realized that my relationship was different, because I wasn't running a cardiac care unit.
And, my patients were really frustrated coming up to 168 Street, which is almost going to New Jersey.
So, basically my practice said, please come back down to Lenox Hill. So, I returned to Lenox Hill. And, I'm still friends -- because, everything, you know -- I -- there was this moment I thought about moving to Columbia would continue that special moment, but everything changes.
Q. And, your current practice, you said you have been in private practice since 2006.
Can you describe for me the breakdown of your professional time, in terms of clinical care, administrative duties, academic responsibilities, along those lines?
A. Yes.

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I mean, my academic responsibilities are substantially less than they were when I was full-time -- in a full-time employee of hospitals and medical schools.
When I was at Lenox Hill for fourteen years, and Cornell for four, almost every day was involved in teaching, simultaneous to practicing clinical care medicine.
I did classroom lectures, giant lecture hall lectures, besides teaching. It was just everything was constantly being taught while we practiced.
In private right now, I have a responsibility of one month out of the year, in most years, to be the attending of the month of the consultation service.
So, that would be a two- to three-hour investment every morning, for the entire month, teaching interns, medical students, cardiology trainees.
I'm still invited to give morning report episodically, which is talking to the residents about

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interesting admissions.
I have asked to give a lecture once a year about chest pain and its management to all the house staff.
And, one month out of the year NYU medical students come to my office, two afternoon a week for three hours to their ambulatory care rotation, where they get to go to different offices to see how office practice occurs.
So, if you add all of that up, it's still not a big percentage of my total practice time. So, you know, its less than five percent.
Administratively, there is very involved, too. So, I would say that ninety to ninety percent of my time is practice, and five to ten percent are other things.
Q. What are the current hours of your clinical practice? Do you work five days a week?
A. Yes. I work five days a week, basically 9:00 to 5:00 for office practice. And, obviously, if I have people in the hospital, I go in after hours or

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before hours.
If there is an emergency, I will go to the emergency room, if it's one of my patients.
I'm not in the rotation of the emergency room, so I -- I mean, I didn't want to continue that kind of crazy life. So, I don't have to go in for new patients, unless I am being consulted, which I will do.
But, basically I have a 9:00 to 5:00 office practice.
Q. Following today's deposition, could you also provide Mr. Joyce with copies of the two lists that you have with you, of your testimonial history for trial and deposition?
A. Of course.
Q. Thank you.
Have you performed any medical literature research in this case?
A. No.
Q. Do you intend to be relying upon any medical literature at trial in this matter, to support your opinions?

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MR. JOYCE: Objection. You can answer.
BY MS. HITZELBERGER:
A. No. I have no intention of using literature. I think my testimony is on very fundamental medical issues.
Q. Do you consider any medical texts on cardiology or publications to be reasonably reliable?
MR. JOYCE: Objection.
BY MS. HITZELBERGER:
A. That question cannot be answered as a simple yes, no.
Q. Why not?
A. I think that when you look at textbooks, most medical articles, printed medical materials that are legitimate, you know, peer reviewed from good publishers, basically, I think they are all authoritative when it comes to the presentation of certain statistics and generally accepted fact.
If a article or a book says that there were 853,000 heart attacks in the United States in 2009, I would consider that authoritative; I would quote that

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number from the book.
I would believe that they are authoritative in terms of accuracy of referencing a quotation.
When it comes to the practice of medicine, how to deal with patients in clinical situations, the vast heterogeneity of patient presentations, there are millions of people with an enormous spectrum of ways their disease can present, with enormous number of exceptions and variations, makes it impossible to reflect the standard of care, or even universal treatment in any form, and they are not written to be generally reliable or authoritative.
They are meant to be rough guidelines, where you must take the fact of the given case, insert them in, and the standard of care is then based on basic principles, but equally so on the variety of presentations, since no article, book, or treatise can account for that giant spectrum of presentations, they are not trying to be -- tell you how to treat patients.
They can't possibly do it. You can't learn medicine through reading a book because you are not

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learning how to adjust it to the clinical arena. That takes clinical experience.
Q. My --
A. So, they are good for occasions, and outright facts, I consider them all reasonably reliable.
Q. Okay.
What medical publications or journals do you currently subscribe to?
A. I get the -- well, I read or get the New England Journal of Medicine every week, the American Journal of Cardiology -- I'm sorry. The Journal of the American College of Cardiology, the Circulation, one word, Circulation.
And, I try to read as often as I can, Lancet, which is the British version of the New England Journal.
Q. When did you first start serving as an expert witness in medical legal cases?
A. I made myself available as expert in 1987, when I completed all of my fellowships, all of my

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training, and board certification.
Q. What percentage of your --
A. Associates --
Q. Sorry. Go ahead.
A. Pardon me. I said twenty-seven years since 1987.
Q. What percentage of your current professional time is devoted to testifying in legal cases, or reviewing cases in legal matters?
MR. JOYCE: Objection. You may answer.
BY MS. HITZELBERGER:
A. I would say fifteen percent of my time, twenty percent of my income, just to jump ahead.
Q. Do you keep any databases, or -- outside of the testimonial list, do you keep any records that would support your estimation of fifteen percent of your time and twenty percent of your income?
MR. JOYCE: Objection.
BY MS. HITZELBERGER:
A. Well, certainly, I would have no way to demonstrate my time; I don't, kind of, write a diary

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every week. I mean, I don't know if that's a reasonable estimate, but I don't know how I would prove that to you.
My income, you know, I mean, I file taxes every year. That said, I mean, I don't -- I mean, I'm under oath, and testifying to the most reasonable estimate I could give you.
Q. The fifteen percent of your professional time being devoted to litigation matters, has that been true for the last five years?
A. Yes. I mean, more or less, yes. I mean, in some years, it might have been a little less, only because my weeks became a lot longer with some philanthropy in medicine work that I did, that quadrupled my hours.
So, technically, even though I never focussed it that way, I went from working like fifty-hour weeks, to ninety-hour weeks. But, I still kept the same number, fifteen percent, just because I didn't want to factor it that way.
Q. How many legal cases did you review in the

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year 2013?
A. I don't know with certainty, but it would be in the range of twenty new cases.
Q. Could you say that again? I did not hear you.
A. Approximately twenty new cases.
Q. Is that number relatively been consistent for the last five years?
A. Yes.
Q. Would you agree that you have been deposed over 900 times prior to today's deposition?
A. Of course. That's completely inaccurate. That's wildly inaccurate. I have probably have reviewed eight- to 900 cases in the last twenty-seven years. I would say between eight- and 900 cases.
I have been deposed about 280 to 290 times, and I have been in court in the range of 190 times.
So, even though many of the depositions and court cases represent the same case, not all of them, of course, you add up all of my testimony between the two means, it's under 500 times, including trials.

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The number you are giving me of over eight- or 900 is more than the cases I have reviewed.
Q. What percentage of the cases in which you have offered testimony as an expert witness in cardiology, are for -- on behalf of a plaintiff or patient, versus a defendant healthcare provider?
A. Whereas fifteen percent of my cases I reviewed -- that I review for defense firms, less than five percent of my testimony is for defense firms.
But, there is a structural reason why an expert would testify --
THE COURT REPORTER: I'm sorry. Could you please repeat that? This is the court reporter. I couldn't get that.
THE DEPONENT: Yes.
BY MS. HITZELBERGER:
A. I said there is a structural reason why an expert would, by necessity, testify in a higher percentage percent of plaintiff cases than defense cases.
Q. Has your expert witness testimony ever

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been -- strike that.
Has any court, in any jurisdictions, ever refused you to offer expert testimony in trial?
MR. JOYCE: Objection. You may answer that to the extent you know.
BY MS. HITZELBERGER:
A. I can't answer that as a simple yes, no. The only reason is that there was one case in Florida years ago, with a firm called Morgan and Morgan.
The lawyer's name was Steve Knox who was Ocala, Florida, where I was coming down to testify about the standard of care of an emergency room doctor and a cardiologist.
From the moment -- when from I was retained in the case, until the time trial came, there had been a first wave of changes in the law in Florida regarding expert witnesses.
Now, I'm not a legal expert; I don't really know any of this, except that Florida began to transform more than -- even if you could demonstrate you did common medicine, you had to be in their field.

