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Exhibits: None

COMMONWEALTH OF MASSACHUSETTS
SUFFOLK, SS SUPERIOR COURT DEPARTMENT
OF THE TRIAL COURT

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MARCIN MARCINIAK AND ANNA MARCINIAK,

Plaintiff,

v.

SELWYN O. ROGERS, JR, M.D.,
AND PETER NAJJAR, M.D.,

Defendants.

* *

BEFORE THE HONORABLE MARK A. HALLAL
DOCKET NUMBER 1484CV01361

TESTIMONY OF DAVID A. MAYER, M.D.
EXPEDITED

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Monday, October 16, 2017

Allyson Pollier
Court Reporter

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I N D E X

P R O C E E D I N G S

(Testimony of David A. Mayer, M.D. commences at 9:51 a.m.)
(Jury present)
(WITNESS SWORN)
DAVID MAYER: Yes.
DR. MAYER: Good morning, Your Honor.
THE COURT: Good morning.
MR. GRACE: Thank you, Your Honor.
(DIRECT EXAMINATION OF DAVID A. MAYER, M.D.)
BY MR. GRACE:
Q Good morning.
A Good morning.
THE COURT: One second, Mr. Grace. Does everybody have what they need by way of notebooks and pencils? Okay.
MR. GRACE: Thank you, Your Honor.
BY MR. GRACE:
Q Would you tell the jury your full

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name please?
A David A. Mayer, M.D.
Q And what's your current profession?
A I am a general surgeon and have been since the 1970s.
Q And can you tell the jury please about your educational background?
A So, I went to Cornell Medical School in Manhattan, New York City, graduated in in 1974.
Then I did a five-year General Surgery residency, which at that time included General and Vascular Surgery, at New York Hospital-Cornell and finished that in 1978.
Then went out into private practice in Long Island, New York in the North Shore-Long Island Jewish Health System.
I sat for the American Board of Surgery Board Certification Exam shortly after my residency, passed on the first attempt, and then have

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recertified every ten years since.
My professional practice as a general surgeon includes all major intra-abdominal surgery, including approximately a thousand appendectomies.
Most likely, about 60 percent were open and 40 percent laparoscopic.
Q Let me interrupt for a second. Describe to the jury the difference between open and laparoscopic appendectomies.
A Yes, of course.
So, for the first 20 years of my practice, we did all -- we meaning general surgeons in the United States did all appendectomies open, meaning with an incision, generally in the patient's right lower quadrant, called a McBurney incision, which is an incision which is a little oblique and a muscle-splitting incision.

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If we knew ahead of time on a CAT scan that it was a ruptured appendix, occasionally we would make a midline incision. But the vast majority were --
Q What's a midline incision?
A That's an up-and-down incision in the abdomen between the rectus or strap muscles.
That's the type of incision that Mr. Marciniak had during his re-operative surgeries.
But the standard, like the gold standard for an open appendectomy as far as incisions is a muscle-splitting incision in the right lower quadrant called the McBurney.
And in the last period of my practice, the last 15 years or so, we started doing more and more laparoscopically, which is minimally invasive, using the camera and small ports so you don't have to make a

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big incision.
And gradually, the majority of the appendectomies I performed were moved into the laparoscopic category. But I would say about -- I have done, at a minimum, around 600 open appendectomies.
My practice also involved taking emergency room call at a level-two trauma center.
And one of the most common patients I was called for were patients with abdominal pain, including appendicitis.
Q Okay. You weren't here for the opening statements by counsel, but assume that Mr. McTague said that --
MR. MCTAGUE: Objection, Your Honor.
THE COURT: Sustained.
BY MR. GRACE:
Q Were you performing appendectomies as of August 2011?
A I was not on that day. I was out on

medical leave, awaiting hip surgery.
Q Is that the only reason you weren't performing appendectomies as of 2011?
A Yes.
Q When was the last appendectomy you had performed before that?
A I believe it was early December 2010.
Q And as of December 2010, had you performed about a thousand appendectomies?
A Yes.
Q Now, has the standard of care for open appendectomies changed since 2010?
A It has not.
Q When did the standard of care with respect to open appendectomies change -- last change?
A Well, I was trained at the New York Hospital-Cornell residency program in the '70s. The standard of care for open appendectomies has not

changed since then. It's the same standard.
Q Same as it was 43 years ago when you were there?
A Yes, sir.
Q Could you explain to the jury please what an appendix is and what it does?
A An appendix is a worm-like structure that comes off the bottom of the right colon or cecum in the patient's right lower side of their abdomen.
It can be a nubbin or it can be very long. In Mr. Marciniak's case, it was about seven centimeters.
That's somewhere in the neighborhood of three inches, 2.54 centimeters an inch, but -- so, he had a relatively long one.
But they can be of various size. It has some lymphoid tissue, which is some immune function, but

basically, in humans now, with evolution, it serves no useful purpose and it's just an organ from evolutionary times.
It's called a vestigial organ, meaning it's not useful, but it can cause trouble, especially if the base gets blocked with balls of calcified stool or inflammation, and then you can get acute infection of the appendix or acute appendicitis.
Q Okay. The appendix is attached to the first part of the large bowel called the cecum, right?
A Yes, and that's -- the small bowel, or ileum, comes into the cecum generally a few inches away from the appendiceal insertion. So, --
Q What's the appendiceal insertion?
A That's the base of the appendix that has a hole or lumen that attaches to the cecum.
Q Okay. And are appendices attached to the cecum in various different

positions?
A They're not attached to the cecum, but the appendix lies in various positions within the pelvis. There is variability from person-to-person.
Q What different positions?
A Well, the majority, or approximately two-thirds of appendixes lie behind the cecum in a retrocecal appendix position, meaning behind the cecum.
That's the normal anatomy for the majority of patients. Appendix can also lie down in the pelvis, called a pelvic appendix, which happens in about a third of the patient.
But a majority have the --
THE COURT: One minute. Go ahead. Sorry, Doctor.
A The majority of patients present -- if they have acute appendicitis will present, as did Mr. Marciniak, with the appendix behind the cecum.

That's the normal or most common presentation of the appendix.
Q And you said two-thirds of --
A Yes.
Q -- appendices are retrocecal or behind the cecum?
A Yes.
Q And how many are, you know, dangling straight down, what percentage?
A Approximately a third.
MR. GRACE: May I approach, Your Honor?
THE COURT: You may.
BY MR. GRACE:
Q Okay. This is a diagram done by Dr. Rogers at his deposition this year that's been marked as Exhibit for identification R.
Is this a fair but crude representation of the relative positions of the terminal ileum, the small bowel coming into the cecum, and different positions of the appendix?

A Yes. It's a fair and accurate representation. The dotted lines are the retrocecal, or behind the cecum, which is the most common.
The others are more of a pelvic presentation of the appendix, which is a less frequent but not uncommon presentation as well.
It's about two-thirds retrocecal, as Mr. Marciniak has one-third free in the pelvis.
Q So, in other words, by far, the most common position for an appendix is retrocecal, right?
A Yes.
Q More than two-to-one?
A Yes.
Q Retrocecal versus pelvic?
MR. MCTAGUE: Objection, Your Honor. Leading.
THE COURT: Sustained.
BY MR. GRACE:
Q What's the percentage that are retrocecal?

MR. MCTAGUE: Objection, Your Honor. Asked and answered twice.
THE COURT: Overruled.
A Yes. It's about two-to-one behind the cecum as opposed to free in the pelvis.
MR. MCTAGUE: Your Honor, may we approach just momentarily?
(SIDEBAR CONFERENCE NOT TRANSCRIBED)
BY MR. GRACE:
Q As of 2011, what were the risks of an open, non-ruptured appendectomy?
A It's important to recognize that if an appendix is not ruptured, it's a simple operation with low attendant risks.
The main risks are just bleeding, if the appendiceal artery tie had slipped off, or wound infection, rarely intra-abdominal abscess.
But the risks are low and it's a straightforward, relatively

simple operation if properly performed.
Q What are the risks of an open appendectomy if the appendix is ruptured?
A If it's ruptured, the patient gets peritonitis and --
Q What's that?
A That's inflammation and infection in the pelvis and eventually the abdominal sac or cavity.
And when that happens, inflammatory response occurs, tissues get swollen and inflamed, bowel can become adherent to the infectious process, an abscess can form, and operation becomes more difficult, especially if there is any delay.
And that's when, in a ruptured appendix setting, injury to adjacent bowel and organs does become a risk of the procedure.
That's not a risk of the

procedure with an unruptured appendix. That's an important distinction.

Q And you have reviewed all of the relevant records in this case, right?

A Yes. I reviewed all the hospital records from the three hospitals, all the depositions in this case and answers to interrogatories and all the attached exhibits to the depositions.

Q Okay. And what was the injury that occurred in the operation on August 22nd into the morning of August 23rd, 2011?

A Dr. Rogers and Dr. Najjar, the assistant, took Mr. Marciniak to the operating room for an appendectomy.

He had come in with right lower quadrant, elevated white count, CAT scan showing appendicitis, non-ruptured, which is important.

And he went to the operating room to do a simple appendectomy through a McBurney right lower side of the abdomen incision, doing it open.

The choice of open versus laparoscopic is choice of the surgeon. Open appendectomy is still within standard of care, although most are done laparoscopic.

At the time of the surgery, the appendix was retrocecal, which is the expected position in the majority of patients.

And there was inflammation and the cecum and appendix were densely adherent to the back of the abdomen, the retroperitoneum.

Q Could you explain that to the jury in plain language what densely adherent means?

A So, the back of the colon is obviously against the back of the patient's abdomen.

The abdomen is a sac called the peritoneal sac, and that sac houses the organs, the liver, spleen, kidneys, -- kidneys are actually behind the sac -- the bowels, small and large.

And the appendix lying behind the cecum makes contact with the back of the sac. And there is just a medical name for the back of the sac that's in the patient's back, in front of the spine and muscles.

It's called the retroperitoneal area, meaning behind the peritoneum. So, since Mr. Marciniak's appendix was lying behind the cecum in a retrocecal position, once it got inflamed, the inflammation gets sticky and the cecum and appendix stuck down to the back of the abdomen.

That's normal and expected with appendicitis and a retrocecal

appendix.

Q What's normal and expected?

A To get inflammation behind the cecum and to have some level of adherence. In Mr. Marciniak's case, it was quite adherent, or what Dr. Rogers described as partially densely adherent in his operative note.

When the surgeon sees that, the proper technique within standard of care is to free up the stuck area, free up the cecum and appendix from the back of the abdomen.

That's the critical first step before you pull up the cecum and small bowel into the wound to do the appendectomy. I should back up a second.

In order to do an appendectomy, you have to lift the cecum and the ileum up into the wound so the appendix is visible and in the operative field.

You can't do an appendectomy

with it stuck to the back of the patient. You have to free it up and gently, the liver, the cecum and ileum into the wound, and then the appendix comes with the cecum.

And then you can get at the appendix and ligate the base properly. But --

Q Let me interrupt for a second. Is an adherent cecum or a densely adherent cecum, is that an unusual finding?

A It's not unusual at all. And it has to be anticipated with a retrocecal appendix with a significant degree of inflammation.

So, the first step is to recognize it, and Dr. Rogers did. He recognized the cecum was densely adherent.

