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VIRGINIA: IN THE CIRCUIT COURT
FOR THE CITY OF NEWPORT NEWS

CASSANDRA M. AGARD, : AT LAW NO.: 09-00233-DP
:
Plaintiff :
:
vs. :
:
CHARLIE M. FAULK, M.D., :
:
Defendant :

VIDEOTAPED DEPOSITION OF
HARRY REICH, M.D.

Taken at The Woodlands Inn, 1073 Highway 315, Wilkes-Barre, Pennsylvania 18702, on Tuesday, March 23, 2010, commencing at 4:28 p.m., before Trisha Sims, Certified Shorthand Reporter and Notary Public, and Frank Jason, Videographer.

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APPEARANCES:

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ALSO PRESENT:
Frank Jason, Videographer

* * *

THE VIDEOGRAPHER: This is tape number one of the videotaped deposition of Dr. Harry Reich in the matter of Agard versus Faulk. This deposition is being held at The Woodlands, 1073 Highway 315, Wilkes-Barre, Pennsylvania, on March 23, 2010. The approximate time is 4:28 p.m. My name is Frank Jason, and I am the videographer. The court reporter is Trisha Sims. Counsel, will you please introduce yourself and affiliation, and the witness will be sworn.

MR. LEWIS: My name is Jim Lewis. I represent Sandy Agard.

MR. FAVALORO: My name is Mark Favaloro, and I represent the defendant, Dr. Charlie M. Faulk, M.D.

* * *

HARRY REICH, M.D., having been duly sworn or affirmed, was examined and testified as follows:

EXAMINATION

BY MR. FAVALORO:

Q. Good afternoon, again, Dr. Reich. We just

met. My name is Mark Favaloro. Again, I'm representing Dr. Faulk in this deposition, and I have reviewed some past deposition of yours. So I am aware that you have been deposed in the past; and you are familiar with the procedure of a deposition and the purpose of it, I assume.

A. Yes.

Q. Can you tell me how many deposition you have given in your career as an expert witness?

A. Approximately 20.

Q. Okay. And do you remember the date of your first expert witness deposition?

A. It would probably have been around 1980.

Q. Okay. And before today, the date of your last?

A. I'm not sure of the date. It was probably about two months ago.

Q. And what kind of case was that?

A. That was a case involving a bowel injury.

Q. Bowel injury? Have you ever given a deposition in connection with a uretal injury?

A. Yes.

Q. And how many, if you recall?

A. Approximately five. I mean, I could look through the records and send them to you, if that would be helpful, but I don't remember exactly.

Q. Do you have records that would indicate when those occurred and the actual transcripts of those depositions?

A. I don't have any transcripts; but I do have, I think, the last one. Actually, the last one was October or November; and that would have been in Stroudsburg, Pennsylvania, at a trial.

Q. You said October or November of 2009?

A. 2009, yes.

Q. Okay. Who were the attorneys involved in that case?

A. The attorney -- the firm was Dougherty, and I'm trying to think of the case exactly. I don't recall.

Q. Dougherty represented the plaintiff?

A. Dougherty's firm, which is a local firm here, represented the plaintiff, yes.

Q. Okay. And do you recall the years or any specifics about the other four cases in which you gave testimony regarding a uretal injury?

A. No.

Q. Do you remember the years?

A. No.

Q. Do you remember whether you gave testimony on behalf of the plaintiff or the defendant?

A. It probably was for the defendant -- well, I'm not sure. I would have to look up -- I'm not even sure of the exact number of ureter cases.

Q. But you think it was approximately five?

A. Approximately. That may even be less.

Q. Okay. You've indicated that you have given 20 depositions as a -- as an expert witness. Can you give me a breakdown of those depositions, whether you were testifying on behalf of the plaintiff or the defendant, in a percentage manner?
A. Yes, because I looked it up this afternoon and anticipated the question; and I've done approximately 10 cases for the plaintiff and approximately 20 for the doctor.
Q. Okay. So that's 30 cases that you've been involved in?
A. Yes.
Q. And of those 30 cases, it's your memory that you gave 20 depositions?
A. Again, approximately. I'm not sure of the exact number. I just looked through the cases in my computer.
Q. Do you remember how many cases you testified at trial?
A. I believe approximately 10.
Q. And what about the percentage breakdown of

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those cases?
A. I would think it's 50/50.
Q. Okay. And, again, your memory is the last trial testimony you gave was October of last year in a uretal case?
A. October or November in Stroudsburg; court.
Q. Was that Superior or Circuit Court? Do you know?
A. I'm not sure.
Q. I don't know what it is in Pennsylvania.
A. I mean, again, like I said, I could easily give Attorney Lewis --
Q. If you would, please, I would appreciate that.
A. Okay.
MR. LEWIS: What exactly do you want?
MR. FAVALORO: Just the style.
MR. LEWIS: Whatever identifying data he can come up with?
MR. FAVALORO: Yes.
MR. LEWIS: Okay. Sure. That's fine.
BY MR. FAVALORO:
Q. Can you give me your present professional address and your professional address prior to that?

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A. Currently it's 3 Crestview Drive, Dallas, Pennsylvania.
Q. Okay. And that's your home as well?
A. And my office, yes.
Q. And where was your office before you had a home office?
A. Office was on Memorial Highway in Shavertown.
Q. Okay. And when did you last conduct office hours at that office?
A. Approximately two years ago.

Q. Okay. Did that office close?
A. I closed that office, yes.
Q. Why did you close that office?
A. Because I was -- I'm -- I'm sorry. I also have an office in New York that I didn't say, and that's on Fifth Avenue and 68th Street.
Q. Okay. And how long have you had that address?
A. For the last 10 years.
Q. Okay. And can you tell me a percentage breakdown of time spent between your New York office and your -- I'm sorry. I didn't jot down the address of your office prior to your home address. What was that address?