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But, the first change was ambiguous. So, when I came to Florida, the defense objected to me, including the ER doctor.
The judge met with them, I never heard what he said, I wasn't there. And, I thought for a period of time that my testimony was being limited, or restricted.
It ends up it was an agreement because they had an ER expert. So therefore, the judge never had to restrict me.
Mr. Knox informed me, and I didn't know this for a few years, that they disagreed it would be easier than worrying about what the law was, because it was ambiguous.
Now, it's not ambiguous; I wouldn't be allowed to testify against a New York doctor in Florida, who has got that -- be of that specialty, even if you could claim you have the same skills.
So, anyway, that's the only time. But, I was not -- it was agreed that they would just have the experts testify against only that one field.

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So, it wasn't excluded, but it might have been, but if they didn't agree.
Q. Do you --
A. So, to my knowledge, I have never been restricted.
Q. Do you recall if that was in approximately 1997?
A. Oh, good heavens. I don't know. It could have been.
Q. Are you aware of -- you are not aware of any other cases in which your expert testimony was excluded by a court, other than the one case in Florida that you just discussed?
A. Well, I don't think I was excluded, it I can't think of an example of when I have been -- of having been excluded.
Q. Okay.
Have you ever been named as a defendant in medical malpractice case?
A. Once.
Q. What were the allegations in that case?

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A. Nothing against me.
Q. Do you know why you were named as a defendant in that case?
A. Yes, I do.
Q. Why?
MR. JOYCE: Objection, but you may answer. Go ahead.
BY MS. HITZELBERGER:
A. Every physician whose name appeared on the chart at New York Hospital was named in the suit. My care and treatment had no overlap with any issue in the case.
There was never an expert retained to comment on my care. My care was never mentioned, nor were the issues of my care part of the case.
The case involved circumstances which I don't even know about that had nothing to do with me.
So, after my discovery deposition, as well as several other people, we were all let go from the case, when the plaintiff was satisfied that we were not involved with any aspect of the case.

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Q. Do you recall the case caption, or the case name in that instance?
A. You know, it was in 1988. It will probably come to me during this deposition, and I'll let you know. It's a long time ago.
Q. Sure.
Have you ever testified in a case, either in deposition or in trial, where an alleged failure to properly manage Dilantin was the cause of the patient's injury?
A. I don't recall any case like that.
Q. Have you ever testified in a case, either at deposition or trial, where a seizure was alleged to have caused a cardiac arrhythmia and then death?
A. Again, I don't recall ever having that specific issue.
Q. Has your license to practice medicine ever been suspended or acted unfavorably upon?
A. No.
Q. Have you ever been investigated by any of the medical boards for your personal medical practice?

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MR. JOYCE: Objection to the last question, as well. You may answer, and I'll just have a continuing, as to that.
MS. HITZELBERGER: Sure.
MR. JOYCE: Thank you.
BY MS. HITZELBERGER:
A. No.
Q. Returning to your CV, I'm not sure that we have the same version, but have you authored any peer reviewed publications since 1992?
A. No.
Q. Are any of your publications relevant to the issues in this case?
A. No.
Q. Have you issued any reports in this case, or any written documentation, with the exception of your timeline that you provided, and your post-it notes, etcetera?
A. No.
Q. Do you currently perform invasive cardiology?

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A. No.
Q. Have you ever?
A. No.
Q. I was provided with an e-mail from Mr. Joyce yesterday discussing your opinions in this case.
And, it states you believe Mr. Jones' cause of death was a combination of a low Dilantin level, his overall compromised condition from a serious staph infection, and airway compromise from that ongoing infection. And, that more likely than not, it was the seizure that killed Mr. Jones.
Do you agree with those statements?
MR. JOYCE: Objection, but you can answer, doctor.
BY MS. HITZELBERGER:
A. I think that just lumped together as it's stated isn't really conveying the depth of my opinion, but the framework is accurate.
Q. Let's start with the low Dilantin level.
Do you have any opinions in this case, to a reasonable degree of medical probability, as a board

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certified cardiologist, that Mr. Jones' Dilantin level caused or contributed to his death?
A. And, again, I'm not too sure where the scope of my testimony begins and ends, where you go from standard of care to causation.
But, I believe that clearly he had a low Dilantin level. There is a comment on the discharge summary where it says that there was an intention on the part of ENT to contact neurology to load the patient with Dilantin.
So, it appears that not only was there a empirically low Dilantin level in a man who had a history of seizures, even though no one quite knew what the full history was.
You have a man who, you see a note by the ENT department saying that they had an intention of having neurology called to load him, even though they didn't call them.
And, even though Dr. Cohen, your ENT expert, said that it would be crazy to call neurology for loading.

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With that said, that comment acknowledges that the defendants themselves, or the care providers, recognized there was a need to reload, or at least an intention.
So, yes. I think that given the low Dilantin level, given the nature of the aggressiveness of his illness, where staph-aureus is the most aggressive bacteria we know, it was tracking in his head and face -- his face and neck.
There is evidence that he was clinically deteriorated on the 17th.
And, I think that it's very clear that a combination of physiological illness, on top of a man with some unmeasured, undocumented, predisposition for seizures, having a low Dilantin level was a significant contributing factor towards why he had his seizure.
And, I think that -- I mean, obviously, my opinion is that he had a primary seizure on the day of his code.
But, again, that's what I'm saying. Each one point isn't really legitimate as an isolated issue.

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Each point is important in the context of the full case.
Q. I understand. But, if we could, I would like to take them one at time, and go back to a few things that you just commented on.
Again, you acknowledged that you are not board certified in otolaryngology, and that you will not be offering standard of care opinions in this case.
Is that still true?
A. You have two things, two separate thoughts, in one question.
One, I am not board certified in ENT. That is apparent. I am not a surgeon, I never trained in that field, nor am I neurologist.
Let's just say it again. I think I have made clear I am not trained nor board certified in the field of neurology or ENT medicine.
I'm absolutely not representing myself as an expert in those fields. But, I am a critical care doctor, an internal, and a cardiologist.
And, I'm affirming, within the field of

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internal medicine and critical care medicine, that he had a low Dilantin level, and I believe it contributed, due to the nature of his critical care -- his critical illness.
So, that is the part of -- in terms of standard of care, I don't think I have been offered as a standard of care witness.
Q. What is your experience in prescribing, or monitoring, or reloading a patient with Dilantin? And, I can break them down individually, or we can lump it all together.
I'm trying to figure out what your experience with Dilantin is, and how, if at all --
A. Well --
Q. -- you have used that with your patients.
A. I'll summarize it.
I have never initiated Dilantin for seizure activity. I have always had a neurologist prescribe drugs for a new patient who has a seizure disorder. I would not even attempt to do that.
I have had many patients over the years on

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Dilantin for different reasons, and therefore, I have, even in a non-neurology position, renewed Dilantin prescriptions for patients over the years.

I have personally certainly taken care of a large number of critical care patients over the years, where I have cared for tens of thousands of patients who have been on Dilantin.

