

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
14 The Videoconference Deposition of BRUCE
15 CHARASH, M.D. was held on Tuesday, January 7, 2014,
16 commencing at 1:20 p.m., at the Offices of Gore Brothers
17 Reporting & Video, 28 Allegheny Avenue, Towson, Maryland
18 21204, before Bracha Goldberger, Notary Public.

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20
21 REPORTED BY: Bracha Goldberger

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1 APPEARANCES:

2

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10 ON BEHALF OF THE DEFENDANT:

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1 PROCEEDINGS,

2 Whereupon,

3 BRUCE CHARASH, M.D.

4 was called as a witness and having been duly sworn by

5 the Notary Public, was examined and testified as

6 follows:

7 EXAMINATION BY MS. HITZELBERGER:

8 Q. Good afternoon, Dr. Charash.

9 Am I pronouncing that correctly?

10 A. Yes.

11 Q. Okay.

12 My name is April Hitzelberger. I represent

13 the defendant in this case, the University of Maryland

14 Medical System.

15 I understand that you have had your

16 deposition taken before?

17 A. Yes.

18 Q. Okay.

19 If I ask you a question that you don't

20 understand, please let me know; I'll be happy to

21 rephrase it to the best of my ability.

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2 Deposition of Bruce Charash, M.D.

3 January 7, 2014

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1 If you answer the question, I'll assume that

2 you understood it, and I will hold you to that answer.

3 Is that okay?

4 A. Well, with one exception.

5 Q. Sure.

6 What's that?

7 A. One exception is, and it's likely to happen,

8 but in life, sometimes we've all had moments where we

9 think we understand a question, and we don't, and we

10 answer a different question. Now, that happens to

11 everyone.

12 I doubt that something like that will happen

13 that would have any consequence, but I -- if I answer,

14 it means I think I understand your question, but it's

15 possible I don't, and you don't realize it.

16 Q. I understand your point, that's taken. But,

17 if you recognize that my question is unintelligible, or

18 if I misstate the medical records in this case, or the

19 medicine in general, please let me know.

20 Okay?

21 A. Of course.

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1 Q. All right.
2 You understand that you have been designated
3 as an expert, to offer opinions against the defendant
4 in this case, the University of Maryland?
5 A. Well, actually, I'm giving more causation
6 opinions than standard of care. So, I'm not really
7 testifying against anybody.
8 Q. Do --
9 A. But, to that degree, I am retained by the
10 plaintiff in this case.
11 Q. You will not be offering any standard of
12 care opinions in this case.
13 Is that correct?
14 A. Correct.
15 Q. Okay.
16 Have you received a copy of your deposition
17 notice, or the amended notice to take your deposition
18 in this case?
19 A. I have it here.
20 Q. Have you had a chance to review it?
21 A. Of course.

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

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

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

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

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

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

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

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

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1 last night, if that is part of your question.
2 Q. We still have not received the charts, so
3 I'll come back to that.
4 Did you have any teleconferences or
5 meetings?
6 A. Pardon me?
7 When you say you haven't received it, are
8 you saying you didn't go through the facts, or no one
9 has brought it in yet?
10 MR. JOYCE: No one has brought it in yet.
11 BY MS. HITZELBERGER:
12 Q. No one has brought it in yet. They said
13 they would check the fax machine --
14 A. Okay.
15 Q. -- and bring it in.
16 A. Okay.
17 Because it certainly is there in the fax
18 machine.
19 Q. Did you have any teleconferences or
20 in-person meetings with Mr. Joyce, prior to your
21 deposition today?

