

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.

Old Dominion Reporting
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EXAMINATION

CHARLIE M. FAULK, MD PAGE

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

9
10 THE VIDEOGRAPHER: We're on the record. The
11 time is 1:31 p.m. This is the videotaped
12 deposition of Dr. Charlie Faulk in the case of
13 Cassandra M. Agard versus Charlie M. Faulk, MD,
14 At Law Number CL09-00233-DP, pending in the
15 Circuit Court for the City of Newport News. This
16 deposition is being taken on behalf of the
17 plaintiff's counsel.

18 My name is Nancy Watters. I represent the
19 firm of Legal Video Solutions, Incorporated,
20 Norfolk, Virginia. Today's date is October 1st,
21 2009. The location is 1092 Laskin Road, Virginia
22 Beach, Virginia. The court reporter is Shannon
23 Mann of Old Dominion Reporting.

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

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

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

5 THE COURT REPORTER: Would you raise your
6 right hand?

7

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

11

12 BY MR. LEWIS:

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

15 A Charlie Mica Faulk.

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

18 A Yes.

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

21 A That's fine.

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

1 A No.

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

4 A No.

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

7 A No.

8

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

11

12 BY MR. LEWIS:

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

18 A Yes, it is.

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

21 A Yes. In the professional experience --

22 Q Yes, sir.

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

25 Q When did you stop practicing obstetrics?
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1 A 2001.

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

5 A The rest of it's fine.

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

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

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

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

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

25 A Yes.

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

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

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

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

11 A Correct.

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

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

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

23 A That's correct.

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

1 A Mary Immaculate Hospital and Riverside Regional
2 Medical Center.

3 Q Just those two?

4 A For admissions.

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

8 A No.

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

11 A Not physically with me today.

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

14 MS. OAST: Yes.

15 MR. LEWIS: Would you mind doing that?

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

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

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

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

24 MS. OAST: Okay.

25

1 BY MR. LEWIS:

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

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

7 Q Yes, sir.

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

11 Q Okay.

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

17

18 BY MR. LEWIS:

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

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

24

25

1 BY MR. LEWIS:

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

3 MS. OAST: Oast Law Firm.

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

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

7

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

10

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

13

14 BY MR. LEWIS:

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

16 A Yes, I do.

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

19 A Correct.

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

22 A Office staff.

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

25 A Not every one. I think I probably have three
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1 different people probably put notes.

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

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

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

9 A That's correct.

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

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

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

22 A I don't know.

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

25 A No. That's my medical assistant.
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1 Q How was this patient -- this is a terrible word --
2 disposed of on the 27th? She -- your medical assistant
3 makes this brief note?

4 A Correct.

5 Q And then what happens?

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

9 Q Right.

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

14 Q Did you see her --

15 MS. OAST: And that --

16 MR. LEWIS: Excuse me.

17 MS. OAST: And that's Page 13.

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

19 MS. OAST: Thank you.

20

21 BY MR. LEWIS:

22 Q Did you see her on this day?

23 A Yes, I did.

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

1 A Yes, it does.

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

4 A Height, five foot six-and-one-half inch, weight
5 180, blood pressure 116/84, well nourished, well developed,
6 normal habitus, abdominal normal, no hernias, liver normal,
7 spleen normal, skin no lesions. Patient was oriented,
8 abnormal -- no abnormal moods or affect, vulva and vagina
9 mildly atrophic. The urethra and urethra meatus was normal.
10 Bladder was abnormal with a grade 1 cystocele.

11 Q What's that?

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

14 Q And you can see that on a physical exam?

15 A Yes.

16 Q Okay. Go ahead.

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

21 Q Okay.

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

1 cells in her discharge, few bacteria yeast.

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

3 A Yes.

4 Q Okay. And your assessment?

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

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

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

19 Q Got it.

20 A And I dated it.

21 Q Okay.

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

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

3 Q Okay.

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

6 Q That means she's not on any?

7 A Correct.

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

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

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

14 A Correct.

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

17 A Well, according to the history in -- in regard to
18 medical and surgical procedures she had a laparoscopy in
19 1998 that showed fibroids, but there -- I think that by her
20 history she told me that she had had endometriosis in the
21 past, but I didn't put it beside that laparoscopy because
22 generally speaking in order to make a diagnosis you have to
23 visibly see the implants. So I'm not quite sure where -- I
24 must have gotten it from her, the history.

