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

CASSANDRA M. AGARD, Plaintiff,	:	
v.	:	At Law No. CL09-00233-DP
CHARLIE M. FAULK, MD, Defendant.	:	

VIDEOTAPED
DEPOSITION UPON ORAL EXAMINATION
CHARLIE M. FAULK, MD

October 1, 2009 -- 1:31 p.m.

Virginia Beach, Virginia

APPEARANCES: SHAPIRO, COOPER, LEWIS & APPLETON, P.C.
By: James C. Lewis, Esquire,
counsel for the Plaintiff.

OAST LAW FIRM
By: Carolyn P. Oast, Esquire,
counsel for the Defendants.

ALSO PRESENT: LEGAL VIDEO SOLUTIONS, INC.
By: Nancy Watters, Videographer.

EXAMINATION

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EXHIBIT INDEX

Videotaped deposition upon oral examination of Charlie M. Faulk, MD, Defendant, taken before Shannon A. Crittenden-Mann, a Notary Public for the Commonwealth of Virginia at Large, pursuant to Notice and Agreement, commencing at 1:31 p.m. on October 1, 2009, at Oast Law Firm, 1092 Laskin Road, Suite 208, Virginia Beach, Virginia, and these in accordance with the Rules of the Supreme Court of Virginia, 1950, as Amended.

THE VIDEOGRAPHER: We're on the record. The time is 1:31 p.m. This is the videotaped deposition of Dr. Charlie Faulk in the case of Cassandra M. Agard versus Charlie M. Faulk, MD, At Law Number CL09-00233-DP, pending in the Circuit Court for the City of Newport News. This deposition is being taken on behalf of the plaintiff's counsel.

My name is Nancy Watters. I represent the firm of Legal Video Solutions, Incorporated, Norfolk, Virginia. Today's date is October 1st, 2009. The location is 1092 Laskin Road, Virginia Beach, Virginia. The court reporter is Shannon Mann of Old Dominion Reporting.

Will counsel please introduce themselves for the record and state whom they represent?

MR. LEWIS: My name is Jim Lewis, and I represent Ms. Agard.

MS. OAST: My name is Carolyn Oast. I represent Dr. Faulk.

THE COURT REPORTER: Would you raise your right hand?

CHARLIE M. FAULK, MD, Defendant, called as a witness on discovery, after having been first duly sworn, was examined and testified as follows:

BY MR. LEWIS:

Q Good afternoon, Doctor. Would you tell us your full name, please?

A Charlie Mica Faulk.

Q And, Dr. Faulk, my name is Jim Lewis. I represent Ms. Agard. Have you had your deposition taken before today?

A Yes.

Q So I don't need to explain to you all the little rules? We can just go forward?

A That's fine.

Q All right. Doctor, since you performed the hysterectomy on Ms. Agard on February the 11th of 2008 at any time prior to today up to and including this moment have you gone back into Ms. Agard's chart and made any additions?

A No.

Q Have you gone back into Ms. Agard's chart and made any deletions?

A No.

Q Have you made any changes whatsoever during that time frame?

A No.

(Curriculum Vitae was marked as Faulk Deposition Exhibit Number Two.)

BY MR. LEWIS:

Q Doctor, let me ask you to take a look at what has been marked by Shannon as Deposition Exhibit Number Two. It was provided to me by Ms. Oast, and I just want you to confirm for me that that is your résumé as it currently exists?

A Yes, it is.

Q Are there any changes, additions or corrections that -- that you feel should be made?

A Yes. In the professional experience --

Q Yes, sir.

A -- it says 1988 solo clinical practice obstetrics and gynecology. I no longer practice obstetrics.

Q When did you stop practicing obstetrics?

A 2001.

Q Any other changes that -- that you feel would be important to make to this document to make it as accurate as it can be?

A The rest of it's fine.

Q Okay. There was an entry in here that I, probably out of ignorance, did not understand. Under professional experience towards the bottom the line starts with the word "July" that says, "1982 locum tenens 30 days private practice in obstetrics and gynecology, Davison, Michigan." What is that?

A As soon as I had finished my residency before I left to work in Dallas working for Cigna Healthplan of Texas I took over a physician's practice who I think he left to go out of the country for 30 days and so I did a locum -- locum tenens.

Q What is that? That -- that is a phrase that I'm unfamiliar with. What is that?

A Oh, that just means that a physician who owns a practice will employ another physician to take over his practice and see his patients, work in his office in his stead. That's what the locum tenens means.

Q Got it. Are you currently board certified, Doctor?

A Yes.

Q Your Virginia Board of Medicine physician practitioner information page is outdated.

A Yeah. It was updated -- well, have you checked recently?

Q I think I looked at it yesterday and it showed that your -- something about -- I can't remember your board certification -- I can't -- I can't remember but I -- I do believe it -- it needs to be updated again.

I noticed on here that in 1990 you were an instructor at a laser laparoscopic cholecystectomy workshop?

A Correct.

Q And I was wondering why an obstetrician/gynecologist would be instructing physicians on how to take out gallbladders?

A Well, that probably was more of a typo, but that particular laser workshop had many OB-GYN physicians as well as general surgeons who did laparoscopic surgery, and in addition to doing GYN lectures there were also general surgery lectures. So that may have been more of a typo on my part not including the GYN portion.

Q GYN. So your participation there was as an OB-GYN teaching OB-GYN stuff?

A That's correct.

Q Okay. At the present time, Dr. Faulk, what hospitals do you have admitting privileges to?

A Mary Immaculate Hospital and Riverside Regional Medical Center.

Q Just those two?

A For admissions.

Q During your career, Dr. Faulk, since you obtained your first medical license has any licensing authority taken any adverse action against your license?

A No.

Q Do you have a copy or the original for that matter of your chart on Ms. Agard available to you?

A Not physically with me today.

MR. LEWIS: Do you have a copy you can put in front of him?

MS. OAST: Yes.

MR. LEWIS: Would you mind doing that?

MS. OAST: He has a copy. You just asked him if he had --

MR. LEWIS: Oh, I'm sorry. The copy -- copy will do -- be fine.

MS. OAST: Yes, he has a copy, and it's got the same numbers as the ones we gave you yesterday if that helps you any.

MR. LEWIS: Yes, that's very helpful.

MS. OAST: Okay.

BY MR. LEWIS:

Q Before I get to that, Dr. Faulk, I see that you have brought with you numerous pages of handwritten notes. Can you tell me what those are?

A Well, I had to review the medical records, you know, before coming to this interview.

Q Yes, sir.

A And I was just making myself notes insofar as what pages certain parts of the records were so I could refer to them quickly.

Q Okay.