The next step is to completely free up the cecum and appendix from being stuck in the back of the abdomen, so that with

gentle traction on the cecum and the ileum, the area can be delivered into the wound and the appendectomy can be done.

You can't put the cart before the horse and pull up on the cecum and ileum before the back is --

MR. MCTAGUE: Objection, Your Honor. Beyond the question asked.

THE COURT: Sustained in that form.

BY MR. GRACE:

Q All right. We'll get to the procedure later. What was the injury in this case?

A The injury was ripping off or avulsing the ileum or the end of the small bowel from the cecum, completely tearing the ileum off of the cecum, the small bowel off of the large bowel.

Q Is that a risk of an open, non-

perforated appendectomy?

A No, it is not and --

Q Could you explain your answer, please?

A The complication is not even a rare or unusual complication. It's a nonexistent complication.

I have personally done 25,000 major surgeries. I was chairman of surgery at one of the North Shore-Long Island Jewish teaching hospitals and I supervised 250 surgeons in my departments.

I have never heard of the complication. It's never been published in the medical literature. It's basically a nonexistent complication.

It is not within standard of care; in fact, it's far outside of standard of care.

Q Is it possible for an ileal avulsion or tear to occur during other appendectomies?

A It is possible. If there was a --

Q What circumstances?

A If there was a ruptured appendix with a big abscess, gangrene, and the bowel was involved in the abscess and was terribly inflamed or even infarcted, meaning it's dying or gangrenous, then the integrity of the tissue could be so weak that it would literally fall apart.

And that actually is possible with an advanced ruptured appendix and a delay in diagnosis. In this case, the pathology --

MR. MCTAGUE: Objection, Your Honor.

THE COURT: Sustained. Next question.

BY MR. GRACE:

Q Based on your review, what did the pathology show in this case?

A In this case, the pathology showed that the ileum was basically completely normal. It had minimal

medically insignificant changes, such as mucosal ulceration and things that would have nothing to do with the integrity of the wall.

And there was no medical reason or the tear to occur based on the pathology.

Q Now, getting back to the standard of care with respect with an open, non-perforated appendectomy in 2011, please proceed with your answer.

A It might be helpful for me to use that illustration.

Q Which one?

A The one of the retrocecal appendix that I --

Q The diagram or the illustration?

A The illustration.

Q Okay. And you can come down.

DR. MAYER: With Your Honor's permission?

THE COURT: You may. Mr. McTague, can you see that?

MR. MCTAGUE: I can, Your

Honor.

THE COURT: Ms. Kogan?

BY MR. GRACE:

Q All right. Proceed, Doctor.

A So, this was the appearance or the or the --

THE COURT: Can all the jurors see?

A This was the position roughly of Mr. Marciniak's appendix. It was behind the cecum.

It's a fair and accurate representation of a retrocecal appendix, which, as I testified earlier, is the normal or more common presentation of an appendix.

The free pelvic appendix is a less common presentation. In Mr. Marciniak's case and in most patients with retrocecal appendicitis behind the cecum, the inflammation occurs behind the bowel and in front of the back of the patient's abdomen called the

retroperitoneum.

In these type of cases, the inflammation occurs here, and it is generally easier to deliver the appendix because it's not stuck.

But with a retrocecal, in the majority of patients that you do an appendectomy on, it's behind the cecum, and the cecum is adherent with inflammation to the back of the abdomen to varying degrees.

And once you make the incision, you feel how stuck the cecum is, and that's why Dr. Rogers was able to determine correctly that there was dense adherence of the cecum and appendix to the back of the abdomen.

So, during an appendectomy, before you grasp the ileum and the cecum and rock it up and deliver it into the wound to remove the appendix, you have to completely free behind the cecum so there is no

resistance.

Because the bowel is a delicate structure, and when you're lifting and pulling on bowel, you can't be pulling against resistance or tethering in the back of the abdomen. You can create an injury.

So, standard of care requires gentle traction on the bowels to deliver it. The first step in an appendectomy is to start working behind the cecum with your hand, bringing up the cecum and appendix completely until it's free.

Then, when you grasp the ileum and cecum, it basically comes out tension-free and effortless with the gentlest of traction. And that's the proper performance of an appendectomy for retrocecal appendix.

In other words, you free up first and pull second. You never pull first when it's still stuck or

bad things are going to happen. That's bad surgery, it's a medical error, and it's below standard of care to pull first and free up second.

You always have to free the cecum and appendix from its attachment in the back of the abdomen.

Q Okay. If a surgeon were having problems freeing up the appendix and cecum, what were the options?

A That's not uncommon, especially with a lot of inflammation, such as Mr. Marciniak had.

So, if it's really adherent and it's difficult freeing, you enlarge the incision. There is actually a name for it. It's called a Fowler-Weir, W-E-I-R, extension.

In other words, you have the McBurney incision. You can make it a little more lateral and you can extend it across the rectus sheath,

which are the strap muscles.

Q Could you speak English, please?

A All right. I'm sorry.

So, you basically, if the incision is this long, you make it a little longer, not in the skin, but in the muscle and fat and connective tissue underneath to make a bigger hole so the surgeons eyes can see in a wider fashion.

And then you can get hands in and work a little better, because the McBurney incision, the right lower quadrant incision is relatively small.

So, if it's stuck, as it was in Mr. Marciniak's case, the first thing you do is recognize it, which Dr. Rogers did. Then you make the incision bigger.

Then you free up the cecum, then it comes right out without having to pull. You never pull first and free this up second,

because then you can tear things.

No surgeon does that. No surgeon should do that. And, unfortunately, Dr. Rogers did it that way and got into a bad complication.

Q Are you done with the illustration?

A I am.

Q Okay. Resume the stand please.

Now, at some point, my office retained you -- retained your services in this case?

A Yes.

Q And then you reviewed all the material you have already gone through, right?

A I have.

Q Are you being compensated for your time?

A Yes. My work on the case before the trial was compensated at 375 dollars an hour.

And I am being paid 6,000 dollars for my time away from my

practice. I came up yesterday from New York and hopefully will return later tonight.

Q And in this case, were your services provided through some company called -- I think it's National Medical Consultants?

A Yes.

Q Now, do you do other medical-legal work?

A Excuse me. I didn't hear that.

Q Do you do other medical-legal work?

A Yes.

Q Okay. Would you tell the jury please about the medical-legal work you do?

A I have been a medical expert, such as my role today, for nearly 30th years. It's around my 80 time testifying in court today. I have done about 120 depositions before trial on cases.

I have reviewed about 700 cases over 30 years. I review for

plaintiff and the defense. For most of my review, the majority were plaintiff cases, patient -- on behalf of the patient, about 90 percent, and ten for defense.

In the last six years, I have gotten much busier on the defense side, and now I am about 60 percent for the patient and 40 percent for doctors and hospitals.

I don't control who calls me, so I am happy to review for either side. And I have testified in about 21 states. This is my second time testifying in Massachusetts in court.

I am based in Long Island, New York, so most of my work is in New York State. And I have worked with National Medical Consultants for about the last three years.

That's a doctor-run expert service that matches experts with attorneys who are looking for

experts. They do mainly plaintiff work.

I have reviewed probably about 20 cases for them over three years. And, Mr. Grace, your case was one of them.

Q All right. When you say doctor-run outfit, what do you mean?

A It's run by an M.D. And generally, I turn down about --

MR. MCTAGUE: Objection, Your Honor.

THE COURT: Next question.

MR. GRACE: Yes.

BY MR. GRACE:

Q Now, of the cases you're asked to evaluate, first say by patients or patients' attorneys, what percentage of the case -- of those cases do you agree with the theory of plaintiffs' or patients' case?

A I have -- I reject about 20-25 percent because I can't support the theory. And in the majority,

they're usually prescreened and vetted fairly well, so the majority I find are valid. But I turn down about, on average, 20-25 percent.

Q All right. Surgeons or, you know, other doctors also retain your services, right?

A Yes.

Q And what percentage of those cases do you agree with, say for example, their defense?

A The majority, but about 20 percent I can't support and I let them know.

Q How do you let them know; what do you say?

A That --

MR. MCTAGUE: Objection, Your Honor.

THE COURT: Sustained.

BY MR. GRACE:

Q And you communicate that to the doctor or lawyer who retains you?

A Yes, sir.

Q You don't agree with them?

A Yes.

Q Okay. Now, you're not licensed to practice in Massachusetts, right?

A I am not.

Q Okay. And you never have been, right?

A Correct.

Q You're licensed to practice in New York?

A Yes.

Q Are standards of care, surgical care, different from state-to-state?

A They are not. There is a nationwide standard of care for General Surgery and it doesn't vary state-to-state.

Q Okay. Doctor, based on your education, training, experience and review of the material in this case, did you form any opinions to a reasonable degree of medical certainty as to whether Dr. Rogers complied with the standard of care in an open, non-perforated appendectomy?

A I have an opinion.
Q And what is that opinion or what are those opinions?
A My opinion is that Dr. Rogers departed from standard of care or good and accepted surgical practice by failing to extend the incision when he noted that cecum was densely adherent to the retroperitoneum.
That would have allowed adequate exposure to properly free the cecum and appendix from the back of the abdomen and would have allowed delivery of the appendix area into the wound tension-free and avoided the injury.
I also found, it's my opinion, that Dr. Rogers departed from standard of care by applying excessive traction to the ileum, attempting to pull out the ileum and cecal area when it was still stuck to the back of the abdomen.
And when I say excessive

traction or the term extremely excessive traction, I am comparing it to the gentle, almost effortless traction that a surgeon should apply to the delicate bowel structures to slip them out of the wound once the fixation to the back of the abdomen has been totally freed up.
There should be no tension. You should not have to pull on the ileum to get the cecum out. It should just be a guide to let the area come up once it's freed properly.
The excessive traction tore the ileum off the cecum, which, in surgery or medicine is called a never event.
A never event is defined as one that should never happen with careful surgeons practicing standard of care. It's an event that's an extraordinary never event.
Q In these circumstances, right?

A In these circumstances, correct.
Q On what do you base that opinion?
A On my review of the case materials, my training and experience, Cornell Medical School and New York Hospital-Cornell surgical residency, my 40 years of surgical practice, my 25,000 major surgeries, my experience as chairman of surgery, heading quality assurance for 250 surgeons, my appointment as associate professor of surgery at New York Medical College and my teaching experience.
Q We have heard some talk of associate assistant professor. You are an associate professor?
A Excuse me?
Q We have heard some talk in this case about assistant professorships, associate professorships, full professorships. You're an associate professor?
A Yes. It usually --

Q How long have you been an associate professor?
A For about 15 years. It's usually dependent on how many articles and publications you write.
I have about 40 articles and three book chapters. If you keep writing and publishing, you can advance in rank.
I am not a full-time academic surgeon. I'm an operating-in-the-trenches operating surgeon and was never full-time -- full-time surgeon means an employed surgeon by a hospital.
I was always in private practice.
Q And are you currently affiliated with any hospital? Do you have operating room privileges at any hospital?
A I currently don't, but I will
st
November 1 . I have my privileges back at North Shore Long Island-

Jewish/Huntington Hospital on Long Island.

I had -- at the end of 2010, I had a physical disability. I had end-stage arthritis of my hip and had trouble and pain walking and standing, which isn't a very safe thing for a surgeon to be operating on patients.