I have had occasions to have to reload patients with Dilantin. If I want to do it intravenously, I think I have consulted a neurologist before, just to make sure, but I don't even remember that with certainty, if I have always did it that way.

Sometimes, we would orally reload. Some of these patients could not be orally reloaded. It just depended on the circumstances. There are a lot of different ways these patients presented.

Most of the patients who had low Dilantin levels, our concern was that the nature of a complex severe medical illness can be one of those stressors that triggers a seizure.

So, we always do a low Dilantin level as

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more urgent in a hospitalized sick patient setting, than in an outpatient stable patient.

Or, let's get two kinds of patients: A patient who has frequent seizures, that's more pressing to raise the level; or a person who has a complex medical illness, is an equally pressing reason to raise the Dilantin level.

But, again, neither goes to standard of care, I'm not here to represent that.

Q. I did not here hear the last part of what you just said, and I -- correct me if I'm wrong. But, I believe you said if someone has a complex medical illness, that's a reason to increase the Dilantin level.

Is that what you said?

A. To see it as an urgent problem. I -- that from my point of view as a practitioner, the two circumstances where I would urgently reload someone with Dilantin, if the level was low, with or without the help of a neurologist, would either be if they had a known frequent seizure disorder.

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Or, if they had any history of a seizure disorder on Dilantin, and they were presenting with a severe medical illness.

Now, within that category, some of them, obviously, more than others, would increase the risk of seizures.

Q. Did Mr. Jones have a history of frequent seizures?

A. No.

Q. What was Mr. Jones -- I believe you said a few moments ago he had undocumented predisposition to seizures.

Is that what you stated?

A. Yes. Because there is no sense of what -- there is really no evidence that he ever had a seizure after starting Dilantin.

And, even trying to track down why he was on Dilantin in the first place, was challenging with the records we have had.

I know he had that episode of falling off of a ladder. You know, he has head trauma, so he has

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reasons to have seizures. There is a plate in his skull.

But, to my recollection of the case, there is no real evidence of -- there is no EEG, or neurology notes discussing his Dilantin use.

There is a lot of -- you know, there is just no documentation that he has seizure disorder as a frequent issue. But, clearly, it was started for a reason.

Q. And, is it fair to assume that his suspected MRSA infection is a complex medical illness, as you described it, sufficient that you think he needed to be urgently reloaded with Dilantin?

A. Well, absolutely. But, it's not just having that bacteria. It's look at the patient who came in; right?

This is patient who came in with a resistant form, able to be treated, but in a more difficult to treat form of staph, which is the most aggressive -- staph-aureus, which is the most aggressive bacteria that can -- you know -- it's

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that -- it's a variance of the staph that's the flesh eating disease.
And, you can have many degrees of aggressiveness, but they tend to be aggressive. Staph tends to be a infection that more readily than others tracks through tissues.
When you have you a man coming in with abscesses, multiple -- more than one abscess, in this case, where puss has been expressed.
And, by his description, it is involving both sides of his face. The left ear, near the eye, the right jaw and neck.
You have the most aggressive organism on both sides of his face. The right side, his neck and jaw, which is close to the airway, with a bacterial that is known to penetrate through skin, and track.
One, you have to acknowledge the potential for that to even track into the brain. It's a very short road from the sinuses to the brain, with an organism as aggressive as staph.
Now, I'm not saying that's what happened to

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him. But, I'm saying is, if you have a patient with a -- the most aggressive organism known to man on their face, you have to make sure, that if they have a history of a seizure disorder, they are back on Dilantin, because you don't know if that's going to happen.
There are a lot of reasons why this guy can have a seizure provoked. He is sitting with a very -- he has like a time bomb on his face, that if it goes the wrong way, it can lead to devastating medical consequences.
He also seems to have tracking in his -- you know, look at the extent of this infection. Yes, this is a critical illness.
And, as I stated, there were some evidence, which I have given you specifics, that show you that he -- on the 17th, he was deteriorating.
And, it's more than just his recurrent pain, although that is one of the evidence --
Q. Just --
A. -- very little --

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Q. Sorry to cut you off, but before we move into that next strain, I want to go back to a few things that you said. And, I'll let you get into the 17th in just a moment.
You stated few minutes ago that was in more difficult to treat form than other infections.
What is the basis for that opinion?
A. Well, this is MRSA, M-R-S-A. It is a form of staph that is resistant to the analogs of penicillin that we usually can treat staph.
So, the antibiotics, although there are antibiotics that treat it, MRSA, M-R-S-A, is more aggressive, because it is harder to have bioavailable antibiotics treat it.
Just, it's by definition a resistant -- bacterial resistant -- an antibiotic resistant version of the bacteria.
Now, it's not completely resistant, but it still has resistance. It's going to be harder to treat.
Q. Did you review the wound cultures, and the

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blood cultures in this case?
A. What do you mean cultures? Are you talking about the counts?
Q. Yes. That the cultures were taken on the 16th, which eventually grew out positive after Mr. Jones' death?
A. I'm sorry --
Q. Cultures.
A. Okay.
Yes, I am aware of the cultures. I do apologize. It was -- the cultures I am aware of.
Q. And, would you agree with me that Mr. Jones was prescribed IV vancomycin, which was later switched to daptomycin.
Is that correct?
A. Yes.
Q. And, the cultures indicated that he was -- that his strain, and excuse me if I'm misstating this, but that his infection was responding to those types of antibiotics.
Is that right?

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A. Well, now you have made -- he was -- cultural sensitivity.
Q. We just broke up.
MR. JOYCE: Doctor, before you go on, can you repeat that? We had a little bit of break-up on the feed.
BY MS. HITZELBERGER:
A. He was appropriately on antibiotics that demonstrated sensitivity in the laboratory. So, he was on the right antibiotics. But, that's different than saying he is responding.
He initially showed a clinical response in the first forty-eight hours when he had drainage of some of the puss from both sides of his face, and the initiation of the antibiotics.
But, like I said, this is a very aggressive organism. The penetration and bioavailability of vancomycin is not as great as the drugs to less resistant organisms.
With that said, it can be treated.
But, what you are talking about potential

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close face infections, and potential infections tracking through tissue planes, you cannot assume that antibiotics alone are going to make it better, or that you are just simply getting better because you started the right antibiotic. He was -- he came in with collections of puss.
Now, unless those are expressed, he cannot get better. Now, we know they did. And, they never found an area that they thought was an abscess. But, that doesn't mean there weren't deep areas.
And, his clinical deterioration on the 17th, in fact, would indicate that he wasn't actually fully responding to treatment, and that he was -- if he had not died, would start demonstrating a flair-up of his disease, which is why I think he had a seizure that day.
(Discussion off the record.)
BY MS. HITZELBERGER:
Q. Can you tell me from reference to the medical chart, where you saw that Mr. Jones had -- I'm not sure if you said abscesses, or pustules, on his

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jaw, on the right side of his face?
A. I -- his jaw.
THE COURT REPORTER: I'm sorry?
BY MS. HITZELBERGER:
A. I didn't say that. I said he had two areas that were drained. I didn't say it was on the right jaw.
I'm saying he had two areas where was there was an abscess drained. One on the 16th, and one on the 17th, or on the 15th and 16th.
There was one in the emergency room, one after the emergency room. He had two areas of tissue that were excised with puss coming out.
Q. And, where were --
A. And, just because those were the -- I think they may have -- one was, I think, near the eye, and the one was probably on the left face, too.
But, that doesn't mean those are the only areas of abscess. And, when you are talking about an infection that is bilateral, where you are talking about swelling of the jaw and neck.

