SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF WESTCHESTER: CIVIL TERM: PART LJL
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KATHLEEN NOCERA, as Administratrix for the Estate of GARY NOCERA and KATHLEEN NOCERA, individually,
Plaintiff,
-against- Index#61337/2014
LINDA CUOMO, MD, BENJAMIN BERNSTEIN, MD, WESTCHESTER COUNTY HEALTH CARE CORPORATION and WESTCHESTER MEDICAL CENTER,
Defendants.
----------x
Trial (Cont'd)
February 13, 2018

B E F O R E:
HONORABLE LEWIS J. LUBELL,
Supreme Court Justice, and a jury.
(Appearances same as previously noted.)

Nicole Ameneiros
Senior Court Reporter

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THE COURT: On the record. Case on trial.

The Court, having previously remitted before counsel, I would like to do so on the record this date.

It has -- it had come to my attention earlier in the trial that Dr. Bruce Charash was going to be called as a witness for the plaintiff. As I have done in previous trials, in 2003, more specifically in September, Dr. Charash was the chief of the CICU at Lenox Hill Hospital. At that time my father was admitted, and Dr. Charash was overseeing his care and treatment. One evening, Dr. Charash and I did have a conversation relative to my dad's treatment and care. We had never met, and we had never spoken after that date.

Subsequently, Dr. Charash has appeared before me as

a witness in both Orange County and in Dutchess County on two separate matters where I remitted same. That being said, those were the only occasions that I have met and spoken to Dr. Charash after that one evening's conversation. It has absolutely no bearing on my ability to sit fairly and impartially in case.

Are there any applications?

Ms. Weisman?

MS. WEISMAN: No, your Honor. I'll trust that you will be fair in this case.

THE COURT: Mr. Vigorito?

MR. VIGORITO: None whatsoever.

THE COURT: Mr. Venditto?

MR. VENDITTO: None on that issue, Judge.

THE COURT: Okay. Are we ready on that issue?

MR. VENDITTO: Yes, Judge.

THE COURT: Have you some other issues or something?

MR. VENDITTO: I do, Judge. In reading prior transcripts pertaining to Dr. Charash, there have been occasions where he has testified to --

MR. VIGORITO: Hold on a second. Maybe Dr. Charash should be excused.

MR. VENDITTO: Okay.

THE COURT: Doctor, could you step out for a

minute?

DR. CHARASH: Of course.

(Doctor steps out.)

MR. VENDITTO: There have been occasions where he's testified to a charity that he runs called Docs to Docks -- so I think it's D-O-C-S to D-O-C-K-S -- in which they take medications and supplies to countries in need of medical care --

THE COURT: So it's like Doctors Without Borders?

MR. VENDITTO: Something along those lines, Judge. Although it's a very nice thing that he does, and I'm sure it's very helpful, I don't believe that's testimony that would be relative or pertinent to his credentials as an expert or to any opinions he may put forth.

MS. WEISMAN: Your Honor, I believe his background and experience is totally appropriate and relevant to his qualifications.

THE COURT: You want to weigh in, Mr. Vigorito?

MR. VIGORITO: Certainly, Judge. I think that we've all heard many, many times in our careers, especially your Honor presiding over trials, the litany and the laundry list of qualifications of experts in myriads of fields of medicine. And I think it's safe to say that there's a line of demarkation that can be drawn between what is relevant to their ability to give testimony on a given subject matter in

medicine before a jury as opposed to all the other things that may have been going on in their professional career. Some of them might be quite laudatory but have absolutely no relevance to their ability to give opinion testimony in this case. I think this is clearly one of those instances.

Certainly we haven't produced any experts yet, but if your Honor rules in favor of this application by Mr. Venditto, joined in by myself, we will obviously tailor our direct examinations of our experts to be in line with that so that we don't run into a ten-minute soliloquy by experts where they tell you, you know, of all their, you know, badges and awards and ribbons that they've received throughout the years.

THE COURT: Well, over my tenure in both as a trial attorney and as a presiding jurist, I don't think a trial goes by where a proponent of an expert doesn't go, Doctor, have you received any awards or, you know, accolades in your profession? And the jury can do what they want with it.

Your application is considered, Mr. Venditto, and I will consider you as joining in on it. Your application is denied. Not -- it may not be relevant to the doctor's ability or what he does, but like I said, there are questions that are always, you know, posed to a witness about anything that elevates them, you know, in their profession, whether it's by talent or contributions to the

medical profession. You can do with it as you deem appropriate.

To the extent that this is adverse to your application, Mr. Venditto, and Mr. Vigorito, you have an exception noted on the record.

MR. VENDITTO: Thank you, Judge.

MR. VIGORITO: Your Honor, I have one other application before we start. It's in regards to the expert witness disclosure for Dr. Charash, and in particular on the issue of the chest x-ray. And I will read in part at page 3, if I'm not mistaken, of Ms. Weisman's disclosure. Second full paragraph down, quote, that the chest x-ray should not have been relied upon and further testing should have been done to evaluate the structures. The reliance on this x-ray and the failure to order further testing was a deviation from accepted medical practice and procedure. That's the relevant part of it, Judge.

So my point is that while we fully expect Dr. Charash to comment on the alleged failure not to have obtained a CAT scan, what is putting us on notice is not that the chest x-ray was misread, but that it should not have been the only radiological object that was relied upon by the defendants in the case. That's not such a fine line, I would say. I think it's a broad line of difference.

So I am asking for a ruling in limine that

Dr. Charash not, based upon that disclosure, give testimony that the chest x-ray was misread, because that's not what that says. What it says is that you shouldn't have just relied on that, you should have gotten other things, too. That is different than misread. So I would appreciate that we not hear language from Dr. Charash that it was misread or that there's a negligent read of the chest x-ray or that it was over read or under read.

THE COURT: Me-too?

MR. VENDITTO: As well as the fact that Dr. Charash cannot offer any negative opinions as to Dr. Bernstein that would overlap what Dr. Sixsmith --

THE COURT: We already went over that.

MR. VENDITTO: Yes, Judge.

THE COURT: And that's already been ruled upon.

MR. VENDITTO: Correct.

THE COURT: Can I see the 3101(d)?

MS. WEISMAN: Sure, your Honor.

MR. VIGORITO: Sure.

MS. WEISMAN: Your Honor, I don't believe he's going to testify as to whether it was misread. That's --

THE COURT: You don't believe?

MS. WEISMAN: Yeah, that's not our claim.

THE COURT: Are you taking him there?

MS. WEISMAN: No.

THE COURT: Okay, then.

MS. WEISMAN: It's the fact that it was relied upon and it was not...

MR. VIGORITO: I'm satisfied with Ms. Weisman's representation, and I trust her implicitly on that. However, and this is by no means a --

THE COURT: Let me stop you there.

MR. VIGORITO: -- a caveat or a slight --

THE COURT: Mr. Vigorito, we all know that at times a physician may go beyond the scope of the question in feeling that they are answering it appropriately. I'm sure that you and Mr. Venditto are going to pay strict and -- attention to every word that comes out of Dr. Charash's mouth in testifying. If you believe that something went beyond, (A), the scope of the question or the scope of the 3101(d), I anticipate and have no doubt that I will see you standing with one word emanating towards the bench.

MR. VIGORITO: You're a thousand percent correct, as usual, your Honor. All I'm saying is that why must I have to put the horse back in the barn --

THE COURT: Mr. Vigorito.

MR. VIGORITO: -- because with Dr. Charash we all know that that is a more-than-likely scenario. With other experts I might not say that, but with a gentleman who has testified 600 times, and I dare say I've read most of those

transcripts at this point, I see a pattern of volunteerism here of opinions that were not in the original question.

THE COURT: Mr. Vigorito, as an officer of the court I take Ms. Weisman's comment to heart that she is not going there. Now, if somebody becomes a loose cannon, then that is -- the onus is going to be on you, Mr. Vigorito. I can only rely upon Ms. Weisman doing her job and maintaining steadfast on her representation to the Court. If -- I cannot hold her accountable for something that might be an oops, unless it's her oops.

MR. VIGORITO: It's all appreciated, Judge. Thank you.

THE COURT: As is all of your professionalism.

MR. VIGORITO: Well, thank you.

MS. WEISMAN: Your Honor, can I talk to him for a second so I can tell him?

THE COURT: Sure.

MS. WEISMAN: Thank you.

(Recess taken.)

THE COURT: Bring them in.

COURT OFFICER: Jury entering.

THE COURT: Jurors, you may be seated as you enter. Counsel, ladies and gentlemen, please be seated. Good morning, Jurors.

JURORS: Good morning.

THE COURT: Hope you had a wonderful weekend. I see everybody has their coffee, tea, their beverages, and they all have lids. Very attentive jury.

You will recall, ladies and gentlemen, that when we released on Friday we had completed receiving the testimony of Dr. Sixsmith as part of the plaintiff's case. We will now continue with the presentation of the plaintiff's case.

Ms. Weisman, call your next witness.

MS. WEISMAN: Okay. Thank you, your Honor. Plaintiff calls Dr. Bruce Charash.

THE COURT: Doctor.

COURT OFFICER: Right this way, sir. Just remain standing for a moment. The judge is going to swear you.

B R U C E C H A R A S H,

called as a witness on behalf of the Plaintiff, having been first duly sworn, was examined and testified as follows:

THE WITNESS: I do.

THE COURT: Doctor, please have a seat. I'm going to ask you to state and spell your full name for the record. Give your business address, and please speak loudly and clearly so that every juror receives the benefit of your testimony.

THE WITNESS: My name is Bruce Charash, C-H-A-R-A-S-H, 205 East 63rd Street, New York, New York 10065.

THE COURT: You may inquire.

MS. WEISMAN: Thank you, your Honor.

DIRECT EXAMINATION

BY MS. WEISMAN:

Q Good morning, Dr. Charash.

A Good morning.

Q Dr. Charash, are you licensed to practice medicine in the State of New York?

A Yes.

Q And when did you become licensed?

A 1982.

Q And would you provide the jury and the Court your medical education and training that you have received?

A Of course. I graduated from Cornell Medical School in 1981, getting my MD degree. From 1981 to 1984 I trained at Mt. Sinai Hospital in New York in the field of internal medicine, which is treating adults for all illnesses, but not the surgical approach but the medical approach.

In 1984 -- the first year, by the way, is called an internship and the second two years are called residency. In 1984, when I completed my training, I was eligible to take a two-day national written test called the boards of internal medicine, and by passing that I became a board-certified internist in 1984.

From 1984 to 1987 I trained at the New York Hospital in

the subspeciality of heart disease called cardiology -- which again, is the nonsurgical approach to heart disease -- in a training known as a fellowship. And in 1987 I likewise took and passed the boards of cardiology, becoming a board-certified cardiologist in 1987.

From 1987 to 1991 I was on the full-time medical school faculty of Cornell Medical School as an assistant professor of medicine and the assistant director of the cardiac intensive care unit.

Then from 1991 to 2005 I was the chief or director of the cardiac intensive care unit at Lenox Hill Hospital in New York and was a clinical associate professor of medicine at NYU Medical School.

For 17 months, February 1st, 2005 to July 1st, 2006, I joined the medical school faculty at Columbia University as an assistant professor of clinical medicine. And then July 1st, 2006, I went into private practice where I am today.

I have admitting privileges at Lenox Hill Hospital, and am still a clinical assistant professor of medicine at NYU.

Q When you say "admitting privileges," can you just describe what that means.

A It means it's the hospital where I'm allowed to see and admit patients in consultation, or the admitting doctor.

Q Have you held any board positions?

A I'm sorry?

Q On professional boards. Okay. Have you done any kind of international work?

A Well, I started my own nongovernment organization where we collect surplus medical supplies in the U.S. that get sent to landfills, thousands of tons a day, and redirecting to hospitals in Africa, Haiti and the Caribbean to rebuild health care institutions.

Q And have you been honored -- received any honors or awards?

A Yes. When I graduated from Cornell Medical School, I was inducted into a national medical school honorary society called Alpha Omega Alpha. In 1986, beginning my second year of my cardiology fellowship, they gave an award for the outstanding cardiology fellow for every academic year, and it was basically a scholarship that funded my position. So I was given the title of the Dan and Elaine Sargent Fellow of Cardiology.

In 2008 an organization called the Greater New York Hospital Association, which represents 300 hospitals in New York State, gave me the doctor of the year award for New York State. And in 2012, most recently, a national organization based in Washington, D.C. called the Caring Institute that promotes the ethics of patient management communication and care gave me their Caring Person of the Year in the United States in 2012.

Q Thank you, Doctor. Doctor, have you been asked to come to court to testify on behalf of Gary Nocera's family?

A Yes, I have.

Q And I have asked you to render an opinion with respect to the care and treatment by the cardiologist, Dr. Cuomo, in this case, right?

A Yes, you have.

Q And is this the first time you've been involved in any kind of medical-legal issues?

A No.

Q Can you just describe your medical-legal experience.

A I was first approached by a lawyer to review a case in 1987, the second part of '87, after I completed my board certification in cardiology. I had been practicing as a board-certified internist for three years. So there was -- that was 1987.

So now it's 31 years, and in that period of time I have reviewed over 900, maybe 950 cases from lawyers across the United States, probably spanning 40 of the 50 states, although the majority have come from a handful of states. I've gotten one case from a different state now and then. I've given opinions about health care providers outside of my own field, including surgeons, gynecology, allergy doctors, ER doctors. But whenever I've testified against a doctor or about a doctor in another field, it's not within their speciality but in general medicine.

So if a surgeon gives an antibiotic to a patient to

take home and I give the same antibiotic, we share the day-to-day responsibilities to recognize an allergy. So only if I've ever talked about another health care provider that's not my field, it's only been in common medicine that we both would have shared responsibility.

I have reviewed -- about 85 percent of the cases that I've received come from lawyers, like yourself, who represent family members, and about 15 percent come from lawyers who defend doctors and hospitals. I have given testimony under oath in something called a deposition before trial in states where that's a requirement. And I've probably averaged 11 a year since I started doing this in 1987. And I've appeared in court averaging seven times a year since I began doing this work as well.

Whereas, 15 percent of the cases I reviewed come from defense lawyers. For a number of different reasons, the times I'm asked to testify for defense cases is much less than in cases from lawyers representing family members. So less than five percent of my total testimony in deposition or trial had been for defense cases.

Q And since January have you testified in trials?

A Yes. In this year -- it's odd, they come in clusters -- I will probably testify ten times this year. But this is my third trial in 2018. There may be a fourth trial coming up within the next week or two, but then I have nothing

scheduled, to my knowledge, till June or July. So they tend to come in clusters. Usually at the beginning of the year and the end of the year there's like three in a row and then a few in the middle.

Q All right. Doctor, are you presently practicing medicine?

A Yes.

Q Okay. And can you tell us about your day-to-day practice.

A Yeah. For the first 20 years of my career, 90 percent of my time was in the hospital and 10 percent was in the office where I ran the cardiac intensive care unit.

MR. VIGORITO: Your Honor, I just have an objection. I think, with all due respect to Dr. Charash, the question was talking about what he's doing right now, not a historical prospective.

THE COURT: Read me back the question.

(Record read.)

THE COURT: I'm going -- I'm just going to sustain the question as to form. I'm going to strike the doctor's answer.

I'm going to ask you to focus your questions on specific time periods so we avoid any objections.

MS. WEISMAN: Okay.

THE COURT: And the doctor can answer as accurately

as possible to your specific question.

MS. WEISMAN: Okay.

Q Doctor, can you tell us presently what is your day-to-day practice?

A I have -- 90 percent of my time is in an office where I see patients Monday through Friday. The majority of my patients are cardiac patients, but I also provide primary care to a certain number of patients. I see patients in Lenox Hill Hospital. That's about 10 percent of my clinical time is in the hospital where I'm engaged in patient care and education of doctors in training. I see people in the emergency room as well, of course.

Q Okay. So you're still treating patients?

A Yeah.

Q Doctor, can you tell us do you have any experience diagnosing and treating patients with aortic dissections?

A Yes, I do.

Q Can you tell us about that.

A Aortic dissection is a life-threatening disease that involves a tearing of the aorta. And in my clinical experience, I've probably treated three a year for the first 20 years of my practice, so 60 during the first 20 years. And in the last 11 or 12 years, I've probably only taken care of two patients with dissection. So it's been between 60 and 70 patients total in my career.

MS. WEISMAN: And your Honor, I'd like to offer Dr. Charash as qualified to offer opinions on this matter with respect to Dr. Cuomo.

THE COURT: Mr. Vigorito?

MR. VIGORITO: I have no objection to that, Judge.

MR. VENDITTO: No objection, your Honor.

THE COURT: All right. There being no objection thereto, doctor -- the Court deems Dr. Charash to render opinions to the current extant issues before the Court.

You may proceed.

Q Doctor, have you reviewed records in preparation for your testimony here today?

A Yes, I have.

Q And what records would those be?

A Well, I reviewed records concerning Gary Nocera -- and I brought them down -- from the Westchester Medical Center from January 18th, 2013, that ER visit.

Q September 18th?

A Pardon, September 18th, 2013. The Hudson Valley Hospital Center when he presented on September 21st in the state of cardiac arrest; multiple previous hospitalizations at Hudson Valley Medical Center that are not related to this issue; his primary care doctor, Dr. Prestiano, and the autopsy report.