So, I went out on medical leave, relinquished my privileges at four hospitals, had a major hip reconstruction, and for the last two years I have been operating full time at ambulatory centers.

Q What does that mean?

A They're certified outpatient surgicenters.

After a three-year-plus gap in operating, I wanted to get my skills back before going to the hospital-based major surgeries again.

I thought that's the safest

approach, so I have been doing outpatient hernias, some cosmetic surgeries just to get the skills going. I have done about three-four hundred of them.

Also, during the time between 2010 and 2015, I have also -- have a law degree and I am an admitted attorney in New York State. So --

Q Why did you do that?

A I did that the last few years of my practice, like 2007 to 2010.

I would practice -- get up at like five in the morning, practice as a surgeon all day, and went to Hofstra Law School at night, graduated, passed the bar in early 2011, got admitted, and I dabbled in a law practice that consisted mainly of helping firms with their inventory of medical-type cases and assisting getting experts.

I continued my expert work

during that time. I assisted them with trials in various capacity.

I found out during that time I am a much better doctor than a lawyer, so I was happy, when I recovered, to be able to go back to surgery again, which I am doing a hundred percent of the time now.

Q Besides your education, training and experience, what particular things did you review in this case to support your opinion that Dr. Rogers did not comply with the standard of care?

The jury book, the records are in front of you.

A So, the most important thing was the operative note.

Q And that's on pages 19 through 21.

A The operative note chronicles the contemporaneous account, meaning at-the-time account of the August 23, 2011 appendectomy.

Q Actually, it started on the 22nd and

went until after midnight on the 23rd, but go ahead.

A Yes. I stand corrected. And it details, on page 20, about ten lines down that "The cecum was partially densely adherent and we were able to feel a firm and indurated retrocecal appendix."

That's a finding that requires freeing up the cecum and appendix from the back of the abdomen in a thorough way so that when you gently apply traction to the small bowel and the cecum, the appendix area slips up in the wound without having to apply any more than general traction, which is all standard of care allows on delicate bowel structures.

When it's densely adherent, you have to make an incision bigger to get adequate exposure and free it up properly.

That's a basic surgical

tenet; that adequate operating field exposure is necessary for safe surgery.

If you find dense adherence -- and remember earlier I said that a retrocecal appendix can be stuck a little, it can be stuck a medium amount or it can be densely adherent, which is, like, the highest stuck -- when you see that, you have to do the extension of the incision, get a broad operative field, completely free up the cecum and appendix safely, and then it slips up in the wound.

Q When you say extending the incision, how big is the initial oblique McBurney incision?

A It's usually about two to three inches. It doesn't --

Q Initial incision.

A Yeah, it doesn't --

Q McBurney.

A It doesn't specify in this case how

big it is. But of interest and in this case is that later --

MR. MCTAGUE: Objection, Your Honor.

THE COURT: Sustained in that form.

BY MR. GRACE:

Q Typically, how big are the McBurney incisions when they're extended; how long are they extended?

A Well, the skin doesn't really get extended much, if at all. You're really cutting the muscle and fascia underneath to allow retractors to get in.

Q What's fascia?

A Fascia is the connective tissue over the muscle and it's firm, so it inhibits getting hands in and getting a good dissection of a densely-adherent cecum.

Dr. Rogers eventually did extend the incision after the injury occurred. After he tore the ileum

off the cecum, he then extended the incision, and it mentions -- just give me one second here.

Q Well, can -- okay. Go ahead, sorry.

A In other words, the injury occurred, then Dr. Rogers extended the incision and then was able to properly dissect and lift up the cecum.

So, things were done backward. The incision should have been extended initially, the cecum should have been freed up, and then the injury would have been avoided.

Q All right. In the middle of this report, you were referring to --

A Yeah, I found it. I apologize.

It's difficult to read because it's like a run-on paragraph, but it says around the middle, "We then turned our attention to mobilize the cecum up into the wound after extending the incision laterally and medially."

That was the maneuver that had to be done at the beginning to avoid the injury in the first place.

And obviously, Dr. Rogers had no problem getting the cecum and appendix up once the incision was enlarged, which proves, in my opinion, that that maneuver would have avoided the injury.

Q And the next line confirms that, right? Read the next line.

A Yes. "With this --

MR. MCTAGUE: Objection, Your Honor.

A "With this --

THE COURT: Sustained.

BY MR. GRACE:

Q Please read the next line.

A "With this --

MR. MCTAGUE: Objection, Your Honor. The document is in front of the jury.

THE COURT: Overruled on that. Go ahead.

A "With this" -- the this referring to extending the incision -- "we were able to easily mobilize the cecum into the wound with the attached, acute, non-perforated," emphasis on non-perforated "appendicitis."

So, unfortunately, the correct --

MR. MCTAGUE: Objection, Your Honor.

THE COURT: Overruled. Go ahead.

A The correct maneuver of enlarging the incision was done too late after the injury occurred.

And then once it was done, the cecum came up easily because Dr. Rogers has adequate exposure, adequate view to do a proper release of the cecum and appendix from the back of the abdomen where it was tethered by inflammation.

Q Now, can you tell from this report who did what at various points in

this operation?

A Well, I read this report many, many times and I found that the word we, referring to Dr. Rogers and his assistant, Dr. Najjar, was used 18 times in a one-page report.

For example, "We made a classical right low quadrant incision, we incised, we split, we entered, we were able -- we were able to feel a firm and indurated appendix."

"We actually then proceeded, we then turned, we took, we then turned attention to fascia anastomosis, we removed the ileocecum, we then used the linear cutter."

MR. MCTAGUE: Objection, Your Honor.

THE COURT: Sustained.

MR. MCTAGUE: The question is can you tell from the document who did what.

BY MR. GRACE:

Q Can you?

A Yes.

The use of the term we is very specific, actually unusual in an operative note, implying -- well, explicitly stating that the we, meaning the surgical team consisting of Dr. Rogers and Najjar, they're the only we because they were the only two at the operating table.

If it was just Dr. Rogers, it would have said I. So, the we refers to both doctors that were operating as a surgical team.

Q Did you find anything else of significance in this operative report, significance to forming your opinions?

A That Dr. Rogers -- once the injury occurred, I have no criticism of what Dr. Rogers did at the time.

Because it was a catastrophic injury and he was

forced to do a bowel resection, and nothing short of that would have been appropriate.

So, Dr. Rogers responded appropriately. When the injury occurred, he made the incision bigger, he freed up the cecum, he did a resection of the cecum and the injured part of the ileum, and then he did a stapled anastomosis.

The fact that the anastomosis broke down and leaked and stool came through Mr. Marciniak's wound is a risk of the anastomosis and the bowel resection. It's not malpractice to have an anastomosis leak.

So, I have no criticism per se of his actions after the injury occurred. I think they were correct and, unfortunately, the anastomosis didn't heal properly.

Q Now, based on your education, training, experience and review of

materials in this case, did you form any opinions to a reasonable degree of medical certainty as to whether Dr. Najjar complied with the standard of care in an open, non-perforated appendectomy?

MS. KOGAN: Objection, Your Honor.

THE COURT: Basis?

MS. KOGAN: Foundation.

THE COURT: Overruled.

A Yes, I have an opinion.

Q What is that opinion or what are those opinions?

A Dr. Najjar was an assistant, co-surgeon, part of the surgical team during the August 22nd into 23rd, 2011 appendectomy. He was there at the time of the complication.

The operative note was dictated using the word we 18 times. The we means that he was an active -- he, Dr. Najjar, was an active participant and not a sideline

observer during the surgery.

And the same criticisms I have for Dr. Rogers apply to Dr. Najjar.

Q Do you need to repeat them or you have already stated them?

A I believe so, yes.

Q Did you form any opinions to a reasonable degree of medical certainty as to whether defendants' negligence or breach of the standard of care was a substantial contributing factor in causing damages or injuries to Mr. Marciniak?

A Yes, I have an opinion.

Q What is that opinion or what are those opinions?

A My opinion is that the departures on the part of Dr. Rogers and Dr. Najjar were substantial contributing factors to the following injuries: the avulsion of the ileum off of the cecum and need for the

ileocecectomy, or bowel resection, and anastomosis on 8/23/11 during the first surgery.

There were also substantial contributing factors in the anastomotic leak, the drainage of stool through Mr. Marciniak's wound, which is medically called a colocutaneous fistula, the need for the second emergency surgery by Dr. Driscoll on 8/29, where he did a right hemicolectomy and an end ileostomy with the bag through a midline incision --

Q Describe for the jury what a midline incision is.

A That's an up-and-down additional cut.

So, on the 29th, Mr. Marciniak had an ileostomy in his right upper side with the bag, and he had a cut up and down his abdomen and he had additional cut in the right lower quadrant of his abdomen

from the McBurney incision.

The departures were also substantial contributing factors of the need -- the March 2012 third surgery to reverse the ileostomy and hook him up again so he would move his bowels normally through the rectum and not in a bag.

The repair of the parastomal hernia. There was a hernia around the ileostomy that had to be fixed. Also, at the time of the third surgery, he needed a midline incision extended up to his breastbone, or xiphoid, to allow more access.

Q Let me interrupt you. The second surgery, the first one by Dr. Driscoll, that's -- the operative note for that is on pages 55 through 57, correct?

A Yes.

Q All right. Please tell the jury what was entailed in that surgery.

A So, I apologize for my cough. I am getting over a little respiratory infection.

At that time, this was a life-threatening infection where the stapled anastomosis that Dr. Rogers did of the bowel broke down and leaked and stool broke through the wound and Mr. Marciniak was having stool draining from his right lower quadrant wound.

So, Dr. Driscoll, who is another general surgeon, took him as an emergency at South Shore Hospital.

This was about six days after the original surgery, or a day after he was discharged, and he had to remove the entire right part of the colon and remove the anastomosis that was leaking.

And the small bowel was brought out to the skin in the patient's right upper part of the

abdomen as an ileostomy, meaning anything he ate would go through the stomach, would go through the small bowel and come out the skin in a bag.

And ileostomies are generally not formed stool like you would pass rectally, but they're liquid and not as easy to manage, but --

Q Could you explain what an anastomosis is? I am not sure that's been explained yet.

A Yeah. So, when Dr. Rogers, at the first surgery, had to -- tore the ileum off the cecum, he had two ends of bowel that weren't connected.

So, ultimately, the bowel has to be hooked up again. And when you hook it up again it's called an anastomosis.

He removed the appendix and cecum, and we normally -- we meaning general surgeons normally do these

anastomoses with stapling instruments, which is the correct way to do it.

And he stapled over the cecum, stapled over the small bowel, brought them together.

There is a linear stapler called the GIA that creates an anastomosis or opening and then you close the end with another stapler called the TA-60.

It's probably over-technical, but you're reconnecting the bowel with stapling instruments is what you're doing. And normally, it heals well, but sometimes areas break down and stool can leak out of an anastomosis.

They don't all universally heal, and the leak rate can be, you know, five-six percent, you know, where it causes a clinical problem, sometimes more in certain circumstances.

So, it's not malpractice to have a leak, but, unfortunately, this was a big leak and stool started coming out of Mr. Marciniak's incision. So, when Dr. Driscoll re-operated on the 29th and did the ileostomy, he removed the stapled anastomosis.