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A. Fifth Avenue and 68th Street.
Q. And your Pennsylvania address before you had your office in your home?
A. On Memorial Highway, Shavertown, S-H-A-V-E-R-T-O-W-N.
Q. And can you give me a percentage breakdown of time spent between the New York office and the Shavertown office?
A. Most of my time seeing patients was in the New York office, and the Shavertown office was mainly for administration and billing.
Q. And how long did you have the Shavertown office?
A. Approximately 10 years.
Q. And how long have you had the New York office?
A. Ten years.
Q. Okay. So if you could be a little more specific in terms of time spent in New York and Pennsylvania at your Shavertown office.
A. I practiced in New York City for 10 years, starting in the city in 1995 at Columbia Presbyterian Medical Center; and in 2000, I began practicing with Dr. Seckin at Fifth Avenue.
Q. Okay. And give me a typical month, if you

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would, from 2005 to 2008 in terms of time spent in New York and Pennsylvania.
A. Almost all of my time was spent in New York, as far as seeing patients, and that -- I say New York, but I have a very strange practice. I have an Internet practice, a very active Internet practice. Because, again, it's very topical, but most operations I do are not -- the patients oftentimes have preexisting conditions, and they don't have insurance.

So we have to make arrangements. And since 2005, I've also done surgery in the Cayman Islands on a regular basis. So, as I said, it's a strange practice.

But the patients contact me over the Internet usually for endometriosis-related problems or large uterus problems for hysterectomy or for extensive adhesions. That pretty much sums it up.

Q. Okay. In the last two years, Doctor, how many hysterectomies have you performed?
A. Approximately 50.
Q. Okay. And what type of hysterectomies?
A. Most of them would be total laparoscopic hysterectomy.
Q. Would that be supracervical?

A. There were maybe two or three supracervicals.
Q. Okay. And of those two or three supracervical hysterectomies, again laparoscopic, were any of those involving a bilateral salpingo-oophorectomy?
A. I believe so.
Q. Would you be able to determine that by checking your records?
A. I'm not sure.
Q. Do you have records of those procedures in the last two years?
A. I have records of most of them; but, again, I operate in many different places and many different countries, in fact. To give you an idea, last month I did hysterectomies in Mexico and in Turkey.
Q. Okay. When was the last time you did a hysterectomy in the United States?
A. The last time I did a hysterectomy in the United States was in 2004.
Q. Okay. And what type of hysterectomy was that?
A. Total laparoscopic hysterectomy.
Q. And if I were to ask you that question in

the last 10 years, what would your answer be?
A. As far as?
Q. How many hysterectomies you've performed in the United States.
A. In the last 10 years, approximately 150.
Q. But none in the last six years?
A. Since 2004 in the United States.
Q. Okay. Why the drop-off?
A. Because 2005, I decided not to take malpractice insurance to do hysterectomies.
Q. And why did you make that decision?
A. I felt it was too expensive.
Q. And you were performing those hysterectomies outside of the country from 2004 forward?
A. Until present.
Q. Okay. And do you have insurance, malpractice insurance, covering you when you perform hysterectomies outside of the country?
A. No.
Q. Do you presently have malpractice insurance in place today?
A. No.
Q. For any procedure?
A. Correct. No.

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Q. Okay. Can you give me a summary of your educational background, starting with undergraduate?
A. I went to Lehigh University for undergraduate. I then went to the Royal College of Surgeons in Dublin, Ireland, for medical school. I interned in Honolulu. I did a year of general surgical residency at Boston, followed by three years of OB-GYN training in Boston, followed by six months of a gynecological cancer surgery fellowship in Hershey, Pennsylvania.
Q. Okay. How did you like your time in Boston?
A. It was good.
Q. Okay. Where do you have admitting privileges today, Doctor?
A. I have admitting privileges today at Wilkes-Barre General Hospital and at two hospital in the Cayman Islands.
Q. What are the names of those hospitals?
A. Chrissie Tomlinson Hospital -- that's T-O-M-L-I-N-S-O-N Hospital -- and Grand Cayman Hospital.
Q. Okay. And what procedures are you performing at Wilkes-Barre?
A. At Wilkes-Barre, I haven't been.
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Q. Okay.
A. But I do have admitting privileges, and I am a staff member at that hospital.
Q. And those are current?
A. Current? Most likely by September-October of this year I will start doing some cases there again.
Q. And will you be able -- will you be able to do those cases without malpractice insurance?
A. No. I'll have malpractice insurance.
Q. So you will --
A. I will have it.
Q. It is your intention to obtain malpractice insurance in the future?
A. It is, yes.
Q. And what is leading to that decision to obtain malpractice insurance again?
A. Well, I have time now. I mean, over the last five years, I was running International Society of Gynecological Endoscopy. That's ISGE. And I was doing a lot of lecturing and surgical demonstrations around the world.
Q. Okay. Can you give me a breakdown in the last year between your clinical practice and academic or lecturing responsibilities, we'll say,
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just to make it easy, from 2009, January 1, forward?
A. Of the places I've been?
Q. I'm looking for a percentage of your time as a physician spent clinically and academically.
A. By -- I think they both mold in together. I mean, most -- most of the lecturing I do is

combined with surgery where I do a day of surgery.
So from 2009, I did 10 days of surgery in Guadalajara, Mexico; and I did approximately 10 days in the Grand Cayman Islands of surgery. And these were completely surgery, not lectures.
Q. When you say completely surgeries --
A. That means --
Q. -- that's all you did?
A. From morning to evening, I do hysterectomies and similar type operations.
Q. And if I were to ask you how many surgical days you had from January 1st, 2009, to date, what would your answer be to that question?
A. Approximately 30.
Q. Thirty days?
A. Yes.
Q. And were you seeing patients during that time period, from January 1, 2009, forward?
A. I was consulting with patients.