25 Q Okay. But as you sit here today, you can't tell
Old Dominion Reporting

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

3 A No, I cannot.

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

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

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

12 A Yes, it was normal.

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

16 A Correct.

17 Q That's not your entry; is it?

18 A No.

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

22 A Correct.

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

1 A Correct.

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

5 A No.

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

8 A No.

9 Q When she came back on July -- on December 12th,
10 2007, did you see her?

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

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

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

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

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

20 Q That's intended to be eight --

21 A The pain started -- eight over ten.

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

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

1 pain started and has an entry saying medication the same as
2 7/27/06.

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

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

7 Q On December 12th?

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

9 Q Okay.

10 A And she ordered a pelvic ultrasound.

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

13 A Of pain, that's correct.

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

16 A That's correct.

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

19 MR. LEWIS: Excuse me. Go ahead.

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

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

25 MS. OAST: I think you asked Dr. Faulk if he
Old Dominion Reporting

1 knew how this patient got to him.

2 MR. LEWIS: I did.

3 MS. OAST: And look --

4 THE WITNESS: Constance Breland, yeah.

5

6 BY MR. LEWIS:

7 Q Former patient --

8 A Yes.

9 Q -- or current patient?

10 A Yeah.

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

12 MS. OAST: You're very welcome.

13

14 BY MR. LEWIS:

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

18 A Correct.

19 Q What were the results of the ultrasound?

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

22 Q Okay. Was it normal?

23 A Normal.

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

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

3 A Correct.

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

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

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

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

18 Q What is it?

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

1 Q So --

2 A And patients have pain, you know, from that.

3 Q So as her gynecologist, with this in hand, two
4 diagnoses were being entertained by you?

5 A Correct.

6 Q All right. Back to your progress notes,
7 Dr. Faulk, did -- did you see this lady on December 12th of
8 '07?

9 A No, I did not.

10 Q Okay. How is the decision made back in the late
11 '07 and '08 when a patient comes in as to who sees her, you
12 or an assistant?

13 A If the patient has a preference patient's will
14 always see me.

15 Q Okay.

16 A Unless I'm either not available or it's much
17 easier to get in to see the nurse practitioner.

18 Q Okay.

19 A And oftentimes even if both of us are there if the
20 patient comes in on her schedule, meaning my nurse
21 practitioner's, and then if -- if it's a complicated case
22 then I'll just go in and -- and see her with Barbara.

23 Q Okay. And is that a conversation that's had with
24 the patient when they call for an appointment, "Who do you
25 want to see, Dr. Faulk or Barbara"?

1 A It should be.

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

4 MS. OAST: You got a problem?

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

7

8 BY MR. LEWIS:

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

11 A Correct.

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

14 MS. OAST: Look at Page Seven, Doctor.

15 A She was seen by me.

16

17 BY MR. LEWIS:

18 Q On Page 21 is that your handwriting?

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

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

23 MS. OAST: Page Seven.

24

25

1 BY MR. LEWIS:

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

5 A Correct.

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

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

16 Q By what, pushing on her?

17 A By -- by pelvic exam, right.

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

20 A Yes. Correct.

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

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

1 Q Uh-huh.

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

9 Next entry on physical exam, blood pressure
10 114/66. The abdomen noted right lower quadrant tenderness,
11 normal bowel sounds, liver, spleen normal, no abdominal
12 hernias.

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

19 Q Yes, sir.

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

1 and the left adnexal area was normal.

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

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

11 A No, I don't.

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

22 A Uh-huh.

23 Q So if you would do that for me.

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

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

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

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

23 Q Which ones and why?

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

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

4 Q Okay.

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

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

18 A If you've demonstrated definite cervical pain.

19 Q Okay. And she had not?

20 A No.

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

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

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

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

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

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

15 A Correct.

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

18 A Preop visit February 1, 2008.

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

21 A Yes.

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

24 MS. OAST: Five and six, I believe.

25 THE WITNESS: 34 actually.

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

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

5 THE WITNESS: 34 is the preop sheet.

6

7 BY MR. LEWIS:

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

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

12 MR. LEWIS: Thank you.

13 MS. OAST: Go ahead.

14 THE WITNESS: Okay.

15

16 BY MR. LEWIS:

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

21 A That's correct.

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

25 A If the patient has hypertension, diabetes,
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1 unstable, asthma, complicated medical problems I'll get a
2 preop clearance by either a specialist or a primary care
3 doctor.