MS. OAST: It was something, just so you know, that I suggested that he do so he would have a very good working knowledge of the medical records and could find quickly what you might need him to show you.

BY MR. LEWIS:

Q Okay. Hopefully I won't send you off chasing too many of them, but if you would take a look at your office chart on this patient.

MS. OAST: That would be behind Tab One, Doctor.

BY MR. LEWIS:

Q And you can start with Page Ten. What is OLF?

MS. OAST: Oast Law Firm.

MR. LEWIS: Do -- let's go off.

THE VIDEOGRAPHER: We're going off the record. The time is 1:39 p.m.

(There was an off-the-record discussion, after which, testimony continues as follows:)

THE VIDEOGRAPHER: Back on the record. The time is 1:39 p.m.

BY MR. LEWIS:

Q Doctor, you have Page 10 in front of you?

A Yes, I do.

Q And that is a preprinted form used by your office back in 2006. It bears the title "History"?

A Correct.

Q And this is a document that you ask your patient to fill out or does your office staff do it?

A Office staff.

Q Can you tell from this handwriting who in your office filled this out?

A Not every one. I think I probably have three

different people probably put notes.

Q Back in 2006 how many people did you have working in your office exclusive of you?

A I don't remember. You know, I would say probably more than five.

Q Okay. Do I gather correctly, Dr. Faulk, that July 27th of 2006 is the first time this lady came to your office?

A That's correct.

Q And when she presented and you don't have to -- you're not limited to Page 10. Your -- your physician progress notes begin on Page 22 if you'd rather go there, but what I want to know from you is what her chief complaint was. Why -- why did she come to see you?

A The patient had no complaints. She came in for a pap smear because the patient had a previous abnormal pap smear done in a clinic locally in May 19, 2006, and so she was coming in to get a repeat one done and an evaluation.

Q And do -- do you know how Ms. Agard came to -- came to see you as opposed to some other health care provider?

A I don't know.

Q I'm back on Page 22, Doctor. Is the 7/27/06 entry in your hand?

A No. That's my medical assistant.

Q How was this patient -- this is a terrible word -- disposed of on the 27th? She -- your medical assistant makes this brief note?

A Correct.

Q And then what happens?

A And then I'm given four sheets and on three of the sheets I'll have entries made by the patient to fill out, and that will probably be Page 11.

Q Right.

A And Page 12. My staff would fill out the first one, which would be Page 10, and then I have a blank sheet for the physical and assessment and plan that I have to fill out after she gets her evaluation.

Q Did you see her --

MS. OAST: And that --

MR. LEWIS: Excuse me.

MS. OAST: And that's Page 13.

THE WITNESS: I'm sorry. That's Page 13.

MS. OAST: Thank you.

BY MR. LEWIS:

Q Did you see her on this day?

A Yes, I did.

Q Okay. Let me find Page 13. And does Page 13 have your entries on it concerning this lady for that visit?

A Yes, it does.

Q Read it for me. Read every entry that you placed on this page for me.

A Height, five foot six-and-one-half inch, weight 180, blood pressure 116/84, well nourished, well developed, normal habitus, abdominal normal, no hernias, liver normal, spleen normal, skin no lesions. Patient was oriented, abnormal -- no abnormal moods or affect, vulva and vagina mildly atrophic. The urethra and urethra meatus was normal. Bladder was abnormal with a grade 1 cystocele.

Q What's that?

A A mild herniation of the bladder into the vaginal vault.

Q And you can see that on a physical exam?

A Yes.

Q Okay. Go ahead.

A Cervix was abnormal in that the patient had mild cervical stenosis, and in order to do her pap smear I had to grasp the cervix with an instrument called a tenaculum that enabled me to be able to complete her pap smear.

Q Okay.

A Her uterus was approximately eight-week size and very irregular making it abnormal. The area of the fallopian tubes and ovaries were normal. Her perineum was normal, and I examined her discharge and I saw very few pus

cells in her discharge, few bacteria yeast.

Q That is a microscopic exam you do in the office?

A Yes.

Q Okay. And your assessment?

A First, ASCUS pap smear. That means the patient had an abnormal pap smear coming to see me that was performed in May of '06 showing atypical squamous cells of undetermined significance, and then I said it was repeated today. And if the pap smear was normal then she would be asked to come back in six months to get another pap smear, but if it was abnormal then possibly she could come in for a colposcopic exam using a microscope to evaluate her cervix, possibly need a biopsy or she may need conization of the cervix, which is a cone biopsy of the cervix.

Q Okay. Is the -- does Page 13 have the only entries you made on this patient on her first visit?

A Page 12 I signed off on her -- this is the page that the patient fills out.

Q Got it.

A And I dated it.

Q Okay.

A And the bottom of the first page, Page 10, I put in the physician note area that she had a history of fibroids and endometriosis and she had treatments for her endometriosis using Lupron for pelvic pain, and over that

particular notation I put -- I'm not quite sure what that is actually. Maybe "time in the past," something like that.

Q Okay.

A And then the last entry it says no estrogen replacement therapy or no ERT.

Q That means she's not on any?

A Correct.

Q And this treatment you -- you noted for endometriosis, that's just medication?

A That's just the medication she's had previously in the past.

Q And did she tell you -- you're getting all of this from her?

A Correct.

Q Did she tell you how her endometriosis had been diagnosed?

A Well, according to the history in -- in regard to medical and surgical procedures she had a laparoscopy in 1998 that showed fibroids, but there -- I think that by her history she told me that she had had endometriosis in the past, but I didn't put it beside that laparoscopy because generally speaking in order to make a diagnosis you have to visibly see the implants. So I'm not quite sure where -- I must have gotten it from her, the history.

Q Okay. But as you sit here today, you can't tell

me whether her endometriosis had been addressed surgically in the past?

A No, I cannot.

Q But one would assume that it had been because of the way you make that -- definitively make that diagnosis?

A Because of fact that she told me she had been on Lupron, and I know that Lupron therapy is used for endometriosis management so --

Q Okay. Doctor, when's the next time this lady came to see you? Strike that. Was the -- was the -- was the pap smear normal?

A Yes, it was normal.

Q Okay. If you will go back to your physician progress notes, it starts on Page 22. The next entry under progress notes is eight -- is that an eight and nine of '06?

A Correct.

Q That's not your entry; is it?

A No.

Q It appears to relate to a phone call to the patient about her normal pap smear and advice for her need for follow-ups?

A Correct.

Q Okay. And the next -- the next entry I see is December 7th -- December 12th of 2007 at least under physician's progress notes; correct?

A Correct.

Q To your knowledge was the patient seen in your office at any time between July 27th of '06 and December 12th of '07?