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And, they said didn't feel fluctuance, which can be a characteristic of a abscess.
But, everyone has to admit that doesn't prove there isn't other areas of abscess. And, in a man with this aggressive an organism, that's always in the back of your mind that he could have another abscess, which would be resistant to therapy.
And, in fact, some of the changes that occurred on the 17th are consistent with that, and suggest --
Q. Did you --
A. -- with that clinically.
Q. Did you review anything in the chart that identifies any abscesses that were close to Mr. Jones' airway?
A. No. But nor, I think, was there any evidence that he didn't.
MS. HITZELBERGER: I think this is a good time for us to take a about -- it's going to be about a ten to fifteen minute break. Unfortunately, we each -- the court reporter and myself, and perhaps

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Mr. Joyce, have to reload our parking meters.
So, I apologize for the delay. We will be back shortly.
(A short break was taken.)
(Charash Exhibits 1-3 were marked for purposes of identification.)
BY MS. HITZELBERGER:
Q. Dr. Charash, you stated a few moments ago that Mr. Jones had facial abscesses. They were tracking in both his face an his neck.
What is the basis for your conclusion that his abscesses were tracking?
A. Well, there's two separate concepts. The first is upon presentation, the recognition of that potential, that what are you seeing is not the full extent of it, especially given the organism, and its known potential.
My reason for believing that he had a greater extent of the infection, is based on the some of the findings in the hospital on the 17th, which would likely be explained by that.

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Q. What are those findings that you are referring to on the 17th?
A. Okay.
Well, one of them, I think, has been mentioned in depositions already. And, that, of course, that on that day, his pain was getting worse. And, that's only one small piece.
But, on page fifty-five of the records, which is the pain log, from the 16th, you can see that by the end of the evening his pain had come down.
He was nine out of ten at 9:00 in the morning, but then the rest of the readings were zero out of ten, until near midnight, when he started going up to two -- three and two out of ten.
But then, of course his pain worsens when his -- on the 17th, with that flow sheet, which is number page --
Q. Page sixty-seven?
A. -- sixty-seven. Yes. Where we see that by 9:20 in the morning, he is having ten out of ten pain. And, at 1:00 in the afternoon he is nine out of ten

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pain.
So, clearly before he coded was having severe facial pain. And, you know, that's significant.
The next thing is --
Q. Sorry to cut you off --
A. -- labs --
Q. Sorry to cut you off again, but before we move away from the pain score, what is the basis for your conclusion that the pain is attributed to his face, or his facial abscesses?
A. That his pain is from the facial abscesses, or infection --
Q. Yes.
A. Because that's what they have been tracking from the very beginning, is the soreness of his face to the infection.
From the beginning, they know that he has pain in his face. That's what they are following. They are not tracking any other source of pain.
You know, these aren't randomly written; these are tracking the pain of his presenting illness.

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And, it makes that at first he had pain relief when the abscesses on his superficial face were drained. That relieves pressure.
But, the fact that his pain was coming back with some aggressiveness, would indicate a strong potential.
Not one piece of information is proof of anything, but it certainly is the beginning of a concern that his abscess was extending.
And, in fact, even Dr. Cohen, as cantankerous, or kind of glib, as he was on occasion, even said that if someone's pain was getting worse, he would worry about an abscess that wasn't found.
That was one of the last things he said in his deposition, part one. I agree with that.
Q. Are these --
A. Now --
Q. Go ahead.
A. Now, going to page ninety-seven of the record --
Q. Are we still talking about pain score?

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A. -- which is -- no. Talking about the other reasons why I think he was deteriorating from an infection.
Q. Okay.
I just want to stick to the pain score for one more minute.
But, in all of the places in the record where you have seen the pain score recorded, in a number out of ten being the denominator, is there any place in the record where it states that this is for facial pain?
A. It's not stated explicitly, but it is absurd to believe it can be anything but facial pain.
Q. Okay.
A. I mean, it would really be somewhat preposterous to try and suggest this is a pain source that is not related to the reason for his admission.
Q. And --
A. That would just be unprecedented. Because there is no discussion of it being elsewhere in his body that could possible be that much.

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He comes in, they talk about having a painful face when he comes in. They are tracking in pain.
There is it no conceivable problem by which he is having ten out of ten pain, from another part of his body, other than his face, and it's not mentioned anywhere else in the chart. The default pain is that when you are tracking pain, it's related to the central disease.
Now, if you want to suggest that this could be a pain in his toe, go ahead. But, it makes no sense.
Q. And --
A. As a physician, I would never doubt it.
Q. As a physician you would never what?
A. Doubt they were reflecting pain other than it's a central admission unless designated.
Q. And, these pain scores are recorded by the nursing staff.
Is that correct?
A. Yes.

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Q. Okay.
Moving on to page ninety-seven. Sorry to cut you off.
A. All right.
It's interesting that you said that. It's interesting that you said that it was that recorded by the nursing staff.
Because Dr. Cohen, in his deposition, demonstrated what seemed to be a mild contempt of the nurses, when he said something very similar to what you just said.
When you suggested the pain could be anything, he said, well, and these are being done by nurses. I can't find it right now, but he said something pejorative about the nursing, as if their ability to record pain on a score of one to ten may not be a reliable mechanism, which I think is contemptuous of nursing.
Q. I did not -- for the record, I did not make any pejorative remarks about the nurses. I asked a simple question of they were being recorded by the

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nurses. I'm not sure what Dr. Cohen said.
A. I --
THE COURT REPORTER: I'm sorry?
BY MS. HITZELBERGER:
A. I know. But, I'm just saying is that Dr. Cohen made a point to go out of his way to suggest that nurses may not be a reliable source.
Q. Do you know what page you are referring to?
A. Yes. Let me find it. It will take one second. Just a second. I will have the page. Here we go. It's on page number forty-six.
He was asked on line four, page forty-six, but his pain score was going up, is that fair to say.
Answer, I'm not necessarily sure what the pain score is associated with. It could be lower back pain. What does pain score really mean from a nursing assessment.
Well, to me, it means the patient had the pain they are reporting. But, for him to say what does a pain score really mean from a nurse's assessment, what does he think it means?

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It means that the patient is reporting pain when asked on a scale of one to ten. And, I don't think the fact that it's a nursing assessment, should matter. But, he may not think very highly of nurses.
Q. Okay.
Moving on. Page ninety-seven, you were referring to the lab values?
A. Yes.
Q. What about the lab values?
A. So -- on one hand, you have the pain score significantly worsening from having really full relief, to now jumping up to three, then to four, and ten out of ten.
On ninety-seven, there are two very important lab values to look at.
First, the glucose level. They have values from the 16th. So, all three of the numbers I'll am talk about are three values for two different things.
The 16th, at 12:04 a.m., which means really the very beginning, either the 15th into the 16th. Then, they have the 17th at 11:28 a.m., and then there

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is a 17th at 4:40 p.m., which is obviously before the code.
So, when you look -- and, this is the time reported, I imagine.
But, the sugar went from 124 up to 201. And then, in a matter of just five hours, went up to 400.
Now, diabetes, and its ability to become exacerbated, occurs due to -- any major inflammatory illness can cause sugars to start jumping out of control.
By major inflammatory illness, I mean, a heart attack, or a stroke, or a infection, and/or a spreading infection.
So, when a patient starts demonstrating -- you know, obviously, we know he didn't eat a high sugar bolus.
Any person who is demonstrating a large, otherwise unaccounted for, leap in their glucose, who came in a with an infection, you must work on the assumption that that increase could be suggesting a extension of that illness.