I reviewed deposition testimony taken before trial of Dr. Linda Cuomo, of Benjamin Bernstein, the ER doctor, and

Kathleen Nocera, his widow. And I had the opportunity to review the trial transcripts of Dr. Cuomo and Dr. Bernstein.

Q Now, was Dr. Nocera (sic) seen by any cardiologist in the emergency room September 18th, 2013?

A Yes.

Q And have you evaluated patients in the emergency room that come in with chest pain?

A Yes.

Q Okay. And in your clinical experience, do you have an understanding of the standard of care of a cardiologist who sees a patient in the emergency room with chest pain?

A I do.

Q Okay. Can you tell us that.

A Well, chest pain is the most common single reason why people come to the emergency rooms. It's the plurality. So the single most common reason why people go to emergency rooms is chest pain. The diagnosis of chest pain, of course, acute chest pain, includes life-threatening diagnoses first. Heart attack, there are about nine hundred thousand admissions a year for heart attack in the United States.

The second most common life-threatening diagnosis for chest pain is called pulmonary embolism, which is a clot to the lungs. That occurs about seven hundred thousand times a year in the United States. And much lower on the list in terms of frequency, but equally life-threatening, is a tearing of the big

aorta or an aneurysm, and that's about 12,000 cases a year in the United States.

I have seen thousands of patients in the emergency room with chest pain over the course of my career. I mean, the majority of them in the first 20 years when I was hospital based, but in the last 12 years, I've seen dozens upon dozens of people. And the job of a cardiologist is to determine whether or not a patient, you know, basically needs to be admitted and tested further or can go home. And the cardiology standard of care is to make sure that a patient is appropriately evaluated and completely evaluated to determine whether or not you can exclude a life-threatening diagnosis or not.

So that's the role of a cardiologist. It's very basic. There are some basic tests that can be done, but the job is to make sure you don't send someone home who has a potentially catastrophic illness and will die.

Q And you indicated an aortic dissection is one of those life-threatening illnesses.

A Yes.

Q Okay. And can you tell us are there particular signs and symptoms of an aortic dissection that a cardiologist will be looking for in a patient in the emergency room?

A Yeah, aortic dissection doesn't have a unique fingerprint that -- it has its own special symptoms that make it unique for dissection, but there's a constellation of symptoms

that would be concerning.

First, if someone comes in with chest pain that's worrisome enough to be a heart attack, then dissection's automatically in the differential diagnosis. And if you have a normal EKG and normal enzymes, which means it's not a heart attack, then you automatically have to start considering other causes of chest pain that are life-threatening. So the lack of a heart attack with chest pain in the emergency room raises the concern about dissection.

The other element that is a very strong concern for dissection is any time pain radiates to the back. That can occur in heart attack, but that's probably the single biggest red flag if a person has back pain associated with their chest pain at any point in their illness, because dissection pain goes away, it's a tearing of the aorta. And after it tears, it's a physical tear, it's self-terminating and it can occur again. If back pain is an element, that is a major red flag.

If there's evidence of disease to the aortic valve, including a new murmur, that would be a high level of concern for aortic dissection. And finally, if the chest x-ray shows what we call the mediastinum, which is the heart and big blood vessels, you can see irregularities on the chest x-ray that would make you worry more about the dissection. Of course, the x-ray must be of acceptable quality to be able to read it for that.

So the elements would be back pain, probably the single biggest red flag, valve disease, chest pain without a heart attack and potentially an abnormal x-ray.

Q You mentioned earlier about the EKG. With respect to aortic dissections, would the EKG be normal?

A Most people who have an aortic dissection, which is a tearing of the big blood vessel, have normal EKGs and have no cardiac enzymes, meaning they don't have a heart attack. A small number of people with dissections, the dissection tears back to the coronary arteries and they can have a heart attack. So, I would say under 10 percent of people with aortic dissection have abnormal EKGs and have positive cardiac enzymes. That's usually a much more catastrophic dissection which is causing imminent hemodynamic trouble. But the point is that the majority of people would have a normal EKG.

Q And Doctor, could you, if necessary, if you need to illustrate for us what an aortic dissection is and how it relates to Gary Nocera.

A Of course. May I draw on the diagram?

THE COURT: Yes you may, Doctor.

THE WITNESS: Thank you, sir.

THE COURT: Mr. Vigorito, Mr. Venditto, if observing the doctor's demonstration requires you to relocate yourself, please do so without further instructions from the Court.

A So basically I'm making this very schematic. The heart is a pump. The left ventricle is the main pump, and it pumps blood up to your chest into the aorta, which is the highway for blood to travel through the body. Medical diagrams are drawn like you're looking at the person. So your right is the left of the patient.

When the heart pumps into the aorta, it goes out a valve called the aortic valve, which is like a saloon door that swings open and then shuts closed to let blood not go back to the heart. There are branches. Everyone has heard of carotid arteries that break the aorta and divides at the feet into femoral arteries, and every part of our body gets oxygen from some branch of the aorta coming out of the left ventricle.

The aorta is a high pressure tube, and it has a wall that has three layers. All arteries have three layers. Now, you have to see them under a microscope. Under visual you'll never see the three levels, but the inner layer of the aorta, the inner layer of the aorta can sometimes get a tear in it and blood can seep behind the wall, which can cause havoc, and that's a dissection.

A dissection is when the inner wall tears, blood can -- red is probably more appropriate. Blood can seep into the wall and that can tear anywhere. It's identified with chest pain generally severe enough to bring a person to an emergency room. And it can jeopardize the aortic valve, and it's very common in

aortic dissection to have blood flow back into the left ventricle called aortic regurgitation. The valve opens but instead of closing normally, it doesn't close normally, it lets blood go back into the heart.

Now, that has two interesting features to it. The first is that there are two ways aortic regurgitation can occur. One is by destruction of the valve, which you would see on autopsy or during surgery when the heart's collapsed. The other is a physiological dilation, meaning that the preparation just expands the entire aorta allowing blood to go back. And on autopsy or the operating room, when the blood isn't pumping, you wouldn't see the problem because it's a dynamic stretching.

When a person has acute aortic regurgitation, which is one of the most common findings of aortic dissection, two things happen: One is that the most common murmur -- a murmur is the sound of blood -- is actually a systolic murmur rather than a diastolic murmur. So I'll have to explain the systolic murmur and the diastolic murmur, and I have to explain the pulse pressure.

Q Okay. Just, yeah, why don't you first explain the aortic regurgitation itself and how that is related to an aortic dissection.

A Well, again, it's because the aorta -- with the pressure, dissection can just expand while blood is pumping, letting the valve separate a little bit, even though it's

intact, and let's blood go back into the heart.

Now, there is something that -- the sound of blood going back in the heart occurs when the heart -- the heart beats pumping by the aorta. When the heart is refilling it's diastole. Systole is the pumping. Diastole is relaxing. Aortic regurgitation occurs in diastole when the heart is filling up again. Blood goes in and there's a very soft diastolic murmur associated with aortic regurgitation. It's very often difficult to hear, especially in the emergency room, but the most common, and there's a great deal of understanding in medicine that if blood enters the heart backwards and blood is filling the heart forwards, the heart is getting super filled. So when it beats, it's pumping out more blood than normal because of this filling from two directions. So a murmur is hearing blood flow.

If you have a stream in your backyard, you may not hear it, but if it rains and floods, the rapids you'll hear. Well, that's what a systolic murmur is. To many people it's rapids because there's so much blood in the heart when it pumps it makes a sound of blood leaving the heart. And sometimes with acute aortic regurgitation, although you might hear the actual murmur of the diastolic sound, what's more common is to hear just a loud sound of blood leaving the heart when it pumps because of the increased volume of blood.

So a systolic murmur, which was found in this case in

Mr. Nocera, which was described three out of six -- most people have a one or two out of six murmur. Three is relatively loud. Often that is the murmur you hear first with acute aortic regurgitation, a new murmur, systolic or diastolic, raises a heightened concern that there is acute aorta regurgitation, which is one of the hallmarks of aortic dissection. And the other is the pulse pressure.

Q Can you tell us about the pulse pressure and how is that related to Gary Nocera with respect to his diagnosis?

A Yeah. The blood pressure in our --

MR. VIGORITO: Your Honor, I'm just not sure we need to be standing for this.

THE WITNESS: I need to just show one thing, if you don't mind.

MR. VIGORITO: Sure.

A When the heart beats into the aorta, and when you get a blood pressure you have a systolic and a diastolic, which means the systolic is when the pressure beats pumping blood into the aorta, that's peek pressure. Then, as blood travels through the body, that pressure begins to drop and then the heart beat's again shooting it up. So the lowest pressure you have before the heart beats again is called your diastolic. So you have your systolic, which is the peek heart beating, and as blood travels through the aorta, you get the lowest number, diastolic. That number would continue to drop if the heart didn't beat

again. But the heart beats again. So you have your upper number, systolic, and lower number, diastolic.

In patients with acute aortic regurgitation, because blood is traveling not only forward but backwards, that lower number collapses to a much bigger difference. So, normally, the difference between the systolic and diastolic, which is called the pulse pressure, if you have a blood pressure of 120 over 70, your pulse pressure is 50, that's the difference between the upper and lower number. Most people have a pulse pressure between 40 and 50. Over 70 is almost universally pathological. 50 over 80, that is extremely concerning.

Now, it doesn't prove that you have aortic regurgitation, but it's very strongly supportive of aortic regurgitation. And Mr. Nocera's initial pulse pressure when he walked in the door was 86, which is a very large pulse pressure. So given that a new aortic murmur, even though it was systolic, that is common in people with aortic regurgitation and such a large pulse pressure of 86, clinically his valve sounded like he was a highly likely candidate for aortic regurgitation. And the only way to tell would be to get an echocardiogram immediately.

The fact that his autopsy didn't show any damage to the valve just means that his aortic --

MR. VIGORITO: Move to object, Judge, and stop the answer at that point.

THE WITNESS: I'm finished.

MR. VIGORITO: Move to strike that last sentence, Judge.

THE COURT: Let me hear the last sentence.

(Read record.)

THE COURT: That was it? It wasn't a complete response.

MR. VIGORITO: I just move to strike that incomplete sentence. It's not responsive to the question.

THE COURT: Sustained. You'll strike that particular last response by the doctor. The jury will disregard it. It will come up somewhere else.

MS. WEISMAN: Like now.

Q Doctor, did you read the autopsy report?

A I did.

Q Okay. And in the autopsy report does it show any damage to the aortic valve?

A No.

Q And the fact that the autopsy shows no damage to the aortic valve, does that conclude your finding of aortic regurgitation?

A No, it doesn't.

MR. VIGORITO: Objection.

THE COURT: Well, he hasn't made that finding yet, is that what your objection is?

MR. VIGORITO: That's my objection. It's also not

in the 3101(d).

THE COURT: Let's go.

(Sidebar held off the record.)

THE COURT: Let the record reflect that an off-the-record conference was held with counsel outside the presence of the witness and the jury. Mr. Vigorito's objection is overruled.

You may continue, consistent with the colloquy held at sidebar.

MS. WEISMAN: Okay.

Q Doctor, did you review Dr. Cuomo's testimony from last week?

A I did.

Q Okay. And Dr. Cuomo testified that Mr. Nocera had a normal aortic valve on his autopsy, so his widened blood pressure was not widened because of dissection. Do you agree with that testimony?

A I agree that was her testimony, but I disagree with the content of the testimony.

Q Can you tell us why you disagree with that?

A Well, as I said, there are basically two categories by which you can have aortic regurgitation. One category is demonstrable permanent damage to the valve. And I agree Mr. Nocera did not have that. The autopsy did not show permanent damage to the valve. So he did not suffer from a

structural catastrophe to the aortic valve.

But it is equally well understood that there's some people who have a dynamic cause of aortic regurgitation due to dilation of the root during the actual flow of blood. The pressure of the dissection can extend the ring of the aortic valve, and you can functionally have aortic regurgitation, but when there's no blood flowing, you won't see any damage. So you do not require permanent structural damage to have aortic regurgitation.

In fact, given that his disease was aortic dissection, given the new systolic murmur, which is the most common auditory finding with aortic regurgitation, and given his large pulse pressure, within a reasonable degree of medical certainty he was suffering from significant aortic regurgitation that day in the emergency room.

Q And given that your opinion is that he was suffering from an aortic regurgitation, what would have been the appropriate course of the cardiologist in the emergency room?

A Well, that's also based on other factors, because he had back pain, which Dr. Cuomo was unaware of, and yet very important that a nurse reported that he had back pain, and Dr. Cuomo did not know that fact, even though it was in the record, and that's one of those major red flags. So in the company of back pain and chest pain without a heart attack, in the company of a pulse pressure that was 86, which is quite

large, and a loud new systolic murmur, the standard of care was to be concerned about an acute aortic dissection.

Now, you don't get -- there's two ways to evaluate the patient. One is an echocardiogram, which is a very common noninvasive test. It's the second most common cardiac test after the regular EKG. It's done all the time. And within reasonable medical certainty, if an echocardiogram had been done, it would have shown acute aortic regurgitation which would have then made dissection very likely.

But the other test is a CAT scan. Now, a CAT scan is one test that can look for pulmonary embolism and dissection. It excludes number two and three of the most fatal cardiac conditions. The most common is heart attack, but then pulmonary embolism, a clot to the lung, or dissection are both diagnosed by CAT scan. We don't get CAT scans only in patients when you know with certainty they have aortic dissection. You get CAT scans when it's enough of a clinical concern that a patient's life depends on it. So you don't have to have complete proof that a person has a dissection, just enough suspicions.

In Mr. Nocera's case, he had chest pain, back pain, which again is a major finding that was not even detected by Dr. Cuomo, which is unacceptable not to know that a patient had back pain if it's in the notes, a new systolic murmur --

THE COURT: Go ahead, Doctor.

A -- new systolic murmur and widened pulse pressure, the

standard of care required a CAT scan to look for dissection, but a minimum of an echo, which would have shown the same thing.

THE COURT: We are going to take our mid-morning recess. I'm going to excuse you to the jury room. Please don't discuss the case amongst yourselves.

Doctor, you may step down.

THE WITNESS: Yes.

THE COURT: Please don't discuss your testimony during the break.

(Recess taken.)

COURT OFFICER: Jury entering.

THE COURT: Jurors may be seated as you enter. Counsel, ladies and gentlemen, Doctor, please be seated.

THE WITNESS: Thank you, sir.

THE COURT: Welcome back, Jurors. You'll recall when we took our recess Ms. Weisman was conducting her direct examination of Dr. Charash, which we will begin our next session along the same lines.

Let the record reflect that Dr. Charash has retaken the stand. Doctor, I remind you you are still under oath or affirmation.

You may inquire.

MS. WEISMAN: Thank you, your Honor.

DIRECT EXAMINATION (Cont'd)

BY MS. WEISMAN:

Q Dr. Charash, when you see a patient in the emergency room, do you review the notes in the chart prior to seeing that patient?

MR. VIGORITO: Objection to the leading.

THE COURT: Overruled.

A Yes, I do.

Q And is it important to review all the notes in a patient's chart prior to seeing a patient for cardiac consult in the emergency room?

A It is critical to read all the preceding notes before you see a patient.

Q And for what reason?

A Well, when patients come to the emergency room, most of the time the first health care provider they meet are nurses. There's triage nurse and admitting nurse, and they usually see the patient before the doctor. But when a person sees more than one health care provider, often they provide information about their symptoms at one time and then don't bring it up again.

For example, in this case a nurse reported back pain. The patient's back pain may have gone away and the patient may just not bring it up again. You have to read the notes -- and it's not a lot of notes -- you just need to read the notes to see what other information everyone achieved. And if you get information from one of their notes, like back pain, and the patient did not tell you they had back pain, then you have to

reconcile that and say to the patient you told Nurse "X" that you had back pain, but you didn't report it to me. What's the reason? And the patient would explain either -- whatever reason that they forgot to bring it up again. But you have to work on the assumption that if they report a symptom to a different health care provider that it was legitimately reported. If it wasn't, then you can reconcile that too, but you can't just work on your history alone because it's very common for people to report isolated symptoms without them understanding what's really important to different providers. And that's why there are notes, and that's why the first contact notes are very important.

Q So, now, there has been testimony that Dr. Cuomo was unaware of the pain radiating to the back when she saw Gary Nocera, and she didn't recall reading the triage notes or the nursing documentation or Dr. Bernstein's notes before she saw Gary Nocera.

Do you have an opinion, based upon a reasonable degree of medical certainty, whether the failure to review the hospital record prior to seeing the patient was a deviation from accepted practice?

A I do.

Q Okay. And what is that opinion?

A It was a deviation not to read the other notes. It was a very clear deviation to be unaware of back pain that was in a

nursing note, especially given how high risk back pain is with regard to dissection.

Q And do you have an opinion, based upon a reasonable degree of medical certainty, whether Dr. Cuomo's failure to review the hospital record caused an injury to Gary Nocera?

A Yes, I do.

Q And what is that opinion?

A Well, Dr. Nocera -- pardon me -- Dr. Cuomo allowed Mr. Nocera to go home where he had already demonstrated multiple reasons to work up for a dissection. And by failing to do so, he died days later after dissection. Her history was incomplete, at best.

MR. VIGORITO: Objection. Beyond the scope.

THE COURT: Of what?

MR. VIGORITO: It was a causation question I believe, Judge.