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Q. Okay. And can you describe, a little more detailed, to me what your consulting arrangement was?
A. Most of my consulting was Internet discussions on e-mail and telephone calls.
Q. Okay.
A. I wasn't seeing the patients actively in the United States. But if they desired surgery in some cases or they were old patients of mine, I would take them to the Cayman Islands.
Q. So if I understand your clinical component of practice then from January 1st, 2009, you've had 30 days of surgery and Internet or telephone consults with patients?
A. Yes.
Q. Is that accurate?
A. That's accurate.
Q. And why were you doing the surgeries in the Grand Cayman Islands?
A. Because I had malpractice there.
Q. You had coverage there?
A. Yes. I'm sorry if I didn't make that clear, but I do have malpractice insurance there.
Q. Okay. And any other countries that you have malpractice insurance?

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A. No. Many other countries you don't need it. Mexico you don't need it. That is true.
Q. Okay.
MR. LEWIS: That's tort reform for you.
MR. FAVALORO: There you go.
MR. LEWIS: There aren't any.
BY MR. FAVALORO:
Q. Okay. Doctor, I want to ask you some questions now about this case, the Agard or Agard, whatever the --
MR. LEWIS: Agard.
BY MR. FAVALORO:

Q. -- pronunciation du jour is. Agard.
What have you reviewed in connection with the Agard case?
A. I have reviewed two depositions; a deposition of Dr. Faulk and the deposition of Ms. Agard.
Q. Okay.
A. And I have reviewed the op notes of the various procedures that Ms. Agard underwent at Mary Immaculate Hospital, and that included the consultations of other doctors. And I reviewed the records of a procedure that was done, I think, at

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Norfolk Hospital afterwards.
Q. Okay. Do you have a summary of what you have reviewed in detail, or are you just telling me from your memory your best memory of what you reviewed?
A. I have a -- I had an original letter saying -- you know, sending me a file, like the file that you have, that listed all of the different things that I reviewed. That would have been sent to the attorney.
Q. Do you have any documents with you today in connection with this case?
A. No.
Q. Okay.
A. I didn't make any outline after reviewing the records.
Q. Do you remember how many hospitalizations of Ms. Agard you reviewed?
A. Let's see. I reviewed the first hospitalization where she had her supracervical hysterectomy.
She was then readmitted for about a five-day stay, and then she was readmitted again for major -- I think that was February 9. So I reviewed that.

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Then there were a couple of hospitalizations after her March procedure; her hospitalizations, I think, in April and in May. Then I think she had a hospitalization in June for major surgery.
Q. Do you remember the date of her first hysterectomy?
A. Yes.
Q. What was that date?
A. That was February 11, 2008.
Q. Okay. How many hours would you say you've spent reviewing materials for this case?
A. Approximately 20 to 25.
Q. Okay. And have you billed for your services provided?
A. I've billed for, I think, the first time that I reviewed it, yes.
Q. And how many hours have you billed?
A. I don't have it right here, but I believe it was probably five or six hours.

Q. Okay. And can you tell me about your billing practices in medical malpractice cases?
A. I usually bill $500 an hour.
Q. Is that across the board?
A. Yes.

Q. So $500 for review, $500 for deposition and $500 for trial per hour?
A. Yes.
Q. And are you prepared to testify in this case if this case proceeds to trial?
A. Yes.
Q. And do you know when the trial is?
A. Yes. It's, let's see, May 19, I think; 18th or 19th.
Q. But you've made arrangements to be available for that trial?
A. Yes.
Q. Have you reviewed any of the legal pleadings in this case?
A. Legal pleadings?
Q. Like a complaint or a designation, a summary of your testimony.
A. I don't believe so.
Q. Okay. Have you ever testified in Virginia before?
A. No.
Q. Have you ever practiced in Virginia before?
A. No.
Q. Have you ever lectured in Virginia?

A. Yes.
Q. And where have you lectured?
A. I lectured in Riverside Hospital, Newport News, a lecture on laparoscopic hysterectomy. That was in 1992.
MR. LEWIS: Was Dr. Faulk there?
THE WITNESS: I don't know. I lectured there, and I lectured at American College, an OB-GYN meeting, at the Armed Forces in -- was it -- it's not Portsmouth. I think where the -- wherever the Navy is in -- Norfolk.
BY MR. FAVALORO:
Q. I was going to say it could be anywhere in the southeast Virginia.
A. I think it was in Norfolk, Virginia, I did lectures. That was also 1992. And I believe I lectured sometime after 1992 because we went down to Williamsburg around holiday time.
Q. But you've never performed any procedures in a Virginia hospital?
A. No.
Q. Okay. Have you ever been sued, Doctor?
A. Yes.
Q. -- for malpractice?
How many times?