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And, in a man who came in with a primary diagnosis of staph aureus in his face, on both sides, where at least two abscesses were found, and without certainty about deeper tissue, and you add it to the fact that he was having ten out of ten pain on the day of his death, that rise in the sugar, and the ten out of ten pain, both raise a very serious concern that he is having a tracking infection that is getting worse.
And, the reason why I say tracking is it's not superficially evident, but this is a deeper tissue infection he has.
The final evidence, which is more ominous than the glucose --
Q. Before we move on --
A. -- is called -- go ahead.
Q. Before we move on from the glucose, can I interject some questions, please?
You are talking and referring to page ninety-seven, the 1/17/2009, 4:40 p.m. labs.
It's your testimony today that -- or excuse me.

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Would you agree with me that these labs are consistent with labs that were run during the course of the code, and not prior to the code?
A. No.
Q. Why not?
A. The time -- because if you take a look at this, the time they give is the time -- it's evident that the time they record on these sheets are the time the numbers are coming back, not the time they were drawn.
For example, the Dilantin level, reflected page 100, says 11:28 a.m. on the 17th. We know it was drawn early in the morning. It was ordered before 4:30 a.m.
It doesn't designate that this is the time of the blood draw. It's more consistent with the time that the blood results came back.
And, if you look, there are all sorts of different times of results coming back, and I don't think the patient had that many blood draws.
So, this is the time it is reported, which

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is 4:40. That means it had to be drawn before 4:40, and the code didn't happen until 5:00.
Q. In looking at the --
A. So, this would be --
Q. Go ahead.
A. 4:40 p.m. on the 17th.
Q. At 4:40 p.m. on the 17th, if you look under the CO2 level?
A. Yes.
Q. The fifteen, is that -- what does L stand for?
A. That's -- low. That's what I'm pointing out to you. That was my -- that was the next area of concern.
Q. Is that --
A. Is bicarbonate.
Q. Go ahead.
A. It's consistent went an infection getting worse.
Q. Is it also consistent with a patient who is being bag masked ventilated during a code.

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MR. JOYCE: Hold on. You are speaking over each other, and then there is a blip in the feed. So, let's just stop. Okay.
BY MS. HITZELBERGER:
A. Number one, these top items -- and I'm sure this can be easily determined from the hospital, don't have any reasonable chance of being the time the blood is drawn, but the time the results are posted.
Because, there are just too many different times different times and different labs, and different times of day being posted.
Otherwise, you would see one time for a whole variety of different labs, and it doesn't happen.
Number two, a drop in bicarbonate is just as consistent with an infection worsening, which is consistent with the sugar going up, and consistent with the pain getting worse.
Now, 4:40 is before the code. Even if this is the time that the lab documents it coming in, it's before the code.
Also, I've been involved in several hundred

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codes in my career, and early in a code, when are you trying to keep a person alive, you don't tend to send a general chemistry. You are getting blood gases for that.
The reason why you are getting blood gasses is that is more immediate, and that's what you need if are you going to get any blood test. But, you are not going sit there and draw venous blood, for a regular chem six. There is no reason to do that.
And, the glucose would be -- by that.
Q. Is --
A. Anyway, there is no way -- you ask the hospital. I can guarantee you they are reporting the time of the posting of the result, not the time that you think the blood was being drawn.
Q. Is it --
A. How would they even know what time the blood is drawn?
Q. Are you finished with your answer? I don't want to cut you off for the court reporter to record it accurately.

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A. Yes, I am.
Q. Is it possible that the 4:40 p.m. time is when the p.m. labs were ordered, not --
A. No.
Q. -- when they were -- came back?
A. No.
Q. Why not?
A. If you look -- because, look at the look at the Dilantin level on page 100. They are posting it -- it was ordered for 4:30 a.m. on the 17th, and it's posted at 11:28 a.m.
There is no order for an 11:28. It is posted -- first of all, the order was written on the 16th to be drawn at 4:30 a.m. on the 17th.
How does that match 11:28 a.m. for Dilantin?
Q. Can --
A. That's more consistent with the time the result is being produced.
Also, lots of bloods were ordered at the same time, and they are not being reported at the exact same time. They are not -- they would be a series of

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labs all ordered at the same time. And, the numbers are all very varied on everything.
This is the time they came up with the results. This shouldn't be a debate; the hospital should know.
Q. Assuming hypothetically for me that this 4:40 p.m. timestamp is not there -- just don't even look at the timestamp. Assume that it says 5:40 p.m., whatever it says.
Is a sodium bicarbonate level of fifteen, is that consistent with a patient who is being bagged masked ventilated during a code?
A. It's possible, but certainly a code could drop the bicarbonate. But, what I'm saying is that that's more consistent with -- and by the way, there wouldn't be an order in the order sheet; it would be a stat drawn run upstairs.
So again, there would be no reason to write 4:40. It would have been ordered at 4:40; it would have been drawn at 4:40. All that is before the code.
So, if nothing about 4:40 matches the code

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-- and, the other thing is, by the way, the patient expired -- I want to see what time he died.
There is a time of death, is at 5:46.
Okay? That's what it says. 5:46.
So, by your estimate, if that's posting the time it's ordered, why was there a CPC drawn at 5:49 p.m. after he died?
On page number ninety-nine, there is a CBC. The result is at 5:59 p.m.
Now, if that's the time they ordered it, they ordered it had after he died. If that's the time they drew, they drew it after he died. If that's the time the results came back, then it was taken before he died or coded, and then it was finally posted at 5:49 because the lab didn't know he was dead.
There is no reasonable possibility that the 4:40 p.m. lab results is reflecting the code. What it is reflecting is the patient beginning to get acidotic from an infection that is spreading.
Q. Again, assuming hypothetically for me that this 4:40 timestamp is not on the lab values, on page

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ninety-seven, is a glucose level of 400 consistent with someone who has received a D-50 times one amp during a code?
A. It could be. Sure. It's not plausible, given the time it's posted. Because why would it be ordered before the code, and if it's a code draw.
Blood that was drawn during the code would -- emergently -- run up to wherever it has to go. It's not routinely sent up.
Why would it be anticipate -- I mean, they are not anticipating the code at 4:40.
And, like I said, there is no chance, based on the other things in this chart, to suggest that these could possibly be anything other than the time the result is available.
But, even if it's the time they drew the blood, it's before the code; if it's the time they ordered the blood, it's before the code; if it's the time they posted the blood, it's before the code. Everything about this blood is before the code.
4:40, whatever it represents, is twenty

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minutes at least, or twenty-five minutes before the code.
That is not a blood that was taken during code, not to mention you tend not to draw a CBC during -- I mean, a regular chemistry during a code, nor would you send a regular CBC during a code.
They foresee the patient lives -- what you are saying makes no sense at all.
And, in fact, the whole point that you are making, that these could be consistent with the code, is the reason why if they are not, it is showing that his infection is worsening, which is, for causation purposes, the reason why he had a seizure.
Q. Returning to the Dilantin, are you familiar with the half-life for Dilantin?
A. Yes.
Q. Do you have any reason to disagree with Dr. Batipps's testimony that a patient who is therapeutic on Dilantin, the half-life would be approximately seven to ten days?
A. That's -- first of all, that is totally --

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that he -- who said that? Dr. Batia?
Q. Batipps, the neurologist.
A. Batipps didn't say seven to ten days is the half-life. The half-life of Dilantin, if you look at the PDR or the literature, it's an average of twenty --
(A short break was taken.)
BY MS. HITZELBERGER:
Q. Do you remember what your last answer was, or we could have the court reporter read back where we were. I think you were in the middle of your answer?
A. It would help if she read back.
(The record was read as requested.)
BY MS. HITZELBERGER:
A. Got it.
The range is between four hours and forty-eight hours.
Which means -- some people are fast metabolizers. So, if you are a fast metabolizer, your half life would be four hours, eight hours, ten hours.
But, the range is four to forty-eight, the average being considered twenty-two.