THE COURT: Overruled.

A Anyway, her history was incomplete. She missed key markers, and the patient should have been diagnosed if the standard of care was adhered to with a dissection, which would have required emergency surgery.

Q Assume Defendant Dr. Cuomo testified that Gary Nocera had no pain when she was seen in the -- when she actually saw Gary Nocera and in the hospital chart there were signs of -- the pain notations were signs of five, and then there were three

notations of zero, and then five as the last notation of pain in the hospital. Is there any significance to those findings?

A Yes.

MR. VIGORITO: Objection.

Q What is that?

THE COURT: Grounds?

MR. VIGORITO: Started out the question linking Dr. Cuomo to -- Dr. Cuomo's testimony clearly is that she was unaware of that last five, Judge. She was no longer present and was not alerted to it. So it's an unfair question the way it's phrased.

THE COURT: Read me back the question.

(Record read.)

THE COURT: Sustained as to form.

Q Assume that Dr. Cuomo testified that Gary Nocera had no pain when she saw Gary Nocera. Is there any significance to those findings?

A Yes.

Q And what is that?

A Any -- a heart attack pain tends to be sustained, and if not treated, if you're having a full-fledged heart attack, you're going to have severe pain that will last 12 to 18 hours until every cell of the heart muscle dies. So heart attack pain is typically a severe, sustained pain. If the arteries open, the pain goes away.

Aortic dissection is different in that there is tearing of the aorta and that tearing is what causes pain, but it usually goes away on its own. Now, it can recur as well.

The fact that Dr. Cuomo examined the patient at a time that he was pain free, although he came in with five out of ten pain -- that's the scale we use, zero to ten for how much pain you have -- means that his pain was gone. Now, that's good in the sense that the -- there was no active tearing going on, but there's always a threat with dissection or pulmonary embolism that you could have recurrent pain.

Now, when she left, the patient did not have recurrent pain, but that danger exists for recurrent pain because dissections -- it's like tearing a fabric. It could be one giant tear and death, or it could be a series of small tears until death. The aorta can tear in pieces or in one giant fatal tear. Most people who come to the emergency room with dissection, they haven't had a fatal tear, they're coming in with pieces of a tear.

So the fact the patient was pain free is good, but the patient was always in danger of having recurrent pain.

Q And the fact that the patient left the hospital on his last note with pain of five, does that have any significance to you?

A Well, for Mr. Nocera it meant that he probably had another small level of tear of his aorta, and he left with the

same pain he came in with, even though he had a gap of no pain. So in terms of what was happening to him, it indicates that his dissection was having another piecemeal tear.

Q I just want to go to the chest x-ray a little bit. You mentioned that you had reviewed the chest x-ray.

A I reviewed the films as well as the reports.

Q Okay. And what would a cardiologist be looking for if somebody comes in with chest pain in an x-ray?

A Well, there are several things you look for. One is to see if the lungs are intact to make sure that one lung isn't collapsed. That is a form of disease that can cause chest pain, it's called a pneumothorax. So you look to see if that was collapsed, which it wasn't. You look for evidence of fluid in the lungs called pleural effusions, which could be related to cardiac illness. That was not present. You look for evidence of congestive heart failure, which is fluid in the airways, which wasn't present. You look to see in terms of aortic dissection whether the heart and major blood vessels show any irregularity.

Now, in order to do that you need an x-ray that can adequately show the mediastinal region. Again, in this case the radiologist read the x-ray as saying there was too much distortion of the mediastinum because it was taken at the bedside, which is not ideal. It's often what we do first, but the conclusion was that the x-ray's quality of looking at the

major structure in the center of the chest was not adequate to be able to read it effectively. So even though it didn't show any acute abnormality, it was clear that the radiologist was reporting that the x-ray was not of adequate quality to be able to make a determination.

Q Okay. And based upon the x-ray indicating that there was a limited evaluation of the mediastinum structure, is there a standard of care for a consulting cardiologist with respect to further evaluation?

A Well, you always have the option, once the patient is at least temporarily stable, to doing a standing up x-ray. When you're sitting in a chair --

MR. VIGORITO: Your Honor, I'm sorry to interrupt Dr. Charash. I'm going to object now based on the 3101(d). We've reviewed it already. This is far beyond what has been spelled out in the 3101(d), I believe.

THE COURT: I think it's consistent with the original objection about what Dr. Charash was going to be permitted to testify to with regard to the x-ray. The objection is sustained.

Q Now, you talked about a CAT scan and that a CAT scan would have shown an aortic dissection if there was one there. Was a CAT scan ordered in the emergency room by Dr. Cuomo?

A No.

Q Can you tell us your opinion, based upon a reasonable

degree of medical certainty, whether the failure to order the CAT scan was a deviation from accepted practices with respect to Dr. Cuomo?

A Yes, I can.

Q And what is that?

A Well, that it was a deviation not to order a CAT scan.

Q And why is that?

A Well, for all the reasons I've given: Primarily chest pain that was not a heart attack; radiation to the back; a new systolic murmur that was loud and the patient never reported it before, meaning something's happening at the aortic valve. And as I said, regurgitation or back flow is commonly found first to have a systolic murmur. And finally, the very large pulse pressure of 86 millimeters of mercury between the upper and lower numbers on his first beep. All of those suggest aortic regurgitation. Again, the threshold to getting a CAT scan is not absolutely certain, but enough concern that a person's life depends on it.

Q So based upon this failure to order the CAT scan, do you have an opinion, based upon a reasonable degree of medical certainty, whether it caused injury to this patient?

A Yes, I do.

Q And what was that?

A That the failure to get a CAT scan and the failure to diagnose him with an aortic dissection resulted in him

experiencing basically a major tear of the aorta and death three days later on September 21st, 2013.

Q And you talked a little bit about the echocardiogram as well. Was an echocardiogram ordered by Dr. Cuomo?

A For -- to be performed after discharge but not in the hospital.

Q Can you tell us your opinion, based upon a reasonable degree of medical certainty, whether the failure to order an echocardiogram in the hospital deviated from accepted practices with respect to Dr. Cuomo?

A Yes, I can.

Q And can you tell us the basis of that opinion?

A Well, it was a deviation to not get an echocardiogram for all the reasons I just gave.

Q And may I ask you this, with respect to the not admitting the patient for further evaluation, did you have an opinion as to whether the failure to admit this patient on September 18th, 2013 was a deviation from accepted medical practices?

A Yes, I do.

Q And what is your opinion?

A Well, clearly the standard of care required a workup that would have proven he had an aortic dissection and he'd be admitted and have surgery. Certainly if you were admitted, he could have had the CAT scan hours later. We know that he didn't

die for three days, so he had plenty of time to have his life saved.

Q Is that the same if they would have done an echocardiogram?

A Yes. Echocardiogram or CAT scan.

Q And Doctor, did you review the autopsy?

A Yes, I did.

Q Okay. Can you tell us what the cause of death was as reflected in the autopsy?

A The dissection, the tearing of the aorta, eventually tore back -- the heart is surrounded by a bag called the pericardium. It's like a lubricated baggy that the heart beats inside. It protects the heart from physical injury, from infection. And that baggy around the heart has a lubricating fluid in it, and the heart beats inside the baggy. If you operate on the heart, you have to cut into the pericardium. An aortic dissection can go back and bleed massively into the baggy. If it does, the baggy can't stretch. So what happens is the blood goes into that space and collapses the heart into a little ball which is associated with sudden cardiac death. The heart can't beat.

Q With respect to the autopsy, were there more than one tear -- was there more than one tear that had shown up?

A No. There was a tear in the first part of the aorta and a distal part of the aorta, which occurs. People can have

tears in more than one place.

Q Is there any significance to the multiple tears?

A No, other than the fact that the tear in the beginning of the aorta is what needed surgical replacement. The tear downstream can usually be treated medically. The one that threatens your life is the one right above the aortic valve. That's the one that leads to death.

Q Is that the ascending aorta?

A That's called the ascending or rising aorta, yes.

Q And a tear in the ascending aorta is a life-threatening condition?

A Yes. It's a surgical emergency.

Q So do you have an opinion, based upon a reasonable degree of medical certainty, whether the pain that caused Mr. Nocera to go to the emergency room on September 18th, 2013 was caused by the aortic dissection?

A Yes, I do.

Q And what is your opinion?

A That it was caused by an aortic dissection.

Q And what's the basis of that opinion?

A Well, his aortic dissection was the cause of death three days later. There were chronic and inflammatory changes in the aorta which means -- if you have an aortic dissection and die instantaneously, there isn't enough time for inflammatory cells to gather. Inflammation in the aorta means that it was at

least several days old.

He went to the ER with pain, it radiated to his back, he had a high pulse pressure, he had a new systolic murmur. It was clear when you look at all the information that with close to medical certainty, close to 100 percent medical certainty, he was dissecting in the ER on the 18th and died of that same dissection on the 21st.

Q Do you have an opinion, based upon a reasonable degree of medical certainty, that the dissection progressed from September 18th through September 21st when he died?

A Yes, I do.

Q And what is that opinion?

A Well, again, it's clear when he left the hospital he was alive. The final tear killed him. So he clearly -- and the fact that he had recurrent pain when he left means that he probably had a small tear when he left the hospital. We have no information to tell us what occurred between the 18th and 21st. But it's not uncommon for someone to feel well and then finally have a fatal tear days later.

MR. VIGORITO: I'm sorry, Judge, can I have that last question and answer read back?

THE COURT: The question and answer?

MR. VIGORITO: Yes, please.

THE COURT: Nicole.

(Record read.)

MR. VIGORITO: Thank you, your Honor.

THE COURT: You're welcome.

Q The testimony that has been presented by Kathleen Nocera was that the patient had pain.

MR. VIGORITO: I object now, Judge. That's trying to refresh her own witness' ability to testify. He just gave an answer just a second ago, which we read back, saying there was no information to tell what happened between the 18th and the 21st. So now I object to any effort by counsel, who brought Dr. Charash here, to lead him and put words in his mouth on this.

THE COURT: I don't know where she's going with this question.

MS. WEISMAN: Complaints of pain and whether that would make a difference.

MR. VIGORITO: Your Honor, with all due respect, the beginning of the question is Kathleen Nocera testified about things, and those things are going to be what happened between the 18th and the 21st for which this --

THE COURT: Are you sure?

MR. VIGORITO: The witness has now said he has no information. He had Ms. Nocera's deposition. He said that at the very outset today.

(Sidebar held off the record.)

THE COURT: Let the record reflect that a sidebar

was held with counsel outside the presence of the witness and jury. Mr. Vigorito's objection is overruled. You may ask the question.

Q Assume that Kathleen Nocera testified that there was pain for the three days from September 18th to September 21. Does that change your opinion?

A No, because --

MR. VIGORITO: Object. I just want my objection on the record, Judge.

THE COURT: Your objection is noted. Overruled.

A No, because that's not medical history. She can only be aware of what her husband tells her. But we don't really have the details of what occurred between his discharge and his death. As a spouse, she could be aware of what he told her --

MR. VIGORITO: Objection.

MR. VENDITTO: Join.

THE COURT: Sustained. I think that's --

MS. WEISMAN: Okay.

THE COURT: -- that's enough.

MS. WEISMAN: Thank you.

Q Doctor, have you treated patients who have had surgical repairs of aortic dissection?

A Yes.

Q And have you referred patients for surgical repairs of aortic dissections?

A Yes.

Q Can you describe what that repair would be.

A Well, the surgeon would operate and replace the aortic root and redirect the arteries to this graft they put in. The aortic valve would be determined whether it needs replacement. Given that there was no structural damage on autopsy, it would probably not need replacement.

MR. VIGORITO: I'm going to object. Move to strike, Judge, based on the 3101(d), your Honor.

THE COURT: Point me to where.

MR. VIGORITO: I'm sorry?

THE COURT: Point me to where.

MR. VIGORITO: Well, that's just it, I mean --

THE COURT: There is no where to point.

MR. VIGORITO: I can't point you anywhere because it's just not in there.

MS. WEISMAN: It's regarding causation, your Honor.

THE COURT: Where are you referring me, Ms. Weisman?

(Sidebar held off the record.)

THE COURT: Read me the question, please, Nicole.

(Record read.)

THE COURT: I'm going to sustain the objection. I don't find it anywhere that would warrant the doctor or permit the doctor or place anybody on notice that the doctor

was going to testify as to what would occur during the aortic dissection. I -- so far I agree and sustain the departures and substantial factor questions which the doctor has answered.

I think this goes beyond the scope. Your -- the objection by Mr. Vigorito is sustained. The response by the doctor is stricken. The jury will disregard it.

Whose is it?

MR. VIGORITO: Mine, Judge.

MS. WEISMAN: Thank you.

Q Do you have an opinion, based upon a reasonable degree of medical certainty, as to what the patient's prognosis would have been had the diagnosis been made in the emergency room and had proper management been given?

MR. VIGORITO: Same objection.

MR. VENDITTO: Join, Judge.

THE COURT: Is that under the 3101(d)?

MR. VIGORITO: I believe so, your Honor. I mean, it's not there.

THE COURT: Well, I didn't see that either, but I'm also going to sustain it as speculative.

You have an exception, Ms. Weisman.

MS. WEISMAN: Thank you.

Q Doctor, do you -- I'm just going to get something out of the way for a second. Were you paid to testify here today?

A Yes.

Q Okay. And were you paid to review the materials?

A Yes.

MS. WEISMAN: Okay, Doctor, thank you.

THE COURT: All right, ladies and gentlemen, we're going to take a brief recess to allow Mr. Vigorito and Mr. Venditto to get their ducks in a row for cross-examination, but I promise you it will be brief. So please don't discuss the case amongst yourselves.

Doctor, you may step down. Please don't discuss your testimony during the recess.

THE WITNESS: Thank you, sir.

(Recess taken.)

COURT OFFICER: Jury entering.

THE COURT: Jurors, be seated as you enter. Ladies and gentlemen, Doctor, please be seated. Welcome back, Jurors.

You'll recall that when we took our recess Ms. Weisman had completed her direct examination of Dr. Charash. We will begin our final session for the morning beginning with cross-examination of the doctor by Mr. Vigorito.

Let the record reflect that Dr. Charash has retaken the stand. Again, Doctor, I remind you you are still under oath or affirmation. You may inquire.

MR. VIGORITO: Thank you, your Honor. Good morning jurors.

CROSS-EXAMINATION

BY MR. VIGORITO:

Q Good morning, Dr. Charash.

A Good morning, sir.

Q Dr. Charash, my name is Alfred Vigorito. I represent Dr. Linda Cuomo and Westchester Medical Center, sometimes referred to as Westchester County Health Care Corporation. And I'm pretty sure that you and I have never crossed paths before, either in a courtroom or outside. Does that sound accurate to you?

A Yes.

Q Okay. Doctor, are you familiar with the term retrospective bias?

A Yes.

Q You've heard of that term before?

A Of course.

Q And you know that it essentially means that since you know what happened at the end a person might be biased looking backward?

A Yes.

Q When you evaluate judgments made -- that people make, you have to evaluate them based upon the facts available when they make those judgments. That would certainly hold true for a

physician like yourself evaluating Dr. Cuomo, my client, in this case, true?

A I agree.

Q That would be the only fair way to do it, in fact, right?

A Of course.

Q And two doctors can be faced with the same day and that one decides to do one thing and the other a different thing, and both can be within the standard of care; that is a possibility as you sit here now, true?

A Yes, as long as it's within the standard of care, yes.

Q And Doctor, up until this point in time you have been on the witness stand many times before and testified about many depositions, true?

A Yes, sir.

Q I think that the number, based upon a trial that happened about two and a half, three weeks ago in Kings County in Brooklyn, New York with my partner Jeffrey Nichols -- do you recall Mr. Nichols --

A I do.

Q -- asking you some questions?

You acknowledged that you have now testified, combined trial and deposition, if not 600 times in total, you're getting there pretty quickly, true?

A Over 30 years, yes.

Q Okay. And would you agree with me that some of your opinions might be viewed as controversial because they might represent an alternative viewpoint?

A You're only referring to what I said about my book written for the public where I was trying to explain medicine.

Q Okay, Doctor, I'm going to cut you off for a simple reason. In those times that you have testified primarily at trial, probably not at deposition, you were probably given a friendly instruction from an adversarial counsel like myself that if you could answer the question with a simple yes or no, would you try to accommodate the question. You've heard that before?

A Of course.

Q Okay. So let's assume that my saying it now in the form of that question is me asking that of you for the purposes of the rest your testimony here today. Fair enough?

A Yes, of course.

Q If you can answer it yes or no, please do so. I will endeavor to try to ask my questions in a way that would call for a yes-or-no answer, which is my prerogative on cross-examination. And if you can't answer it yes or no, just tell me that and I'll either let you answer it the way you see fit or I'll move on to something else. Fair enough?

A Of course.

Q Doctor, at this point in your career have you reviewed

a thousand cases?

A It's possible. I think it's less, but it's possible.

Q And would you say that your testimony here today is based on assumptions that you have made based on the records that you have reviewed and your knowledge from your years of practicing medicine, primarily cardiology?

A Yes.

Q And would you agree with me that if your assumptions -- at least those that are based on facts -- that you discern from your review of the records and the depositions and the trial testimony, if those facts were not as you thought them to be when you formed your assumptions, then the underpinnings for those assumptions might fail, true?