He cut it out and stapled over the transverse colon, which goes around, and just left it in there, and brought the ileum out as the business end of the bowel so the patient would move their bowels in a bag temporarily and then it would be hooked up in a later procedure.

Because of all the infection, he had to leave the wound open, which is -- I believe that there are pictures before the jury of Mr. Marciniak's wound.

The reason that big wound was open is because you can't close the skin tightly after all this

infection or you get a massive wound infection.

So, you have to leave it and it heals over weeks from the bottom.

Q Now, that infection, is that the diagnosis on page 55, fecal peritonitis; is that --

A Yes.

Q -- what you're talking about?

A Yes, that's --

Q What fecal peritonitis?

A That's one of the most severe abdominal infections you can have. It's where stool is actually in the abdominal cavity.

And the stool, of course, is bacteria that cause an infectious reaction. And if you don't operate soon, the patient could die from it, so this was a lifesaving reoperation at this point.

Q What's the peritoneum? Peritonitis means inflamed peritoneum, right?

A Peritoneum is the sac that houses

the organs and the bowel and the abdomen.

Q In other words, it's the lining of the abdomen?

A Yes, yes.

Q All right. Proceed what was entailed here please.

A Excuse me?

Q Proceed with what was entailed during the operation now.

A So, this operation was an irrigation of the stool out, resection of the right part of the colon, an ileostomy, and no hookup because the old hookup was removed and all the infection has to clear, and then another operation is necessary to reconnect the bowel.

And the wound was let open to prevent infection.

Q Okay. Was the wound ever closed medically by a procedure?

A Not generally. Generally, it heals from the bottom with wound care and

visiting nurses. It can sometimes be closed, but I don't believe it was --

Q In this case?

A No, it closed on its own as far as I could tell.

Q And what other damages or consequences were caused by the initial negligence or malpractice by the defendants?

A The initial negligence also were substantial contributing factors to the March 2002 third --

Q 2012, sorry.

A 2012 -- I'm sorry -- third major reoperation where the ileostomy was reconnected to the colon.

Q Let me stop you there. That operative note on pages 83 to 86 -- it's just the signature on page 86, but pages 83 to 85. Describe to the jury please what was involved or entailed in that procedure.

A There, the midline incision had to

be reopened up and down in the abdomen.

And it actually had to be extended up to the top of the abdomen and the epigastrium, so the cut was made even bigger.

Q How long was that cut?

A It went really from his breastbone down to his pubis and pretty much --

Q What's the pubis?

A -- the whole abdomen at this point. And the ileostomy was removed from the abdominal wall. A hernia was repaired where the ileostomy was with a --

Q What's a hernia?

A That's a -- it's like a hole that develops in the abdominal wall around a stoma called a parastomal hernia.

And they repaired it with a biologic mesh procedure. And the bowel was reconnected at that point so he could have normal bowel

movements.
And at that point, the skin could be closed primarily because the infection had cleared up. This was, like, over six months later.
Q Almost seven months, right?
A Yes.
Q What other consequences or damages were caused by the defendants' negligence?
A The need for a January 2016 incisional hernia repair with mesh. The midline wound had separated at the fascia and muscle layer and a hernia occurred.
And Dr. Boyd repaired it with mesh at that time.
Q And let me interrupt for a second. The operative report for that -- I don't have it exactly, but it's around page 185-186. Can you find it? I think I lost mine.
A I see it at 187.
Q Please tell the jury what was

entailed or involved in that surgery on January 15, 2016.
A This was at Beth Israel-Deaconess Hospital, and Dr. Boyd was the surgeon. And he found a complex incisional hernia with severe diastasis. That means --
Q What's that?
A That means -- complex hernia means a large complicated hernia. And diastasis means the rectus strap muscles had spread, which aggravates the hernia.
Q What are those please?
A They're the muscles that go up and down. Like when you work out in the gym and you get a six-pack or abs, you know, that -- what you're looking at are the rectus muscle.
So, this was a complicated hernia repair that involved extensive cutting of abdominal scars or adhesions, which had formed from all the peritonitis and infection.

And he did component separation, which means you cut the muscles on the outside of the abdomen and move everything into the middle over a piece of mesh.
So, it was a very complicated hernia repair that appears to be, you know, well-done and well-conceived.
And he used about a ten-inch piece of polypropylene mesh. Polypropylene is like a plastic material similar to that blue fishing tackle that you use that's woven into a net.
Q What other damages or consequences were caused by negligence?
A Well, because Mr. Marciniak is only approximately 34 years old now, and he has already had adhesions and incisional hernias that required surgery, he has future risk of more adhesions, bowel obstruction from adhesions, and future risk of

abdominal incisional hernias.
Also, in July of 2017, he underwent removal of his gallbladder. That's normally a same-day procedure done laparoscopically with minimal discomfort and quick return to work.
Because of his all his prior surgeries and scars and adhesions, they had to do it through an open incision, which was yet another incision in his abdomen.
So, the need to do the cholecystectomy open as opposed to laparoscopic was another result of the defendants' departures from standard of care.
Q And the operative note for that from Mass General just this past July are on pages 193 and 194, right? Yes?
A Yes.
Q Describe what occurred during that surgery by Dr. Carlos Fernandez-Del-Castillo at Mass General.

A They were trying to do a laparoscopic removal of the gallbladder, but they said the amount of adhesions were not allowing the abdomen to blow up with air. The technical word is "were not allowing us to obtain a complete pneumoperitoneum."

They couldn't find a safe window to put the trocars in with all the adhesions, so due to the adhesions or scars from his peritonitis and prior surgeries, they had to abandon laparoscopy and do it through an open incision.

That's done in a very minor amount normally of cholecystectomies. The vast majority --

Q Cholecystectomy is gallbladder removal, right?

A Yes. The vast majority are done laparoscopically.

Q And this open wound or open incision

for that, was it through a previous incision or was it a totally new incision?

A No, they actually -- it's a totally new incision along the right upper side of the patient.

Q And you mentioned risks of further injuries because of -- further injuries or conditions as a result of the defendants' negligence. What are those risks?

MR. MCTAGUE: Objection, Your Honor. Can we approach?

THE COURT: You may.

(SIDEBAR CONFERENCE NOT TRANSCRIBED)

BY MR. GRACE:

Q Doctor, you mentioned risks of further injury or conditions as a result of the defendants' negligence. You said risk of more adhesions. Would you explain that please to the jury?

A Adhesions are internal scars that occur in the abdomen between the

bowel and other areas of bowel or between the bowel and the wall of the peritoneal cavity or abdominal sac.

And we know that Mr. Marciniak was developing them because, at the time of Dr. Boyd's incisional hernia repair, he had to cut a lot of adhesions to do it.

And at the time of the cholecystectomy, the gallbladder removal at Mass General, they couldn't do it laparoscopically because of all the adhesions.

So, he is an adhesion former from the peritonitis and all the surgeries, the infection and the surgeries, and he is at risk for more adhesions, which naturally occur over time, especially given his young age.

That can cause kinking and obstruction of small bowel and --

MR. MCTAGUE: Objection,

Your Honor. This is now disclosure. Move to strike.

THE COURT: The jurors will disregard that last comment by the doctor. Next question.

BY MR. GRACE:

Q What other risks of further injury? Please explain them to the jury.

A And since he has had two abdominal hernias, one at the ileostomy site in the right upper quadrant, repaired with a collagen or biologic mesh, and the other complex hernia in the midline incision, repaired with a ten-inch piece of artificial mesh, he is at risk for development of further hernias, which I would estimate in the 30-to-40-percent range lifetime risk.

And they, of course, would require more surgery.

Q What are the consequences of, you know, further hernias?

A He'll need more -- he has about a

30-40-percent chance to --
MR. MCTAGUE: Objection. This has been asked and answered, Your Honor.
THE COURT: Sustained.
BY MR. GRACE:
Q What are the consequences of further adhesions?
MR. MCTAGUE: This has also been answered.
THE COURT: Sustained.
BY MR. GRACE:
Q Did you form an opinion at some point about whether Mr. Marciniak was discharged too early after the surgery by Dr. Rogers and Dr. Najjar?
A I do have an opinion, yes.
Q Okay. And what is that opinion?
A Mr. Marciniak was running fevers, especially on the 26th, which would be the third postoperative day. They went up to 101. That can be a sign of an anastomotic leak.

It was my opinion a CAT scan should have been done prior to discharge. It would have diagnosed the problem earlier and he wouldn't have been so sick by the time Dr. Driscoll re-operated on him.
I don't have any criticism against Dr. Rogers or Najjar for that, because they -- I found out on further review they were not involved in the discharge.
So, -- but I do feel he was prematurely discharged.
Q Okay. But upon further reviewing of materials, you discovered that they weren't involved in the decision of when to discharge, correct?
A Correct. So, I have no criticism against Dr. Rogers or Najjar for that discharge.
Q Thank you. That's all I have.
A Thank you.
THE COURT: So, jurors, we're going to start cross. But why

don't we take our morning break. Let's take our morning break. Leave your notebooks and your jury books on your chairs. And why don't you try to be back no later than 11:25.
THE COURT OFFICER: All rise. Jurors, please step down and follow me.
(JURY EXITS)
(Court is in recess at 11:09 a.m.)
(Court resumes at 11:29 a.m.)
MR. MCTAGUE: May I proceed, Your Honor?
THE COURT: You may.
(CROSS-EXAMINATION OF DAVID A. MAYER, M.D.)
BY MR. MCTAGUE:
Q Good morning, Doctor. I didn't introduce myself before. My name is Paul McTague, I represent Dr. Selwyn Rogers. It's fair to say that you were initially contacted through National Medical Consultants to work on this case this year, correct?

A Yes.
Q And that's in 2017?
A Yes.
Q So, 2017, at the time that Mr. Grace was seeking an expert with regard to this case involving general surgery, is it fair to say that at that time, in 2017, you did not have any active hospital privileges that you were utilizing in performing surgeries such as appendectomies, correct?
A Correct.
Q And in fact, it would be fair to say that the last time you had had those privileges had been in 2010, correct?
A Yes.
Q Now, Mr. Grace, if he's looking for a surgeon to talk about appendectomies, he wouldn't find you as an active participating surgeon at a hospital, with an academic title at the hospital in a position performing the surgery in 2017 when

you received these materials, correct?
A Well, I had an academic appointment as associate professor, but I didn't have active privileges. Well, correct, when I was first contacted about the case.
Q And you had, in the past, authored articles that have been published in various publications, correct?
A Yes.
Q When was the last one in the medically peer-reviewed literature? What year was that?
A It was before 2010. I don't know the exact year.
Q Was it actually the early 2000s?
A I think -- 2007 or 2008 might've been the last one.
Q I'm talking about in the peer-reviewed literature.
A I'm not sure off the top of my head.
Q Now, Doctor, in August of 2011, when this particular case occurs, you did

not have, at that time, an active surgical practice in a hospital?
A That's correct.
Q You have -- I think you told us a number of times, I can't recall. You have testified over the course of many years in both courtrooms and in legal offices with regard to your opinions on medical malpractice cases, correct?
A Yes.
Q And you have been deposed and testified in cases since 2010, right up to today, correct?
A Yes.
Q And do you recall that you have often spoke of the issue of your disability and medical leave and your attempts to come back and start a full practice again, correct?
A Yes.
Q And that's a question that's been asked of you for many years, correct?