4 Q Okay. Under A what does that word say?

5 A Ready.

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

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

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

13

14 BY MR. LEWIS:

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

17 A Or -- or handwritten.

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

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

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

5 Q And she fit into that category?

6 A Yes.

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

9 A Yes.

10 Q Can you read it for me?

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

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

17 A That day.

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

20 A After the patient had -- had left.

21 Q And did you go back and add it?

22 A Yes, I did.

23 Q Why?

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

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

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

14 A Yes.

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

18 A I don't remember that independently, no.

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

22 A No, I don't.

23 Q That's something you keep in your office?

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

25 MS. OAST: I might have it.
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1 THE WITNESS: Okay.

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

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

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

7

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

10

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

15

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

18

19 BY MR. LEWIS:

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

24 A Correct.

25 Q And has it been marked by our court reporter as
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1 Exhibit Three?

2 A Correct.

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

10 A Correct.

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

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

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

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

5 Q "Them" being the ureters?

6 A Correct.

7 Q Okay.

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

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

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

1 having explained to her?

2 A Yes.

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

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

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

8 MS. OAST: Dr. Faulk.

9

10 BY MR. LEWIS:

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

13 A That's correct.

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

16 A Yes, it was.

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

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

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

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

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

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

13 A No.

14 Q Where did you learn that technique?

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

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

20 A No.

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

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

25 Q Yes, sir.

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

10 Q Where did you learn that?

11 A Well --

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

15 A No.

16 Q -- laparoscopic procedures for OB-GYNs?

17 A No. They were just beginning.

18 Q Okay.

19 A That was back in late seventies, early eighties.

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

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

24 Q And where were you?

25 A I was in Dallas, Texas.

1 Q And how were you trained?

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

7 Q Right.

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

9 Q Okay.

10

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

13

14 BY MR. LEWIS:

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

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

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

24 A Yes.

25 Q As a general rule does it contain a reference to
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1 every significant surgical maneuver that you perform
2 intraoperatively?

3 A No.

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

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

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

24 Q Always do what?

25 A We have a certain structural way to be able to
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1 identify where you are and where the anatomy is. So you
2 grab the ovary and tube. You pull it medially to the middle
3 of the patient. You cut the support ligaments. You go
4 along the pelvic side wall to identify the ureter to make
5 sure it's well away from the adnexa, and then once you've
6 clearly identified then you cauterize the blood supply. You
7 cut it and you keep on down the line, and I must admit, you
8 know, on cases where the patient has very little adhesions
9 and has very good anatomy I must admit there's some cases I
10 probably will omit to talking about where the ureter is.

11 Now, if --

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

14 A Okay.

15
16 (Operative Report was marked as Faulk Deposition
17 Exhibit Number One.)

18
19 BY MR. LEWIS:

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

23 A Correct.

24 Q And it appears, Dr. Faulk, that you dictated it
25 the day of this surgery. Was it your practice back then to
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1 go straight from the OR to an area where you had dictation
2 equipment available to you?

3 A Correct.

4 Q While the surgery was fresh on your mind?

5 A Correct.

6 Q Have you reviewed that recently?

7 A Not recently but --

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

10 A Okay.

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

16 A In the middle of the patient.

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

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

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

1 trocars been placed above the 12 millimeter midline
2 suprapubic trocar?

3 A Usually, yes.

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

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

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

13 A Correct.

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

17 A Yes.

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

20 A No.

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

24 A Yes, just -- just the op note.

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

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

5 A Correct.

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

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

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

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

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

23 A No.

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

1 hysterectomy?

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

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

7 A Correct.

8 Q Why?

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

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

13 A No.

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

19 A Usually medial.

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

23 A Correct.

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

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

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

14 A Correct.

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

18 A What dates? Up to what, just --

19 Q As of today?

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

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

23 A She had a ureteral injury.

24 Q And did you inflict that injury during this
25 surgery?

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

6 Q Yes, sir.

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

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

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

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

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

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

3 A I did not.

4

5 BY MR. LEWIS:

6 Q You mean --

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

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

14 MS. OAST: I'm going to object to the form.

15 He didn't say it didn't enter his mind.

16

17 BY MR. LEWIS:

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

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

22 Q Okay.

23 A No question.

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

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

21 MS. OAST: I think --

22 A Am I answering your question or --

23 MR. LEWIS: I think I forgot the question.

24 MS. OAST: No. This is what he wants to

25 know. When you realized that there was an injury

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

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

5 MS. OAST: I think. Is that --

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

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

8 THE WITNESS: Okay.

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

11 MR. LEWIS: Yeah.

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

16

17 BY MR. LEWIS:

18 Q During the procedure you performed?

19 A Uh-huh.

20 Q Okay. That's a yes?

21 A Yes.

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

1 visualized by you?