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

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

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

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

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1 A. I graduated Cornell Medical School 1981.
2 From '81 to '84, I did internship and residency at
3 Mount Sinai Hospital in New York in the field of
4 internal medicine. In 1984 -- '81 to '84.
5 In '84, I took and passed the national
6 boards to begin a board certified internist. From '84
7 to '87, I trained in cardiology in subspecialty
8 training, called a fellowship, at the New York Hospital
9 in New York.
10 Likewise, in 1987, I took and passed the
11 boards of cardiology, becoming a board certified
12 cardiologist.
13 From '87 to 1991, I was hired by Cornell
14 Medical School as an assistant professor of medicine,
15 and as the assistant chief of the cardiac intensive
16 care unit.
17 From 1991 to 2005, I was the chief of the
18 cardiac care unit at Lenox Hill Hospital in New York,
19 as well as a clinical associate professor of medicine
20 at NYU Medical School.
21 From February 1st, 2005, until July 1st,

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

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1 And, twenty-five percent of my practice are
2 patients who came to me only as a primary care
3 provider, without any initial heart disease to bring
4 them to me.
5 While I was chief of the cardiac care unit
6 at Lenox Hill for fourteen years, and while I was the
7 assistant chief at Cornell for another four years, so
8 for a total of seventeen years, a great deal of the
9 medical decision making in critical care medicine, even
10 for the heart, are nonmedical issues.
11 We took care of seizures, and fevers, and
12 renal failure, liver failure, and hematologic problems.
13 So, it's very hard to quantify how much of
14 my entire medical practice has been internal medicine.
15 But, internal medicine is a giant part of critical care
16 medicine, regardless of the reason why someone is in
17 critical care.
18 Q. Is there a separate board certification for
19 critical care medicine currently?
20 A. There is, and actually when that board was
21 being created, I was grandfathered in to be eligible to

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1 take the boards because of my -- the nature of my
2 training, I was a year of critical care at my job, but
3 I never opted to take it.
4 I have no idea if I am still considered
5 board eligible. I was when they started these boards,
6 but I would not -- yes. I just was too busy to worry
7 about taking those boards.
8 Q. Are you licensed to practice in any state
9 other than -- excuse me -- in any state other than New
10 York?
11 A. No. Never have been.
12 Q. And, your first employment position after
13 your postgraduate training, as the assistant attending
14 physician in 1986, was that the same type of breakdown
15 that you just described, in terms of internal -- a
16 combination of internal medicine and cardiology?
17 A. I'm not sure I understood your question.
18 Q. Why don't you describe for me what you did
19 as the assistant attending physician in 1986, which was
20 for New York Hospital Cornell Medical Center.
21 You worked there until 1991?

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1 A. First of all, I think in 1986 to 1987, I was
2 considered an instructor in medicine. That should be
3 what's on my CV. And, that was my third year of
4 fellowship, but we were given the title of instructor
5 in the department of medicine.
6 And then, I became an assistant attending
7 physician at Cornell Medical School in 1987. I hope
8 that's reflected on my resume.
9 Q. I'm trying to figure out --
10 A. It was not --
11 Q. What was your clinical practice, if any,
12 during those years? I'm looking at page one of your
13 resume, three quarters of the way down, assistant
14 attending physician.
15 A. Okay.
16 That should say 1987, though.
17 Page one?
18 Q. Yes. Perhaps I have a different version
19 than you?
20 A. No. Maybe -- you know what? You are right,
21 I'm sorry. That's the hospital title, as opposed to

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1 the academic. I'm sorry. My own error. I apologize.
2 We were an assistant attending physician in
3 '86. I was an instructor at Cornell Medical School,
4 not an assistant professor. That's where I got
5 confused.
6 From 1986, which was a final year of
7 training, it was a fellowship year, but it was also a
8 year of being on the faculty. It was a hybrid year.
9 It was in 1986.
10 Cardiology fellowships only had to be two
11 years, so if you opted for a third year, which I did,
12 which focused on critical care, we were given hospital
13 appointments, but we were still fellows, because we did
14 an optional third year.
15 And, at that time, I was running an
16 intensive care unit with two other people. And, I was,
17 every third month, the attending on record in the
18 cardiac care unit, dealing with all sorts of medical
19 problems, as well as cardiac.
20 During other months, I did clinical
21 research, or I was the attending on the stepdown floor.