A Yes.
Q Now, you testified in March of this year that you had no active hospital privileges but were in the process of applying at that time, correct?
A Yes.
Q And you have actually testified to that as far back as 2012, 2013, 2014, correct?
A Yes.
Q And so, you have told many juries, here and today, in New York, that you're wanting to return to an active practice but, up until today, you have not done so?
A Well, I've been in active practice for over two years, but it's been in an outpatient setting through ambulatory procedures. My hospital privileges start November 1st.
Q So, I'm clear, you have told juries, since as early as 2012, that your intent is to get back into a hospital privilege practice and

practice the type of surgeries we're talking about here in this courtroom again, correct?
A Yes.
Q And all the way up to today, in 2017, although you've told us you're going to have privileges on November 1st, you have yet to obtain those privileges, correct?
A That's correct.
Q Now, are you a member of the American College of Surgeons?
A I was for 35 years. Currently I'm not, I'm a member of the International College of Surgeons.
Q Is there a reason why you're no longer a member of the American College of Surgeons?
A I pared down my membership. It's like a fraternity of surgeons and then the dues became too high. I was like in 20 organizations, so that's really the only reason.
Q In 2011, when this surgery took

place, you were a member of the American College of Surgeons?
A I believe so, yes.
Q And that group, the American College of Surgeons, has a statement on the physician acting as an expert witness. Are you familiar with that?
A I've seen it. I don't remember every word of it, but I --
MR. MCTAGUE: May I approach, Your Honor?
THE COURT: You may.
BY MR. MCTAGUE:
Q Now, Doctor, this particular statement -- and I'm going to read parts of it.
Right in the very beginning, after the italics, it actually says, "Physicians understand they have an obligation to testify in court as expert witnesses on behalf of the plaintiff or defendant as appropriate." Did I read that

correctly?
A Yes.
Q And then it's going to list a number of qualifications and discuss these parameters.
But the next paragraph says, "Failure to comply with either the recommended qualifications for the physician who acts as an expert witness or with the recommended guidelines for behavior of the physician acting as an expert witness, may constitute a violation of one or more of the bylaws of the American College of Surgeons," correct?
A That's what it says, yes.
Q Now, one of the things it says, if you look down for the recommended qualifications, the third paragraph says, "The physician expert witness who provides testimony for a plaintiff or a defendant in a case involving a specific surgical

procedure should have held, at the time of the alleged occurrence, privileges to perform those same or similar procedures in a hospital accredited by the Joint Commission or the American Osteopathic Association," correct? Did I read that correctly?
A Well, you're reading from a document of an organization that I'm not a member of, but that's what it says. Yes, sir.
Q It's fair to say that at the time of this alleged negligence or occurrence, in August of 2011, you didn't have such privileges to perform at a hospital, the surgical procedure you're discussing, correct?
A I was teaching at two medical -- at one medical school, which included the treatment of appendicitis and abdominal conditions, but --
Q Could you try my question, Doctor?

My question is, at the time of this alleged occurrence in August of 2011, you did not hold privileges to perform this same procedure in a hospital accredited by the Joint Commission, correct?
A Well, I mean, we've established that, yes.
Q We've established it now when you said "yes" so, thank you. The next line says, Doctor, "The physician expert witness should be familiar with the standard of care provided at the time of the alleged occurrence and should have been actively involved in the clinical practice of the specialty or the subject matter of the case at the time of the alleged occurrence."
And it's fair to say you were not involved in the clinical practice at that time, in August of 2011, correct?
A I don't understand the question.

Are you saying whether --
Q Let me rephrase it if you don't understand the question.
A No, I'm speaking. Whether these advisory recommendations, whether I agree with them or are you asking me -- I don't understand your line of questioning.
Q Do you not understand my question?
A No, I don't understand it.
Q So, the question is -- let me ask it again simply.
MR. GRACE: Objection.
THE COURT: Overruled. He's going to ask it again.
BY MR. MCTAGUE:
Q My question was, you agree that at the time of this incident, in August of 2011, you were not actively involved in the clinical practice of the specialty or the subject matter of this case at the time of its alleged occurrence?
A Well, I disagree because teaching

surgery is considered the active clinical practice of surgery. So, I disagree with your characterization.
Q Teaching is clinical practice?
A Yes, sir.
Q So, if you're in a position to have an academic title and dealing with a resident, in a clinical practice you meant by teaching by observation of that resident or assistance with you in an operation, correct?
A That's one form of teaching, correct.
Q But you're talking about in August of 2011 you were teaching courses?
A I wasn't teaching courses, but I was on the faculty of New York Medical College.
Q Okay. Were you teaching about -- in August of 2011, were you teaching about appendectomies?
A In what manner?
Q In any manner, Doctor.
A Well, I had performed 1,000

appendectomies.
Q Doctor, not my question.
A I had actually published on appendicitis and gluteal abscess from fecal fistula and I was having my hip operated, so no, I was not in an operating room in 2011.
Q And in August of 2011 you weren't teaching about this either, correct?
A Well, I later was at Hofstra Medical School.
Q Doctor, again, if you don't understand my question -- I thought it was simple. We're talking about August of 2011. We know you weren't in a clinical practice operating in a hospital doing appendectomies at that time, correct?
A Correct.
Q And we now know that you weren't actively teaching on this, even though you were trying to say that means clinical practice, you weren't actively teaching on this in August

of 2011, correct?
A Well, I was recovering from surgery, so no I was --
Q For whatever reason, Doctor.
A -- not actively teaching --
Q The answer to my questing is yes, correct?
A -- at that point in time, correct.
Q Doctor, these are guidelines, as you say, but would you agree with these guidelines, that the physician expert should review all the relevant medical information in the case, do you agree?
A Yes, I agree.
Q Do you think you've read all the relevant medical information?
A Yes.
Q Do you still stand by your statement here that Mr. Marciniak had a fever on the day before his discharge?
A Not on the day of discharge.
Q On the day before his discharge?
A I think he had a low-grade fever.

Q Okay, we'll get to that. And do you also agree that you are to testify to the content of medical records in a fair, honest, and balanced manner, correct?
A Of course, yes.
Q And that as a physician expert you may be called upon to draw an inference or an opinion based on facts and, in so doing, you should apply the same standards of fairness and honesty, right?
A Yes.
Q Now, do you remember just a few moments ago testifying about the unusual nature of Dr. Roger's operative note?
A Yes.
Q In which it says "we," consistently?
A Yes.
Q You know, Doctor, in your years of practice -- and you told us you were a chief of surgery at some point?
A Yes.

Q You know in your years of practice, from the colleagues you've watched and from the industry and from all the records you've reviewed, that that is a fairly standard way of a surgeon describing an operative procedure, correct?
A I disagree.
Q Would you turn to page 106 -- 188? Do you have that, Doctor?
A Yes.
Q If you go back to page 187, could you tell us what we're looking at here?
A That's Dr. Boyd's operative note.
Q If you look on page 188, as we go down that whole page, we can see -- and I'll read through them, if we go down about six lines on the left.
It says, "We then created lipocutaneous flaps." Do you see that?
A Yes.
Q Next line is -- it doesn't have

anything in it. The line after that.
"After we identified the external oblique fascia, we divided the external oblique fascia."
It goes on to say, "This allowed us to bring the rectus muscles to the midline. We then cut away the hernia."
Down below, "We then took a 26 x 36-centimeter mesh."
Keep going. "We then tunneled."
And down at the bottom even more, "We then extubated the patient," correct?
A Yes, they were operating as a surgical team, both involved in the surgery.
Q Not unusual, correct, Doctor?
A Not to operate as a team. It's -- I haven't seen many operative notes using the "we" that way in my experience.

Q But in your review of this particular case, of the five surgeries we're talking about -- well, let's look at another one, page 193.
Now, Dr. Del Castillo down at Mass General Hospital. As he describes this, we go down to the third line of his.
"We introduced the Hasson trocar."
A little further down, "As we advanced the camera we realized --."
Further down, "We attempted to see if we could have a safe window."
Down further, "We knew that this would not be safe and accordingly we proceeded to convert to an open procedure."
So, in this very case, we see a usual practice, Doctor, of surgeons describing, in their

operative notes, their surgeries in this manner, correct?

A Other surgeons have also used that terminology to describe the surgical team and active participation of all members of the team, yes.

Q Now, I think you'll get more questions on this later. One way you could distinguish what the "we" means in Dr. Selwyn Rogers' operative note was to have read the transcripts of Dr. Rogers and Dr. Najjar, correct?

A Yes.

Q Did you do that?

A Of course.

Q And after reading those, you still stand by the opinions you stated in this case about the roles of those two surgeons at that surgery?

A Yes.

Q Okay. Now, Doctor, just so we're clear, this is regarding your going back to active hospital privilege.

MR. MCTAGUE: May I approach, Your Honor?

THE COURT: You may.

BY MR. MCTAGUE:

Q I have a transcript of a deposition -- actually, trial testimony of yours, in the case of Glover v. Partridge. It was in the Nassau Supreme Court, is that on Long Island?

A Yes.

Q Okay. And that's your testimony here?

A Yes.

Q And when you were being cross examined at that time you were asked a question as you were being pressed about your active privileges.

The question was, "And now that you're an attorney, by the way, is your medical practice open at the present time?"

At that time, you said, "Not currently. I expect to go back in

the near future," correct?

A Which I did in the outpatient setting and for the reasons I stated.

Q Did I read that correctly?

A Yes.

Q Okay. Now, this is testimony in -- do you see the circle up there? March 19, 2014?

A Yes.

Q That attorney then said to you, "And you told jurors in cases just recently down in Brooklyn, before Judge Bunion (phonetic) in November, right -- November 2013 that would be? You testified down there. You said that you've had some offers for four hospitals and you intend to go back to your medical practice."

You said, "Yes," correct?

A Yes.

Q But you're not going back to a hospital practice until, you say, in November?

A Yeah, I had offers to go back as a full-time faculty member, but I decided I would hone my skills and regain my skills before going back, which was, I believe, a prudent choice.

Q And you would say -- the next question down here is, "You had said the same thing in 2012. You told the jury before Judge Hart (phonetic) in Queens, surgery is your true love and you're going to go back to your medical practice. Didn't you say that?"

And your answer was? Your answer was "yes."

A Yes, which I have done.

Q Now, you have been doing some operations, as you said, operating out of a surgery center?

A Yes, it's a Quad A certified OR in Manhattan and Great Neck, New York.

Q And that's located on 903 Park Ave in New York?