A Well, I can't answer the question the way you phrase it limited to a simple yes or no.

Q It's kind of like a hypothetical.

THE COURT: Hold it, hold it. Let the doctor finish. You asked him a question.

Doctor, as I'm sure you're aware, and we may have even had this discussion at other trials, wait for Mr. Vigorito or any counsel to completely finish asking the question before you commence your answer. This way we'll avoid, you know, any confusion as to what the true nature of the question may be.

With equal emphasis and equal courtesy, I'm going

to direct counsel that if you're in the process of an answer that they wait until you completely finish your answer, and then I will entertain any applications to the extent that there may be.

THE WITNESS: Yes.

THE COURT: Go ahead, Mr. Vigorito.

MR. VIGORITO: I'm not sure, Judge, if the doctor got to answer the question. Your original objection was that I cut the doctor off, so I'm not sure if he answered my question.

THE COURT: Read the question and answer up to the point of Mr. Vigorito's commentary, and then I'll determine whether or not, or I'll ask the doctor if he had completed his answer.

(Record read.)

THE COURT: Is that it, Doctor?

THE WITNESS: Yes, sir.

THE COURT: Thank you.

Q Well, for example, Doctor, a little while ago Ms. Weisman asked a question and you said that you don't know, there's no information about what happened with Mr. Nocera from the time he left the hospital on the 18th until the day of death on the 21st. Do you recall giving that answer?

A I do.

Q About 20 minutes ago?

A Of course.

Q Okay. And as you sit here now, that's not entirely accurate, is it?

A Well, I meant it from a medical point of view. What Mrs. Nocera reported is her understanding of what he told her, but we don't have a medical history of the pattern, the duration. That's what I was referring to. We don't have an interval medical history.

Q Okay. Because he didn't see any doctors between the time that he left and the time of his death, true?

A Correct.

Q He died essentially in his sleep and woke up basically asystole and pulseless?

MS. WEISMAN: Note my objection.

Q Correct?

MS. WEISMAN: That's assuming facts in evidence.

THE COURT: He said he died in his sleep and then woke up.

MR. VIGORITO: When they woke up in bed, Judge.

Q He was essentially dead, right?

A Yes.

THE COURT: But your question -- your question was not who woke up.

MR. VIGORITO: I understand, Judge, I'll --

THE COURT: So I'm going to sustain the objection

as confusing and allow you to rephrase it.

MR. VIGORITO: Okay.

Q The judge is right, Doctor, you realize I'm talking about Mr. Nocera never woke up, he died in his sleep; you agree with that?

MS. WEISMAN: Note my objection, your Honor.

THE COURT: Overruled.

A Yes.

Q He woke up presumably, as we've heard in testimony we rely on, with Mrs. Nocera next to him, she heard a gurgle and looked at him and there was no response; you're aware of that?

A Yes.

Q You got that all from Mrs. Nocera's deposition testimony, right?

A Correct.

Q Okay. In addition to her deposition testimony, did you have the benefit of reading another transcript of Mrs. Nocera's testimony in this case besides her deposition?

A No.

Q Are you aware that in addition to the formal deposition that was taken in the case, which presumably you were supplied with and did read, there is a transcript from what we call a statutory hearing? Because in a case against Westchester County Health Care Corporation there's a notice of claim requirement and people, litigants, have to give a -- almost like a

pre-deposition. Were you aware that such a transcript existed?

A I'm not sure I even understood what you were saying, but I've only read her deposition transcript.

Q Just one transcript?

A Yes, sir.

Q How about her trial testimony that she's given thus far in this case, did you read that?

A No.

Q Okay. And so when you say you didn't have the benefit of any medical knowledge between the 18th and the 21st, it's because he didn't see a doctor after he left Westchester. And by the time they took Mr. Nocera to Hudson Valley Hospital in Cortlandt Manor he was essentially pronounced when he got there?

A Yes.

Q But there is knowledge of what Mr. Nocera was feeling between the 18th and the time he went to bed the evening of the 20th going into the morning of the 21st?

A Yes.

Q And that it is within the province of either Mrs. Nocera, perhaps a little bit of one or more of the children who may have had contact with him in those couple of days?

A Yes.

Q Did you have occasion to read any of the testimony of the three Nocera children in this case?

A No.

Q Okay. So, as you sit here now, would you not be in possession of any knowledge of any contact or observations that the children made of their father over that course of time?

A Correct.

Q So you would be limited to whatever your recall is of what Mrs. Nocera said?

A Yes.

Q Okay. And now, as you sit here now, do you have specific recall of what Mrs. Nocera said her husband's condition was from the moment he left Westchester Medical Center on the 18th until that unfortunate happenstance of waking up and finding your husband to be pulseless?

A Only that he had reported some pain to her, but I don't have a cogent history.

Q When you say reported some pain to her, can you elaborate on that, or is that the sum total of your understanding?

A It's the sum total. By memory, that's my sum total of my understanding.

Q Did you know that Mrs. Nocera, both in her deposition, the one that you had, and in her trial testimony -- and when I say did you know, I mean did Ms. Weisman tell you or did you learn it from anywhere else, that her testimony under oath, both of those times, in court and out of court in a deposition, stands for the proposition that her husband was in a significant

amount of pain the entirety of the time from when he left Westchester Medical Center until he did not wake up on the morning of the 21st? Were you aware of that fact, yes or no?

A Only if it was in her deposition, but not any other form of testimony.

Q If I were to tell you that is her testimony, both at trial and at deposition, and I'd ask you to accept that, based upon the testimony that you've given thus far, if I heard you correctly, would that necessarily mean that Mr. Nocera was experiencing a tearing of the aorta over that entire period of time because he had significant pain?

A The answer would be that you need a more detailed history. Somebody can say they spent the weekend vomiting the entire weekend, but it doesn't mean it was a sustained vomitus. She might believe that he was constantly in pain, but many people relate recurrent pain as always being there.

We don't have a medical history on Mr. Nocera. There are very few conditions which lead to 24/7 pain without any change or interruption. She's not a trained health care professional and she's not the doctor. So her being aware that he had pain is only her awareness of pain, but she can't know what the pattern was. There wasn't a medical history taken.

Q Do you know, as you sit here now, whether Mrs. Nocera recounted, either in her deposition, which you read, or her trial testimony, which you haven't seen yet, that from the time

that Mr. Nocera left Westchester Medical Center's emergency department on the 18th until not waking up on the morning of the 21st that he was complaining of back pain? Do you know, yes or no?

A No, I don't know.

Q Do you know if her recounting of his pain was limited to his saying that he had chest pain? Just a yes or a no.

A I don't recall the specifics.

Q Do you know, as you sit here now, whether her recounting of pain, on both of those occasions, included any complaint of pain radiating from the chest to any other anatomic part of his body? Just a yes or a no.

A No.

Q So you wouldn't know if it radiated to his neck, correct?

A Correct.

Q To his shoulder, correct?

A Correct.

Q To his back, correct?

A Correct.

Q Between his shoulder blades, correct?

A Correct.

Q By the way, did Mr. Nocera have a history of back pain? Just a yes or no.

A I'm trying to think back to his primary care. He may

have had some back pain at some point, but his problems were more GI and reflux disease.

Q He had been diagnosed with gastroesophageal reflux disease, commonly called GERD.

A Yes, he had.

Q And he was taking a medication for that?

A Yes.

Q And do you know which medication he was taking?

A I don't recall which one. I'd have to look at the chart.

Q Okay. What about chiropractic care? Sometimes people, especially tradespeople, as Mr. Nocera was a fully credentialed carpenter, might develop joint pain, back pain, leg, knee pain just from the wear and tear of what they do for a living. Are you aware of whether or not Mr. Nocera saw a chiropractor?

A I don't recall seeing records from a chiropractor's office, so I don't have an opinion one way or the other.

Q Okay. If I told you that we have the records of Biffer, B-I-F-F-E-R, Chiropractic in evidence, because they are care and treatment records for Mr. Nocera, would that be the first time you're hearing about the mere existence of chiropractic records?

A Yes.

Q And as you sit here now, obviously with that as a backdrop, you wouldn't know whether those records speak to the

issue of whether Mr. Nocera had a history of back pain?

A Not offhand, but, I mean, that wouldn't change the opinions in court.

Q Getting back to a question I asked you earlier, I think there might have been an objection. I just want to see if I can clear it up.

If the facts upon which your assumptions were changed, if they're not as you found them to be when you made your assumptions, might that change your opinions? Just a yes or no. If you can't answer that yes or no, you can tell me.

A It will depend on the facts.

Q Let's talk about the amount of testimony, Doctor, when I say 600 times combined trial and deposition, you know that that's now a pretty accurate number, true?

A I think it's a little under 600, but I think it's generally accurate.

Q And each of those times you've been compensated for your testimony, whether it's trial or deposition?

A Yes.

Q And out of those 600 times thereabouts, it breaks down somewhere on the orders of 250 times in court and about 350 times at a deposition, accurate?

A Yes.

Q And you've reviewed over a thousand cases at this point in your career, as you said, over 30 years, right, starting

what, 1987?

A Yes.

Q And 95 percent of the time you're testifying in court or at a deposition for a plaintiff, a litigant who's suing a doctor or a hospital in a medical malpractice case, true?

A Ninety-five percent are plaintiff, not all of them are malpractice. I've dealt with a fair number of cases of injuries from accidents affecting the heart, and I've dealt with a number of cases about drugs affecting people. So not all of them have been malpractice, but 95 percent of my testimony has been for plaintiff-related cases.

Q So if it was 600 times, if we use that as the number -- and I understand you might think it might be a tad under that -- 90 percent of 600 is 540, 95 percent would be nine -- would be 575. So out of 600, 575 times have been for the litigant, the person bringing the lawsuit?

A Yes.

Q And you started doing that the very same year you finished your cardiology training in 1987, true?

A Yes.

Q And you would agree that doing that kind of work, the review and the testimonial work, that has nothing to do with your actual patient care, it's in addition to it?

A Yes, it is.

Q Doctor, you didn't testify when counsel asked about the

rate of compensation for this case, so let me ask that now. Are you being compensated monetarily for your time in court today?

A Yes.

Q Is that a flat fee or an hourly fee?

A An hourly fee.

Q And what is the rate of compensation per hour to be away from the practice of medicine and be with us today?

A $500 an hour from 9:00 to 5:00. I got here before 9 o'clock, but I don't charge for travel time since I wouldn't be working. So it depends on how many hours in the 9 to 5 o'clock, 8-hour interval I miss due to the trial.

Q Okay. And I take it that you charge either the same rate or perhaps a slightly reduced rate for the review of materials and for meetings and telephone conversations, things of the like, maybe emails, to get ready for and to have reviewed the materials to be able to come to court and testify?

A Yes.

Q And what is the rate of compensation for that?

A $450 an hour, all of this is since 2015.

Q Okay. That's when the rate went up?

A Yes.

Q Prior to that it wasn't 500 per hour for court, 450 per hour for review, it was slightly less than that?

A It was.

Q And what were the numbers prior to 2005, did you say?

A '15.

Q Oh, '15. What were the numbers prior?

A Well, it started, I think, at $200 an hour or 250 an hour in the early years. Eventually, it went up to $400 an hour for all testimony, and then 450 and 500.

Q I think you've testified in the past that in 2015 you took a look around you and saw what the industry standard kind of was and you reviewed some, maybe some transcripts of other witnesses and decided that you were not charging an appropriate rate, so to speak, and you raised your rate; is that accurate?

A That was part of it. The other part was I had not raised my rate in over a decade.

Q So tell us, Doctor, based on the items that you were given that you enumerated today, how much time have you spent reviewing those records, depositions and meetings with counsel, which I'll ask you about in a moment, right up to the 9 o'clock hour today? How many hours had you accumulated on the Nocera case?

A Probably eight hours.

Q Okay. And those were billed at 450 per --

A Yes.

Q Okay. So that's $3,600, I think, if my math is correct, eight times 450?

A Okay.

Q All right. And now the clock is running from 9 o'clock

this morning for whatever time you're here today. And do you charge for your travel time going back into the City at all?

A Only 9:00 to 5:00. If I leave here at 5:00 I won't charge for the travel time.

Q Okay. But if you get out of here today at 4:00 and you don't get home until 5:00?

A Then I missed 9:00 to 5:00 work, so it's eight hours.

Q Okay. So eight times five conceivably could be another $4,000?

A Yes, sir.

Q With the 3600 it would be up to $7600 for this case?

A Yes.

Q And the amount of materials that you reviewed in this case, it wasn't a lot of records I don't think, was it?

A No, it was not.

Q Okay. Would you say that this was a smaller amount of records than the average case that you do review out of those thousand cases that you've reviewed?

A It was a smaller amount of records but more meeting time than normal.

Q Okay. Let's talk about the meeting time. How much time did you meet with counsel to discuss the case?

A Three and a half hours.

Q Okay. And when was that taking place?

A Couple weeks ago.

Q Was it all at once, one session or more than one session?

A Well, we had phone discussions that were factored into the billing earlier, but we met for about three and a half hours to discuss this trial.

Q And have you been compensated for that prep time so far?

A Yes.

Q You've already received payment for that?

A I have.

Q Okay. Have you already received payment for your time in court today?

A No.

Q Because you have to bill that separately per hour?

A Yes.

Q Okay. Did you bring with you any materials, any notes that you might have made in this case?

A I didn't make any notes, but I brought Post-Its of some of the records that we would be discussing.

Q How about billing records, did you bring any billing records, a bill for the $3,600 that you billed so far?

A Well, it wasn't a single invoice, obviously. It was spread out over different points of time. But no, I did not.

Q Now, Doctor, there's a firm in Florida that you've testified for on several occasions, and you would acknowledge

that you've actually earned $50,000 in one year from testifying for that one firm in Florida, true?

A Yes.

Q And in 2014, would you acknowledge -- and you have in the Shanoff case -- that you've testified 27 times in one year, true?

A Combining trial and deposition, yes.

Q And you would acknowledge that 100 percent of those 27 testimonies in that year 2014 were all for the litigant, all for the plaintiff bringing the lawsuit, true?

A Probably. I don't -- I don't have independent memory, but if I testified to that it would be true.

Q And you recall testifying in the Knote case, K-N-O-T-E, that you have given more than 24 depositions in some calendar years, true?

A In the past -- I -- what year? Which is the Knote deposition? I just --

Q Well, just that thought, Doctor, that you have given 24 or more depositions in one calendar year, you recognize that to be a true statement?

A Probably. I mean, there was a peak about a decade ago, so it may have been true. I just don't have an independent memory.

Q And that same case you acknowledged that you had testified in court 15 times in one year, true?

A Yes.

Q And you would agree that $10,000 is a typical amount you collect on cases that go to trial in recent years, you gave that testimony in the Colon case, true?

A Yes, for out-of-state cases, but a lot of the cases in New York are half days.

Q Let's talk about out of state for a second. I think you did mention to this Court and our jury earlier today that you have testified in was it 40 different states?

A No, I reviewed cases from lawyers in as many as 40 states. I've probably only traveled to 12 for testimony.

Q And in some of those cases that are out of state, they have what they call federal rules where you have to give a deposition, true?

A I don't know what rules they are, but I know that there are states where I'm deposed.

Q Okay. And sometimes you can do those depositions right here in New York that might be done with a video link or by telephone link of some kind, true?

A They're almost always done in New York.

Q So you don't even have to leave New York to give that kind of deposition?

A That's correct.

Q Sometimes you might have to travel for the actual trial following the deposition to another state, true?

A Yes.

Q Okay. And how many states would you say you've testified in?

A Twelve.

Q Okay. And a couple weeks ago did my partner, Mr. Nichols, establish with you that you've testified essentially in every state along the eastern seaboard of the United States; is that true?

A Probably. I'm not sure it was every state.

Q Did you tell Mr. Nichols --

THE COURT: Hold it.

MR. VIGORITO: I'm sorry, Judge. I apologize.

THE COURT: Did you finish your answer, Doctor?

THE WITNESS: No.

A I'm not 100 percent sure it's been every state on the eastern seaboard, but the majority of the times I've testified have been locally.

Q And Doctor, you have testified, and did so again three weeks ago in Brooklyn, that you will find a meritorious cause of action in 95 percent of the matters that are submitted to you by plaintiff attorneys, true?

A You've stated it incorrectly. I do find --

Q No, it's a yes or a no.

A Well, you said I will find. That's a future statement. I have found after the first level of screening by telephone

that after reviewing the case, after telephone screening, that about 95 percent of the times I'm sent a case I find it meritorious after our telephone screen.

Q Now, when you told us initially this morning that sometimes you do actually do work on behalf of the defense, is that in a medical malpractice action?

A Yes.

Q When was the last time you testified in defense of a doctor in New York State? Was it this year?

A No.

Q Was it in 2017?

A No.

Q Was it in 2016?

A No.

Q Can you name the case?

A There was a Staten Island case for New York State testifying was probably 2015.

Q Do you know the name of the attorney that you worked with on that case?

A I think it was a Mr. Lopresti, and it was in Staten Island.

Q When you say it was a New York case, do you mean it was like a Court of Claims case against the State of New York?

A I don't know what you're talking about. It was just that I've done defense cases in New York State, in Florida, and

a few other states. So the last time I recall testifying in a New York-based case in a trial would have been probably 2015.