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

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

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

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

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1 interesting admissions.
2 I have asked to give a lecture once a year
3 about chest pain and its management to all the house
4 staff.
5 And, one month out of the year NYU medical
6 students come to my office, two afternoon a week for
7 three hours to their ambulatory care rotation, where
8 they get to go to different offices to see how office
9 practice occurs.
10 So, if you add all of that up, it's still
11 not a big percentage of my total practice time. So,
12 you know, its less than five percent.
13 Administratively, there is very involved,
14 too. So, I would say that ninety to ninety percent of
15 my time is practice, and five to ten percent are other
16 things.
17 Q. What are the current hours of your clinical
18 practice? Do you work five days a week?
19 A. Yes. I work five days a week, basically
20 9:00 to 5:00 for office practice. And, obviously, if I
21 have people in the hospital, I go in after hours or

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

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1 MR. JOYCE: Objection. You can answer.
2 BY MS. HITZELBERGER:
3 A. No. I have no intention of using
4 literature. I think my testimony is on very
5 fundamental medical issues.
6 Q. Do you consider any medical texts on
7 cardiology or publications to be reasonably reliable?
8 MR. JOYCE: Objection.
9 BY MS. HITZELBERGER:
10 A. That question cannot be answered as a simple
11 yes, no.
12 Q. Why not?
13 A. I think that when you look at textbooks,
14 most medical articles, printed medical materials that
15 are legitimate, you know, peer reviewed from good
16 publishers, basically, I think they are all
17 authoritative when it comes to the presentation of
18 certain statistics and generally accepted fact.
19 If a article or a book says that there were
20 853,000 heart attacks in the United States in 2009, I
21 would consider that authoritative; I would quote that

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

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

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1 training, and board certification.
2 Q. What percentage of your --
3 A. Associates --
4 Q. Sorry. Go ahead.
5 A. Pardon me. I said twenty-seven years since
6 1987.
7 Q. What percentage of your current professional
8 time is devoted to testifying in legal cases, or
9 reviewing cases in legal matters?
10 MR. JOYCE: Objection. You may answer.
11 BY MS. HITZELBERGER:
12 A. I would say fifteen percent of my time,
13 twenty percent of my income, just to jump ahead.
14 Q. Do you keep any databases, or -- outside of
15 the testimonial list, do you keep any records that
16 would support your estimation of fifteen percent of
17 your time and twenty percent of your income?
18 MR. JOYCE: Objection.
19 BY MS. HITZELBERGER:
20 A. Well, certainly, I would have no way to
21 demonstrate my time; I don't, kind of, write a diary

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

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

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

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

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

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1 So, it wasn't excluded, but it might have
2 been, but if they didn't agree.
3 Q. Do you --
4 A. So, to my knowledge, I have never
5 been restricted.
6 Q. Do you recall if that was in approximately
7 1997?
8 A. Oh, good heavens. I don't know. It could
9 have been.
10 Q. Are you aware of -- you are not aware of any
11 other cases in which your expert testimony was excluded
12 by a court, other than the one case in Florida that you
13 just discussed?
14 A. Well, I don't think I was excluded, it I
15 can't think of an example of when I have been -- of
16 having been excluded.
17 Q. Okay.
18 Have you ever been named as a defendant in
19 medical malpractice case?
20 A. Once.
21 Q. What were the allegations in that case?

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

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

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1 MR. JOYCE: Objection to the last question,
2 as well. You may answer, and I'll just have a
3 continuing, as to that.
4 MS. HITZELBERGER: Sure.
5 MR. JOYCE: Thank you.
6 BY MS. HITZELBERGER:
7 A. No.
8 Q. Returning to your CV, I'm not sure that we
9 have the same version, but have you authored any peer
10 reviewed publications since 1992?
11 A. No.
12 Q. Are any of your publications relevant to the
13 issues in this case?
14 A. No.
15 Q. Have you issued any reports in this case, or
16 any written documentation, with the exception of your
17 timeline that you provided, and your post-it notes,
18 etcetera?
19 A. No.
20 Q. Do you currently perform invasive
21 cardiology?