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A That's one of the places, yes.
Q And as you testified before, that's something run by a Dr. Shahar?
A Yes.
Q And when you went back to do that work, the work you were doing at that point were minor excisions, correct?
A Yes.
Q Liposuction?
A Yes.
Q Adipose-derived stem cell therapy, what is that?
A That's taking the patient's own natural healing stem cells from the fat around the midsection, purifying them, and deploying them to treat a wide variety of inflammatory and degenerative conditions.
Q And so, Dr. Shahar runs a surgicenter that's called Natural Look Institute?
A Yes.
Q And that is a cosmetic surgery

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location?
A Correct.
Q In addition to this type of surgery, you were also involved in hair transplant surgery?
A Yes.
Q And you were involved in the opening of a hair restoration company location on Great Neck, Long Island, correct?
A Yes.
Q And when did you start doing that?
A About a year ago.
Q Okay. Now, none of the surgeries we've talked about, either a hair transplant surgery or the surgeries at the cosmetic institution would involve honing your skills on operating on bowel or into the abdomen, correct?
A Well, I've also done hernia surgeries which often contain bowel, but you're correct. I'm honing my surgical ability and regaining a

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comfort level after being out for a few years and I feel my skills have returned. I'm ready to go back to the hospital setting next month.
Q Doctor, how many times have you testified in a court?
A 80 times.
Q And so, this is not the first time a defense attorney has asked you questions in cross examination, correct?
A Correct.
Q You recognize that if you can answer my question yes or no you should do so?
A I'm attempting to do that.
Q So, the question I asked, and tell me if you can't answer this yes or no.
The types of surgeries we're talking about, Doctor, the hair transplantation, the cosmetic liposuction, and minor excisions, those were not surgeries where you

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were honing your skills with regard to surgery on the small bowel or large bowel, correct?
A That's correct. I'm not operating on intestine.
Q And you're still not operating on that yet?
A Not for two weeks.
Q Now, you have done this medical legal work for a number of years, correct?
A Yes.
Q Now, through this company called National Medical Consultations, an attorney such as Mr. Grace can match himself up with an expert, correct?
A I assume so. I don't know exactly how it runs, but --
Q Well, you've been with them for a number of years, correct?
A Yes.
Q And how many cases did you tell us you received from them?
A About 20.

Q And every one of those cases has been a case to review on behalf of a patient, correct?
A **Yes.**
Q Now, you testified today that you would receive 6,000 dollars for your trial appearance, correct?
A **Yes.**
Q You're aware that the payment for your time here, to that National Medical Consultants, will be 7,000 for your time here, correct?
A **I'm not aware of that.**
Q Have you ever seen their posted fee agreement and schedule?
A **I have not.**
MR. MCTAGUE: May I approach, Your Honor?
THE COURT: You may.
BY MR. MCTAGUE:
Q So, on their website, we've been through this in the court, for their website they have trial fees, 7,000 dollars, correct?

A **Yes.**
Q So, an attorney such as Mr. Grace would pay a 1,000-dollar premium to National Medical Consultants to have tracked you down to obtain you to testify here, correct?
A **It appears so, yes.**
Q Now, you have also, in the past, advertised in other areas for your expert work, correct?
A **I have.**
Q You have yourself put out advertisements in a placed called Seek or a literature called "Seek" - -
A **Yes.**
Q -- so they can match you up? After you stopped your medical practice, back in 2010, 90 percent of your income came from your medical legal work, correct?
A **It remained the same, but I didn't have the surgical income, but it didn't increase. I think -- so,**

probably that might be true.
Q Well, you've testified before that that's true, haven't you?
A **I believe so, yes.**
Q Well, you know so, correct? You have testified before, in answering that very same question that after you stopped your medical practice 90 percent of your income came from your medical legal work, correct?
A **Yes, because I didn't have the surgical income. I wasn't active at that time.**
Q You are licensed to practice in what states?
A **New York only.**
Q Is that it?
A **Yes.**
Q And that's right next to New Jersey as well --
A **Yes.**
Q Obviously, New York and New Jersey?
A **Yes.**
Q In 2007 you started law school?

A **Yes.**
Q And law school is typically three years. Did you graduate in 2010?
A **Yes.**
Q That's about the same time you stopped your medical practice?
A **Yes.**
Q And for a while you were a practicing lawyer, correct?
A **Yes.**
Q Now, Doctor, going to the case we're talking about here and talking about general anatomy, is it fair to say that the appendix, which sits at the end of the cecum of the bowel, has a variation in its size, where it comes off the cecum, whether it's retrocecal or some other way, there's a variation there, correct?
A **Yes.**
Q And in addition, can we agree that there's variation in the anatomy with regard to where the terminal ileum will enter the cecum, correct?

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A To a lesser extent, yes.
Q So, generally, how big is the cecum if we were to take it all out and look at it?
A It can vary, but it's usually somewhere between five and seven centimeters across.
Q You know what it was in Mr. Marciniak, right?
A I would have to -- it actually can be bigger than five to seven centimeters. It can be maybe --
Q I can't. I'm sorry, I just can't hear you.
A Yeah, I think I underestimated the size. I haven't been asked that question before. It's -- it can be, really, up to ten centimeters, sometimes even a little larger, because it's the largest part of the small bowel.
Q But it wasn't larger in this case, correct?
A I would have to check the exact

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dimensions.
Q I just want to be sure. One of the things you've testified here in criticism of Dr. Rogers is he made an incision that was too small, originally, to give him the access he needed to this cecum in Mr. Marciniak, correct?
A Not to the cecum, to free up the cecum from the dense adherence behind it. It's a difference.
Q Doctor, when you make a McBurney incision in the skin of a patient, you're trying to get it over the place where the cecum will lay underneath your incision, correct?
A Yes.
Q Because the first step in this procedure, you're making an operative incision to create a surgical field to view the cecum, correct?
A Yes.
Q You know, if you looked, how big and

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wide Mr. Marciniak's cecum was, correct?
A Yes.
Q How big was it?
A I'll just check the pathology to give you an accurate answer.
Q Well, I can save you the time, Doctor. In this case where the sizes of these things will matter because of incision sizes, the width of his cecum was 4.5 centimeters. Does that sound correct? Page 26.
A Probably not correct because the -- once you go to pathology you lose like 25 percent or so of the normal size, you get contraction. So, it's not really that accurate, but it says 5 by 4.5 centimeter.
Q It says 5 by length, correct?
A Yes.
Q And 4.5 by width, correct?
A Yes.
Q So, are you aware that there was a pathologist who testified in this

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case?
A Yes.
Q He would know about what happens to a specimen when it gets into his laboratory, correct?
A I would assume so.
Q Would you agree with him that the size of Mr. Marciniak's cecum was 5 by 4.5?
A Well, that's what it says.
Q Now, Doctor, in this particular case, you had indicated that a doctor can perform either an open or a laparoscopic appendectomy, and you talked about surgeons preferred method, correct?
A Yes.
Q A patient can also have input into how his surgery will be performed, correct?
A Yes.
Q Are you aware of Mr. Marciniak's preference in this case?
A I don't think I looked at that

because I have no criticism that it was done open.
Q Okay.
A So, I haven't looked at it.
Q So, in this case, it was elected to do an open appendectomy at the request of Mr. Marciniak and Dr. Rogers was comfortable doing that. That's appropriate, correct?
A Yes.
Q Now, you believe, actually, that an open appendectomy, that procedure is better and safer than the laparoscopic approach?
A It can be, yes.
Q You testified it's better and safer before, haven't you?
A Well, it generally has less complications, in my opinion, but both are within standard of care.
Q Doctor, you have testified, in the past, that an open procedure is safer than the laparoscopic approach, correct?

A I thought I testified regarding laparoscopic ventral hernia repairs. I'm not aware that I testified a laparoscopic appendectomy is more dangerous or anything.
Q Again, maybe I'm not speaking loud enough. I didn't say anything about dangerous. I said, you have testified, Doctor, that an open appendectomy is considered by you to be better and safer than a laparoscopic procedure, correct?
A I don't remember that testimony, but I think open appendectomy is a good method and within standard of care. I have no criticism for Dr. Rogers doing an open.
MR. MCTAGUE: May I approach, Your Honor?
THE COURT: You may.
BY MR. MCTAGUE:
Q A case called Dungan v. McGee, deposition of David A. Mayer back in 2008.

A Okay.
Q And on page eight you were asked -- the question was: "Just generally, if you can, for me, how often do you presently perform laparoscopic appendectomies?"
Answer: "I probably do about ten a year. Because of the majority of the appendectomies I do, I do my incision using the open technique, which I personally believe is a better technique and safer, but there is still a group of patients that insist on laparoscopic, so probably around ten per year laparoscopically," correct?
A Yes.
Q Now, Doctor, in addition to having performed, 2010 and before, appendectomies both open and by laparoscopic approach, had you been involved in other operations that involved operations in which you cut, maneuvered, or evaluated the

bowel; small intestine or large bowel?
A Yes.
Q And those would be open or laparoscopic abdominal surgeries where you're dealing with the bowel?
A Yes.
Q Okay. Now, are you aware of the Tencel properties or the strength of bowel, generally?
A Generally, yes.
Q It's part of something that you're taught, even as far back as your residency with regard to strengths of tissue that you as a surgeon would be operating on, correct?
A Yes.
Q Now, would we agree that -- or can we agree, Doctor, that bowel actually; small intestine and large bowel, actually has some pretty significant strength and can be maneuvered quite easily and with traction during operations?

A **General traction, yes.**
Q Okay. And general traction has a wide range to define it and I'll ask you what you think. But you've been telling this jury, on at least three occasions during your testimony with Mr. Grace, about the delicate nature of bowel, correct?
A **Of course, yes.**
Q Actually, bowel has some fairly decent strength and integrity, doesn't it?
MR. GRACE: Object to the form.
THE COURT: Overruled.
A **I disagree. It's a delicate structure.**
Q Have you, Doctor, in the course of keeping up with the literature and in the course of continuing medical education, had -- kept up with studies that show how much force is necessary to tear or disconnect bowel?

A **I haven't seen such studies.**
Q Never? Would it surprise you, Doctor, that there are studies that suggest that the amount of pressure is upwards of 130 pounds per square inch to defeat the integrity of bowel?
A **I haven't seen studies that measured that.**
Q I'm not talking about a study. I said, would it surprise you that there are studies that said that the amount of force necessary to tear a bowel is about 130 pounds per square inch?
A **Then you can only imagine how much pressure and tension Dr. Rogers put on the bowel.**
Q So, we'll get to that, Doctor. Again, do you know what my question was? Could you repeat it for me?
A **My answer stands. I'm not aware of such studies.**
Q That wasn't the question. Would it

surprise you, Doctor, that there are studies that show that up to 130 pounds per square inch of pressure is necessary to break the integrity or tear bowel?
A **There are no such valid studies. Surgeons are not engineers. We don't perform studies such as that.**
Q Doctor, in the course of your teachings of surgery, you have, I'm sure -- well, maybe you haven't. Are you aware of journals that deal with biomechanics in medicine?
A **There are some.**
Q There are some and they're published and they're peer reviewed and they're respected, correct?
A **I'm not sure of that. They're not in the mainstream surgical literature.**
Q But never during the courses you've taught have you talked about the integrity and strength of bowel?
A **That's not a topic that I've taught.**

The bowel is a delicate structure that has to be treated with care and respect.
Q Doctor, how much force do you believe would be necessary to use to avulse a healthy terminal ileum off a healthy cecum?
A **Grossly in excess of the gentle traction that is proper surgical technique.**
Q If proper traction, gentle traction that is proper surgical technique was applied, is there any way that a terminal ileum can avulse off the cecum unless that tissue in the cecum and terminal ileum is not healthy?
A **If the surgeon doesn't free up the cecum from the retroperitoneum then injuries can occur, but with this ileum being basically normal, it's impossible that the injury could have occurred with gentle traction.**
To a medical certainty and a

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scientific certainty, gentle traction was not applied to that ileum.

Q Doctor, let me ask you this. What is your understanding of the actions of Dr. Rogers at the time the terminal ileum avulsed? What was he doing with his hands at that time?