Q In addition to this case, Doctor, you testified recently in the Shanoff case back on January 22nd of this year where Mr. Basichas called you as a witness, true?

A Yes.

Q And that was for the plaintiff in this case with my partner, Mr. Nichols, along with several other attorneys, true?

A Correct.

Q And how about a case called Fishon, F-I-S-H-O-N, versus Richmond University Medical Center, have you testified in that case yet, or is that case on the future agenda for you?

A I actually don't recognize the case.

Q Okay. How about the case of Goodwin versus St. Francis; do you recognize that case?

A Not off the top of my head, no.

Q How about the case of Wilson versus Rite Aid Corporation where you were noticed as a witness up in Fulton County, New York; do you recognize that case?

A I don't recall being called in Fulton. There is a Rite Aid case, but that's not the name of the case, as I remember it.

Q Doctor, when you gave the address earlier this morning that you did give us for the record, the 205 East 63rd Street, is that an office address or a residential address?

A Both.

Q Is that a -- an office that you practice medicine out of?

A Yes.

Q Is it also an apartment that you live in?

A Yes.

Q Is that in an apartment building on the Upper East Side of Manhattan?

A It is.

Q Is it a ground floor apartment or somewhere on an upper floor?

A The 16th floor.

Q Does it have an apartment designation?

A Yes.

Q What is it?

A 16G.

Q Is there a reason why when you give the address you don't say Apartment 16G? Just a yes or a no. Is there a reason why you do not give the apartment, yes or no?

A No.

Q Isn't it true that at this time, Dr. Charash, you do not maintain a separate office just for the practice of medicine? True or false?

A I can't answer the question the way you phrased it. I lived --

Q Let me try to make it more specific.

THE COURT: Hold it. Let the doctor finish.

MR. VIGORITO: Absolutely, Judge.

THE COURT: Please.

A I cannot answer the question the way you phrased it limited to a simple yes or no.

MR. VIGORITO: Okay.

THE COURT: Thank you. Go ahead, Mr. Vigorito.

Q Isn't it true that other than this address that we've just mentioned again and Apartment 16G, you, Bruce Charash, MD, do not maintain another separate office exclusively for the practice of medicine, true?

A I can't answer that question limited to a simple yes or no.

Q Do you have a -- withdrawn.

In addition to this address that I just recited to you, Apartment 16G, do you have another office address?

A At Lenox Hill Hospital there's an outpatient facility for cardiology which sees patients.

Q You realize that you are not listed on the Lenox Hill Hospital directory, you realize that, right, Doctor?

A Yes. That's voluntary.

Q And you don't go there very often, you don't go there at all; isn't that true, Doctor?

A Go where?

Q To Lenox Hill outpatient.

A I go there two days a week to see patients as an outpatient and three days a week out of my home office.

Q And you don't admit patients to Lenox Hill very often anymore; isn't that true, Doctor?

A Well, I have about three to five patients a month in the hospital. Some of them are admitted by primary care doctors and I'm the consultant. Others are admitted in my name. Depends on the circumstance.

Q Doctor, would you say that $450 per hour is significantly more money than you would make seeing patients for office visits at 205 East 63rd Street? Just a yes or no.

A Yes.

Q Would you say, Doctor, that it's a fair statement by me to suggest to you that at this stage of your career as a medical-legal expert you have made in excess of $1 million; is that fair?

A You're talking about adding up 31 years of income?

Q Yeah.

A Probably.

Q And is it fair that in some cases you've testified that you have made in excess of $150,000 in one tax year from your legal-medical activities; is that fair? Yes or no?

A I do not recall it ever being that high.

Q Is it fair, Doctor, that you have derived 15 to 20 percent of your yearly income from your activities in

medical-legal work?

A Yes, that's correct.

Q Is it fair that in certain years, as many as two or three, that percentage has reached as high as 25 percent of your total income for those years?

A Yes.

Q Doctor, page 460 of your testimony just a couple of weeks ago in the Elena Shanoff case, at page 460 you were asked these questions and you gave these answers. I'm just going to ask you to listen along for a second. Question, line 13:

"Doctor, you have, in the course of offering your opinion in a nonpatient setting in medical-legal cases like this, earned upwards of $1.2 million dollars, correct?

Answer: Are you talking about adding my income for 30 years? Yes.

Question: Okay. And Doctor, better years you would characterize between upwards of $100,000, true?

Answer: There were two years where it reached that level."

Do you recall being asked those two questions and giving those two answers three weeks ago?

A Yes.

Q So there are at least two years where you earned at least $100,000 per year, true?

A Yes.

Q Doctor, you're only licensed to practice medicine in the State of New York; is that accurate?

A Yes.

Q But you have been contacted, I think you mentioned now, by lawyers from at least 40 states, true?

A Yes.

Q And that would include not only trial matters but deposition cases?

A Well, no, no. I mean, I've reviewed cases for lawyers in 40 states. I've appeared in 12 or so states for trial and probably have done depositions in another 10 states. So probably half of the states that have contacted me I've done nothing more than review a case.

Q Doctor, you're not licensed in the State of Massachusetts, correct?

A That is correct.

Q And you have reviewed in excess of 50 cases in that state for the law firm of Lubin & Meyer, true?

A Yes.

Q You're not licensed in the State of Florida, correct?

A Correct.

Q You have reviewed at least 50 cases for the law firm of Morgan & Morgan, true?

A Yes.

Q In the State of Florida alone you have given 60

depositions and testified in 30 trials, true?

A Over the 30 years, yes.

Q You have physically traveled to upwards of 15 states to give testimony, true?

A Yes, probably 12 to 15, but yes.

Q You've testified in Pennsylvania, yes?

A Yes.

Q Arizona?

A I think so.

Q New Jersey at least a dozen times?

A Yes.

Q Connecticut?

A I never appeared in court in Connecticut.

Q Gave depositions in Connecticut cases?

A I gave one deposition --

Q There was one case from Danbury, I think.

A I don't remember where in Connecticut.

Q Okay, fair enough. Illinois?

A Yes.

Q Washington, D.C.?

A Yes.

Q Georgia?

A Yes.

Q Kansas?

A Yes.

Q Virginia?
A Yes.
Q New Mexico?
A Yes.
Q The five boroughs of New York City, right?
A Yes.
Q Westchester County?
A Yes.
Q Rockland County?
A Yes.
Q Orange County?
A Yes.
Q Nassau and Suffolk?
A Yes.
Q I don't want to offend any of our friends in Ulster County or Dutchess County.
A I'm not sure.
Q Have you testified there as well?
A I believe in Dutchess County once.
THE COURT: All right. I'm going to break for the lunch hour. We're going to have a little treat today. For example, I'm not going to have you back until 2:30. I have a very brief proceeding that I need to conduct at 2 o'clock, so I don't want to have everybody just sitting in the jury room wondering why are we still here.

So, that being said, I'd like everybody in the jury room at 20 after 2:00 so we can start at 2:30, and I would like to insure that we complete Dr. Charash's testimony by the end of the day. So, that being said, please don't discuss the case amongst yourselves, don't discuss it with anybody else. Have a wonderful lunch and I'll see you at 2:30.

Doctor, you can step down. Please don't discuss your testimony during the lunch hour.

THE WITNESS: Of course, sir. Thank you.

(Lunch recess taken.)

COURT OFFICER: Jury entering.

THE COURT: Jurors may be seated. Counsel, ladies and gentlemen, Doctor, be seated. Welcome back, Jurors. I hope you had a pleasant lunch, and thank you again for always being so prompt and ready to serve when we start.

You will recall that when we took our lunch recess Mr. Vigorito was in the process of conducting his cross-examination of Dr. Charash. We will begin the afternoon session with a continuation of Mr. Vigorito's cross-examination.

Let the record reflect that Dr. Charash has retaken the stand. Doctor, as redundant as it may be, I remind you again you are still under oath or affirmation.

Mr. Vigorito, you may inquire.

MR. VIGORITO: Thank you, Judge.

Q Good afternoon, Dr. Charash. Good afternoon, Jurors.

A Good afternoon.

Q Dr. Charash, can you and I agree, have you ever given any thought to how much time, in your so far 30-year career since you finished your fellowship, you've actually spent involved and invested in this medical legal process?

A About probably 10 to 15 percent of my time on average.

Q Let's see if we can, you know, deal with the numbers a little bit and see what it turns out to be from a logical standpoint. Six hundred testimonies, just about, right?

A Yes.

Q Okay. So if we budgeted a day for testimonies --

A They're two hours. Most of the depositions are two hours.

Q But you never know that going in --

A Well, no.

Q -- to testimony?

A I usually budget two hours for a deposition.

Q Like today, you can't tell how long this was going to be?

A Trial?

Q Right.

A I assume it would be a day, but most of my depositions have been two hours.

Q Bear with me. If you had 600 testimonies and you reviewed a thousand cases, and I think in the past you've testified that on average you spend sometimes between, what, like five to seven hours --

A No.

Q -- reviewing a case?

A No.

Q What -- would you say it's less than that?

A Many of those cases were an hour or two hours, the ones that I didn't testify in. Many of the cases where I did depositions I also testified in so they were the same case so there is a lot of overlap. But many cases the initial review is an hour to two hours, and at least 30 percent of my cases never resulted in testimony.

Q If you did a thousand cases at three hours that would be 3,000 hours, right, of time?

A Yes.

Q And if you did 600 cases and they took a half a day each --

A That's not fair.

Q -- or at least took up enough time that it affected your schedule to the opportunity of a half a day each, if we added all that up and divided it the hours to come up with days and we say that there are, you know, be generous, 250 days in a year to work, it would turn out that you spent over two years of

your professional life of the last 30 doing what you're doing today, true?

A I would have to calculate it and see if that's legitimate. The first ten years was only five percent of my time, but that said, if you want to average it to 10 to 15 percent of my professional life I might make sense of it over 30 years. I've not added it up like that.

Q Doctor, when you were working at Lenox Hill Hospital on the east side of Manhattan for a period of time you were a salaried employee paid by the hospital, true?

A Yes.

Q And that's no longer the case, true?

A That is correct.

Q And then at some point you moved to Columbia Presbyterian, true?

A Yes.

Q And did you leave Columbia Presbyterian on your own accord?

A Yes.

Q And at some point you were -- were you at New York Cornell as well?

A My original career was at New York Cornell.

Q Were you ever a full-time attending at New York Cornell?

A Yes.

Q Yes?
A I was -- well, full-time medical school faculty member.
Q Doctor, I would be accurate that you have not published anything in any peer review since 1991?
A Absolutely.
Q And we haven't talked about this topic yet, but peer review is something -- the term is something you recognize?
A I do.
Q And that's when a medical professional, in this particular situation a fellow like yourself, might submit a writing to a journal and the editorial board of the journal, the peer review, will read that article and make a determination whether or not they want to accept it and publish it, true?
A Yes.
Q And you haven't done that since 1991, true?
A Correct.
Q You have testified that the American College of Cardiology guidelines are not authoritative? Just a true or false.
A True.
Q You did not recertify in internal medicine when you were able to, true?
A I was not required to. I was given a lifelong certification.
Q You have an option to sit every 10 years for

recertification; is that true?

A It may be true, I don't know, but I was grandfathered in. All my colleagues from my years we were given lifetime certifications.

Q And the last time you taught in a medical school was in 2004; is that true?

A Yes.

Q Doctor, you testified this morning that there are 12,000 cases a year of aortic dissection; do you recall that?

A Yes.

Q Where did you get that data from?

A Just my understanding of it from the years of reading literature, but I don't have a specific source.

Q Do you recall testifying in the case of Helene Andrews, Administrator of the Estate of Mary Degross (ph), against Dr. Suresh Dhumale, D-H-U-M-A-L-E, on January 5th, 2007? Here's that case in Danbury. It's Superior Court of Connecticut, Danbury District Court. Do you recall that case, Doctor?

A I don't recall the case.

Q Do you recall the case of Nancy Jollie, the Estate of Fred Jollie, in Orange County, you testified on October 29th, 1992, against St. Luke's Cornwall Hospital, Drs. Woude, W-O-U-D-E, Hulihan, H-U-L-I-H-A-N, Crawshaw, C-R-A-W-S-H-A-W, and George; do you recall that case?

A From 1992, no. The name is familiar, but I certainly

don't recall anything about the case.

Q Okay. Page 14 of your testimony, you testified there are 2,000 dissections in the United States. Do you recall saying that in that case?

A No. Not in 1992.

Q You don't remember 1992?

A I don't remember the testimony from 1992. I remember the year.

Q Do you think that in 1992 you were of the opinion that there were only 2,000 aortic dissections in the United States?

A I can't relate to why '92 I would think there were 2,000. The number is closer to 10 to 12 thousand.

Q Now, you just said 10 to 12 thousand I noticed, but when you testified on direct examination when Ms. Weisman was asking you questions you said 12,000. Do you recall that?

A No one knows the exact number. We're talking about a relative ballpark national so I'm giving a range.

Q I understand that, Doctor. But when you testified on direct you didn't qualify your answer as bracketing it and giving a 10 to 12 thousand, you said 12,000, true?

A Yes.

Q You recall that?

A I do.

Q Now, a moment ago you now said 10 to 12 thousand, you just said it, right?

A I did.

Q And I just read your testimony where in 1992 you said it was 2,000. Now I'm going to read you testimony from 2007 in the case of Andrews against Dhumale. You were asked this question and you gave the following answer. I just ask you to listen along with me for a second and then I'll ask you a question.

"And there are a lot of other diseases and conditions that are not associated with the heart that those patients get diagnosed with as well, correct?

Answer: Well, at our level it's less than half. The majority of our patients who we admit, based on story and risk factors, have heart disease. Many of them we don't have an answer. Once we prove it's not heart disease we acknowledge -- I mean, short of an aortic aneurysm and pulmonary embolism and is life-threatening and that's actually eight hundred thousand a year in this country, compared to 1.2 million heart attacks, so pulmonary embolism is big. Dissection is only about 10,000 a year. Once you get past that you don't have too many life-threatening."

Do you recall being asked those questions and giving that answer?

A No.

Q Do you recall that case at all, Doctor?

A Not from 11 years ago.

Q Andrews versus Dhumale in Danbury you said there was only one time you testified in Connecticut before the lunch break?

A That was 11 years ago. I would need something to remind me of the facts of the case.

Q That was the same case where you, on examination by the defense witness, acknowledged that obtaining two sets of troponin levels for a patient that presented to an emergency room was in fact excellent practice, true?

A Yes -- well, I don't remember saying that, but it would be. If you get two sets it would be appropriate and excellent.

Q And that if a doctor, whether it's an emergency room doctor or cardiology consultant, coming in obtaining just one troponin level, also known as a cardiac enzyme, without following it up with a repeat study in six to eight hours that would be negligence, true?

A Yes, that would be.

Q And how many troponin levels were obtained in our case at the behest of my client, Dr. Cuomo, do you know?

A Yes, two sets.

Q You also testified in that case that obtaining an EKG would be proper and good practice, true?

A Yes.

Q And that was done in our case as well, true?

A It was.

Q You also said in that same case, Doctor, see if this refreshes your recollection, that sending any patient home from an emergency department with instructions to come back if they are not feeling well or having additional pain is not good practice; do you remember saying that?

A Well, you have to understand the context --

Q Doctor, the question is not contextual. It's do you remember saying it?

A Well, I don't remember directly saying it, but I have said things like that in certain circumstances.

Q Let me read to you, Doctor, from page 188 of that transcript. The question was:

"All right. I will rephrase it. Doctor, I don't get insulted if you don't understand my question, trust me. So just let me know and I'll rephrase it as many times as necessary for you to understand. Are you saying, Doctor, that it is inappropriate for an emergency medicine physician to advise an 85-year-old woman, in whom he has made a diagnosis of gastritis, to return to the emergency room if her symptoms got worse?

Answer: It depends on what the reasons are for why he wants her to return. It depends on if there are any other circumstances. An ER is a very inappropriate place for anyone to go unless they have to be there."

Do you remember being asked that question and giving that answer? It's just a yes or no.

A I don't recall it.

Q And you went on on the next page, page 189, to answer a question where you said:

"So unless there is a specific reason why they need to return to the emergency room, identified as a reason why emergency room intervention is needed, it's highly inappropriate to have people come back, especially when they have a treating doctor."

Do you recall saying that in that case?

A I don't recall saying that in that case, but it would seem appropriate to that case.

Q And in the same transcript at page 190 you said, under oath:

"Why go back to the ER and register and have an intravenous line put in and get all this crap for gastritis. It's a dangerous combination to do this. There are bacterial infections. We don't casually introduce people into the portal of the hospital for no reason, and you can't give a rational reason for doing it, other than he knew he had not evaluated the heart completely."

Do you recall being asked a question and giving that answer?

A I don't recall it, but that answer sounds like me.

Q Doctor, when did Mr. Nocera experience his initial tear of the aorta in your opinion, just when?

A When he first complained of his pain.
Q Which was when?
A I'll have to look to see exactly. It began the day before he came to the ER so it would have been on September 17th, 2013.
Q What time?
A I'm not sure if the time is reported. I have to find it.
Q Would the amount of time that elapsed from the inception of the pain to his presentation to the ED be a piece of information that might be of significance to people treating Mr. Nocera, yes or no?
A I can't answer the question the way you phrase it limited to a simple yes-no reply.
Q Can you and I agree, Dr. Charash, that as you sit here now, looking at whatever documents you have in front of you, I guess -- is the hospital record?
A It's the ER chart.
Q That that does not give you that piece of information that I'm asking about, what time of day the inception of the pain started?
A Yes, that's correct.
Q Okay. Let's go at it a different way. Do those records give you the location where Mr. Nocera was when the pain started that day?