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

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

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

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

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

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1 Dilantin for different reasons, and therefore, I have,
2 even in a non-neurology position, renewed Dilantin
3 prescriptions for patients over the years.
4 I have personally certainly taken care of a
5 large number of critical care patients over the years,
6 where I have cared for tens of thousands of patients
7 who have been on Dilantin.
8 I have had occasions to have to reload
9 patients with Dilantin. If I want to do it
10 intravenously, I think I have consulted a neurologist
11 before, just to make sure, but I don't even remember
12 that with certainty, if I have always did it that way.
13 Sometimes, we would orally reload. Some of
14 these patients could not be orally reloaded. It just
15 depended on the circumstances. There are a lot of
16 different ways these patients presented.
17 Most of the patients who had low Dilantin
18 levels, our concern was that the nature of a complex
19 severe medical illness can be one of those stressors
20 that triggers a seizure.
21 So, we always do a low Dilantin level as

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1 more urgent in a hospitalized sick patient setting,
2 than in an outpatient stable patient.
3 Or, let's get two kinds of patients: A
4 patient who has frequent seizures, that's more pressing
5 to raise the level; or a person who has a complex
6 medical illness, is an equally pressing reason to raise
7 the Dilantin level.
8 But, again, neither goes to standard of
9 care, I'm not here to represent that.
10 Q. I did not here hear the last part of what
11 you just said, and I -- correct me if I'm wrong. But,
12 I believe you said if someone has a complex medical
13 illness, that's a reason to increase the Dilantin
14 level.
15 Is that what you said?
16 A. To see it as an urgent problem. I -- that
17 from my point of view as a practitioner, the two
18 circumstances where I would urgently reload someone
19 with Dilantin, if the level was low, with or without
20 the help of a neurologist, would either be if they had
21 a known frequent seizure disorder.

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1 Or, if they had any history of a seizure
2 disorder on Dilantin, and they were presenting with a
3 severe medical illness.
4 Now, within that category, some of them,
5 obviously, more than others, would increase the risk of
6 seizures.
7 Q. Did Mr. Jones have a history of frequent
8 seizures?
9 A. No.
10 Q. What was Mr. Jones -- I believe you said a
11 few moments ago he had undocumented predisposition to
12 seizures.
13 Is that what you stated?
14 A. Yes. Because there is no sense of
15 what -- there is really no evidence that he ever had a
16 seizure after starting Dilantin.
17 And, even trying to track down why he was on
18 Dilantin in the first place, was challenging with the
19 records we have had.
20 I know he had that episode of falling off of
21 a ladder. You know, he has head trauma, so he has

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1 reasons to have seizures. There is a plate in his
2 skull.
3 But, to my recollection of the case, there
4 is no real evidence of -- there is no EEG, or neurology
5 notes discussing his Dilantin use.
6 There is a lot of -- you know, there is just
7 no documentation that he has seizure disorder as a
8 frequent issue. But, clearly, it was started for a
9 reason.
10 Q. And, is it fair to assume that his suspected
11 MRSA infection is a complex medical illness, as you
12 described it, sufficient that you think he needed to be
13 urgently reloaded with Dilantin?
14 A. Well, absolutely. But, it's not just having
15 that bacteria. It's look at the patient who came in;
16 right?
17 This is patient who came in with a resistant
18 form, able to be treated, but in a more difficult to
19 treat form of staph, which is the most
20 aggressive -- staph-aureus, which is the most
21 aggressive bacteria that can -- you know -- it's

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

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

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1 Q. Sorry to cut you off, but before we move
2 into that next strain, I want to go back to a few
3 things that you said. And, I'll let you get into the
4 17th in just a moment.
5 You stated few minutes ago that was in more
6 difficult to treat form than other infections.
7 What is the basis for that opinion?
8 A. Well, this is MRSA, M-R-S-A. It is a form
9 of staph that is resistant to the analogs of penicillin
10 that we usually can treat staph.
11 So, the antibiotics, although there are
12 antibiotics that treat it, MRSA, M-R-S-A, is more
13 aggressive, because it is harder to have bioavailable
14 antibiotics treat it.
15 Just, it's by definition a
16 resistant -- bacterial resistant -- an antibiotic
17 resistant version of the bacteria.
18 Now, it's not completely resistant, but it
19 still has resistance. It's going to be harder to
20 treat.
21 Q. Did you review the wound cultures, and the