A No.

Q Do you know if she had the follow-up pap smear six months after August 9th of 2006?

A No.

Q When she came back on July -- on December 12th, 2007, did you see her?

A I believe my nurse practitioner, Barbara Haywood, saw her.

Q Look at Page 22 for me, Doctor. Is that your entry on the bottom?

A On the intrapelvic, no, that's my medical assistant entry.

Q Can you -- can you read that entry for me?

A Patient is here. Patient is having low abdominal pain. Pain is rated an eight.

Q That's intended to be eight --

A The pain started -- eight over ten.

Q That's intended to be eight over ten, okay. Go ahead.

A The pain started Sunday. Patient had a UTI or urinary tract infection, and when patient finished meds this

pain started and has an entry saying medication the same as 7/27/06.

Q And how was the patient disposed of by your office on December 12th?

A It should be noted that my nurse practitioner did repeat her pap smear.

Q On December 12th?

A On that day, December 12th, '07.

Q Okay.

A And she ordered a pelvic ultrasound.

Q That would be because of the complaints Ms. Agard registered?

A Of pain, that's correct.

Q And when you say "ordered," it makes it sound like to me she had to go somewhere else to get that test done?

A That's correct.

Q Okay. When's the next time she was seen in your office --

MR. LEWIS: Excuse me. Go ahead.

MS. OAST: I'm sorry. Answering a question you asked earlier on, not that it's of any moment, would you turn to Page Four for a minute if you don't mind?

MR. LEWIS: I don't. I'm there.

MS. OAST: I think you asked Dr. Faulk if he

knew how this patient got to him.

MR. LEWIS: I did.

MS. OAST: And look --

THE WITNESS: Constance Breland, yeah.

BY MR. LEWIS:

Q Former patient --

A Yes.

Q -- or current patient?

A Yeah.

MR. LEWIS: Okay. Thank you, Ms. Oast.

MS. OAST: You're very welcome.

BY MR. LEWIS:

Q So your nurse practitioner or physician's assistant performed a pelvic exam, did a pap smear and sent the patient out for a pelvic ultrasound?

A Correct.

Q What were the results of the ultrasound?

A I wanted you to make note of her repeat pap smear dated 12/12/07 on Page 48.

Q Okay. Was it normal?

A Normal.

Q Okay. Doctor, I'm looking at Page 168. If you can find it I think that will answer my question. Is this

the report that you received secondary to the ultrasound which your assistant ordered on this patient?

A Correct.

Q And would you give me your -- the benefit of your interpretation of what this report tells you as this lady's gynecologist?

A The findings indicate a dysmorphic fibroid appearing uterus that measured 6.9 by 4.4 by 5.4 centimeters. Discrete fibroids were not able to be captured reliably and neither the right or the left ovary was seen.

Q As this lady's gynecologist, Dr. Faulk, what does that tell you?

A That she probably has fibroids but the ultrasound probably didn't pick up discrete ones, and her uterus was reasonably normal size and she possibly could have another condition called adenomyosis that sometimes is not seen by -- by ultrasound very well.

Q What is it?

A It's a condition where the lining of the uterus grows into the muscle wall, and it creates a scenario where the uterus is enlarged. It bleeds into itself. Patients have abnormal bleeding. She's a -- she is menopausal, but the actual irregularity of the uterus and what it looks like is kind of similar to fibroids, but it's difficult to pick up discrete fibroids.

Q So --
A And patients have pain, you know, from that.
Q So as her gynecologist, with this in hand, two diagnoses were being entertained by you?
A Correct.
Q All right. Back to your progress notes, Dr. Faulk, did -- did you see this lady on December 12th of '07?
A No, I did not.
Q Okay. How is the decision made back in the late '07 and '08 when a patient comes in as to who sees her, you or an assistant?
A If the patient has a preference patient's will always see me.
Q Okay.
A Unless I'm either not available or it's much easier to get in to see the nurse practitioner.
Q Okay.
A And oftentimes even if both of us are there if the patient comes in on her schedule, meaning my nurse practitioner's, and then if -- if it's a complicated case then I'll just go in and -- and see her with Barbara.
Q Okay. And is that a conversation that's had with the patient when they call for an appointment, "Who do you want to see, Dr. Faulk or Barbara"?

A It should be.

Q Okay. It looks like Doctor, Page 21 -- we're going backwards here, but that's all right.

MS. OAST: You got a problem?

MR. LEWIS: Huh? Not for me. I do it all the time.

BY MR. LEWIS:

Q The next time this lady was seen by someone in your office appears to me to be January the 8th of 2008?

A Correct.

Q And again she was seen by Barbara or by you -- by you?

MS. OAST: Look at Page Seven, Doctor.

A She was seen by me.

BY MR. LEWIS:

Q On Page 21 is that your handwriting?

A The only part of it that is my handwriting it says, "See GYN sheet," and then I have my signature, which is kind of on the next line.

MR. LEWIS: What am I looking for, Carolyn?

MS. OAST: Page Seven.

BY MR. LEWIS:

Q Okay. Just give me an overview, Dr. Faulk, of what goes on with this patient during this visit. She comes in. Barbara sees her as reflected in -- on Page 21?

A Correct.

Q And then what happens as -- as you can tell from your -- your medical record?

A Well, the patient comes in to see me and she still has pain, and she indicated to me during the interview after talking about the different reasons why you have pain with those two diagnoses, and she wanted a hysterectomy because I -- I remember now because I put that in my note that she desired to have major surgery to, you know, irradicate the problem since I reproduced her pain on my examination with her that day.

Q By what, pushing on her?

A By -- by pelvic exam, right.

Q Okay. All right. Page Number Seven is in your hand?

A Yes. Correct.

Q Go ahead and read all the entries that you made either by checking something, circling something or writing.

A Chief complaint, pelvic pain, questionable fibroids. Pap smear was not done today. Urinalysis was normal.

Q Uh-huh.

A History is right lower quadrant pain starting December '07. It's now worse. There's an entry above that that I'm not quit sure if I understand my own writing, but continuing. Yesterday urinary frequency, ultrasound in December '07, no well-defined fibroids, and there was an entry stating that colonoscopy was done three years ago and was normal.

Next entry on physical exam, blood pressure 114/66. The abdomen noted right lower quadrant tenderness, normal bowel sounds, liver, spleen normal, no abdominal hernias.

On pelvic exam she had a normal vulva. Vagina was normal. The area around the urethra and urethra meatus was normal. Bladder was normal. In respect to pain, uterus was moderately tender, and I designate that by putting a two plus over four plus numerical description of how much pain she had.

Q Yes, sir.