A He had his fingers around the ileum and a Babcock clamp on the cecum and he was lifting up against resistance, trying to deliver the appendix when the cecum was not freed up from the back of the abdomen.

Q Now, Doctor, let me ask you this. Is it your testimony that if there were adhesions and connections behind the cecum, and that a surgeon with a Babcock clamp on the cecum is moving it up into the surgical field, and had his fingers on the terminal ileum, that that normal gentle traction, because the cecum

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had some attachments, if applied, would tear apart the bowel?

A Not generally. So, we know that much more than normal gentle traction had to apply.

MR. MCTAGUE: Objection. Your Honor, may I have instruction for the doctor to answer my questions?

THE COURT: Just try to answer the question, Doctor, that's asked.

DR. MAYER: I was trying my best, sir.

THE COURT: Okay. No, try better, please.

BY MR. MCTAGUE:

Q Okay. I'll do it so it's very clear. In a circumstance where you say that there was partial adherence of the cecum to the back of the abdominal wall, if a surgeon has a Babcock clamp in his left hand, is applying upward traction in the

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usual practice, and in his fingers of his right hand is holding the terminal ileum, and bring them up in the usual fashion, do you have an opinion that that bowel would separate if it's healthy bowel?

A The minute you feel traction, any resistance, you have to immediately stop, but of course --

MR. MCTAGUE: Objection, again, Your Honor.

A Of course, gentle traction would not cause the injury. This was gross ripping of bowel off of the cecum. This was not a gently performed procedure.

And to say otherwise flies in the face of all the evidence that I've looked at.

Q Now, Doctor, going to that evidence then, you have described what the opening is in a McBurney excision, right -- incision, correct?

A Yes.

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Q So that when Dr. Rogers is going to bring up the cecum into the surgical field, what is the distance he needs to bring that cecum up to get it into the surgical field?

A It varies person to person. It's probably, you know, four or five inches or so.

Q So, let me get this straight. There's an incision, a McBurney incision -- well, let me ask it this way. In the hundreds of open appendectomies you've performed, a good portion of the time at least, a third according to what you say, that appendix is not retrocecal, but just out at the end of the cecum, correct?

A About a third, yes.

Q And there are times when you open that McBurney incision and the cecum, which is not always fully attached to the back of the abdominal wall, is right there and

the appendix and the cecum just appear right into the surgical field, correct?

A It can occur when there isn't a retrocecal adherence, yes.

Q Again, Doctor, you need to stay with my question. In those cases, where you have an appendix that's not retrocecal, understand? There are times when you open that McBurney's incision and that cecum with the appendix is right there, popped up into the surgical field, correct?

A Very rarely, but I've seen that occur.

Q In this case it was retrocecal, correct?

A Yes.

Q But that particular cecum is laying how far below the surface of the skin?

A It can vary. If it's tethered in the pelvis from retroperitoneal adhesions, it can be a number of

inches from the skin.

Q Do you believe, in your opinion here today as a foundation, that when Dr. Rogers had to bring that cecum up into the wound that he had to move it four or five inches?

A At least a few inches because this was not a free-floating cecum and appendix. This was retroperitoneum.

Q Doctor, you've just testified that this was a lot of force applied to move two objects, so I want to get the basis of that opinion.

Let me ask you this again. How much distance do you think Dr. Rogers was going to move that, or trying to move, that cecum when he applied traction?

A It's probably three or more inches. It's a distance.

Q And when he was -- he had a Babcock clamp on the cecum and his left hand was holding that, correct?

A Yes.

Q How was he holding the terminal ileum?

A Between his fingers.

Q How?

A Like scissoring it. He had one finger behind it --

Q So, like this?

A I believe so, yes.

Q So, if the terminal ileum -- I used the wrong hand -- is coming into the cecum like here, Dr. Rogers -- with a gloved hand?

A Of course, yes.

Q Has his two fingers on the terminal ileum?

A Yes.

Q And is moving that up three inches?

A Or however many inches it was. It's variable person-to-person. He didn't quantitate in his operative note how far the cecum was from the skin.

Q You didn't answer me, Doctor. How far is Dr. Rogers going to move --

A Well, I think I've given you a range, three to five inches.

Q So, three to five inches?

A Yes.

Q And with the Babcock clamp in one hand and the terminal ileum held between gloved fingers --

A Yes.

Q -- to bring it up to five inches, you think he applied tremendous force in separating them?

A I said grossly in excess of general force, I didn't use the word tremendous.

Q How was he bringing up the cecum and the terminal ileum? Were they in conjunction together coming up or was he applying force in different directions? How was he doing it?

A You apply it in conjunction with the Babcock and with the fingers.

Q So, when he's applying this traction, he has a Babcock clamp in his fingers and he's lifting this

way three to five inches when this avulses?

A The cecum isn't going anywhere because it's stuck in the back, so he's trying to pull it out from the ileum instead of freeing it up properly.

Q How did Dr. Rogers, in his operative note, describe the cecum and its attachment?

A He said partially densely adherent.

Q What do you think partially means?

A A part of it is stuck in the back.

Q Right. So, it's not all stuck down, correct?

A It was stuck down pretty good to cause --

Q Doctor, let me ask you this. He used a particular word, partially, to describe what he found, correct?

A He did.

Q So, it wasn't all adherent at the time, correct?

A Not the entire cecum which --

Q Right. And then after he found that, what he did with two fingers of his hand is broke down bluntly the adhesions behind the cecum, making progress to bring it up into the wound, correct?

A Well, that's what he said years later during litigation and interrogatories and deposition, it's not in the operative note.

Q Okay. So, just so I'm clear on this, is it your thought process then, as part of your basis, that Dr. Selwyn Rogers is misrepresenting what he did?

A I'm saying his story changed from the operative note dictated on the day of surgery to when he did his deposition years later after he had been sued. I'm making no conclusions. That's not my role as an expert.

Q How did it change with regard to his freeing up the cecum?

A He then described doing dissection in the retroperitoneal area of the cecum and freeing up the cecum, which is a good technique. He described that in a deposition and interrogatories years later, but it's not in the operative note.

Q I'll get to that.

A The only freeing of the cecum in the operative note --

THE COURT: One second, Doctor.

MR. GRACE: He was answering the question.

MR. MCTAGUE: My motion is to strike that answer after he did answer my question, Your Honor.

THE COURT: That's stricken, jurors.

BY MR. MCTAGUE:

Q Now, Doctor, just with regard to your experience, both personal and otherwise, have you ever had a circumstance where you've conducted

the operation on a non-ruptured, a non-perforated appendix in the open manner and as a result of the inflammatory process, even though unruptured, had to remove any colon or terminal ileum during your appendectomy?

A I've never personally had that experience, no.

Q Have you ever had a case where your operation revealed inflammatory processes that impacted the wall of the cecum and the terminal ileum?

A Only a missed appendix where the patient got appendicitis, it wasn't diagnosed, and then at a later point, days or weeks later, you went in and there was an inflammatory mass, sometimes you're in a position to have to do that, not with an acute appendix operated promptly. I haven't had that.

Q Okay. Now, Doctor, one other way that a terminal ileum can avulse off

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the cecum, other than from excessive traction, which I understand is your opinion, is that the tissue is impacted and the injury occurs despite the application of the typical traction. That's another possibility, correct?

A I think I said that earlier. If it was gangrenous or there was a ruptured appendix that was sitting around and it was involved in an abscess and the tissue was destroyed, you know, then it could fall apart, you know, with normal tension, but that wasn't the case here.

Q Doctor, again, my question was simple. Another way that an avulsion could occur between a terminal ileum and the cecum is, for whatever reason, that the tissues, the integrity of the tissues, is affected and it's not the normal strength, correct?

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A If that --

Q It's a yes or a no, correct?

A Yes, I agree with that.

Q Now, just so I'm clear on this before we get to the actual operation, if I correctly understand it, this partially adherent cecum, which is being held with a Babcock clamp, and the terminal ileum between the two fingers of Dr. Rogers is being brought up into the field in this direction, correct, together?

A Yes.

Q And at that point there's an avulsion, correct?

A When he was pulling on the ileum he pulled the ileum right off the cecum, yes.

Q Now, if you could turn to page 20 -- actually, 19 and 20 of this book. Are you set, Doctor?

A Yes.

Q On page 20, if we look down at the

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bottom, this indicates that it is dictated at 1:24:21 a.m. on August 23rd; is that correct? Page 20. I'm sorry if I brought you to the wrong place.

A Yes.

Q So, then approximately an hour after the surgery these are the words dictated into a machine by Dr. Selwyn Rogers about the events of the surgery, correct?

A Yes.

Q Now, in this particular case, if we go look at page 19, Dr. Rogers, as he describes this surgery, begins his op note with indications for procedure. Do you see that?

A I do.

Q And he notes, as you go down, a reference to the abdominal CT scan, correct?

A Yes.

Q And Dr. Rogers, right in his note, indicates that that CT scan is

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consistent with acute non-perforated appendicitis, correct?

A Yes.

Q Have you ever looked at the films themselves?

A Yes.

Q You'd agree that that was -- Dr. Rogers is correct, as he notes in his procedure, that this was an acute nonperforated appendicitis based on that CAT scan?

A Yes.

Q Now, we then turn to page 20. If you go down a little more than halfway down the page -- and it may be easy to reference, there's a section where there's an underline point. This was done, then a blank.

A Yes.

Q If we go about six or seven lines down it starts with, "With this we were able to easily mobilize the cecum into the wound"?

A Yes.

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Q Okay. And it then goes on to say "With an attached acute nonperforated appendicitis," correct?
A **Yes.**
Q What Dr. Rogers is saying right there, that when he sees it in front of him, it's a nonperforated appendix, correct?
A **Yes.**
Q And he puts that in the medical record of this patient at the South Shore Hospital, correct?
A **Yes.**
Q Now, if we go up on top of that on procedure in detail, if you read -- if we read down a little bit, it has a typical presentation at the beginning about prepping a patient and getting him ready, draping. It then says, "We made a classical right lower quadrant McBurney incision," correct?
A **Yes.**

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Q And based on your thorough review of the deposition transcripts, who made that incision?
A **Probably the resident made it.**
Q Okay. And then he goes on to say -- so, that's the -- the skin is incised, correct?
A **Yes.**
Q And the McBurney, I think you said, of three inches on the skin level?
A **It doesn't say, but that's typical.**
Q Okay. I know it doesn't say, but you told the jury typical about three inches?
A **Something like that.**
Q Okay.
A **Yeah, it could be two to three inches.**
Q Okay. And then there's a discussion, "Subcutaneous tissue was split with electrocautery and fascia was incised," correct?
A **Yes.**
Q And you told us a little bit about

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that in your direct examination. These are the layers below the skin, then opened up to provide a view inside, correct?
A **Yes.**
Q Okay. And is it fair to say that when you're looking in you're looking in sort of, as a surgeon, from the skin incision into sort of a funnel, that it opens up underneath the level of the skin?
A **Yes.**
Q Okay. And then it goes on to -- it keeps going. "We incised the external oblique muscle and then incised the internal oblique fascia." So, they're still opening up down below to get to the cecum to open up so we'd have this funnel from the skin level down to the cecum, correct?
A **Yes.**
Q And then it says, "We entered into