A. Four.

Q. Okay. Can you tell me about the first time?
A. The first time was in 1994.
Q. Okay. What were the circumstances of that suit?
A. Necrosis of the small intestine.
Q. Okay. Was the allegation that you misdiagnosed?
A. The allegation was that I -- I'm not sure of the exact allegation. But it was a small bowel case where the patient developed necrotic changes in the small bowel from the superior mesenteric artery.
Q. And what was the outcome of that suit?
A. That was settled.
Q. Do you know how much was paid?
A. I'm not sure. I think it was around 200, but it would be in the data bank.
Q. And who was your attorney in that case?
A. The attorney who was -- filed the suit was the law firm of Arlen Specter's son. I'm not sure what his name is. He's our State Senator.
Q. And is that in Philly?
A. Philly. In those days, they could take cases from Wilkes-Barre and try them in

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Philadelphia. I believe they finally did away with that in the last few years.
Q. And do you know the law firm or lawyer who represented you in that case?
A. His first name was Bart. I'm blanking on his full name.
Q. Where was the firm?
A. In Philly.
Q. And what was the plaintiff's name in that case?
A. Mary Williver.
Q. Wilber?
A. Williver, W-I-L-L-I-V-E-R.
Q. What about the next one?
A. The next one was Cathy Anselmi.
Q. Would you spell that, please?
A. A-N-S-E-L-M-I.
Q. And the year?
A. 1998.
Q. Okay. The circumstances?
A. That was an operation where the patient had a bowel problem postoperatively, but not a perforation, but it just lingered for around three weeks, and then she had an operation to resect some intestine.

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Q. Was there a perforation?
A. No perforation.
Q. But there was necrosis?
A. She just -- it was -- no necrosis, as strange as it seems; but it was -- basically, she just was having problems passing gas. We call it like hypotonic small intestine.
Q. Okay. And what was the outcome of that

case?
A. That was also settled by the same lawyer, Specter.
Q. Okay. And do you remember how much?
A. I think it was settled for 500.
Q. Okay.
A. I believe. I haven't checked.
Q. Okay. And the next one?
A. And there was -- the next one was -- I'm trying to think of the name, but the next one was Westchester County. It was a ureteral injury, and that was in -- the case occurred in nineteen -- yeah, 1995.
Q. Okay.
A. It was settled in 2000 for 25,000.
Q. Okay. And who was plaintiff's counsel in that case?

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A. My lawyer was Jay Gebauer, G-E-B-A-U-E-R.
Q. G-E-B --
A. G-E-B-A-U-E-R.
Q. Okay. Do you remember plaintiff's counsel?
A. No.
Q. Plaintiff's name?
A. Let's see. No, I don't remember.
Q. And if I could ask you just a few questions about the case in that it was a uretal injury.
A. Yes.
Q. What was the allegation against you in that case?
A. The allegation was that there was a ureteral injury.
Q. Was a transection alleged?
A. There was a ureteral injury that was repaired at laparoscopy, and the patient had no ill-effects afterwards, but the suit was filed just because there was a ureteral injury.
Q. Was the allegation -- was there a hysterectomy involved in the case?
A. No.
Q. And what was the procedure by which the

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uretal injury could have occurred?
A. The injury occurred because, to be honest, it was -- it looked like a pretty easy case, and I went very fast. So I was probably negligent in that case, but I noticed the injury. I had to excise endometriosis during the operation, noticed the injury. I fixed it by laparoscopic surgery.
Q. And what was the procedure you were performing when the injury occurred?
A. Oophorectomy --
Q. Okay.
A. With -- an excision of endometriosis.
Q. And it's your memory that you recognized the injury intraoperatively?
A. Yes, very quickly.

Q. Okay. And did the repair occur intraoperatively or within several days?
A. Repair occurred immediately.
Q. Okay.
A. In fact, I show that video at many conferences.
Q. And is it your understanding that you transected the ureter when you were performing the oophorectomy?
A. No, not at all. It was just a small hole

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that I could see in the ureter. So I was able to fix that small hole.
Q. What was your opinion as to what created the hole?
A. The hole was created by cutting current electrosurgery. The current that I was using to dissect in the area, I could see the spark go in the direction -- it was an active spark. I could see it, and immediately I saw a hole in the ureter. I dissected out the ureter to be sure, and then I repaired the ureter after putting a stent in the ureter.
Q. And what complications did the patient suffer?
A. Absolutely none.
Q. Do you have an opinion as to why the suit was filed against you?
A. I really don't.
Q. But the case settled, as far as you know, for 25,000?
A. I do know it was -- I did not want to settle the case, but you know how insurance companies can get. They tend to think that's the less expensive way out.
Q. Okay. And, again, I'm sorry if I'm

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repeating myself; but your attorney in that case was Jay Gebauer?
A. Gebauer.
Q. And he's out of what city?
A. I think somewhere in New York. Westchester County.
Q. Okay. And the plaintiff's name in that case?
A. I could send you that. I'm blanking out on that. I should know it, but I'm blanking out on that.
Q. If you would, please, get that to Attorney Lewis. Thank you. And the last case?
A. The last one is -- was -- occurred in the year 2000, went to trial in Brooklyn in 2003; and it was an extensive adhesion operation with a pelvic mass. And the pelvic mass turned out to be a kidney, and I removed it.
Q. What was the allegation against you?
A. That I had removed the kidney.
Q. In error?
A. Well, it was an abnormal kidney. The

patient had a normal kidney. The question is whether it functioned or not, but they still sued me, and it went to trial in Brooklyn.

Q. And what was the result?
A. We lost.
Q. And what was the verdict?
A. Just that I had taken out the kidney.
Q. The amounts? The amount of the --
A. I'm not sure. But, again -- I'm not sure what they finally settled on.
Q. Was there a verdict and then a post-verdict settlement or --
A. There was a verdict.
Q. -- was there a settlement prior to verdict?
A. I think the verdict was like two million.
Q. And who was your attorney in that case?
A. Dwyer; Jerry Dwyer. Jerry or Gary. It's Dwyer, though, D-W-Y-E-R.
Q. Was he from New York City?
A. Yes.
Q. Could you get that information to Attorney Lewis as well?
A. Sure.
Q. Okay. Thanks. Have you ever had your privileges revoked?
A. No.
Q. Okay. Have you ever been reported to a medical review board within a hospital in which you had privileges or were performing surgery?
A. No.
Q. I'm going to show you a document, Doctor, and ask you if you've ever seen it before.
MR. LEWIS: And we'll mark this as Exhibit 1:
(Reich Exhibit No. 1, written designation, was marked for identification.)
(Pause in proceedings.)
THE WITNESS: Who is Dr. Soffer?
BY MR. FAVALORO:
Q. That's another expert. Let me just ask you to start reading below your name. I'm sorry. I should have told you that when I gave it to you.
A. Okay.
(Pause in proceedings.)
A. These would be the records that I reviewed. Yes, I've seen this.
Q. Okay. When was the first time you saw that document? And, again, we're just stopping on the last page where it ends with your name.
A. I'm not sure of the date.
Q. Did you prepare this document or have a hand in preparing it?