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So, no one said that it was a week half-life. He said that it might take a week to drop down to zero.
And, by the way, no one is saying the level is zero. If it's -- under two-five, what's the difference if you have a level of two or zero.
It doesn't mean it really is zero; it means that they don't bother measuring below two-and-a-half. But, it doesn't mean the level is zero. It can be 2.5, it can be two.
So, my point is, if somebody is a twelve-hour metabolizer, at thirty-six hours they can go from sixteen, down to eight, to four, to two, in just three half-lives, which could be thirty-six hours. Or, if they are four-hour half-life, in twelve hours they could be down to under two, starting at sixteen.
He is given the average, and the average is twenty-two hours. And, he's right that if you have a -- basically a full day half-life, it may take three, four, or five days to get down to under two to five. But, that's the average. That doesn't mean all

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patients are the same.
Q. Would you disagree that --
A. I'm sure he agree -- go ahead.
Q. Would you disagree then, that it could take longer than five days to get down to less than 2.5 level; for example, taking seven days?
A. If they were a forty-eight hour metabolizer, the slowest possible, yes, it could take that long.
Q. What is the basis for your opinion in this case that Mr. Jones -- I believe you testified earlier that the primary event for him was a seizure.
Is that right? That he had a --
A. Yes.
Q. -- seizure as a primary event on the 17th?
A. Yes.
Q. And, what is the basis for that conclusion?
A. Very good. And, that's going to rely on my timeline, and this is to dispel the defense position.
And, I want to first start by saying that I'm the first person to agree that seizure is often the first evidence of a cardiac arrest in people.

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If someone is not being monitored, when you have a cardiac arrest, you get hypoxic within the first thirty seconds or so of a cardiac arrest. Some people have grand mal seizures.
And, unquestionably, a grand mal seizure could be the beginning of a cardiac arrest. There is no doubt that that happens.
And, I have testified to that in cases where I believe that has happened, where evidence shows that a seizure is most likely to be a hypoxic seizure.
As a cardiologist, I think I am rather expert on hypoxic seizures due to cardiac arrest, because I have probably seen more than Dr. Batipps. It's just my career.
Now, going to their theory, here is the problem: Dr. Batipps believes that Dr. Cohen seems to believe, and probably Dr. -- that his seizure, or whatever motion he was, even though everyone thinks it was seizure-like was there, was caused by a cardiac arrest.
Okay. Let's take that as theory; that he

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had cardiac arrest, and the seizure was a hypoxic reflection.
That means that if he had a cardiac arrest, he had been in an arrest for -- in the range of twenty to thirty seconds, because you have to have time to get hypoxic if you had a seizure.
So, let's look at the timeline. The nurse -- and that's my timeline here.
The seizure-like activity, I wrote, had to have occurred between 5:08 and 5:10. Certainly could be closer to 5:10, because we know that it was not until after the seizure-like activity, and I'm sure she spent a moment to evaluate the patient, that the resident was contacted at 5:10.
Now, I guarantee that it's not instantaneous contact. There must be a physical time to reach out the to resident, and have them call you.
So, what I'm saying is that, you know, the person has the activity, and the nurse clearly had to evaluate the patient, and call the resident.
So, I would think at some point before 5:10,

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that event occurred, or on -- close to that time. And then, she contacts the resident at 5:10.
The resident now heads towards the floor. He gets there closer to 5:14, roughly four minutes of change.
On route, he gets a text saying the patient is unresponsive. Someone had to break away, and spend the time to text him saying the patient is unresponsive, on top of what he has been told.
When he arrived at 5:14-ish, and the nurse writes it 5:15, the patient is foaming at the mouth. And then, they notice the patient is pulseless, and a code is called.
So, my question is, if the cardiac -- had the nurse, by the way, in her actual text, which is the second half of my page says, on page forty-seven of her depo -- when patient began -- page forty-seven of the records. Sorry.
Number one, patient began to shake, body shifted.
Two, called ENT stat. Like I said, there is

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a physical time. The ENT guy says he is reached at 5:10.
Three, few minutes later, patient starts foaming at mouth.
Four, code called, started CPR.
Five, code team arrived. So, the code starts at 5:15.
So, my question is they start CPR at a 5:15 because his heart stops. So, what was happening -- the defense is saying that he had a cardiac arrest around 5:10, or before 5:10 leading to a seizure.
But then, for five minutes they don't recognize that he is in a cardiac arrest. And then, he goes into a cardiac arrest at --
There is no reasonable possibility that he had a prolonged code leading to a seizure, but didn't code until five minutes later.
And, that's the part of the case that makes no sense. There is a nurse in the room. She clearly says that minutes went by between the seizure activity and foam in the mouth.

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She is there in the room. I guarantee this patient was not pulseless, because she would have called the code immediately.
She is standing over the patient. Only after there is foam in the mouth does she then recognize after that, that the patient becomes pulseless, which you can generally visibly see that a person is not breathing. You can see that their facial color is changing.
The nurse reports a code, specifically at 5:15. So, unless -- is saying that the nurse just sat there, and decided not to do CPR for five minutes, or not call for help for five minutes, or that your nurses are not qualified to assess the vital signs. It makes no sense.
The other -- so you can't explain -- the defense can't explain the several minutes, up to five minutes, of the patient having the seizure until he codes. It just doesn't make sense about any of their discussion.
Q. Can I ask you --

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A. The other the part --
Q. Can I -- before we move on, let me interject a few questions. Thank you.
In looking at your timeline, again, you stated that these numbers are yours, that you derived based on your review of the records. They are not actually -- these numbers are not reflected in the records.
Is that correct?
A. Well, most of them are. And, the rest are just basic discernment. For example, the resident is reached at 5:10.
Q. Can you look at page --
A. Now --
Q. Excuse me.
Can you look at page forty-four of the medical records?
A. Yes.
Q. That's the resident's note.
A. Yes.
Q. And, would you agree with me that it says,

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called to see patient around 5:10 p.m. for witness seizure-like activity?
A. Yes.
Q. And --
A. But then, he says he arrived roughly at 5:14. So, he may not know the exact time, but he knows it took him four minutes to get there.
Q. And, this note is timed --
A. That part he's reliable.
Q. Excuse me.
This not is timed at 18:04.
Is that correct?
A. Yes. So, it's timed minutes after the patient died.
Q. And --
A. Not minutes -- yes. Minutes after the patient's dead. He got there right after the patient died.
Q. The nursing note --
A. And also, the nurse on page forty-seven --
Q. Correct.

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A. -- she says a few minutes went by between the seizure and the foaming of the mouth, and then the code came.
So, again, both of these parties are showing you several minutes between the seizure and the code.
Q. What time is the nurse's note --
A. You can --
Q. -- timed on page forty-seven? What time is that entered?
A. That's written at 8:01 p.m.
Q. And, that says --
A. But, it doesn't matter. She -- your memory can change about exact time a code begins, but your memory doesn't change that a person had a seizure, and several minutes go by until they foam at the mouth and code.
The resident doesn't forget that it took him about four minutes to get to the patient, and he arrived, and just then the patient was foaming in his mouth and coding.
The two notes match each other almost

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exactly.
Q. Had you --
A. And, neither note in any way consistent, or reasonably possible, that the patient was already in a code when he seized. It is just not possible.
Q. Dr. Charash, do you see any indication in the resident's note that the patient was foaming at the mouth at the time he arrived, or that he witnessed the patient foaming at the mouth?
A. Let me look.
No. He doesn't mention the foaming at the mouth; the nurse does. But, the nurse says foaming at the mouth was just before the code. And, he walks in just around he code.
Q. And also, looking at page forty-four, it states midway through the paragraph, patient appears to be in PEA arrest.
Is that correct?
A. Yes.
Q. Am I correct that PEA stands for pulseless electrical activity?