A Yes, I think it does. I have to find it.

Q Take your time.

A I can't find a note referring to where he was when it occurred. I thought there was one. At this point I can't find one.

Q In addition to reading or looking at the WMC Hospital chart now, specifically the emergency department record, was there some other piece of information that was given to you to facilitate your review of this case and enable you to come to court and give opinions before these nice people and this judge that might have that information in it?

A I don't understand your question.

Q Okay. Let me make it easier. Did you tell us earlier today that you were provided, when you first got this case from Ms. Weisman, with the deposition testimony of Kathleen Nocera?

A Yes.

Q Did you review that deposition testimony within the last week or so?

A No.

Q When was the last time you reviewed the deposition of Kathleen Nocera?

A When I first got the case, probably over a half year ago.

Q When was that? How long ago?

A Over a half year ago.

Q Six months ago?

A Yes.

Q Do you have any correspondence that you brought with you today from counsel or anything that you sent in response to counsel that might corroborate when you got the case for the first time six months ago, as you say?

A Well, it's my estimate six months ago, but I have nothing to corroborate exactly when I received it.

Q Is there a piece of paper that exists in Apartment 16G that would corroborate what you've told this Court and jury?

A No.

Q Is there a file in Apartment 16G?

A No, I brought my records here. Everything was sent electronically, so I guess on my home computer I might be able to find out what day it arrived.

Q So what you brought today doesn't contain even a cover letter from the attorney who retained you in this case, true?

A That's correct.

Q And you have no correspondence, not even a copy of an email, going back to her or anyone else regarding this case, true?

A Correct.

Q And in preparation for your testimony here today, knowing that the only person who could shed light on where Mr. Nocera was at the outset of the pain was Mrs. Nocera, and

she was the only person who could shed light on the time of the onset of the pain or the general condition of her husband, you didn't read her testimony before coming here today, true?

A Well, I didn't reread it, but that's true.

Q The first time you read it was six months ago?

A Or whenever I first got the case. That's the ballpark.

Q Well, Dr. Charash, we're relying on you to tell us when you got the case because you don't have anything in writing. Is it six months ago, or do you want to hedge on that?

A I'm not hedging on that. That's my best estimate.

Q I'll accept it. I want to know when you say if it was six months you believe it was six months ago?

A Yes. I think that's my best estimate.

Q Okay. Fair enough. Does any of this discussion that you and I are having right now, does it serve to refresh your recollection as to where Mr. Nocera was when he first experienced chest pain?

MS. WEISMAN: Note my objection, your Honor. It's been asked and answered.

THE COURT: I'm going to give him one more chance.

A No, I don't recall where he was when he first had chest pain.

Q If the circumstances were that Mr. Nocera was doing something of a physical nature when the pain first exhibited itself and was limited to his chest without any complaint of

radiating to any other part of his body, would that be an important piece of information for the clinicians, for Dr. Cuomo and Dr. Bernstein, to know?

A Yes.

Q And yet you don't know it?

A I don't recall it. I have a vague memory of it -- there being physical activity. But it would not change your differential diagnosis. Dissections are often brought on by physical activity that leads to a blood pressure surgery that tears the vessel. So in terms of the approach to him, memorizing that, and they're in the -- in the records in the hospital, but memorizing that wouldn't change the differential diagnosis with the information he had when he came in.

Q Was Mr. Nocera working on his car at the time that the pain started?

A That sounds familiar.

Q Where do you get that from?

A It sounds familiar. I had read the depositions, I just don't remember it.

Q Did Mr. Nocera position himself in an awkward way while he was doing some mechanical work of some nature and then experienced the chest pain for the first time?

A I don't recall.

Q Was Mr. Nocera standing straight up, lying on the ground, on his back or side --

A I --

Q -- kneeling or in some other position?

MS. WEISMAN: Note my objection, your Honor. It's already asked and answered. He does not know.

THE COURT: Can I hear Mr. Vigorito's question.

(Record read.)

THE COURT: Overruled. Can you answer the question, Doctor?

THE WITNESS: I don't recall. I don't know if anyone knows.

THE COURT: Doctor, I'm not -- no one here is asking you to guess.

THE WITNESS: I don't recall.

THE COURT: And that's perfectly an acceptable answer to the Court.

THE WITNESS: Very good.

Q Dr. Charash, with all due respect, saying I don't recall intimates that at one time you did know it. So my question to you is: Do you think, as you sit here now, you knew at one time what position he was in when the pain first started?

A No. I know that I had read Mrs. Nocera's deposition. I don't recall the details, and there's certainly no documentation of it in the emergency room chart. With that said, I don't recall what was described about the events the day before that resulted in him coming in on the 18th to the

emergency room.

Q It's your testimony now under oath before this Court and jury that there is no information in the Westchester Medical Center emergency room record that would shed any light on that particular point?

A No. I said right now I couldn't find it. I don't recall.

Q If we wait five minutes more can you find it?

A I don't know --

MS. WEISMAN: Your Honor, objection.

A -- if I have the complete chart, but if you give me the original --

THE COURT: Doctor --

THE WITNESS: I'm sorry.

THE COURT: -- there is an objection. I'm going to ask that you hold off until I sustain or overrule.

Can I hear the question again, please.

(Record read.)

THE COURT: Doctor, if I give you a few minutes to peruse or review the chart, would that be helpful?

THE WITNESS: I would need the original chart, because I don't think I have the complete chart here with me.

MR. VIGORITO: Your Honor, it's a digital chart. We have a copy of it. The only way to have an original is

to have a projection of it. I can project the record up -- there is no original chart.

THE COURT: Does -- Mr. Vigorito?

MR. VIGORITO: Judge, you know what, Judge? I want to save five minutes myself because I have other things to ask.

THE COURT: I'll tell you what, is there -- is Plaintiff's Exhibit 12, which is in evidence, the full chart of Westchester Medical Center concerning Mr. Nocera?

MR. VIGORITO: There's a consult note as well. It should be in evidence and it should be there.

THE COURT: Do you wish to continue with this line of questioning, Mr. Vigorito, or do you wish to change gears?

MR. VIGORITO: No, I'm not changing gears just yet, Judge, but I will ask a different question so we don't have to take any time to look. Let me ask a different question. Court's permission?

THE COURT: It's your examination.

MR. VIGORITO: Thank you.

Q Dr. Charash, in addition to the record that you've been looking at, did you ever read the cardiac consultation note that was compiled in this case?

A I did, the one written by a fellow, yes.

Q Right. And is that note, does it bear any writing from

Dr. Cuomo on it?

A There's some writing by her at the end of the note.

Q Where she acknowledges that she read the note and spoke to the fellow that first examined Mr. Nocera, which, by the way, would be customary practice?

A Yes, it would be.

Q And when you read that note -- withdrawn.

Did you ever say to counsel, gee, this note, it's tough to read? Can you get me a better copy of it so I can know exactly what it says? Did you ever say that or words to that effect? Yes or no.

A I don't recall. I thought that that was covered in Dr. Cuomo's deposition.

Q Okay. Do you remember what you read in that consult note?

A I would rather see the note rather than try and remember what I had.

Q I'm not trying to make this a memory test for you, trust me, but I'm just asking you, as you sit here now, is that something that you saw recently, or like the transcript of Ms. Nocera, is it something you haven't seen for, you know, six months perhaps?

A No, I've dealt with Dr. Cuomo's testimony where she read her note or at least discussed that note in her deposition, and I had read that right before trial. I just don't remember

what's exactly in the note without seeing a copy of it.

THE COURT: Time out.

MR. VIGORITO: May I?

THE COURT: Yes, you may.

MR. VIGORITO: Thank you.

Q Dr. Charash, are you reading the consult note?

A I found a copy of the consult note.

Q Okay, great. So looking at that two-page note, does it refresh your recollection that you ever asked Ms. Weisman, during the past six months that you may have been involved in this case, for, you know, an enlargement of it or a translation of it because it's a little tough to read? Did you ever do that?

A No.

Q Okay. Are you able to read it?

A Much of it.

Q Okay. Do you see anything in that note that sheds any light on what Mr. Nocera was doing at the time of the onset of the chest pain?

A Well, this says he was doing light work that began yesterday. Patient was doing light, and then this word is cut off, work.

Q Uhm-hum. Do you see anything in there that he was in an awkward space or he positioned himself in a difficult position?

A Yes.

Q Do you see anything about what he was doing, whether he was working on a car or doing something else?

A I can't see the word car in here.

Q Do you see anything about the onset of the pain occurring --

A It's --

Q -- when --

A Sorry.

THE COURT: Hold on. One at a time, please.

THE WITNESS: I apologize. I apologize.

Q I'm sorry. You were still going, Doctor?

THE COURT: No, he wasn't. You were in the middle of a question and the doctor started to answer when I stopped him. So please continue with did you see anything.

MR. VIGORITO: Right. Thank you, Judge.

Q Did you see anything, Doctor, in the note about him getting up off the ground and standing up and then experiencing the chest pain?

A Yes.

Q And you know that that in fact is something that Mrs. Nocera has testified to as well?

A Yes.

Q And you know that that happened sometime the day before when he was working at home, whether he was working on a car or

something else, that was really the onset of the chest pain?

A Yes.

Q And you can agree with me, I think, Doctor, that based on this consult note and based on what Mrs. Nocera said in her deposition, at least initially, that his complaint was limited to chest pain across his chest, yes?

A From what she was aware of, yes.

Q And she would be aware of it because her husband might have expressed that verbally? That's one way, right?

A Yes.

Q Or the other way would be if she made some observations of him over a period of time of where his pain was located and she gave her impression.

A Yes.

Q Like a present sense impression, right?

A Yes.

Q And at least from the day before, Doctor, whatever time it was that he was working on whatever it was, whether it's a car or something else, when he got up off the floor he had chest pain across his chest, and that was his initial complaint to the triage at Westchester Medical Center on page 1 of the Westchester Medical Center record, true?

A Yes.

Q Okay. Up until at least that point in time, which we know to be the afternoon, the early afternoon of the 18th,

right?

A Yes.

Q There is -- there has yet to be a mention at all about any type of back pain, true? Only page 1, up to page 1 of the Westchester record.

A Meaning up to page 1 or on page 1? I'm a little confused.

Q Including page 1. And you can look at page 1 again if you need to.

A I'm sorry. I'm not understanding. The reference to back pain is not on page 1. Is that what you're asking me?

Q The indication of anything other than chest pain is not in the initial triage note on page 1.

A That's correct.

Q You know that as you sit here now, you knew that when you came in today, right?

A Of course.

Q You know that there's only one mention in the entire record of back pain, right, and that's on page 2?

A Yes.

Q Okay. And that's for the first time when Mr. Nocera gives a history that the pain radiated from his chest to his neck, his jaw and his back, true?

A Yes.

Q Okay. And it's the only time, true?

A Yes.

Q And you know, Doctor, and you would agree, that the constellation of symptoms, classic for aortic dissection, are number 1, a patient with high blood pressure chronically; isn't that true?

A That's not a symptom. Chronic high blood pressure is the --

Q Doctor, it's a yes or no.

A You asked me about symptoms. It's not a symptom of dissection. One of the biggest risk factors for dissection is hypertension, but that's not a symptom of a dissection.

Q Well, Doctor, in the transcript of your testimony in the case of Jollie against St. Luke's at page 14 you said the following:

"Chest pain is the most nonspecific, nonlocalized comment a patient can make. The constellation of symptoms classic for dissection are one, a patient with high blood pressure chronically, as a -- by the way, Fred Jollie."

Do you remember saying that?

A No. That's terrible wording because that's not a symptom, that's a chronic risk factor. So I said it very poorly there. No one would consider -- hypertension is not a symptom.

Q By the way, Doctor, while we're on this particular page, did you ever testify that there were only 2,000 dissections in the states?

MS. WEISMAN: Note my objection. Asked and answered.

THE COURT: Asked and answered.

MR. VIGORITO: I don't think from this transcript, Judge.

MS. WEISMAN: Yes.

THE COURT: That transcript.

MR. VIGORITO: Okay, okay. It's all right.

THE COURT: Thank you for your approval.

Q Did you testify in the same case that it's a severely terrifying feeling to have an aortic dissection?

A Yes. It often is.

Q Did you testify that one of the symptoms is a tearing back pain of tremendous pain and it's quite traumatic for the patient?

A Yes, that's a very common symptom for it.

Q And can you and I agree that Mr. Nocera did not have a terrifying tearing back pain when he got to Westchester Medical Center? Can we at least agree on that?

A Well, I don't know if it was terrifying. The back pain wasn't well characterized, although Dr. Cuomo did testify that the pain was sharp, which is more consistent with dissection. But I agree he didn't have a dramatic severe pain that made him collapse, which is often seen in dissection.

Q Do you remember testifying in this same case, Doctor,

that other symptoms would be a sense of sweatiness, yes or no?

A Yes.

Q Shortness of breath, yes or no?

A Very commonly, yes. I mean, I don't recall that transcript but, yes, that is a common symptom.

Q A sense of dreadness or concern, yes or no?

A Yes, very -- well, I'm sorry. I agree that's a symptom. I don't recall that testimony. But I agree that is a common symptom.

Q And when asked this question: This condition for a cardiologist or an internist, is this a highly unusual condition? Your answer was it's not highly unusual because there are 2,000 cases a year. Do you remember being asked that question and giving that answer?

A No.

Q Would you like me to show it to you?

A No. I mean, if you showed it to me -- I don't recall testifying in 1991, but the real number is closer to 10 to 12 thousand. No one knows the exact number. But if I said 2,000, I don't know if that's a typo, whether I corrected it or whether or not I had an opportunity, but -- or whether that time the number was that. I don't recall from 25 years ago what I testified. But the number of aortic dissections in the United States is around 10 to 12 thousand. That's been at least for the last decade.

Q Well, Doctor, if I told you that -- and I stand by the judge's ruling, and Ms. Weisman's quite correct, it was 2,000 on page 14 -- and there you go again answering a question saying it's 2,000 on page 16. You seem to be the kind of fellow who speaks pretty clearly. You think it was a typo in that transcript?

A I don't know. Or whether the number I was lowballing then. I don't know.

Q You used the term "lowballing." In this case are you highballing the number by saying it's 10 to 12 thousand?

A No, nor does the number really matter whether it were 2,000 or 10,000. It wouldn't change the standards of care or what was found because this man was having a dissection and was easily diagnosable, but the number is --

MR. VIGORITO: Move to strike as nonresponsive to the question, Judge.

THE COURT: Overruled.

Q Doctor, if you could accommodate me with a yes or a no, that would be great. If you can't, just tell me that, as I said before, and I'll move on or I'll let you answer the question.

A Of course.

Q Okay. You didn't make it 12,000 in this case because you thought that that would sound like a more significant number and lead credence to your opinions that it should have been diagnosed because it should have been more obvious?

MS. WEISMAN: Just note my objection, your Honor.

Q Yes or no?

A No.

THE COURT: Overruled.

A Absolutely not.

Q You have testified in the past, Dr. Charash, and I've read it, I have it here, that oftentimes, if not every time, the best information that you get from a patient or a loved one with a patient is that initial triage information when they first get to the hospital. Sounds --

A Yes.

Q -- right?

A Yes, close.

Q You've said it countless times in testimonies, true?

A I don't know if it's countless, but when it comes the first information given to the earliest health care providers provides insight that sometimes you don't get from later notes.

Q Okay. And if we look at the triage note, and if --

MR. VIGORITO: Could you put that up, Ed?

Q On page 1, the history of present illness, that would serve as the first piece of information given by Mr. Nocera -- by the way, when he got to Westchester he walked in, right?

A Yes.

Q He didn't come in by ambulance, right?

A Correct.

Q Where did he come from, by the way?
A I don't recall.
Q What was he doing immediately before he came in and set foot in the ER at Westchester Medical Center?
A I don't recall.
Q Did he drive himself to Westchester Medical Center?
A I don't recall.
Q Did someone else drive him to Westchester Medical Center?
A I don't recall.
Q Did he need to be escorted or helped in any way into the ER because of the chest pain he was having?
A There's no evidence of that.
Q Did he go to work that day?
A I don't recall.
Q Did you ever know it?
A Probably. I had read Mrs. Nocera's deposition.
Q When was the first time you knew this --
THE COURT: Again. I'm not going to say it again.
MR. VIGORITO: Judge, I apologize, Judge. I'm sorry. I truly am.
Q Go ahead, Doctor, you were going to answer.
A I had read Mrs. Nocera's deposition, but I don't recall. None of those facts would have any bearing on my testimony to that.

MR. VIGORITO: Judge, now I move to arrest the answer and strike that answer because that's not responsive to my question.

THE COURT: We're going to take a five-minute recess, ladies and gentlemen. Please don't discuss the case amongst yourselves.

Doctor, you can stand down. I will ask that you not discuss your testimony --

THE WITNESS: Of course, sir.

THE COURT: -- with anyone.

(Witness excused.)

(Jury exits.)

THE COURT: Nicole, can I just hear the question and answer.