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1 blood cultures in this case?
2 A. What do you mean cultures? Are you talking
3 about the counts?
4 Q. Yes. That the cultures were taken on the
5 16th, which eventually grew out positive after
6 Mr. Jones' death?
7 A. I'm sorry --
8 Q. Cultures.
9 A. Okay.
10 Yes, I am aware of the cultures. I do
11 apologize. It was -- the cultures I am aware of.
12 Q. And, would you agree with me that Mr. Jones
13 was prescribed IV vancomycin, which was later switched
14 to daptomycin.
15 Is that correct?
16 A. Yes.
17 Q. And, the cultures indicated that he
18 was -- that his strain, and excuse me if I'm misstating
19 this, but that his infection was responding to those
20 types of antibiotics.
21 Is that right?

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

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

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

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

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

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

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1 pain.
2 So, clearly before he coded was having
3 severe facial pain. And, you know, that's significant.
4 The next thing is --
5 Q. Sorry to cut you off --
6 A. -- labs --
7 Q. Sorry to cut you off again, but before we
8 move away from the pain score, what is the basis for
9 your conclusion that the pain is attributed to his
10 face, or his facial abscesses?
11 A. That his pain is from the facial abscesses,
12 or infection --
13 Q. Yes.
14 A. Because that's what they have been tracking
15 from the very beginning, is the soreness of his face to
16 the infection.
17 From the beginning, they know that he has
18 pain in his face. That's what they are following.
19 They are not tracking any other source of pain.
20 You know, these aren't randomly written;
21 these are tracking the pain of his presenting illness.

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

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

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

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

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

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

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

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

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

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

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

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

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1 A. Yes, I am.
2 Q. Is it possible that the 4:40 p.m. time is
3 when the p.m. labs were ordered, not --
4 A. No.
5 Q. -- when they were -- came back?
6 A. No.
7 Q. Why not?
8 A. If you look -- because, look at the look at
9 the Dilantin level on page 100. They are posting
10 it -- it was ordered for 4:30 a.m. on the 17th, and
11 it's posted at 11:28 a.m.
12 There is no order for an 11:28. It is
13 posted -- first of all, the order was written on the
14 16th to be drawn at 4:30 a.m. on the 17th.
15 How does that match 11:28 a.m. for Dilantin?
16 Q. Can --
17 A. That's more consistent with the time the
18 result is being produced.
19 Also, lots of bloods were ordered at the
20 same time, and they are not being reported at the exact
21 same time. They are not -- they would be a series of

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1 labs all ordered at the same time. And, the numbers
2 are all very varied on everything.
3 This is the time they came up with the
4 results. This shouldn't be a debate; the hospital
5 should know.
6 Q. Assuming hypothetically for me that this
7 4:40 p.m. timestamp is not there -- just don't even
8 look at the timestamp. Assume that it says 5:40 p.m.,
9 whatever it says.
10 Is a sodium bicarbonate level of fifteen, is
11 that consistent with a patient who is being bagged
12 masked ventilated during a code?
13 A. It's possible, but certainly a code could
14 drop the bicarbonate. But, what I'm saying is that
15 that's more consistent with -- and by the way, there
16 wouldn't be an order in the order sheet; it would be a
17 stat drawn run upstairs.
18 So again, there would be no reason to write
19 4:40. It would have been ordered at 4:40; it would
20 have been drawn at 4:40. All that is before the code.
21 So, if nothing about 4:40 matches the code