A. Yes. I gave some of my opinions, and maybe they were -- I believe they were incorporated in the document.

Q. I'm just going to -- because I am going to ask you questions about it, I'm going to ask you to read it; and after reading it, tell me if there's anything that you disagree that's set forth in this designation.

MR. LEWIS: Do you want to go off?

MR. FAVALORO: Yeah. Why don't we go off.

THE VIDEOGRAPHER: The time is 5:05. We're off the video record.

(A brief recess was taken.)

THE VIDEOGRAPHER: The time is 5:07. We're back on the video record.

BY MR. FAVALORO:

Q. Doctor, you've had a chance to review what we've marked in this case as Deposition Exhibit 1. Is there anything in that document that you disagree with in terms of your opinion?

A. No.

Q. Doctor, this designation indicates that you have reviewed specifically certain medical records, and you've had a chance to look at those

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records or that summary of those records, correct?

A. Yes.

Q. And that accurately reflects the documents and records that you have reviewed in this case, correct?

A. I believe so.

Q. What do you mean you believe so?

A. I -- looking at the records, I have -- it's my opinion or my recollection that I reviewed them.

Q. Okay. Well, it wasn't meant as a trick question. Again, it's a very particular and detailed list of documents and records that you've looked at. I'm just asking you now to confirm that that list is accurate.

A. Yes, it is.

Q. Okay. Doctor, can you tell me why you believe Dr. Faulk breached the standard of care on February 11, 2008?

A. Yes. Okay. Dr. Faulk was -- on that date was doing a laparoscopic supracervical hysterectomy. And the beginning of the operation, he put a sponge in the vagina -- again, this is from his operative report, from what I could understand -- put a sponge in the vagina, and he put nothing in the uterus.

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I believe that was a breach of the standard of care because with a sponge in the vagina, you can't manipulate the uterus away from the ureters.

The proper way to do this operation is to put something in the vagina -- or I'm sorry -- put something in the uterus so you can push the uterus upward and away from the ureters when you do the operation.

I mean, that's like basic laparoscopic

hysterectomy or supracervical hysterectomy technique.
Q. Okay. On that issue then, let me ask you, given that the sponge was in the vagina, what would have been the appropriate procedure or action by Dr. Faulk regarding the uterus?
A. On the market today, really, since the mid '80s, there are multiple devices. We call them uterine mobilizers or uterine manipulators.
There are many devices to be able to insert into the uterus that stick out of the vagina so the surgeon could use them as a lever to push the uterus upwards and push the uterus from side to side to be able to identify structures.
And, again, this is extremely important,

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especially if you have a large uterus, which was present in this case, slightly enlarged uterus, and this wasn't done.
Q. Okay. Any other violations of the standard of care on February 11?
A. Yes. He then does laparoscopy; and going by his operative report, the first thing he does -- the first part of the operation is to bipolar desiccate the uterine vessels.
What he does is, he grasps probably the Fallopian tube or the ovary and pulls it toward the midline; and then he uses bipolar coagulation.
Okay. When you use bipolar coagulation, it makes -- it stops the blood supply to the uterine vessels; but it also causes blanching, or whitening, in the area.
So then he takes a harmonic scalpel, and he coagulates again to cut. And I believe -- well, I'm sorry. I don't believe -- from the op note, that is my opinion, that that's when the ureter was cut and divided and semisealed at that time.
It's -- it's totally against the standard of care to coagulate with one instrument and then try to coagulate with another instrument in the same place, especially after you have, as I said, the

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blanching and the whitening around the area that one coagulation would cause.
The correct method would have been to cut with the scissors on the same white line that was just coagulated.
And usually if one does open the peritoneum in that place, the ureter falls away from the area to be dissected. But Dr. Faulk continues with this procedure. He coagulates and then -- with two different instruments.
So it makes sense that the first coagulation will shrink the blood vessel as it stops the blood flow from going through; and that, in itself, will move the ureter closer to the tube and ovary on the pelvic side wall. Then he takes the harmonic scalpel and coagulates again and cuts with the harmonic scalpel, probably cutting the ureter.

Q. So you believe that the -- there was a transection of the ureter by virtue of using the harmonic scalpel?
A. I do believe that in the beginning of the operation that's what occurred.
Q. Okay. And what leads you to that conclusion as opposed to the transection occurring later or perhaps the existence of a thermal injury?