A The uterus was enlarged about the size of an eight-week pregnancy and was irregular, which goes along with the diagnosis of uterine fibroids. The cervix was normal. The right adnexa or the area where the tube and ovary's located showed significant tenderness, mild to moderate, as designated by one to two over four plus pain,

and the left adnexal area was normal.

Under the -- the assessment I indicated that the patient probably had degeneration pain secondary to uterine fibroids, history of endometriosis, and I wrote in parentheses, "Patient wants hysterectomy," and then I -- plan was to do a laparoscopic supracervical hysterectomy, bilateral salpingo-oophorectomy, and she was told to take Advil for her pain because she did not want any narcotics.

Q Doctor, do you have a present recollection of that visit?

A No, I don't.

Q Then what I would ask you to do is to give me your standard operating procedure in terms of sitting down with a patient with Ms. Agard's presentation, and you're going to talk to her about her options. Here's what we can do. Here's what we can't do. I don't know how you do that, but if you would just kind of share that with me so I have an abbreviation for your standard operating procedure, and I understand you don't remember this conversation but I'm going to assume that whatever conversation we -- you had with her was reasonably in approximation to your SOP.

A Uh-huh.

Q So if you would do that for me.

A Well, usually with pelvic pain problems I talk about medical therapy first. Since this patient is

menopausal it probably would not be a great benefit to put her on any kind of estrogen, progesterone combination or therapy since if a patient has endometriosis that will make her pain even worse. The next thing I will probably talk to her about is laparoscopy to look in to find out if there are other causes for pain, more as a diagnostic procedure, and if we find another reason that I can take care of it at the time of laparoscopy then we can do so. And so that would be the conservative surgical approach, evaluation and laparoscopy. Then if the patient's very adamant about proceeding with, you know, major surgery then we talk about hysterectomy, types of hysterectomy, whether it's a total abdominal, whether it's vaginal hysterectomy, whether it's laparoscopic-assisted vaginal or laparoscopic supracervical hysterectomy.

Q And if you can tell me, in Ms. Agard's case were all of those approaches options that were available to you if she chose hysterectomy?

A Well, I don't have any independent recollection -- recollection of that, but based on the patient's physical exam, there are certain types of surgeries probably would not be appropriate for her.

Q Which ones and why?

A If the patient has very little uterine prolapse, if there's not much relaxation in her pelvic ligaments then

it would be a difficult procedure to do either a vaginal hysterectomy or possibly a laparoscopic-assisted vaginal hysterectomy.

Q Okay.

A And a patient certainly could have a total abdominal hysterectomy because that's pretty much our standard for most procedures. The laparoscopic supracervical probably intrigued her mostly because the return to function is quicker and the patient's pain from surgery is much less because they have laparoscopic incisions. So that's my usual -- I usually go through the whole gamut of the types and then I would probably tell them which procedure I thought fit them best based on their physical findings.

Q Assuming the patient's choices are total abdominal or supracervical, under what circumstances would you not do a supracervical?

A If you've demonstrated definite cervical pain.

Q Okay. And she had not?

A No.

Q Question I meant to ask you a few minutes ago, during this physical exam how do you examine her bladder to note it as being normal?

A Well, from a pain standpoint all you do basically is to by -- if you -- you have to separate out the uterus

from the bladder and by talking to the patient and pretty much get them focused on something different, and so what I'm trying to do is to see if the patient has significant pain from bladder prolapse. When you reduce the prolapse, meaning push the bladder back up, and the pain is better then you've isolated to see if the pain is coming from the bladder proper.

Q And so you're doing that during your pelvic exam?

A As I am talking to them, and that's one reason why I kind of talk and run my mouth as I'm doing the exam to do that.

Q Okay. And so at the -- at the conclusion of the January 8th visit, Ms. Agard and you were in agreement that she was going to have this surgery?

A Correct.

Q Can you tell me when the next time was she was seen in your office?

A Preop visit February 1, 2008.

Q It looks like you got a form called a preop history and physical?

A Yes.

Q Although I can't tell you what page number it is. Maybe Ms. Oast can.

MS. OAST: Five and six, I believe.

THE WITNESS: 34 actually.

MR. LEWIS: I'm not readily putting my hands on it, but that's all right.

MS. OAST: Tell me again what Page 34 is called.

THE WITNESS: 34 is the preop sheet.

BY MR. LEWIS:

Q What's it say rather than wasting everybody's time looking around for it?

MS. OAST: I don't need it. Hold -- hold on just a second, Dr. Faulk.

MR. LEWIS: Thank you.

MS. OAST: Go ahead.

THE WITNESS: Okay.

BY MR. LEWIS:

Q Actually whoever filled this out I can actually read their handwriting. That's okay. Unlike yours. Okay. Referral for medical clearance, the words "none needed" are written in there?

A That's correct.

Q How is it determined by you or your office whether a patient does or does not need a referral for medical clearance?

A If the patient has hypertension, diabetes,

unstable, asthma, complicated medical problems I'll get a preop clearance by either a specialist or a primary care doctor.

Q Okay. Under A what does that word say?

A Ready.

Q Ready, consent signed, detailed -- detailed history and physical written, what does that mean?

A Well, that means that the out -- for the hospital, that means the H and P is written for the hospital admission.

MS. OAST: That was the Page Five and Six I was referring you to.

BY MR. LEWIS:

Q And so the H and P is actually dictated by you at the time the patient is preoped?

A Or -- or handwritten.

Q Okay. Why was Lovenox considered as a postop medication?

A She had high risk -- I go through an assessment of every body that's going to surgery to see if they need Lovenox, and that's the assessment to see if they're at risk for deep venous thrombosis, and so when I talk to her, you know, we have a -- a sheet that we go through and ask questions, and certain questions have a certain numerical

risk and then when you add up the numbers if the -- if the numbers are greater than five I believe then the person has an increased risk for DVT and then you put them on Lovenox postop.

Q And she fit into that category?

A Yes.

Q "Complications discussed at length," is that in your handwriting?

A Yes.

Q Can you read it for me?

A Ureter, bladder injury and repair, bowel injury and repair, wound infection, bleeding requiring transfusion or blood transfusion and deep venous thrombosis, and I put dash Lovenox.

Q Was the word "ureter" added later after this entry was originally made?

A That day.

Q While the plaintiff was there or while the -- after the patient had left?

A After the patient had -- had left.

Q And did you go back and add it?

A Yes, I did.

Q Why?