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1 -- and, the other thing is, by the way, the patient
2 expired -- I want to see what time he died.
3 There is a time of death, is at 5:46.
4 Okay? That's what it says. 5:46.
5 So, by your estimate, if that's posting the
6 time it's ordered, why was there a CPC drawn at 5:49
7 p.m. after he died?
8 On page number ninety-nine, there is a CBC.
9 The result is at 5:59 p.m.
10 Now, if that's the time they ordered it,
11 they ordered it had after he died. If that's the time
12 they drew, they drew it after he died. If that's the
13 time the results came back, then it was taken before he
14 died or coded, and then it was finally posted at 5:49
15 because the lab didn't know he was dead.
16 There is no reasonable possibility that the
17 4:40 p.m. lab results is reflecting the code. What it
18 is reflecting is the patient beginning to get acidotic
19 from an infection that is spreading.
20 Q. Again, assuming hypothetically for me that
21 this 4:40 timestamp is not on the lab values, on page

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1 ninety-seven, is a glucose level of 400 consistent with
2 someone who has received a D-50 times one amp during a
3 code?
4 A. It could be. Sure. It's not plausible,
5 given the time it's posted. Because why would it be
6 ordered before the code, and if it's a code draw.
7 Blood that was drawn during the code
8 would -- emergently -- run up to wherever it has to go.
9 It's not routinely sent up.
10 Why would it be anticipate -- I mean, they
11 are not anticipating the code at 4:40.
12 And, like I said, there is no chance, based
13 on the other things in this chart, to suggest that
14 these could possibly be anything other than the time
15 the result is available.
16 But, even if it's the time they drew the
17 blood, it's before the code; if it's the time they
18 ordered the blood, it's before the code; if it's the
19 time they posted the blood, it's before the code.
20 Everything about this blood is before the code.
21 4:40, whatever it represents, is twenty

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

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

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

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

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

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

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

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1 a physical time. The ENT guy says he is reached at
2 5:10.
3 Three, few minutes later, patient starts
4 foaming at mouth.
5 Four, code called, started CPR.
6 Five, code team arrived. So, the code
7 starts at 5:15.
8 So, my question is they start CPR at a 5:15
9 because his heart stops. So, what was happening -- the
10 defense is saying that he had a cardiac arrest around
11 5:10, or before 5:10 leading to a seizure.
12 But then, for five minutes they don't
13 recognize that he is in a cardiac arrest. And then, he
14 goes into a cardiac arrest at --
15 There is no reasonable possibility that he
16 had a prolonged code leading to a seizure, but didn't
17 code until five minutes later.
18 And, that's the part of the case that makes
19 no sense. There is a nurse in the room. She clearly
20 says that minutes went by between the seizure activity
21 and foam in the mouth.

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1 She is there in the room. I guarantee this
2 patient was not pulseless, because she would have
3 called the code immediately.
4 She is standing over the patient. Only
5 after there is foam in the mouth does she then
6 recognize after that, that the patient becomes
7 pulseless, which you can generally visibly see that a
8 person is not breathing. You can see that their facial
9 color is changing.
10 The nurse reports a code, specifically at
11 5:15. So, unless -- is saying that the nurse just sat
12 there, and decided not to do CPR for five minutes, or
13 not call for help for five minutes, or that your nurses
14 are not qualified to assess the vital signs. It makes
15 no sense.
16 The other -- so you can't explain -- the
17 defense can't explain the several minutes, up to five
18 minutes, of the patient having the seizure until he
19 codes. It just doesn't make sense about any of their
20 discussion.
21 Q. Can I ask you --