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A. Yes.
Q. It doesn't necessarily mean that the patient doesn't have a pulse.
Am I correct in my understanding that it's just that a pulse cannot be palpated?
A. No. Generally -- well, the patient was deemed to be in a code. The patient was clearly not breathing. They called a full code. And, you can't be breathing if you have -- you will be breathing if you have circulation.
A pulseless electrical activity, yes, in theory, with cardiac tamponade, a person can have a pulse so thready, so won't feel it.
But, generally, pulseless electrical activity, which is a generalized term, means that there is some form of electrical activity on the monitor, but the patient doesn't have a pulse.
And, you can't determine if that rhythm until they are attached to an EKG machine.
Q. What is the likelihood, or percentage of being able to successfully resuscitate a patient, once

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they are in PEA?
A. Okay.
It's low, largely because pulseless electrical activity tends to be a response of more trauma. If a person goes into a V-fib arrest -- by the way, if it is a V-fib arrest, technically, that is pulseless electric activity, and, you know, they are shocking him -- to be able to survive -- with near certainty.
THE COURT REPORTER: I'm sorry -- I'm sorry, Doctor. I need you to repeat. The combination of the not great connection we have, and your fast talking. So, I apologize.
THE DEPONENT: Okay. No, please. I'll slow down.
THE COURT REPORTER: Thank you.
BY MS. HITZELBERGER:
A. When a patient -- if I patient has a ventricular fibrillation arrest that's witnessed, that's pure electrical arrest.
Technically, that is pulseless electrical

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activity. And, those will have a one hundred percent resuscitation, if shocked immediately, if it's an electrical arrest.
There are a lot of reasons why I could prove that point.
But, if you have a pulseless electrical arrest, my argument is, in this case, that the arrest occurred after progressive hypoxia from airway obstruction.
Now, you have a man who is fifty, with high blood pressure. The medical examiner turned him down for those reasons, which meant that the medical examiner believed that given the fact that he died, that more likely than not he probably had underlying coronary disease.
Statistically, the medical examiner is right; he probably does, given everything we know.
So, what I'm saying is, here is a man who had some clinical coronary disease. There is a strong likelihood, who has a seizure due to a worsening infection, who more likely than not had some level of

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airway compromise, due to the infection growth.
Who then has a seizure, which then causes his airway to become obstructed between his tongue, and whatever degree to which infection is contributing.
And then, over the course of the next five minutes, he is hypoxic. Maybe not a hundred percent hypoxic, but he is hypoxic. His oxygen drops.
Prolonged oxygen depravation, especially if the patient has any vulnerability in the heart, will lead to a cardiac arrest.
But, that cardiac arrest is a lot worse than a primary electrical arrest, because this is due to the suffocation of the heart, so the arrest is begun by the heart having been oxygen deprived, which is different than a pure electrical arrest, which is just an electrical phenomenon.
So, I believe that this pulseless electrical activity, if it was not v-fib, was more likely than not an ominous indication, because his arrest wasn't just a random electrical arrest.
His arrest was due to prolonged airway

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obstruction. And, that puts him in much worse shape when they code.
Q. What is the basis of your opinion that Mr. Jones had a prolonged airway obstruction, or any at airway obstruction at all?
A. As the most likely explanation to explain all of the facts. I believe there is objective evidence that the infection was worsening; his pain was worse, he was getting acidotic, and hyperglycemic.
His code occurred after he had a seizure-like activity. The only way that you could explain the seizure-like activity reasonably, as a result of a code, would be if he had a seizure-like activity, and was immediately recognized to be in a state of cardiac arrest.
But, that's not the case here. If he had a seizure due to cardiac arrest, which could happen, it's generally twenty, thirty seconds into the arrest, the nurse would have recognized what she saw him have the seizure, to be pulseless and not breathing.
But, she makes it clear in her own

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narrative, that several minutes went by between the patient seizing, contacting the resident, to the point that the patient foamed at the mouth, and then coded.
This is the nurse on the scene clearly showing that the seizure predated the code.
So therefore, in my opinion, more likely than not, the seizure led to airway obstruction, which caused the code.
I don't understand why that is too complicated for Dr. Batipps, in that he obsessively talking about status epilepsy, ongoing epilepsy, how that presents.
I'm talking about -- we know that airways can get obstructed with seizure. Good heavens, we all know about the swallowing your tongue, and trying to protect the airway.
Well, with any degree of pathology from the infection, one can easily imagine that becoming worsened.
Q. Would you agree with me that a seizure as a result of a code -- excuse me -- that a seizure causing

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a code is more rare than a seizure that happens following a cardiac arrest?
A. Okay.
Well, again, yes for several reasons.
Number one, most people who have seizures aren't presenting with facial and neck infections, showing that they have a proclivity.
Number two, most people with seizures are having their airway protected.
Number three, if you don't, they will get into trouble. But, sure. I would unquestionably agree. Because, first of all, there are 400,000 sudden deaths a year in the United States.
I don't think there are 400,000 seizures -- grant mal seizures. I don't know the number.
But, I would absolutely agree, that at least in my clinical experience, cardiac arrest -- by a code, with -- seizure from a cardiac arrest would be more common than a seizure leading to airway obstruction and a cardiac arrest. I have no doubt about that.
But, that doesn't change the fact that this

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patient could not have had a cardiac arrest, because the nurse noticed the cardiac arrest minutes after the seizure. And, that could not have happened if he was in an arrest already.
Q. That --
A. That part is the part that the defense can't account for.
Q. Returning to the airway, and just perhaps it's me, and I'm having trouble understanding. But, am I correct that there is no evidence in Mr. Jones' clinical record, that documents that his airway was obstructed in any way?
A. Right.
I'm giving opinions within a reasonable medical certainty, not with absolute medical certainty.
Q. And --
A. No one can be ever absolutely certain. But, he had an infection that clearly involves his neck. We have evidence that he was getting worse by worse pain and worse blood tests, and the fact that he did have a code after he had a seizure, which strongly suggests

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that he had an obstructed airway.
And, I would think, more likely than not, that the infection, which was almost certainly worsening on the 17th, more likely that was a contributory factor towards his airway obstruction.
Although, technically, he could have just had a seizure, and blocked his airway from his tongue alone.
But, I think, more likely than not, his infection played a role.
Q. And, there is no documentation in -- from any members of the code team, that a surgical airway needed to be attempted, because Mr. Jones had an obstructed airway?
A. Well, first of all, I have no idea if a surgical airway needed to be attempted. By the time physicians reached the room, the patient was in a state of cardiac arrest.
Q. Is there any documentation at all that a surgical airway was attempted?
A. No.