A Well, because I routinely talk to patients. When I talk to anyone who has any kind of pelvic surgery that's

anywhere close to the urinary tract I go through. I have a diagram -- I have picture diagram that I talk to them. I show them exactly where the surgery's going to be, and I always say there's always a risk for bladder injury, and I go into why -- how we repair those, go into urethral injury, and I think in this particular case I must have just kind of forgotten to put "ureter," and at the end of the day I always kind of go back through my -- my papers and make sure I've updated properly, but that's something I do for every one so I know that's the case so --

Q And is your testimony, Dr. Faulk, that you had a discussion with Ms. Agard about the possibility that her ureter would be injured during this surgery?

A Yes.

Q Did you also discuss with her the possibility that a -- that the ureter could be injured and not known or not realized by you at the time?

A I don't remember that independently, no.

Q Okay. Do you have in any of these records in front of you today the picture that you have referred to with me?

A No, I don't.

Q That's something you keep in your office?

A Yes, I do. It's -- it's a --

MS. OAST: I might have it.

THE WITNESS: Okay.

MS. OAST: Let's -- can we take a break?

MR. LEWIS: Sure, and I'm going to give that back to you, Carolyn.

THE VIDEOGRAPHER: We're going off the record. The time is 2:16 p.m.

(There was a short break, after which, testimony continues as follows:)

THE VIDEOGRAPHER: This is the beginning of Tape Number Two in the deposition of Dr. Charlie Faulk. The time is 2:33 p.m. We are on the record.

(Diagram was marked as Faulk Deposition Exhibit Number Three.)

BY MR. LEWIS:

Q Dr. Faulk, Ms. Oast has kindly provided us with a copy of what I believe to be the diagram you were referring to in your earlier testimony about how you consent your patients prior to a -- a hysterectomy?

A Correct.

Q And has it been marked by our court reporter as

Exhibit Three?

A Correct.

Q Okay. What I'd like for you to do, Doctor, and if you can turn it around so that the video can -- can pick up the picture as well is just walk me through your usual presentation for your patients using Exhibit Three, and as I understand it, you don't have a current recollection of consenting Ms. Agard, but you do have a standard procedure that you used during this time frame?

A Correct.

Q Okay. Go ahead and tell us what your standard procedure is.

A Well, first of all, I try to highlight anatomically where the uterus is in relationship to the bladder and in relationship to the pubic bone so that they are very well aware of where the uterus sits and it sits behind the bladder, and then I also make a comment about where the vagina is, where the rectum is, and the bowel of course fills up the rest of the space in the pelvis. Then I'll jump over to the urinary system, and I want to make them aware of the fact that the uterus is sitting right in between the two ureters and right behind the bladder as I stated previously.

And as I start to describe risk factors for ureteral injury and bladder injury I always tell them at the

time of hysterectomy we have to physically push the bladder off of the uterus, and when doing so that enables us to be able to increase the space in between the uterus and the ureters hopefully to get them out of harm's way.

Q "Them" being the ureters?

A Correct.

Q Okay.

A And so then I go into explanation of what happens when you have a bladder injury, and if a hole is made then once recognized we repair it and then a catheter is put in for at least seven days postop to allow it to heal, and then I'll usually say if -- if a ureteral injury occurs and it's recognized then we call in a urologist and then he will make some recommendations in regard to treatment.

Then I'll start talking about bowel injury, and depending upon if the patient's had numerous intraabdominal surgeries before, if I suspect a lot of adhesions I'll recommend to get a bowel prep prior to surgery, and that's the reason why. And so usually that takes care of those of particular systems, and then I'll go in to talk about the DVT risk, pneumonia risk, wound infection risk, risk of bleeding and what have you.

Q Okay. Can we assume because you went forward with this procedure that Ms. Agard expressed an understanding of those risks and consented to going forward with those risks

having explained to her?

A Yes.

Q Okay. She was not bowel prepped; was she?

A Not to my knowledge or else I would have put it on my sheet.

Q Okay. And as I understand it, Dr. Agard, prior to February the 11 --

MS. OAST: Dr. Faulk.

BY MR. LEWIS:

Q I'm sorry. Dr. Faulk, prior to February the 11th of 2008 you had never operated on this patient?

A That's correct.

Q So the next thing that happened with her after her preop visit was the surgery itself?

A Yes, it was.

Q Why was it decided, Dr. Faulk, to remove this patient's ovaries?

A The patient is always counseled regarding ovarian preservation, and depending upon the patient's age, if the patient's over 45 statistically I'll talk about the risk of ovarian cancer. If you retain the ovaries it will be less than one percent, and then I always talk about the risk of adhesions that may form around the ovaries as a consequence of the surgery. They could be totally normal at the time

you look at them, but postoperatively then they may generate pain from just the scarring. And so I'm a -- I'm usually a little bit aggressive about removing ovaries in a menopausal patient. If she's peri-menopausal I'll pretty much let them make a decision.

Q So the decision to remove her ovaries was for therapeutic predicting, therapeutic good reasons?

A That's right, because since she came in for pelvic pain reasons I wanted to reduce the risk that she would have pelvic pain after her surgery so --

Q During your formal training, Dr. Faulk, were you trained to do supracervical hysterectomies?

A No.

Q Where did you learn that technique?

A At a medical conference. I can't remember specifically which one. At the time when I did her surgery though I had done at least 30, 35 cases.

Q Did any of those cases -- in any of those cases did you encounter any complications?

A No.

Q Okay. When you were trained were you trained to perform laparoscopic hysterectomies?

A Well, prior to doing laparoscopic supracervical we as gynecologists are used to doing vaginal hysterectomies.

Q Yes, sir.

A And then we're used to doing operative laparoscopies. So it's a natural process for most of us laparoscopic surgeons to do laparoscopic-assisted vaginal hysterectomies, and so on the learning curve when you take on a procedure like a supracervical it's kind of a natural process because we already know about the anatomy in the lower pelvis and to do it laparoscopically so it's fairly easy to transition to that procedure. So I already knew how to do laparoscopic-assisted vaginal hysterectomies.

Q Where did you learn that?

A Well --

Q I'm just trying to get a timeline on your education. When you were in your residency were they teaching --

A No.

Q -- laparoscopic procedures for OB-GYNs?

A No. They were just beginning.

Q Okay.

A That was back in late seventies, early eighties.

Q Where did you get your training in laparoscopic abdominal surgery?

A In between 1982 and '88 before I came to Newport News.

Q And where were you?

A I was in Dallas, Texas.

Q And how were you trained?

A Partly by going to conference, partly by tutoring because that was part of the -- the hospital privilege -- the privilege requirement that if you entered in a new procedure you have to have someone to tutor you to do the procedure.

Q Right.

A And they had to sign off on it so --

Q Okay.