(Record read.)

(Recess taken.)

COURT OFFICER: Jury entering.

THE COURT: Jurors, you may be seated. Ladies and gentlemen, Counsel, Doctor, you may be seated. Welcome back, Jurors.

We're going to go into our last session. We may go a little past 4:30. I hope not. Just so you know, we may wind up going to a quarter to 5:00, so, but I do not want to have to bring the doctor back tomorrow for 15 minutes.

So, that being said, you'll recall that when we

took our recess, Mr. Vigorito was still conducting his cross-examination of Dr. Charash, which we will continue.

Let the record reflect that Dr. Charash has retaken the stand. Doctor, again, I remind you you are still under oath or affirmation.

THE WITNESS: Thank you, sir.

Q Dr. Charash, before we look --

THE COURT: Excuse me. There was an objection. There was an application to strike the doctor's testimony. I have reheard it. Under the circumstances, overruled.

MR. VIGORITO: Okay.

CROSS-EXAMINATION (Cont'd)

BY MR. VIGORITO:

Q Doctor, before we take a look at the highlighted triage note, in light of the testimony that you've given so far, the onset of the aortic dissection, in your opinion was the onset of the pain from the day before?

A That's the first tearing of the aorta, but it's a stuttering process.

Q Right.

A Where you get muscle tears.

Q And if there's no pain, if there's a significant period of no pain, would you be of the opinion that the tearing has subsided, at least during that period of time?

A No, that --

Q Just a yes or no.
A Well --
Q Is it a no?
A I can't answer the question the way you phrase it, limited --
Q Okay.
A -- to a simple yes, no.
Q All right. You realize that there may be an opportunity for counsel to ask you more questions on something called redirect; you know that, right?
A Yes.
Q Okay. So if the pain is continuing from the onset of the pain, does that mean that there's a continuing tearing process going on?
A No.
Q Just a yes or no.
A No, that doesn't mean that, no.
Q But the initial complaint of chest pain in your mind, at least your opinion, is that that's when the aortic dissection begins to tear?
A That was the initial tear.
Q And if there is continuous pain over the next, whatever, 12 hours, that's not an indication of the tear ongoing and continuing? Just a yes or no.
A No.

Q But when the pain stops and there's a significant period of time, five or six hours or more, of non-pain, that's not a sign that the tearing has stopped either, true?

A I cannot answer the question the way you phrase it --

Q Okay.

A -- limited to a simple yes, no.

Q Let's take a look at -- and if you can follow either up there, if you can see it, or on your page, this is the initial note, the first thing that Mr. Nocera said when he got to Westchester Medical Center, right?

A Yes.

Q Chief complaint, patient complaining of mid-chest pain --

A Moderate. Oh, mid-chest pain.

Q Mid-chest pain starting yesterday. Primary triage dysphagia. Patient complains of moderate chest pain that began yesterday. The symptoms are constant. Let me stop there for a second.

The fact that it started yesterday and the symptoms are constant, are you not of the opinion that the tearing was continual up to the moment he said those words? Yes or no, Doctor.

A I cannot answer the question the way you phrase, the way you limit it to a simple yes, no.

Q That's fair enough. That's your answer.

The patient describes the pain as a five dash ten. The pain is described as squeezing. So that word squeezing, that's a word that Mr. Nocera chose. You would ascribe to that, right?

A Yes, I would.

Q Okay. That's not the same adjective as tearing?

A I agree.

Q So when he first comes in he's not complaining of any back pain whatsoever, to triage?

A He's not reporting it in his initial statement.

Q Right. But you and I have already agreed these initial statements the patient say are critically important because it's the first thing the patient tells somebody what they've been feeling for the past half a day or day now. This has been going on for quite some time, right?

A No, right, it's very important what he says when he first comes in, but obviously anything reported later has to be considered equally valid.

Q All right.

A The point is you might -- if you don't read these notes, you might miss something.

Q Okay. You're right. So let's read the very next note. The pain is located in the mid-sternal area. Can you demonstrate where that would be on you?

A Right under the breastbone.

Q Okay. That's where he's saying he's feeling the pain,

right?

A Yes.

Q That's important, right?

A Yes, it is.

Q Okay. That's not radiating to the back yet, right?

A It's not being reported as radiating to the back yet.

Q Okay. He then reports the pain radiates to his left shoulder, his neck and his left jaw. All comes from Mr. Nocera, right?

A Right. We don't know whether those were prompted by questions or not.

Q Right.

A Because it's not all in a quotation mark that the patient came in saying I have the following.

Q Right. Now, this note tells us how he got there that day, right?

A I don't understand what you mean.

Q It says, arrival, patient arrived ambulatory via automobile from home.

A Yes.

Q Do you know if that's accurate as you sit here right now?

A I don't recall.

Q Do you know if there is an alternative fact pattern as to where he arrived from that day?

A No.

Q Would you think and ascribe to the notion that where he arrived from and how he got to the hospital was told to somebody by himself, by Mr. Nocera?

A I'm sorry, I don't understand what you're saying.

Q Sure. Bad question. Let me rephrase it.

Where it says arrival, the patient arrived ambulatory via automobile from home, the patient was accompanied by, colon, immediate family member, would you think that that came from Mr. Nocera, that information?

A Presumably.

Q ABCs, what does ABC stand for, Doctor?

A Airway, breathing, circulation.

Q Okay. And the nurse wrote there the airway is open and patent. Breathing is spontaneous and nonlabored. Radial pulse is equal and normal bilaterally. Those are normal findings, true?

A Yes.

Q LOC, what does that stands for, Doctor?

A I'm not sure what that acronym means here.

Q Okay. The patient is awake, alert with a calm affect. Would you agree with me that patients in the throws of an aortic dissection rarely have a calm affect? Just yes or no.

A I think most have a calm affect. They might be in pain but their affect is often calm. It depends on the patient's

threshold for pain.

Q The patient is oriented to place and time. Skin color, the patient's skin is normal for age and race. The skin is warm and dry, has good turgor. What does that mean, turgor?

A Turgor means the fluid content of the skin if you pinch it, how long it rises and whether or not you feel there's adequate fluid in the tissue.

Q Now, it tells us who the historian is for this entire note because they have a category on this that says historian, colon, the patient is the historian, so we know it comes from Gary Nocera?

A Yes.

Q And now we have some nursing documentation below that, and if you could roll that up and highlight nursing documentation.

He's got a blood pressure, a heart rate, and an O2 saturation monitor or probe in place. And under general, his level of consciousness is age appropriate. And now at 12:46 p.m. on the date of arrival, September 18th, he verbalizes or demonstrates a symptom of pain. The pain is acute, new onset. They use a numerical scale, and his pain level or his pain at that moment at 12:46 is a four, and his pain is a six on average. And the goal was to get it to zero. And then they have these categories behavioral indicator of pain. It says positive vocal expression. So he's speaking, telling the nurse?

A Yes.

Q Okay. Description of pain, positive pressure. Location of pain, chest radiating to his neck. True?

A Yes.

Q Still no mention on page 1, I think it's the end of page 1, there's no mention of it radiating to his back?

A Correct.

Q He certainly didn't present with that as an initial complaint which typifies a patient in the throws of an aortic dissection; you would agree?

A Well, I can't answer that as yes or no. Back pain is a typical finding --

Q Okay.

A -- of a dissection.

Q Neurologic, the patient's neurologic assessment shows no acute neurologic issues. His respirations are relaxed and unlabored.

Do you normally find relaxed unlabored respiration in a 57-year-old man who's having an aortic dissection? Yes or no?

A It depends on how much pain he's in and how he tolerates pain. Usually respirations go up because of pain. Some people respond differently than others.

Q Doctor, before we switch over to the next page, earlier today when you testified on direct examination about the frequency with which you've had some experience with aortic

dissection patients, you were talking about your treatment of patients who had aortic dissections, I take it?

A Yes.

Q The treatment of those patients is not the same as the diagnosis of those patients; you and I can agree on that, right?

A Yes.

Q So all the answers that you gave this morning on direct to Ms. Weisman related to you coming in after the dissection was diagnosed and rendering some level of treatment, whatever it was, aftercare treatment or management of the patient, true?

A Yes.

Q Okay. Let's go to page 2. So, Doctor, at the very top -- this is a continued rundown of physical findings by the nurse -- it starts with ears, and he denies auditory disturbances. Nose, there's no discharge, no deformity. Mouth seems to be normal. And then neck.

So let's read this one. Neck is free of surface trauma, no markings on the neck that would lead the nurse to suspect that he sustained any type of trauma, right?

A Correct.

Q Scars or enlarged areas, no tenderness noted. The trachea is midline. That's a normal finding, right?

A Yes.

Q No jugular vein distension. Other, chest pain three dash six slash ten radiates to throat and back. Denies nausea,

dizziness or diaphoresis. No shortness of breath or palpitations. Tell us what diaphoresis is.

A Sweatiness.

Q Okay. SOB is shortness of breath, right?

A Yes.

Q Okay. Now, this note does say radiates to throat and back. And this is the first time in the chart that we see an indication of a radiation to the back, right?

A Correct.

Q And do you know, as you sit here now, whether we're going to see any other note in this entire chart until he's discharged at around 7:30 that indicates he ever experienced a radiation to the back again?

A No, that's the only location.

Q They examine his abdomen, his pelvis, his arms, his legs, his skin, and they don't find anything unusual, true?

A Correct.

Q And then they go down to pain assessment, and the pain score now is a five because this is something that's constantly being monitored by the nurses, right, they want to know from the patient how you're feeling now, right?

A Yes.

Q Okay. And the goal is to get it down to a two because that would be, you know, a pretty low score and he'd be feeling better, right?

A Yes.

Q And the score acceptable to the patient, he says, or at least you would think this is coming from the patient, the pain score is acceptable to the patient. And that would refer to the five, right? He's not uncomfortable even with five out of ten pain?

A Well, it just means --

Q Is that your read of it?

A -- that he's able to handle five out of ten pain.

Q Okay. We go down into history. We see the meds that he's getting for his gastroesophageal reflux is Nexium. Okay, so we did have that. I remembered this morning you weren't sure what it was, right?

A Correct.

Q He has no surgical history or past surgical history, no past surgeries. Was that accurate, do you think? You read some of his records.

A He had a hernia problem at one point. I don't recall if he had surgery for it.

Q Okay. He had a vasectomy at one point, hernia surgery at one point, right?

A Yeah.

Q Now we get down to vital signs at the bottom of the page.

MR. VIGORITO: Ed, if you could highlight that

block for me.

Q So at 12:34, very soon after he arrives on the 18th, he's got a pulse of 76, respiratory rate of 18, systolic is 143, diastolic is 57. I'm not talking to you now about pulse pressure at all, but just in general there's 143 over 57. Is that considered a high blood pressure?

A It's a high systolic and low diastolic.

Q Okay. And a little while ago I read to you from a past transcript where you said one of the symptoms was, I think -- and correct me if I'm wrong -- of an aortic dissection would be a sustained high blood pressure, right?

A One -- again, since I obviously use the word symptom, which is a poor word, hypertension has two roles. Chronic hypertension significantly predisposes for a dissection, one of the reasons for it. The other is if a person has an acute dissection they can be either hypertensive, hypotensive or normal. But if somebody has a hypertensive crisis coming in, that would add to the concern for dissection.

Q So, Doctor, if he had a pain level of five when he came in, and there it is recorded at 12:34, and you believe he had the beginnings of an aortic dissection the day before when he first felt the pain at 12:34, a pain score of five and a report to the nurse of constant chest pain, do you have an opinion, with a reasonable degree of medical certainty, is he still dissecting at that time?

A I cannot answer the question the way you phrase it --

Q Okay.

A -- limited to a simple yes/no format.

Q That's the answer. That's fine.

When his pain scale score goes to zero at 1:29 p.m., is he dissecting at that time, within a reasonable degree of medical certainty?

A He's not --

Q Yes or no?

A He's not tearing at that moment.

Q Okay. And you can say that because it's a zero pain scale; is that the primary reason? Because what else has really changed here?

A When you have a dissection, when you get a tear, it doesn't just hurt the moment it tears but the pain carries on. It's like being hit in the shoulder with a baseball bat. The bat might be finished, but you might feel pain for several hours.

Dissections typically have an initial pain which then takes time to resolve. If someone goes down to zero pain, that means that they're not tearing that moment and they haven't torn since the last time they tore. When pain comes back from zero to five, that generally indicates another episode of tearing, and that pain could last for hours.

So the point is that at the time you're zero pain, it

means that you're not tearing at that moment, nor are you on the tail end of the pain from your last tear. So people have two or three tears in a row, you could have pain, it could drift down possibly to zero, and then you get another tear and your pain will be there and eventually drift down, but it could keep tearing and keep recurring. So it just depends. But the pain can last for multiple hours after a tear.

Q Doctor, that initial systolic and diastolic 143 over 57, looking at the case in a vacuum with just chest pain and that blood pressure reading, are you of the opinion that that warranted the performance of a CAT scan? Just a yes or no.

A No.

Q Had Mr. Nocera received -- withdrawn.

Would the administration of any type of pain medication necessarily have any effect on the pain emanating from an aortic dissection?

A Well, anti-inflammatories like Motrin can help the pain, but it wouldn't be very rapid. Like any physical pain, it takes time. Narcotics would have an immediate effect.

Q So if Mr. Nocera had been given Motrin at or around 12:34, hypothetically, some period of time thereafter it might have a saltatory effect on his pain level?

A It might. It helps all pain, but generally it's a mild remedy. But it's also an anti-inflammatory, and tearing is inflammatory. So it could help, just like a shoulder if you

were hit with a baseball bat, it might help.

Q Sure. Are you of the opinion in this case, having reviewed it in the last six months, that the administration of any pain medication contributed to the reduction of his pain to a zero at 1:29 p.m.?

A It would be difficult.

MS. WEISMAN: Let me object. I don't think we have a timeframe as to when the Motrin was given. That's not what the evidence states.

MR. VIGORITO: Judge, that's interrupting my cross and trying to suggest an answer to a witness, quite frankly, and highly inappropriate.

THE COURT: Is there a question pending?

MR. VIGORITO: There was, and it was interrupted by the objection.

THE COURT: Answer the question, Doctor.

A Certainly. Motrin, whether it was given or not, would not act that rapidly in reducing pain from a dissection. There would be no reasonable way that Motrin would help any pain that rapidly, so any reduction that takes place in less than one hour would be its own resolution, not any pharmacological therapy. The only thing that would work that rapidly is a narcotic, which he did not get.

Q Do you know, since it's now been brought up, do you know when Mr. Nocera received Motrin in this case?

A I don't remember the exact time, but it was at some point in that afternoon.

Q Do you know if he received it before or after his 1:29 p.m. pain scale score of zero?

A I have to look. I mean, I don't recall the exact time. But I never factored the Motrin as being the reason for his pain relief.

Q Do you know if he received it before or after the pain scale score of zero at 3:12 p.m.?

A I'll have to look and see what time it was administered, which is right here, so give me a moment.

Q Sure.

THE COURT: Counsel, approach.

(Sidebar held off the record.)

A I am unable to find the time the Motrin was given on a quick review of these records.

Q I'm sorry, Doctor, you couldn't find it?

A I'm unable to determine the time based on the records I have here.

Q Okay. I'd like you to accept we've established, I think, in this case it was ordered around 4:00 p.m., given around that time. So in terms of the 1:29, the 3:12 and even the 4:32, if it was given at -- if it was given at 4 o'clock, the 1632 would be 4:32, you wouldn't think the Motrin would have a contributory effect of his pain going to zero?

A I agree it couldn't possibly even if it were given when he came in.

Q Doctor, I asked you this morning -- I know you said you hadn't reviewed the records of Biffer Chiropractic. Over the lunch break did you have a chance to look at those records?

A No.

Q Do you know if those records, which are in evidence, indicate that Mr. Nocera had a history of back pain?

A No.

Q Doctor, on this page, nursing procedures under comfort measures, about four lines down, the patient was informed of status. The patient was given a warm blanket. Explanation of wait provided to patient. A TV was provided for the patient. The patient was repositioned to a position of comfort. That's all noted at 12:49.

And then on the plan of care, plan of care discussed with the patient. Care plan includes universal precautions. Call bell in reach. Input outpatient, observe, reassure and position of comfort. He's being monitored with an automatic blood pressure cuff. There's a cardiac monitor and a pulse ox that's measuring his oxygenation level, right?

A Yes.

Q Okay. EKG was completed, right?

A Yes.

Q And that was normal, you read that?

A Yes.

Q You looked at the actual EKG printout?

A Yes.

Q And you found it to be satisfactory?

A Yes.

Q That, combined with the normal cardiac enzymes, the troponins that do ultimately come back, that would be reassuring to the clinicians, like Dr. Cuomo and Dr. Bernstein, that this gentleman was not having an acute coronary syndrome?

A Not having a heart attack. It couldn't completely exclude an acute coronary syndrome.

Q Now, I want to go down to nurse's progress note where it says notes. Patient sitting upright on stretcher. No complaints offered. Patient's wife at bedside. And that was entered at 3:14 p.m. So that's pretty much an hour before he ever got the Motrin for the first and only time. You see that note, right?

A Yes.

Q Would that kind of information, would that be reassuring to the doctors as well that his pain is now subsided, it's been a zero, it's not radiating anymore, he doesn't have any pain at all, if they were thinking of acute coronary syndrome, it's kind of now been lessened on the scale of differential diagnosis?