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A. A thermal injury certainly did not occur in this case because, with a thermal injury around the ureter, the ureter would just narrow over time. Most -- if you look, even in the literature, some of the thermal injuries with this operation, supracervical hysterectomy, you'll see that in most of them, even if they're diagnosed late, they -- the ureter is intact. It's not like broken in a spot or separated, like it was in this case.
So I think it's obvious that the ureter was severed with the harmonic scalpel in the beginning.
The surgeon then continues dissecting downward. If he had a uterine manipulator in at that point, he would have been able to push the uterus up and away from the ureter, but he didn't do it because there's nothing in the uterus. It's like a floppy thing there.
From the beginning of doing these operations in the '80s, it's always important to be able to push the uterus upward and away from the area being dissected and to, in most cases or many cases, dissect off the ureter itself to see exactly where it is.
Q. Okay. Any other violations of the

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standard of care?
A. I think that's enough.
Q. So that's it? It's failure to do a uterine manipulation --
A. Yes.
Q. -- and the use of a harmonic scalpel in light of the bipolar cauterization?
A. Using two methods to coagulate when one would suffice. In effect, by using the second one after the area had been distorted, it's -- it was a setup for him to then come across the ureter.
Q. Okay. And those two actions form the basis of your conclusion that Dr. --
A. I --
Q. Let me just finish the question for the record.
-- that Dr. Faulk violated the standard of care during this procedure?
A. Those were the major things that I could see. I mean, the case itself, I believe, was done in a bizarre fashion.
Here's a woman with -- who presents to this doctor with a cervical problem, and he's doing an operation to preserve the cervix. That doesn't

make much sense to me.

Q. What should he have done at that point?
A. And then at the end of the operation, he does a procedure to take out the affected portion of the cervix -- he called it a LEEP -- at the end of the procedure, a cone biopsy. And the pathology from that document says he didn't take out the area that he was supposed to. He didn't get the transformation zone.

So he's leaving this patient who presented to him with an abnormal pap test and -- so he's leaving -- whatever caused that abnormal pap test, there's a good chance he's leaving that lesion in there at the end of the procedure.

But, again, that's not what caused the ureteral injury. That just was bizarre. I just have never seen that kind of procedure done.

Q. If the ureter was transected upon the use of the harmonic scalpel, in your opinion, and based upon your review of the operative report, was there evidence of that transection on February 11, 2008?

A. I believe there was not evidence because the harmonic scalpel will seal -- just like bipolar -- will seal the edges that it coagulates. The difference between bipolar and harmonic is that harmonic device divides the tissue. Bipolar just

coagulates it. Harmonic coagulates it and cuts it.

Q. So is it your opinion that, subsequent to the use of the harmonic scalpel, there was nothing to indicate to Dr. Faulk that he transected the ureter?

A. Nothing, unless he looked. I mean, most surgeons would then look at the area because it's opened up. And if they looked at the area, they would see that there's no ureter, because the ureter would have been coagulated and then would, quite possibly, retract a little bit.

I think the main point is that you're right there. The ureter is very easy to see on the right side, much easier than on the left side, because it comes into the pelvis over the iliac vessels. So it's right there where the ovarian vessels are.

So if you divide that ligament, the infundibulopelvic ligament, you would see the ureter. So I would think at that time, most surgeons would look to see that the ureter was fine; and if he did look there, he wouldn't have seen the ureter because it had already been separated. That's my opinion.

Q. And was it possible, in your opinion, to

visualize the ureter at the conclusion of this procedure?

A. If he looked at any point during the procedure, he would have been able to find the ureter, even if it had been divided.

Q. And is it your opinion that Ms. Agard was at risk for injury during this procedure?
A. It's my opinion that she's at minimal risk. She didn't have adhesions. She didn't have endometriosis. She had fibroids. So I think it was a basic standard, pretty straightforward hysterectomy.
Q. So there was minimal risk for Ms. Agard during this procedure?
A. I believe minimal risk, if the surgeon does the right procedure with the right instruments.
Q. Okay. So it's not as if Dr. Faulk looked at this patient and said this is a high-risk patient in terms of this procedure?
A. I agree, yes.
Q. Okay. Would you look at your first sentence on -- the first paragraph on page 16? The first paragraph, just let me read it to you, "Dr. Reich is expected to testify that Mrs. Agard's ureters were at risk for injury during the

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February 11 laparoscopic supracervical hysterectomy bilateral salpingo-oophorectomy performed by Dr. Faulk, and this fact was well-known to him."
That seems to contradict what you just told me.
A. Well, anyone who has a ureter could be at minimal risk of being injured.
Q. But that's not what this sentence says.
A. No? What does -- I would think it does.
Q. Doesn't the sentence say that your expected testimony is that Ms. Agard's ureters were at risk for injury, and this fact was well-known to Dr. Faulk?
A. Well, everyone who has a hysterectomy we could say that the ureter is at risk. I mean, it's just the same as everybody who has a cholecystectomy. We would say that the common bile duct is at risk. But if it occurs, it's not right. Even though it's at risk, I believe that it shouldn't happen.
Q. So you believe that the risk was a minimal or low risk for injury?
A. Yes.
Q. And "this fact was well-known to Dr. Faulk" refers to what?

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A. Well, I believe anyone who does gynecological surgery would believe that you could injure various, different organs in the pelvis; ureter and bile being the primary suspects.
Q. And I know we talked a little bit about this, Doctor; but your designation indicates that "he needed to make sure he had properly visualized, identified and protected the plaintiff's ureters during the procedure."
Again, what do you believe that Dr. Faulk should have done to visualize, identify and protect plaintiff's ureters?

A. Like I said, at the beginning of the operation, if he pulled, like he said he did in the operative report -- if he pulled the tube and ovary over towards the midline, like he said he did in the operative report, he would see the ureter because the ureter is coming into the pelvis right there.

And I remember reading his deposition. He states that's what he should have done, but obviously he didn't do it. I think it was on page 41 of his deposition.

Q. Okay. Was a cystoscopy indicated on February 11?

A. It's been my belief for many years that

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cystoscopy following indigo carmine dye should be done at the end of all hysterectomies if the ureter has not been dissected.