(There was an off-the-record discussion, after which, testimony continues as follows:)

BY MR. LEWIS:

Q Doctor, in your practice in 19 -- in 2008 what was the purpose for which an operative report was dictated by you postoperatively?

A Well, it gives a description of intraoperative findings, technique in achieving the goal and any problems that would occur.

Q Is it intended to tell the reader all of the essential surgical actions that you took to accomplish your surgical goals?

A Yes.

Q As a general rule does it contain a reference to

every significant surgical maneuver that you perform intraoperatively?

A No.

Q Can you tell me how it is when you're sitting down with whatever dictating equipment is available to you, how do you decide what portions of your surgical maneuvers to include and what portions of your surgical maneuvers not to include?

A Well, you certainly want to include any sort of abnormal findings that would justify the surgery and to explain why the patient had the pain or the mass, and so you would describe that, and in Ms. Agard's case whenever you're doing any kind of laparoscopic removal of ovaries and tubes you do have to talk about the pelvic side wall, and the pelvic side wall anatomically obviously you have to disconnect the blood supply and disconnect where the ovary and tube and uterus is -- is being attached.

Now, whenever the patient has a very normal anatomy I must admit that sometimes I may not go through all the steps to describe in my op note sometimes that the ureter was seen and it was evaluated, but as an operative surgeon laparoscopic surgeons always do that. We have a certain --

Q Always do what?

A We have a certain structural way to be able to

identify where you are and where the anatomy is. So you grab the ovary and tube. You pull it medially to the middle of the patient. You cut the support ligaments. You go along the pelvic side wall to identify the ureter to make sure it's well away from the adnexa, and then once you've clearly identified then you cauterize the blood supply. You cut it and you keep on down the line, and I must admit, you know, on cases where the patient has very little adhesions and has very good anatomy I must admit there's some cases I probably will omit to talking about where the ureter is. Now, if --

Q You're -- you're getting ahead of me. I'm going to take you there in just a few minutes. Okay?

A Okay.

(Operative Report was marked as Faulk Deposition Exhibit Number One.)

BY MR. LEWIS:

Q Take a look at Exhibit One for me and confirm for me that that is the operative report you dictated secondary to your February 11th, '08 surgery.

A Correct.

Q And it appears, Dr. Faulk, that you dictated it the day of this surgery. Was it your practice back then to

go straight from the OR to an area where you had dictation equipment available to you?

A Correct.

Q While the surgery was fresh on your mind?

A Correct.

Q Have you reviewed that recently?

A Not recently but --

Q Why don't you read it for me just so that there's no surprises?

A Okay.

Q Doctor, in -- in that document I think it's on Page Two you described the placement of the 12 millimeter trocar as midline suprapubic. Can you give me a better idea of exactly where that trocar placement was on this patient? By midline I assume you mean in the middle?

A In the middle of the patient.

Q Suprapubic, how low is that? Can you tell me how low -- how many centimeters or millimeters below the umbilicus it is?

A Well, it's probably -- probably three, four centimeters above the pubic bone.

Q Okay. You also describe the two five millimeter trocars in the left and right lower quadrant. Would they have been above the placement if -- if you're going from the patient's feet to her head would the two five millimeter

trocars been placed above the 12 millimeter midline suprapubic trocar?

A Usually, yes.

Q And can you tell me how many millimeters or centimeters right and left of the patient's midline they were placed?

A Generally about two to three centimeters medial to the anterior iliac crest on the side, the bones on the side.

Q Okay. And I take it from your earlier comments, Dr. Faulk, that the patient's ureters are in close proximity to the surgical instruments you're manipulating during the surgery?

A Correct.

Q And I take it from your earlier comments that the ureters are at risk for injury during a supracervical laparoscopic hysterectomy like the one you did on Ms. Agard?

A Yes.

Q Do you have a present recollection of this surgical procedure?

A No.

Q Is the medical record essentially what's available to you to talk to me and share with whoever asks you how this surgery was performed?

A Yes, just -- just the op note.

Q Okay. As I read the op note, Dr. Faulk, I didn't

see -- and I stand to be corrected by you and I'm not offended if you can, but I didn't see any reference in there to your having visualized and localized this patient's ureters?

A Correct.

Q And is that because -- well, I'm not going to do that. Tell me why that's not in there.

A As I stated previously, there may be times when the anatomy is very normal. The patient has very little adhesions or scar tissue that I will omit stating that the ureters were evaluated and I traced them down to the level of where the blood supply is and where you transect or cut across the cervix.

Q Give me an example of a patient getting this procedure where you would have specifically dictated, I have identified the ureters and whatever it is you do, traced them down to make sure they were out of harm's way.

A Patient who has significant pelvic adhesions where the anatomy has been altered and you have to identify every piece of anatomy specifically as you go down.

Q Uh-huh. And that wasn't the case with this patient?

A No.

Q In Ms. Agard's surgery, can you tell me whether you dissected out the ureters before proceeding on with the

hysterectomy?

A I can't tell from the medical -- from the OR note, op note.

Q When you're operating -- when you're performing a supracervical hysterectomy like the one you did on this lady, are there case where you don't dissect them out?

A Correct.

Q Why?

A Because you can visualize the pathway through the peritoneal lining as you go.

Q Okay. And you can't tell me whether you did or did not on this patient?

A No.

Q Do you have -- in just reading through the literature, Doctor, some authors describe the dissection technique as either medial superior or lateral. When you dissect out a patient's ureters do you have a preferred approach?

A Usually medial.

Q And that you learned as part of the training you've told me about you received over the years since completing your residency?

A Correct.

Q And that was the -- was that the only approach you were taught or it's simply the approach you prefer?

A Well, depends on the anatomy. In most cases a medial approach is probably preferred because you can -- you have more space between the ureter and the pelvic side wall to visualize it, but there are times if -- if a patient has a big uterus or she has real bad endometriosis you have to use both techniques. You have to retract it medially. You have to retract it laterally toward the pelvic side wall and literally view it as the anatomy goes down naturally, and sometimes even dissect the peritoneal lining off or right above the ureter so you know where you're going.

Q Okay. Dr. Faulk, from reading this operative report it does not appear that you appreciated any injury to this lady's ureters intraoperatively?

A Correct.

Q As you followed her during the days, weeks and months after this surgery did you formulate an opinion as to whether or not an injury had been inflicted on her ureter?

A What dates? Up to what, just --

Q As of today?

A Well, immediately postoperatively I can say that I did not feel like the patient had a ureteral injury.

Q Yes, sir. Do you feel like she had one today?

A She had a ureteral injury.

Q And did you inflict that injury during this surgery?

A Well, I cannot say specifically yes. All I can say is that later on in the medical records when I operated on her to do a laparoscopy I -- I saw that the ureter was injured and there was -- actually you could see urine leaking out of the hole.