A I can't agree with that statement. It's better to be

pain free, but it doesn't provide you insight as to what the diagnosis is because acute coronary syndrome, pulmonary embolism or dissection are well-known to have pain-free intervals. But of course it's better to be pain free.

Q And Doctor, you talked a little bit about the fact that a chest x-ray was done, right?

A Yes.

Q And it was a portable chest x-ray?

A Yes.

Q And were you provided with the x-ray?

A Yes.

Q How -- what format did you get the x-ray in?

A As an actual film.

Q A flat film?

A Yes.

Q Not a disc?

A No.

Q Did you bring that with you today?

A No.

Q Where is it now?

A Ms. Weisman gave it to me and took it.

Q And you have some familiarity with looking at chest x-rays, although you're not a radiologist, right?

A Correct.

Q On Friday we had Dr. Diane Sixsmith, a board-certified

emergency room doctor, tell us that she would defer the reading of that x-ray to a board-certified radiologist. So I'll ask you the same question, would you defer to the reading by a board-certified radiologist as to what that film shows?

A I can't answer the question the way you phrase it limited to a simple yes, no. I will --

Q Okay. That's your answer.

A Okay, yes.

Q You don't have to go any further.

Would you defer to a board-certified radiologist as to his or her opinion of the quality of that film? Just a yes or a no.

A I can't answer the question the way you phrase it limited to a simple yes, no.

Q Would you defer to a board-certified radiologist working in a hospital setting as to what should or should not have been done as a result of the read of that chest x-ray? Just a yes or a no.

A That's a clinical decision, not a radiology decision.

Q But would you defer to the opinion of a radiologist?

A No.

Q And do you sometimes see radiologists write in their reports clinical correlation needed or warranted or recommended?

A Yes, frequently.

Q So those are radiologists making a recommendation, at

least a limited recommendation, as to what should be done, what follow-up might be necessary?

A Well, when they say clinical correlation, they're saying it's up to the clinician to correlate it, which is always understood.

Q Was that included in this radiology report, if you know without looking at it?

A I don't recall.

Q Do you remember testifying in the Jollie case, Doctor, that you suspect an aortic dissection when a patient appears in an emergency room who is a chronic hypertensive, whose chief complaint includes a significant portion of their problem being back pain, and I didn't mention this before, classically when they come to the emergency room initially their blood pressure is usually higher than usual? Did you say that in the Jollie case? Just a yes or no.

A Yes.

Q Did you further say in the Jollie case that the diagnosis at that point was a constellation of symptoms, mainly his back pain, shortness of breath and ultra high blood pressure in a patient who has been chronically hypertensive that is a signal for dissection? Did you say that, yes or no, in that case those were the signals, yes? Are you remembering the Jollie case now?

A Well, the language --

Q Just a yes or no, Doctor. Are you remembering the Jollie case now that I've read you significant statements that you've made from that case? Just a yes or no.

A No, but the tense by which you --

Q You've answered the question, Doctor. Thank you.

Did you also say in the Jollie case that back pain in a hypertensive, that's a red flag, it has to be a red flag? Did you say that, yes or no?

A I'm certain I did.

Q Did you also say in the Jollie case in 1992 that what you want to do in these cases is lower their blood pressure, the whole essence of treating dissection is right away to lower the blood pressure? Did you say that, yes or no?

A Well, if it's elevated, yes.

Q And did you say in the Jollie case at page 143:

"Question: And not just severe pain, but excruciating pain; is that true?

Answer: In some patients it's extremely excruciating."

Did you say that, yes or no?

A I'm certain if you're reading it.

Q Did Mr. Nocera give the fellow that came in for the cardiac consultation information that he felt the pain for the first time when he got up off the floor? Did he say that?

A Yes.

Q After he was working on something?

A Yeah.
Q Did he say that?
A Yes.
Q You looked at the autopsy report you told us earlier --
A Yes.
Q -- right?
There's no sign in that autopsy report of any problem with the valve, true?
A True.
Q Now, I want to talk about murmur. You know that there are two different kinds of murmurs: There is systolic ejection murmur and diastolic ejection murmur, and that in medical literature, taught in every medical school in this country, it's the diastolic murmur, not the systolic murmur, that is linked to aortic dissection occurrence. You know that, don't you, Dr. Charash?
A No.
Q Yes or no, Doctor?
Doctor, I'd like you to answer it any --
THE COURT: Mr. Vigorito.
MR. VIGORITO: Yes.
THE COURT: The doctor is trying to.
MR. VIGORITO: It's a yes or no, quite simple.
THE COURT: I understand that. I'll allow the doctor to answer. Go ahead, Doctor.

A I cannot answer the question the way you phrase it limited to a simple yes, no.

Q Doctor, systolic ejection murmurs are simply not linked to aortic dissection, true?

A No, where there's aortic regurgitation --

Q It's true or false.

A -- it's --

Q Not no and then answer.

A Systolic murmurs are --

Q Doctor, please.

MR. VIGORITO: Judge.

THE COURT: Let's move on.

MR. VIGORITO: I'm trying to.

THE COURT: Keep trying.

Q Was there ever a finding of a diastolic ejection murmur in this case?

A They're not called ejection murmurs, but no one reported a diastolic murmur, which are harder to hear.

Q And you said to us earlier today that a three out of six is on the grade scale is what, you said, slightly louder or slightly more prominent than what?

A Most people who have a mundane ejection murmur are one or two out of six. Three out of six is a little bit more prominent, and because it is new and because systolic murmurs are often the first audible finding of acute aortic

regurgitation, that would be a red flag that needs resolution.

Q Did Mr. Nocera express the desire to leave the emergency department and go home?

A I would hope so.

Q Did he feel well enough to express that he -- he didn't think that he needed to stay there overnight and wanted to go home? Do you know?

A I don't know offhand, but, I mean, he's not making a diagnosis. If his pain had gone down to zero I wouldn't blame him. I don't know if anyone asked him when his pain went back up to five.

Q Doctor, was he given any discharge instructions?

A I'm certain of it. I've seen them, but there were a lot of pages of discharge instructions.

Q Well, whether there were a lot of pages or a little amount of pages, did you read those pages as carefully as you seemingly read the rest of this chart? Yes or no?

A Yes.

Q Did you take note of the fact when you read those pages so carefully that they were telling Mr. Nocera that if you have any increase in pain, new onset of pain, chest pain, because we really are not sure at this stage what was causing your chest pain, we think it might have been musculoskeletal, that you should return to an emergency department or to a physician? Did you read that?

A Yes.

Q Are you -- withdrawn.

Do you ascribe to the belief that Mr. Nocera was in pain, had chest pain for the next two full days after he left the emergency room? Do you ascribe to that?

A I ascribe that he had pain over those two days. No one knows what the real pattern was.

Q Do you know what he did over the next two days?

A Not by memory.

Q Did you see it anywhere in any of the records or testimony thus far what he did over the next 48 hours?

A I said not by memory.

Q Do you know if he went home and sat in his easy chair and watched TV?

A I said I don't remember.

Q So you wouldn't be able to answer the question at all?

A That's what I'm saying.

Q And if he had chest pain and it was increasing, and he had instructions that he signed off on at the hospital to return to the hospital, would you be of the opinion that by not returning to seek medical treatment Mr. Nocera may have contributed to his own demise?

A I would --

Q In that respect, just a yes or no.

A -- I would entirely blame the hospital for that. If

somebody --

Q Doctor, it was a yes or no. It wasn't an explanation.

A No, the hospital would be entirely at fault.

MR. VIGORITO: I have no further questions.

THE COURT: Mr. Venditto?

MR. VENDITTO: Thank you, Judge.

CROSS-EXAMINATION

BY MR. VENDITTO:

Q Good afternoon.

A Good afternoon, sir.

Q My name is Anthony Venditto. I'm with the law firm of Furman Kornfeld & Brennan, and I represent Dr. Bernstein.

Doctor, you and I have never met before; isn't that true?

A Yes.

Q And would I be correct, Doctor, that you have testified at trial in New York on approximately how many occasions? You tell me.

A In trial in New York State?

Q Yes.

A Forty, 50 times.

Q Okay. And you would agree with me that the instruction that counsel usually gives during cross-examination to a witness is for the witness to answer the questions either yes or no, and if he or she can't do it to let the attorney know. You've heard

that numerous times, true?

A Yes.

Q And you can do that for me right now?

A Yes.

Q Okay. You know, as a result of being an expert witness, that, thanks to the hard work of court stenographers, we get transcripts of the testimony, true?

A Yes.

Q You have been cross-examined by other defense lawyers in malpractice cases with the use of your prior testimony, true?

A On occasion, yes.

Q Would we say -- when we say on occasion in the number of trials that you've testified in this state in medical malpractice cases, would you agree with me that in each and every one of those cases you were cross-examined with prior testimony?

A No, I wouldn't say in each case.

Q Would you say 90 percent?

A I would say probably over 50, but not 90.

Q Do you know how many transcripts exist concerning your prior testimony as an expert, just in this state?

A No.

Q Do you know how many transcripts exist in other states, whether it be depositions or trials?

A Not exactly, no.

Q Would I be correct, Doctor, that because you know that there are transcripts with your prior testimony that you phrase your answers in such a way to prevent defense attorneys from confronting you with what you have said before; isn't that true?

A No.

Q You are a cardiologist, correct?

A Yes.

Q You are affiliated with Lenox Hill Hospital?

A Yes.

Q Can you tell the members of our jury how many other cardiologists are affiliated with Lenox Hill Hospital?

A I don't know the exact number.

Q Give me an approximate.

A Forty.

Q How many are affiliated with Montefiore Medical Center?

A I don't know.

Q How about Northwell?

A Northwell is a giant network. I don't know. There must be hundreds.

Q You would agree they have cardiologists, correct?

A Of course.

Q How about Montefiore, do you know?

A I don't know the number for Montefiore.

Q Albert Einstein?

A I don't know the number of any other institution.

Q How many in the State of New York? How many board-certified cardiologists exist in the State of New York?

A I don't know.

Q More than 100?

A Obviously.

Q More than 500?

A I would think so. I think it would be in the thousands, but I don't know the number.

Q In the states that you have offered expert opinion as a cardiologist, in those particular states, can we agree that there are board-certified, licensed cardiologists who actually work in those states?

A Yes.

Q Who actually treat patients in those states?

A Yes.

Q Aside from testifying against physicians, can we agree, Doctor, that you've offered negative comments, departures against nurses, true?

A Yes.

Q And before offering a negative opinion against a nurse, Doctor, while you were at Lenox Hill Hospital did you ever go to the department of nursing and say, you know, before I criticize a nurse, let me shadow a nurse for a day and see what it is that he or she does? Did you ever do that?

A I did more than that, I did peer review of the nurses.

I wrote up --

Q I asked you if you shadowed a nurse in doing her or his exact job. Yes or no?

A Every day in the cardiac care unit, all the nurses I followed.

Q You shadowed them?

A Yes.

Q Now, you have an office you told us that's part of your home, correct?

A Yes.

Q And that's in a residential building in Manhattan, true?

A Yes.

Q And do you have a receptionist that works at your office?

A Yes.

Q And do you have an examination room?

A Yes.

Q Do you have an EKG machine?

A Yes.

Q And this is all on the 16th floor?

A Yes.

Q And do you have those little boxes outside your office where people put samples, whether it be blood tests and the like?

A No, I send them to Lenox Hill for blood.
Q That's a co-op, correct, that you live in?
A Yes.
Q Do you have board approval to operate an office out of your apartment?
MS. WEISMAN: I'm going to object, your Honor.
THE COURT: Sustained.
Q You were questioned about your fee in medical malpractice cases as an expert witness, true?
A Yes.
Q We can agree also, Doctor, can we not, that this certainly was not the first time you were questioned about how much money you have made as an expert witness, true?
A Correct.
Q And we are here in the month of February 2018, correct me if I'm wrong, federal and state tax would be due April 15th of this year, correct?
A Well, I'm filing it October. I have an extension.
Q Okay. Are you aware, as you sit here right now, how much money you made last year as a result of being an expert witness?
A Not exactly.
Q You have an accountant who does your taxes?
A Yes.
Q And you knew you were going to be questioned about how

much you make, you get questioned about it all the time, true?

A Not all the time, but frequently.

Q Isn't it true, Doctor, that you were once questioned at a deposition to give the name of your accountant, correct?

A Yes.

Q And you refused to do so, correct?

A I said that if the judge asked me I would, but I've had people harassed in my life, and that's not fair to them.

Q I'm not asking about harassment. I'm just asking have you been asked to find out from your accountant how much money you have made as an expert witness. True?

A I can tell you how much I made on a year after taxes are filed.

Q So how much did you make last year?

A I haven't gotten all my W-9 forms. I haven't calculated. I can tell you --

Q How much did you make the year before?

A In medical-legal work?

Q Correct.

A $72,000.

Q 72,000?

A Yes. More -- I mean, roughly. Well, I mean 72,800. I don't know what the exact amount was.

Q And that would be for calendar year what, Doctor?

A 2016.

Q Now, when you're testifying here in court, you can't see patients back at your apartment, true?

A Correct.

Q And when you're meeting with lawyers to go over the materials to prepare, you can't be seeing your patients and treating them, correct?

A Well, I try and have my meetings at night. And most of my trials are vacation days.

Q Okay. So you scheduled your vacation day trial -- I'm sorry, you scheduled today as a vacation day, correct?

A Correct.

Q Who do you work for?

A Myself.

Q So really scheduling a vacation day is really irrelevant, because who do you -- what do you do, you call up yourself and say I'm not coming to work today?

MS. WEISMAN: Objection.

THE COURT: Sustained.

A I just don't take off vacation days.

MR. VENDITTO: I'll withdraw it, Judge. I'll withdraw it, Judge. My apologies, Judge. I'll withdraw that. I need a moment, Judge.

THE COURT: You need one or you're having one?

MR. VENDITTO: No, I'm not having one yet. We haven't begun, Judge.

Q When you received the materials in this case you reviewed, in what order? What items?

A I'm not sure I understand. I think I would have looked at the Westchester Medical Center chart first.

Q Okay. What else did you review?

A Well, I got pretty much everything altogether, the autopsy report, the admission to Hudson Valley when he came in after his cardiac arrest, previous Hudson Valley admissions, transcripts of the two defendant physicians and Mrs. Nocera.

Q Are you aware that a nurse gave deposition testimony in this case, Doctor?

A I never saw it.

Q I'm not asking you if you saw it --

A Unaware of it.

Q Doctor, if you were aware of it would that have been something you would have wanted to have read prior to coming here and offering opinions?

A If it had any new information, yes.

Q Well, you don't know if it has new information or not unless you review it, true?

A But I didn't know it existed.

Q We're going around in circles here, correct?

A I'm just --

Q I'm asking you to assume that a nurse gave deposition testimony in this case, okay? Had you been informed of that

would you have said I want to read this testimony, yes or no?

A I would first ask whether it -- whether it discussed anything that was not available on the chart. And if there was information that was not available on the chart, yes.

Q Let me see if I understand you correctly, and just correct me if I'm wrong, you would ask a plaintiff's lawyer to tell you whether there was information that a nurse testified to that was significant or not? Would you rely on the lawyer rather than yourself?

A No, I said --

MS. WEISMAN: Note my objection. That's not what his answer was.

A There was information beyond what was written in the chart.

Q And you wanted to read it for yourself rather than rely upon the lawyer, yes or no?

A I can't answer the question the way you phrase it limited to a simple yes, no.

MR. VENDITTO: Nothing further, Judge. Thank you.

THE COURT: Ms. Weisman?

MS. WEISMAN: In the interest of letting everybody go, I have no questions.

THE COURT: Your courtesy, I'm sure, is greatly appreciated by everybody. However, the time is not a preclusion for you to extend a redirect if you deem

appropriate or necessary.

MS. WEISMAN: Okay. Thank you, your Honor. I don't think it's necessary.

THE COURT: Okay. Doctor, you can step down, with the thanks of the Court.

THE WITNESS: Thank you.

(Witness excused.)

THE COURT: Well, ladies and gentlemen, that concludes our session for the day. I want to thank you for your patience; it's been a long day. And as you can see when we do have medical experts on the stand, as we did with Dr. Sixsmith and Dr. Charash, and I'm sure when we put the other experts on for Mr. Vigorito, it gets to be a vigorous and rigorous day, and you guys have been great. And I will thank you on behalf of the parties as well as counsel. There isn't one moment that I haven't seen any of you not paying attention, and we are all gracious and thankful for that. The service can't be done without you and your assistance, and your cooperation is greatly appreciated by the Court and others.

So, tomorrow half day 9:30 to 12:30. I'd like you up at 20 after 9:00, and we will take the box promptly with, I will gather, a continuation of Mrs. Nocera.

MS. WEISMAN: I think so.

THE COURT: Barring any unforeseen circumstances.

So get home safely. Have a wonderful evening. Please don't discuss the case amongst yourselves or with anybody else. We'll see you tomorrow morning.

(Proceedings so concluded.)

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THIS IS TO CERTIFY THAT THE ABOVE TRANSCRIPT IS A TRUE AND ACCURATE TRANSCRIPTION OF MY STENOGRAPHIC NOTES.

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Nicole Ameneiros
Senior Court Reporter

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