Q. And is that your practice?

A. Yes.

Q. Is it your practice to dissect the ureters?

A. For many years, it was; and then in some cases, I decided not to do it if I was going to do a cysto [sic] at the end and if I had ligated the ureter with a suture because if -- if you move quickly and ligate the ureter with a suture and you find out it was ligated, you can always remove the suture.

So for ureteral safety, we look in. We make sure there's blue dye coming out of both ureters.

If there isn't and you've cut off the blood supply with suturing instead of bipolar or a harmonic scalpel, you can always go back and take off a suture and place it in the right place.

Q. Other than visualization of the ureters, was there any other indicators to Dr. Faulk on February 11 that a transection might have occurred?

A. He didn't look to find out or do anything

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to see if it had occurred.

Q. Were there any conditions that the patient experienced postoperatively on February 11 that could have or should have indicated to Dr. Faulk in your opinion that a transection may have occurred?

A. Not on February 11.

Q. What about on February 12?

A. I'd be a little concerned then, because she went like with a lot of pain postoperatively, according to her deposition. Even Dr. Faulk felt that she had a lot -- more pain than was usual at the time of discharge.

Most laparoscopic surgeons, especially with supracervical hysterectomy, the patient should be in fantastic shape the next day; and if they're not, we should be thinking there could be something going on. And the most obvious things are the bowel and ureter. And if found about it at that time, most of them can be corrected by laparoscopic

surgery, especially bowel.
Q. And do you believe there was indication that there was either a bowel or a ureter problem on February 12, 2008?
A. Well, she was having pain. So if the patient is not having the typical course that you

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believe most people having this type of surgery should have, you should think about bowel or ureter complications.
Q. And in your opinion, what should Dr. Faulk have done on February 12?
A. I believe he should have done an IVP, which is an injection of dye in the veins, and that is concentrated in the kidneys, so one can be sure that the ureters are okay.
Q. Anything else?
A. I think that's the standard. Although, you could consider a CAT scan or an MRI to see if the kidney is swollen; but that doesn't make that much sense. An IVP you see right away, and you could do it with very minimal radiation. We call it a single shot IVP.
Q. What was the urinary output on February 12? Do you know?
A. I believe it was fine.
Q. And would that indicate or contraindicate a uretal transection?
A. It makes absolutely no difference. If you have one kidney that's working, the output would be the same.
Q. Okay. So urinary output is not

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indicative, in your opinion, of a uretal injury?
A. No, unless bilateral.
Q. Do you find fault with any other action or inaction of Dr. Faulk on February 11 or February 12 other than what you've testified to?
A. No.
Q. Okay.
A. I'm sorry. Could I go back there?
Q. Sure.
A. On February 11 or 12, no, at that point, but I mean -- then she was readmitted. But, again, that's another story.
Q. In your opinion, was it a violation of the standard of care to discharge Ms. Agard after her hysterectomy the first time?
A. Honestly, I don't have an opinion on that because I wasn't there. I can't tell you how much pain that she was having at that time. So I would have to defer on that.
Q. Okay. So you do not find the discharge of Ms. Agard to be a violation of the standard of care based upon your review of the records?
A. No.
Q. Do you find any further fault with Dr. Faulk regarding his treatment of this patient?

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By "fault," I mean a violation of the standard of care.
A. No.
Q. Do you intend to offer opinions on causation at the time of trial in this case?
A. Yes.
Q. And what are those opinions?
A. My opinion is that the procedure of supracervical hysterectomy with a fibroid uterus without a uterine manipulator is a deviation of the standard of care, and that the use of two different energy sources to coagulate the blood supply of the uterus is a violation of the standard of care.
Q. Okay. I understand that. I'm asking you about causation testimony. In other words -- do you know what causation testimony is?
A. I thought that was the cause of her ureteral injury.
Q. The standard of care relates to whether the doctor, in essence, did something wrong in his care and treatment of the patient.
Causation relates to what was the consequence of any violation of the standard of care and injury, any negative results. So let me put the question to you again. Are you looking to and

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intending to offer any testimony as to causation at this trial?
MR. LEWIS: I don't mean to be interrupting, but I will. I'm going to ask you him causation questions, as I think I have indicated in the expert witness disclosure.
So if you're trying to find out whether you need to go down that path with him here today so you understand what his opinions are, I would suggest you go down that path because I'm going to do it at trial.
MR. FAVALORO: I am expecting -- I am expecting that question based upon the designation.
MR. LEWIS: Okay. Fair enough.
BY MR. FAVALORO:
Q. But I'm just trying to make sure you understand what causation is.
A. I'm still confused. You're saying -- I would have thought causation means the cause of the injury to the ureter, but you're saying it means something postoperative?
Q. It means, did the -- let me give you a generic description, and counsel can certainly pipe in if he disagrees.
MR. LEWIS: Okay.

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BY MR. FAVALORO:
Q. Causation means that because a doctor did something wrong, there were negative consequences. To give an easy example, you cut my hand off. I can't write, and it cost me $50,000 to get a prosthetic.
A. Yes.

Q. So --
A. I understand now.
Q. Okay. So with that example, what do you see causation damages to be to this plaintiff?
A. Causation damages? Well, I mean, this patient had a ureter that was severed, and the severed ureter caused urine to collect in her peritoneal cavity.

She then was admitted to the hospital where the doctor felt it was a bowel problem or -- it's hard to understand what he could have thought then because she didn't have ovaries to have an ovarian cyst leaking.

But, somehow, he did a drainage of the vagina, which is just drainage of all the urine that was in that place.

Then she went back home and had to suffer with urine pouring out of her vagina for a few days;

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and following that, she had to come back into the hospital and have a nephrostomy tube placed in her back to help the inflammation around the ureter to go away. And to prevent loss of her kidney, it was done.