Q Yes, sir.

A So at that point in time the diagnosis was made. Up until that -- that point in time I didn't know that the patient's ureter was injured.

Q No, and I know that, Dr. Faulk. That -- that wasn't my question. My question is did -- and I'll ask it a little bit differently. Have you formulated an opinion with your patient during your care and treatment of her as to how she got that injury?

MS. OAST: Let me just tell you one thing, Dr. Faulk. He doesn't want to know anything you and I have discussed. He wants to know as her treating physician did you at the time come to an etiology as to the damage to her ureter?

THE WITNESS: At the time she had her original surgery?

MS. OAST: No. When you continued as her treating physician including when you saw leaking urine did you then say, oh, this must have been what happened or that must have been what

happened? And if you didn't, then don't do it now.

A I did not.

BY MR. LEWIS:

Q You mean --

A And I didn't. I really did not.

Q Okay. I -- and if this question sounds argumentative it's because it probably is, and I'm not intending to argue with you, but I find it astonishing that as this lady's surgeon when you go in and find something like urine leaking out of a ureter it doesn't enter your mind as to, gee, how in the world could that have happened?

MS. OAST: I'm going to object to the form. He didn't say it didn't enter his mind.

BY MR. LEWIS:

Q Okay. Did it enter your mind as to wonder how this happened?

A It entered my mind. I was -- I was groping with trying to go through differential diagnoses.

Q Okay.

A No question.

Q And did you ever come to a conclusion to your satisfaction as to how this lady's ureter got injured?

A Well, you'll see in one of the reports with her second hospitalization that there was a CT scan done showing pockets of fluid inside the patient's abdomen, and the large pocket which was about ten centimeters was actually on the left side of the patient. Then she had smaller pockets on both left and right side. Of course she had a right ureteral injury. Then there was mention that her sigmoid colon was -- was thickened both the -- I think the distal and the medial aspects. The wall was thickened and so the examination -- examining radiologist basically stated that there was a possibility the patient could have had a diverticulitis or some sort of bowel problem, and to some degree at that point I became somewhat fixated on that as the main diagnosis because I really had no reason to suspect that the patient had a ureteral injury. She had excellent urine outputs. She had no flank pain. She had no fever. She had no urinary tract infection problems, and so I went off on a tangent particularly with that hospitalization to make sure I brought in a general surgeon, infectious disease doctor, and so that was my main diagnosis at the time.

MS. OAST: I think --

A Am I answering your question or --

MR. LEWIS: I think I forgot the question.

MS. OAST: No. This is what he wants to know. When you realized that there was an injury

to her ureter did you, as her treating physician, determine in your mind how that occurred?

THE WITNESS: Oh, okay. Is that -- is that --

MS. OAST: I think. Is that --

MR. LEWIS: You did a better job than I did.

MS. OAST: Well, I don't know if I did.

THE WITNESS: Okay.

MS. OAST: But I think that's what he wants to know.

MR. LEWIS: Yeah.

A Okay. Well, because of the location of the injury and it was what I thought a fairly good distance from the bladder it had to have occurred sometime with the initial stages of removal of the ovary and tube.

BY MR. LEWIS:

Q During the procedure you performed?

A Uh-huh.

Q Okay. That's a yes?

A Yes.

Q Thank you, sir. Doctor, in -- in the course of working through this complication in your mind have you been able to -- well, strike that. Can you tell me how this injury could have occurred intraoperatively but not be

visualized by you?

A Well, one way it could happen, we use various cautery techniques.

Q Yes, sir.

A And so there's always a potential that you can cauterize tissue that's very close to the ureter and because in some cases the actual damage of tissue goes far beyond where you think the burn is, and so if there is a reduction of blood flow to that segment of the ureter it certainly could over time I believe cause it to necrose and -- and it could open, just come apart.

Q Okay. Doctor, do you know what a cystogram is?

A Yes.

Q Do you perform it?

A No.

Q How about a cystoscopy?

A Cystoscopy I do perform.

Q And in what cases do you perform a cystoscopy?

A If I believe that there is a bladder injury at the time of surgery.

Q You'd use it as something to confirm a suspicion, confirm or disconfirm a suspicion.

A Yes.

Q I take it you don't routinely do them in all laparoscopic hysterectomies irrespective of whether or not

you think there's a bladder or a ureteral injury?

A Correct.

Q And you didn't do one on this patient?

A Correct.

Q In your experience will a cystoscopy identify a ureteral injury if one has occurred?

A Not just a cystoscopy alone. You would have to put dye through intravenously.

Q Right.

A And then watch to see the colored urine come through the orifices or the openings in the dome of the bladder.

Q So the cystoscopy with indigo carmine or whatever dye you want to use?

A That's correct.

Q Okay. When you were being trained in this surgical technique did any of the instructors or trainers or mentors, whatever you want to call them, suggest to you that it might be a good idea to do a cystoscopy in every laparoscopic hysterectomy?

A No.

Q Is it a difficult procedure to perform?

A No.

Q Is it time consuming?

A No.

Q Is it expensive?

A Relatively, no. Can I say something though?

Q Oh, certainly. Don't ever think I'm trying to cut you off, because I'm not.

A It requires though that a gynecologist, who is not trained in doing urological procedures you have to go back and get extra training to do cystoscopy. So like the routine person who comes out of residency training I feel they'll probably have to go back just all -- like all of us do to get essential training to do that particular type of procedure. That's all.

Q Yes, sir. But you are well trained in performing cystoscopies; aren't you?

A Yes.

Q And experienced?

A Yes.

Q Doctor, was any portion of this surgery, the February 11th surgery, videotaped or photographed by you or anyone else?

A I took one photograph -- oh, no. Strike that. I'm sorry. Not this procedure.

Q A later procedure?

A Right.

Q Okay. Doctor, rather -- rather than sludge through all of this lady's postoperative records, as I read

it, and you -- you've described some of this for me already. You -- you took care of this patient for a period of time and then it looked kind of like she was handed off to Dr. Darby?

A Correct.

Q And -- and I believe you're aware from looking at your record that he then handed her off to Dr. Fabrizio?

A Correct.

Q And once it was determined that her problem, her central problem anyway was a ureteral injury, then I don't want to say you weren't her doctor anymore, but her care went over to the urologist?

A Correct.

Q Okay. Doctor, can you tell me what professional organizations you belong to?

A American --

MS. OAST: Academy -- American College.

A Yeah, American College of OB-GYN.

MS. OAST: Yeah.

THE WITNESS: I'm glad you said that.

BY MR. LEWIS:

Q Any others?