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

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1 called to see patient around 5:10 p.m. for witness
2 seizure-like activity?
3 A. Yes.
4 Q. And --
5 A. But then, he says he arrived roughly at
6 5:14. So, he may not know the exact time, but he knows
7 it took him four minutes to get there.
8 Q. And, this note is timed --
9 A. That part he's reliable.
10 Q. Excuse me.
11 This not is timed at 18:04.
12 Is that correct?
13 A. Yes. So, it's timed minutes after the
14 patient died.
15 Q. And --
16 A. Not minutes -- yes. Minutes after the
17 patient's dead. He got there right after the patient
18 died.
19 Q. The nursing note --
20 A. And also, the nurse on page forty-seven --
21 Q. Correct.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 in no way had anything to do with his seizure and code.
2 That's pretty narrow-minded and bizarre, because maybe,
3 just coincidentally, they happened at this time, and he
4 was programed to die.
5 Anyway, so I think for all of the evidence
6 that -- representing, there is no possibility that the
7 defense theory, that the seizure was caused by a code,
8 is reasonable a possibility in this case.
9 MS. HITZELBERGER: Thank you, Dr. Charash.
10 Those are all the questions I have.
11 EXAMINATION BY MR. JOYCE:
12 Q. Doctor, I have just a couple questions.
13 Doctor, do you have page fifty-four of the
14 medical records in front of you?
15 A. I'm turning to it. No, I didn't copy page
16 fifty-four.
17 Q. Okay.
18 A. What's on fifty-four?
19 Q. It's the -- if I could submit to you, it's
20 the anesthesiologist emergent consultation.
21 A. Okay.

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1 Q. And -- well, since you don't have it in
2 front of you -- if Mr. Jones --
3 (Telephone Interruption.)
4 (A short break was taken.)
5 BY MR. JOYCE:
6 Q. If the -- on page fifty-four, if the
7 anesthesiologist indicated that there was endotracheal
8 intubation, would that have any affect on your opinions
9 regarding the code, and --
10 A. No.
11 Q. Okay.
12 A. None.
13 Q. None. All right.
14 I don't have any further questions.
15 A. I mean, the code -- just to make clear why
16 not, I believe that the seizure was hypoxic. I mean,
17 the seizure was a primary seizure, which led to an
18 airway obstruction, which was a combination of probably
19 tissue swelling, with the tongue blocking the airway on
20 top of it.
21 And, once you start to intubate someone, you

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1 pull the tongue forward, and there would not be an
2 obstruction when try to intubate. So, it would have no
3 bearing on my opinion.
4 Q. I understand, doctor. Thank you.
5 No further questions.
6 MR. JOYCE: Doctor, you have a right to
7 read, under Maryland law, to read and sign your
8 testimony.
9 Would you like to take an opportunity to do
10 that?
11 THE DEPONENT: I will.
12 MR. JOYCE: Yes, I suggest you do that just
13 because of the feed, and everything like that.
14 THE DEPONENT: I will. Thanks.
15 MS. HITZELBERGER: Thank you, doctor.
16 MR. JOYCE: Thank you.
17 (Deposition concluded at 3:37 p.m.)
18
19
20
21

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1 CERTIFICATE OF DEPONENT
2
3 I hereby certify that I have read and
4 examined the foregoing transcript, and the same is a
5 true and accurate record of the testimony given by me.
6
7 Any additions or corrections that I feel
8 are necessary will be made on the Errata Sheet.
9
10
11
12 _____
13 BRUCE CHARASH, M.D.
14
15 (If needed, make additional copies of the Errata Sheet
16 on the next page or use a blank piece of paper.)
17
18
19
20
21

1 ERRATA SHEET
2
3 Case: JONES v UMMS
4 Witness: BRUCE CHARASH, M.D. DATE: 1/07/2014
5 PAGE/LINE SHOULD READ REASON FOR CHANGE
6 _____
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2
3 I, Bracha Goldberger, the officer before
4 whom the foregoing proceedings were taken, do hereby
5 certify that the foregoing transcript is a true and
6 correct record of the proceedings; that said
7 proceedings were taken by me stenographically and
8 thereafter reduced to typewriting under my supervision;
9 and that I am neither counsel for, related to, nor
10 employed by any of the parties to this case and have no
11 interest, financial or otherwise, in its outcome.
12 IN WITNESS WHEREOF, I have hereunto set my
13 hand and affixed my notarial seal this 17th day of
14 January, 2014.
15
16 _____ 
17 Bracha Goldberger
18 Notary Public
19
20 My commission expires:
21 August 15, 2017

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