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Q. Is there any documentation that any -- anything other than bag mask ventilation was used to ventilate this patient?
A. No. The man didn't have a permanent airway obstruction. I'm saying -- the -- seizures had associated with it the posterior tongue temporarily blocking the upper airway.
And, in conjunction with an infection, that could easily be worsened.
But, once the tongue is moved out of the way, there wouldn't be an obstruction. He wasn't obstructed when he had the seizure.
I think that more likely than not, if he had had an autopsy, they would have shown an infection in the neck. I think that he had an airway sensitive towards his tongue going back, and blocking it.
But, that's not a permanent obstruction -- pulled the tongue forward. It would not be an obstruction at that point.
Q. Is there any evidence at all that he was intubated? Are you saying if he had an autopsy --

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Is there any evidence that this patient was intubated?
A. I don't remember, actually now. Let me look. That's funny. I don't think he was. I don't see anything documenting intubation. But, let me check the code sheet. I don't want to make mistake.
Q. Take your time.
A. I apologize.
(A short break was taken.)
BY MS. HITZELBERGER:
A. I'm sorry. I know I have the code sheet somewhere. I just don't want to make the mistake -- I wrote I can't remember. That's strange. I would know that normally. Code sheet. Thank you.
MR. JOYCE: Fifty-four.
THE DEPONENT: I have it.
BY MS. HITZELBERGER:
A. No. He wasn't trach'd. I didn't want to get -- his code sheet. I mean he wasn't trach'd -- he wasn't intubated -- I don't see evidence of an intubation on the code sheet. I don't see it.

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Q. Is there any documentation that Mr. Jones vomited during the code, or that he aspirated vomit during the code?
A. No.
Q. Have we covered the scope of the opinions that you intend to offer at trial, Dr. Charash?
A. Yes. But, there is one fact that you didn't let me bring in.
Q. I did not let you bring in?
A. There was one thing -- well, you kept saying wait. I just want to make sure I say it.
Q. Sure. Go ahead.
A. When you look at page -- this is a very brief thing.
But, if you look at the nursing vital signs from right before the code, if you look at page sixty-seven, that blood pressure that heart rate of fifty-four.
Q. Yes.
A. And, the blood pressure of 140 over either forty-six or ninety-six, I can't see what that is.

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Right?
Q. Yes.
A. If you look at the right of it, it says unable to retrieve. It's a little odd, since I don't know what they were unable to retrieve.
But, that said, if you look to the left, even though this has been written -- someone wrote on top of themselves, that time looks like 17:10 to me, not 17:00.
And, your guy was -- your experts, Dr. -- I think Batipps -- was saying that he was getting slow before the code, which indicated that he was slowing down. But, I don't think so.
And, if you look at that 17:10, because that's what it looks like to me, would mean that he had vital signs at the time he had his seizure, which the nurse may well have taken right afterwards.
You would think that the first thing nurse would do after a patient has a seizure is take their blood pressure and heart rate.
I mean, what else would you do? The most

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important thing to do after a person has a seizure, would be to take their vitals. It would be almost inexcusable if a nurse did not take their vital signs after a seizure.
You a have a range of several minutes until a resident arrives, and it would be inconceivable to me that a nurse would not write down the vital signs right after the seizure.
And, if you look at this, this says 17:10. It doesn't say 17:00. That's a strange assumption on the part of your experts.
And, I challenge that. And, I know that there has not been a discovery deposition of the nurse, but that says 17:10, if you look at it, not 17:00.
And, there is a good chance that these were the vital signs taken after the seizure. It could be consistent with a seizure, and potentially with an airway obstruction.
But, there is no way you can tell me that that is 17:00. That looks like 17:10.
Q. Is it your testimony --

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A. And, quite frankly, the way it's written is kind of -- the time is written strange. I'm just saying is that I think it's more likely to be a vital sign after he seized, than it is to be one at 17:00.
Q. Is it your testimony that a respiration of twenty-two is consistent with a possible airway obstruction?
A. Yes. He could be having efforts to breath. And, like I said, it could be a near total obstruction, because he was breathing. We know he was breathing until he coded.
But, I think that he had an airway obstruction, which caused him to get progressively hypoxic.
And, by they way, that could be the reason why -- because I don't know the unable to retrieve, I don't know what it relates to.
If it was relating to a oxygen saturation, that would be consistent with him having a problem. But, it's a little vague.
But, what does unable to retrieve mean?

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And also, does it really look at the spacing they are doing the vital signs, that they just happened to take the vital signs five minutes before his seizure by chance.
I think it is more likely that that was taken after he seized, again tanking the argument that he was in a code.
But, again, you cannot get around the fact that he coded minutes after a seizure. So, no matter how much more the phenomenon exists of arrest causing seizures, than seizures causing arrests, there is no doubt about this.
Also, by the way, another thing I wanted to say is Dr. Cohen testified that he doesn't know why this patient died, but he is absolutely certain, or relatively certain, it was not related to the facial infection.
So, does Dr. Cohen believe that his code was just randomly -- just going to happen anyway, and it had nothing to do with his admission.
He thinks that this man's admitting illness

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in no way had anything to do with his seizure and code. That's pretty narrow-minded and bizarre, because maybe, just coincidentally, they happened at this time, and he was programed to die.

Anyway, so I think for all of the evidence that -- representing, there is no possibility that the defense theory, that the seizure was caused by a code, is reasonable a possibility in this case.

MS. HITZELBERGER: Thank you, Dr. Charash. Those are all the questions I have.

EXAMINATION BY MR. JOYCE:

Q. Doctor, I have just a couple questions.

Doctor, do you have page fifty-four of the medical records in front of you?

A. I'm turning to it. No, I didn't copy page fifty-four.

Q. Okay.

A. What's on fifty-four?

Q. It's the -- if I could submit to you, it's the anesthesiologist emergent consultation.

A. Okay.

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Q. And -- well, since you don't have it in front of you -- if Mr. Jones --

(Telephone Interruption.)

(A short break was taken.)

BY MR. JOYCE:

Q. If the -- on page fifty-four, if the anesthesiologist indicated that there was endotracheal intubation, would that have any affect on your opinions regarding the code, and --

A. No.

Q. Okay.

A. None.

Q. None. All right.

I don't have any further questions.

A. I mean, the code -- just to make clear why not, I believe that the seizure was hypoxic. I mean, the seizure was a primary seizure, which led to an airway obstruction, which was a combination of probably tissue swelling, with the tongue blocking the airway on top of it.

And, once you start to intubate someone, you pull the tongue forward, and there would not be an obstruction when try to intubate. So, it would have no bearing on my opinion.

Q. I understand, doctor. Thank you.

No further questions.

MR. JOYCE: Doctor, you have a right to read, under Maryland law, to read and sign your testimony.

Would you like to take an opportunity to do that?

THE DEPONENT: I will.

MR. JOYCE: Yes, I suggest you do that just because of the feed, and everything like that.

THE DEPONENT: I will. Thanks.

MS. HITZELBERGER: Thank you, doctor.

MR. JOYCE: Thank you.

(Deposition concluded at 3:37 p.m.)

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CERTIFICATE OF DEPONENT

I hereby certify that I have read and examined the foregoing transcript, and the same is a true and accurate record of the testimony given by me.

Any additions or corrections that I feel are necessary will be made on the Errata Sheet.

_____

BRUCE CHARASH, M.D.

(If needed, make additional copies of the Errata Sheet on the next page or use a blank piece of paper.)

ERRATA SHEET

Case:JONES v UMMS

Witness: BRUCE CHARASH, M.D. DATE:1/07/2014

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CERTIFICATE OF SHORTHAND REPORTER - NOTARY PUBLIC

I, Bracha Goldberger, the officer before whom the foregoing proceedings were taken, do hereby certify that the foregoing transcript is a true and correct record of the proceedings; that said proceedings were taken by me stenographically and thereafter reduced to typewriting under my supervision; and that I am neither counsel for, related to, nor employed by any of the parties to this case and have no interest, financial or otherwise, in its outcome.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal this 17th day of January, 2014.

Bracha Goldberger
Notary Public

My commission expires:
August 15, 2017

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