A That's it.

Q AMA?

A No.
Q Any gynecological organizations?
A No.
Q Any laparoendoscopic organizations?
A No.
Q Have you ever been?
A I've been to the courses that they -- they represent, but I haven't gone to any of the national organization stuff.
Q You haven't joined?
A No.
Q Doctor, are there any textbooks that address laparoendoscopic surgical procedures that gynecologists perform that you consider to be authoritative?
MS. OAST: Well, hold on. Because he's not here as an expert I don't think you can ask him what textbooks he thinks are authoritative.
MR. LEWIS: If you're telling him not to answer, that's fine.
MS. OAST: Well, I -- I can't ethically do that.
MR. LEWIS: You can't ethically. Oh, so you're just stating an objection?
MS. OAST: No. I'm just hoping you weren't going to ask -- you would withdraw the question.

MR. LEWIS: Well, I'm not going to --

MS. OAST: Ask him which ones he knows off or which authors he finds highly regarded but to ask --

MR. LEWIS: Okay. All right.

MS. OAST: Thank you.

BY MR. LEWIS:

Q Do you have any go-to textbooks, Dr. Faulk, when you want to refer to a text that addresses itself to laparoscopic hysterectomies?

A No, I don't, sir.

Q How about periodicals, same question, ones that you regularly read that address themselves to laparoscopic procedures that might be on your menu of things you do?

A I don't have any one particular one that I --

Q Which ones do you subscribe to?

A "Contemporary OB-GYN."

Q Okay.

A The "American Journal of OB-GYN."

Q Okay.

A And Sterility Fertility.

Q What was the first?

A I mean, let me see. What is that called? Fertility Sterility -- Fertility Infertility. It's a

journal of infertility.

Q Okay.

A Or something like that.

Q Okay.

A Purple journal.

Q Any others. The purple journal?

A Yeah, that's what I call it.

Q Okay. That come to mind?

A That would probably be it.

Q Okay. Are you familiar with a textbook, Doctor, that was edited by I think his first name is Paul Wetter entitled "Prevention & Management of Laparoendoscopic Surgical Complications"?

A No, I'm not aware.

Q Ever read it?

A No.

Q Doctor, just a few questions about your previous litigation experience. It looks like you were sued in 1994 by a patient named Karren Hecht. Do you remember that?

A Correct.

MS. OAST: Hang on just a second. I -- I want to renew my objection to his having to answer these questions just so I won't be deemed to have waived it down the road.

MR. LEWIS: Yes, ma'am.

MS. OAST: Thank you.

BY MR. LEWIS:

Q Do you recall that case?

A Yes, I recall it.

Q Do you remember what Ms. Hecht's complaints with your care were?

A I delivered her baby and repaired a midline episiotomy. There was a sponge that was left in and she went home, had an infection in her -- her episiotomy site. It did not break down. She was treated with antibiotics and she did well, and then I got sued.

Q It appears from the court documents that the case was settled in 1997. Does that sound right to you?

A That's about -- that's about right.

Q Was this lady paid any money?

A Yes, and I believe it was $5,000 or something.

Q It also looks like you were sued by a physician named Paul Meyers in 2001. Does that ring any bells?

A That was a peer review problem.

MS. OAST: We can go off for a second.

MR. LEWIS: Let's go off.

MS. OAST: I'll tell you about that.

Nance --

THE VIDEOGRAPHER: We're going off record.

The time is 3:07 p.m.

(There was an off-the-record discussion, after which, testimony continues as follows:)

THE VIDEOGRAPHER: We're back on the record. The time is 3:07 p.m.

BY MR. LEWIS:

Q Doctor, was your deposition taken by the plaintiff's lawyer in Karren Hecht?

A I don't have any independent recollection of that but --

Q Okay. It also looks like a patient named Yvette Ferguson-Young sued you in 2000. Do you recall that?

A Correct, I do.

Q And do -- do you remember what her complaint was?

A She was -- she was a patient of mine who came in questionable labor, and at the time she was on labor and delivery an abnormal fetal heart rate -- fetal heart rate tracing appeared that I was not notified of in time, and then they called me rather late in the -- her stay on labor and delivery, and by that time I believe that the tracing had become bradycardic and which means that the heart rate was below 60 beats a minute. So we rushed in and did an

emergency C-section and the baby was nonviable, so she sued Mary Immaculate and then I was sued also being the attending physician.

Q Yes, sir. And do you recall how that case was disposed of? I know it was settled, but do you know how?

A I believe it was settled in the case of Mary Immaculate, and I was never recontacted.

Q And to your knowledge no moneys were paid to this lady on your behalf?

A Correct.

Q Okay. You may have already answered this, Doctor, and I apologize if I'm repeating myself, but are you familiar with a periodical entitled "Human Reproduction"?

A Yes, I'm familiar with it.

Q Have you ever subscribed to it?

A No.

Q Same question, a periodical entitled "Gynecological Surgery"?

A I've seen that.

Q Have you ever subscribed to it?

A No.

Q "Journal of Minimally Invasive Gynecology," you familiar with that?

A I'm familiar.

Q Ever subscribe to it?

A No.

MR. LEWIS: Let's go off the record for just a minute, and I may be done.

THE VIDEOGRAPHER: We're going off the record. The time is 3:09 p.m.

(There was a short break, after which, testimony continues as follows:)

THE VIDEOGRAPHER: We're back on the record. The time is 3:11 p.m.

BY MR. LEWIS:

Q Dr. Faulk, after you determined that this lady had a ureteral injury did you sit down with her and talk to her about what the injury was and how the injury had occurred?

A I remember talking to her about the injury, but I don't recall talking to her about how it occurred.

MR. LEWIS: Dr. Faulk, that's all the questions I have for you. Thank you very much for coming here today and answering them.

MS. OAST: He'll read.

THE VIDEOGRAPHER: This concludes the videotaped deposition of Dr. Charlie Faulk consisting of two tapes. The time is 3:12 p.m.

We are off the record.

(The witness was excused.)

COMMONWEALTH OF VIRGINIA AT LARGE, To-Wit:

I, Shannon A. Crittenden-Mann, a Notary Public in and for the Commonwealth of Virginia at Large, whose commission expires May 31, 2012, certify that the foregoing videotaped deposition of CHARLIE M. FAULK, MD, was duly taken and sworn to before me at the time and place for the purpose in the caption mentioned, and that the foregoing is a true and correct transcript to the best of my ability of the testimony given by the witness.

I further certify that I am not a relative or employee of attorney or counsel of any of the parties or financially interested in the action.

Given under my hand this _____ day of _____, _____.

_____

Notary Public

Registration No. 217036