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

4 Q Yes, sir.

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

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

13 A Yes.

14 Q Do you perform it?

15 A No.

16 Q How about a cystoscopy?

17 A Cystoscopy I do perform.

18 Q And in what cases do you perform a cystoscopy?

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

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

23 A Yes.

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

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

2 A Correct.

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

4 A Correct.

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

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

9 Q Right.

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

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

15 A That's correct.

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

21 A No.

22 Q Is it a difficult procedure to perform?

23 A No.

24 Q Is it time consuming?

25 A No.

1 Q Is it expensive?

2 A Relatively, no. Can I say something though?

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

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

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

14 A Yes.

15 Q And experienced?

16 A Yes.

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

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

22 Q A later procedure?

23 A Right.

24 Q Okay. Doctor, rather -- rather than sludge
25 through all of this lady's postoperative records, as I read
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1 it, and you -- you've described some of this for me already.
2 You -- you took care of this patient for a period of time
3 and then it looked kind of like she was handed off to
4 Dr. Darby?

5 A Correct.

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

8 A Correct.

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

13 A Correct.

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

16 A American --

17 MS. OAST: Academy -- American College.

18 A Yeah, American College of OB-GYN.

19 MS. OAST: Yeah.

20 THE WITNESS: I'm glad you said that.

21

22 BY MR. LEWIS:

23 Q Any others?

24 A That's it.

25 Q AMA?

1 A No.

2 Q Any gynecological organizations?

3 A No.

4 Q Any laparoendoscopic organizations?

5 A No.

6 Q Have you ever been?

7 A I've been to the courses that they -- they
8 represent, but I haven't gone to any of the national
9 organization stuff.

10 Q You haven't joined?

11 A No.

12 Q Doctor, are there any textbooks that address
13 laparoendoscopic surgical procedures that gynecologists
14 perform that you consider to be authoritative?

15 MS. OAST: Well, hold on. Because he's not
16 here as an expert I don't think you can ask him
17 what textbooks he thinks are authoritative.

18 MR. LEWIS: If you're telling him not to
19 answer, that's fine.

20 MS. OAST: Well, I -- I can't ethically do
21 that.

22 MR. LEWIS: You can't ethically. Oh, so
23 you're just stating an objection?

24 MS. OAST: No. I'm just hoping you weren't
25 going to ask -- you would withdraw the question.

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

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

5 MR. LEWIS: Okay. All right.

6 MS. OAST: Thank you.

7

8 BY MR. LEWIS:

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

12 A No, I don't, sir.

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

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

17 Q Which ones do you subscribe to?

18 A "Contemporary OB-GYN."

19 Q Okay.

20 A The "American Journal of OB-GYN."

21 Q Okay.

22 A And Sterility Fertility.

23 Q What was the first?

24 A I mean, let me see. What is that called?

25 Fertility Sterility -- Fertility Infertility. It's a
Old Dominion Reporting

1 journal of infertility.

2 Q Okay.

3 A Or something like that.

4 Q Okay.

5 A Purple journal.

6 Q Any others. The purple journal?

7 A Yeah, that's what I call it.

8 Q Okay. That come to mind?

9 A That would probably be it.

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

14 A No, I'm not aware.

15 Q Ever read it?

16 A No.

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

20 A Correct.

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

25 MR. LEWIS: Yes, ma'am.
Old Dominion Reporting

1 MS. OAST: Thank you.

2

3 BY MR. LEWIS:

4 Q Do you recall that case?

5 A Yes, I recall it.

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

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

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

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

16 Q Was this lady paid any money?

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

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

20 A That was a peer review problem.

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

22 MR. LEWIS: Let's go off.

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

24 Nance --

25 THE VIDEOGRAPHER: We're going off record.
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1 The time is 3:07 p.m.

2

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

5

6 THE VIDEOGRAPHER: We're back on the record.

7 The time is 3:07 p.m.

8

9 BY MR. LEWIS:

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

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

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

16 A Correct, I do.

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

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

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

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

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

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

10 A Correct.

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

14 A Yes, I'm familiar with it.

15 Q Have you ever subscribed to it?

16 A No.

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

19 A I've seen that.

20 Q Have you ever subscribed to it?

21 A No.

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

24 A I'm familiar.

25 Q Ever subscribe to it?

1 A No.

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

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

6
7 (There was a short break, after which, testimony
8 continues as follows:)

9
10 THE VIDEOGRAPHER: We're back on the record.
11 The time is 3:11 p.m.

12

13 BY MR. LEWIS:

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

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

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

22 MS. OAST: He'll read.

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

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We are off the record.

(The witness was excused.)

1 COMMONWEALTH OF VIRGINIA AT LARGE, To-Wit:

2

3

4

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

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

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

19

20

21

22

Notary Public

23

24

Registration No. 217036

25