She didn't lose her kidney, but she went through many months with this problem. I imagine that would affect somebody pretty badly, to have urine leaking out of your vagina for -- really, until she had the reimplantation.

Then after the reimplantation, I believe she still was having some problems with the area where the ureter came into the bladder.
Q. Do you know when that reimplantation occurred?
A. The implantation was -- I think it was June; May or June. And about a year later --
Q. May or June of 2009?
A. Of 2008, May or June. So four months later.
Q. Uh-huh.
A. But I believe I did read some notes that in 2009 she was still having some question that -- whether that was open or not, and the surgeon had a problem finding it with cystoscopy.

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Q. Okay. Any other damages or consequence of what you believe to be a transection of the uterus to the plaintiff?
A. Yes. Just going that length of time with all that urine in the peritoneal cavity would cause a lot of irritation to the surfaces of the peritoneal cavity, which could lead to lots of adhesions in that area. That could affect future bowel mobility and motility.
Q. Do you know if any adhesions have formed since this procedure?
A. Honestly, no, because when she had the implantation, they did it retroperitoneal. So they didn't go into the peritoneal cavity. I think they

did it retroperitoneal so they wouldn't have that mess to deal with, to find the ureter.
Q. Okay. Anything else?
A. No.
Q. So the damages you see then, Doctor, was the collection of urine, the urine pouring out of the vagina, the nephrostomy tube and the reimplantation --
MR. LEWIS: And pain.
BY MR. FAVALORO:
Q. -- and pain?

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A. Yes. This patient, from what I could tell from her deposition, has ongoing pain and bladder pressure and now has the feeling that she always has to go to the bathroom, like she can't hold her water.
Q. And how old is this patient now?
A. 58, 59.
Q. Is that condition common in patients that age, irrespective of whether they've had uretal damage?
A. That condition is a totally new condition. I mean, we call it a spastic bladder. A spastic bladder is something she didn't present with when she had her original surgery.
Q. Isn't lack of bladder control a condition that presents more frequently as we all get older?
A. It can.
Q. Okay. Is there any literature that you believe is reliable authority in this case?
A. I mean, there are case reports and textbook chapters that I'm familiar with that tell how to do this operation.
This operation was first done around 1990 by Dr. Tom Lyons. So I've read his work in his chapters. So I know his incidence of complications.

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I have an idea of the incidence of complications of Cleveland Clinic and of some other centers in the world who have done large numbers of supracervical hysterectomies.
Q. Are you aware of any literature that stands for the proposition that to place a sponge in the vagina in connection with a laparoscopic hysterectomy, absent uterine manipulation, is a breach of the standard of care?
A. I've never heard of that technique in benign gynecology. I don't know of anyone who would ever consider doing that.
Q. You're talking about putting the sponge in the vagina without --
A. Without a uterine -- without something to manipulate the uterus and move it around.
Q. My question to you is whether you know of any literature that stands for that proposition or indicates that uterine manipulation is the way to do it?
A. There's much literature. Almost any

literature that you read about the technique of how to do this operation would include using a uterine manipulator.
Q. Is there ever a situation where a uterine manipulator would not be indicated?
A. Yes.
Q. What would that situation be?
A. Cancer.
Q. Absent cancer.
A. Pardon?
Q. Absent cancer.
A. Absent?
Q. In other words, in cases other than those --
A. Cancer is -- surgeons immediately, at the beginning of the operation, duct tape [sic] up the ureters; and they don't want to disturb whatever is inside.
So in those situations, they don't put a manipulator in. But absent cancer, I don't know of any other situation.
Q. Okay. Doctor, let me just show you your CV, which is not a short one. This a copy that I think Attorney Lewis had. I just want to ask you if that is the most current. It would probably take you three hours to read through it.
A. It probably isn't the most current.
Q. Is it something you update regularly?
A. I updated it recently, I think, yes.

Q. Okay. Can you get me an updated copy, to the extent that is not the updated copy?
A. Sure.
MR. LEWIS: Okay. Let's just go off the record for a few more minutes. We're almost done.
THE VIDEOGRAPHER: The time is 5:42. We're off the video record.
(Discussion held off the record.)
THE VIDEOGRAPHER: The time is 5:45. We're back on the video record.
BY MR. FAVALORO:
Q. Doctor, do you believe that the original laparoscopic hysterectomy was indicated in this occasion?
A. Probably, yes. I'd say that because the patient wanted it and she -- it's post-menopausal with a large uterus.
Q. Okay. Is there anything else you need to review in terms of documents, medical records, absent any other discovery, depositions that may be happening, to solidify your opinions for trial?
A. No.
Q. Okay. Is there anything question I didn't ask you today that you thought I would?

MR. LEWIS: I'll object to the form. Go ahead and answer it, Doctor. Go ahead and answer

it, if you can.
THE WITNESS: No.
BY MR. FAVALORO:
Q. The questions that I asked you today relate to the testimony you're intending to give at trial?
A. Yes.
Q. Were there any topics that you intend to testify at trial that we did not cover today?
A. I don't believe so.
MR. FAVALORO: Okay. Thank you, Doctor. No further questions.
MR. LEWIS: No questions.
THE VIDEOGRAPHER: The time is 5:46. This completes the deposition.
(Witness excused.)
(Videotaped deposition concluded at 5:46 p.m.)
* * *

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0060

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OF
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I hereby acknowledge that I have read the foregoing videotaped deposition, dated March 23, 2010, and that the same is a true and correct transcription of the answers given by me to the questions propounded, except for the changes, if any, noted on the attached errata sheet.

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C E R T I F I C A T E

I hereby certify that the evidence and proceedings are contained fully and accurately in the notes taken by me of the testimony of the witness who was duly sworn by me and that this is a correct transcript of the same.

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