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the abdominal cavity and then attempted to mobilize the cecum into the wound," correct?
A **Yes.**
Q So, in this description, these surgeons are describing that they've incised the skin, they're then going down through the fascia and muscle layers to create this surgical field as it where, this opening that they can view what they hope is the cecum and appendix, correct?
A **Yes.**
Q It goes on to say, "The cecum was partially densely adherent." And you've talked a little bit about that, correct?
A **Yes.**
Q Now, you indicated that the "densely" meant that there had been a lot of inflammation in this case, behind the cecum, and that was caused by the appendix, correct?
A **Yes.**

Q So, you had that diagram -- and I think we probably have it sketched in our mind by now. I could bring it out again if you want.
But for this particular patient, his appendix came off, at some point, near the bottom of the cecum and then was tucked up underneath the cecum, correct?
A **Yes.**
Q Because that appendix was laying between the retroperitoneum --
A **Correct.**
Q -- and the cecum? It's in between them?
A **Yes.**
Q In contact with both, correct?
A **Yes.**
Q So, this inflammatory process of the appendix is causing this development of whatever happens to cause the cecum to become adherent to that back of the abdominal wall, correct?
A **Yes.**

Q This is a process that goes over hours and days?
A **Yes.**
Q So, that inflammatory process from this acute appendicitis is causing this inflammatory process behind the cecum and against the abdominal wall, correct?
A **Correct.**
Q Dr. Rogers then says, "We were able to feel a firm and indurated retrocecal appendix." What does that mean?
A **He was able to palpate the appendix, inflamed behind the cecum.**
Q So, that what one of these surgeons, or perhaps both, were able to do was put their fingers into the wound to get behind the cecum and they could feel that appendix under there, right?
A **Yes.**
Q So, that would mean that in order to feel it, they can get their fingers

under it, which means as they're doing that some of these attachments have to be coming loose or maybe they're not even attached at that level, correct?
A **Well, it doesn't necessarily mean their fingers are underneath. You can feel it through the adhesions and the inflammation.**
Q Okay.
A **And it's not -- that doesn't mean to say they were dissecting anything when they felt.**
Q Okay. What it means is they're able to get their fingers behind the cecum enough to feel a firm and indurated appendix, correct?
A **Not necessarily. You don't -- you don't have to be behind, you can just feel through the back wall of the cecum, you can feel the appendix.**
Q But then you can feel --
A **It's not clear --**

Q -- the back wall of the cecum, correct?
A **Yes.**
Q And the appendix is laying with it, correct?
A **Yes.**
Q This record indicates they can feel the appendix, correct?
A **That's what it said.**
Q So, they are behind the cecum and they are feeling the appendix, correct?
A **Or a portion of it, it's not clear exactly what was done at that point.**
Q Okay. It's clear to you, it's not plausible that they could feel the appendix through the back wall of the cecum at this point, correct?
A **No, but you feel under the back wall of the cecum, but it doesn't mean you're doing the proper dissection. You're just scouting out what the problem is and then a bell should go off, this is adherent, I need to**

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enlarge the incision and do a proper dissection.
Q Doctor --
A It's like a scouting mission.
Q So, this scouting mission, as it were, with the fingers of the surgeon --
A Yeah.
Q -- allowed them to be able to get those fingers underneath the cecum to feel a firm and indurated appendix, correct?
A Yes.
Q So, by definition, that means they were able to fit their fingers somewhere underneath the cecum and between that retroperitoneum or back wall, to be able to feel this appendix, which was how long?
A Seven centimeters.
Q If that cecum is attached to the back wall of the abdomen, they can't get their fingers into that plane to feel that, can they?

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A Well, you might be able to get it under enough to at least identify the problem in your scouting portion of the operation. It doesn't mean you're freeing the cecum up.
Q Okay. But it could mean that, correct?
A No, it's obviously not, because then the injury wouldn't have occurred. So, that's not possible.
Q Okay. And that's because with any attachments on the back of the cecum, if the normal operative pressures are done in the direction as they were put by Dr. Rogers, you're telling us the bowel would never have separated?
A I'm telling you he used -- did not use the normal gentle pressure.
Q Can you answer that yes or no, Doctor? By the way, do you know Selwyn Rogers?
A I do not.
Q Have you heard of Selwyn Rogers?

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A I have not.
Q Now, he then goes on to state, "We were able to mobilize the terminal ileum up to the wound as we were mobilizing the cecum to the wound, retraction to the terminal ileum," correct?
A Yes.
Q Okay. And at this point, the terminal ileum was avulsed off the cecum, correct?
A Yes.
Q Now, at this point, as we go on, just to be clear, I believe you testified that everything that Dr. Rogers, and for that matter Dr. Najjar, did was perfectly appropriate.
And the fact that there was a breakdown of an anastomosis had nothing to do with improper care or technique, correct?
A Up to the point of the tear -- avulsion.

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Q After the point of the tear.
A Yeah, after the point of the tear, I have no criticism --
Q Okay.
A -- of Dr. Rogers or Najjar.
Q Now, you have told this jury that you believe that there's no indication here that there was a problem with the terminal ileum or the cecum, correct?
A Not of any medical significance. There was some inflammation at the base of the appendix.
Q Doctor, did you tell the jury what I just asked you if you told them? Let me ask again.
You told the jury there's no evidence in these medical records of a problem with the terminal ileum or the cecum, correct?
A I think I said terminal ileum. The cecum had an inflamed appendix on it.
Q Now, as we go down here, Dr. Rogers

says he uses a -- it says, "A five-millimeter linear cutter used to transect the terminal ileum proximally." What does proximally mean?

A It means upstream of the tear --

Q Okay.

A -- toward the more -- if you're moving along the small bowel toward the stomach.

Q So, if we were considering how the food, or food as it's broken down, passes through the bowel, it comes down the intestine, will eventually get dumped into the cecum?

A Yes.

Q And then starts this process through the large bowel, correct?

A Yes.

Q So, proximal to the end of the terminal ileum would be further upstream a bit, as it were, correct?

A Yes.

Q And we've heard some testimony with

this, but how much small bowel might the human being have in their body?

A About 20, 21 feet.

Q Dr. Rogers went up and he cut with that cutter -- he transected the terminal ileum so that, at that point, he has the sample that will go to pathology, correct?

A Yes.

Q His op note is page 20, Doctor. At that point, Dr. Rogers says, "This was done in the viable area of the terminal ileum." What does viable mean?

A Good supply and it looked healthy.

Q And where was that in comparison to where the terminal ileum had avulsed? Where was this area where the terminal ileum looked to Dr. Rogers to be healthy with a good supply?

A It was about 21 centimeters away from it.

Q About eight inches, correct?

A That's about right.

Q "We then sent the terminal ileum for specimen," and I'll ask you about that in a minute as well. It then says, "We then turned our attention to mobilize the cecum up to the wound after extending the incision laterally and medially. With this we were able to easily mobilize the cecum into the wound with the attached acute nonperforated appendix," correct?

A Yes.

Q So, can you tell me where in here Dr. Rogers describes that he then did any more blunt dissection behind the cecum to free it up?

A The op note doesn't describe blunt dissection either then or even before he caused the tear. That's the point. He missed the whole -- he violated patient safety rules by not freeing the cecum before he pulled and tore it, the ileum.

Q Doctor, I'll repeat my question.

MR. MCTAGUE: Your Honor, may I --

A I believe I answered it very specifically, but not to your liking, sir.

Q So, let me ask -- I'll ask you this.

THE COURT: Listen to the question. Go ahead, Mr. McTague, ask the question. Doctor, wait for the question and then answer just the question that's asked.

MR. MCTAGUE: Sorry, Your Honor.

THE COURT: Go ahead.

BY MR. MCTAGUE:

Q I read these lines to you, Doctor. "We then turned our attention to mobilize the cecum up to the wound after extending the incision laterally and medially. With this we were able to easily mobilize the cecum into the wound with the attached acute nonperforated

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appendix."
My question was then, can you tell me where in those lines, Doctor, is any mention of Dr. Rogers having to perform or performing any further dissection to free up the cecum?
A **The word mobilize means dissection. You mobilize by freeing.**
Q So, why don't we go back up top and use your words in a fair manner, Doctor. "We entered into the abdominal cavity." Can you see that?
A **Yes.**
Q "And then attempted to mobilize the cecum into the wound," correct?
A **Yes.**
Q By your definition right there, that means Dr. Rogers was bluntly dissecting behind the cecum, is that what you just told this jury? That's what mobilized means, correct?

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A **He did some attempt, but then he said --**
Q Doctor, does mobilizing mean dissect behind the cecum?
THE COURT: Wait for the question, Doctor, and answer the question.
A **No, because --**
THE COURT: Wait one second, Doctor. Mr. McTague, question again, please.
BY MR. MCTAGUE:
Q Doctor, let me ask it this way. You just told this jury that when Dr. Rogers said mobilize the cecum into the wound with the attached acute nonperforated appendicitis, meant that Dr. Rogers had been mobilizing by dissecting bluntly to free up the cecum.
Aren't those the words you just told this jury?
A **Well, once he enlarged the incision --**

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Q Doctor, are those the words?
A **-- the cecum would not have come up --**
MR. MCTAGUE: Objection, Your Honor.
A **-- unless he did the dissection.**
THE COURT: Okay. That's stricken. Just a yes or a no answer, Doctor.
DR. MAYER: I can't answer that yes or no, I could explain.
BY MR. MCTAGUE:
Q No, Doctor, let me ask again so you can understand. Aren't those the words you just used with this jury, yes or no?
A **I can't answer it yes or no. I could -- I'm happy to explain.**
Q Okay. Maybe you just didn't understand, I'll ask it one more time.
A **I understood, sir.**
Q No, I'm not sure you did. My question to you is simple. In

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reading that line, "With this we were able to easily mobilize the cecum into the wound with the attached acute nonperforated appendix."
You just told this jury that meant -- mobilized meant Dr. Rogers had done further dissection behind the cecum to bring it up into the wound. Isn't that, yes or no, what you just told this jury?
A **At that point in time, yes.**
Q At that point in time --
A **I wasn't defining the word mobilize. It wouldn't have been mobilized unless he freed it. It couldn't have come up because it was partially densely adherent.**
MR. MCTAGUE: Move to strike after yes, Your Honor.
THE COURT: Yes was the answer, the rest will be stricken.
BY MR. MCTAGUE:
Q So, Doctor, as we go ahead, up

farther, Dr. Rogers had described, "We entered into the abdominal cavity and then attempted to mobilize the cecum into the wound," correct?

A That's what he dictated.

Q And you've described already what mobilized means, correct?

A No, I have not. I described what it involved --

Q No, you have not.

A -- at a later point in time. I did not define the word mobilize.

MR. MCTAGUE: Your Honor, I object and move to strike and I would ask to be seen at sidebar.

THE COURT: Yes, sidebar please. Jurors, you can stretch.

(SIDEBAR CONFERENCE NOT TRANSCRIBED)

BY MR. MCTAGUE:

Q Doctor, in this particular note, Dr. Rogers has used mobilize on a number of occasions, correct?

A Yes.

Q Now, in addition, Doctor, as we look at this note, back to where we were before, he does say, "We entered into the abdominal cavity and then attempted to mobilize the cecum into the wound," correct?

A That's what he says.

Q Just yes or no, Doctor. Do you want to try to describe mobilize in different definition there than you did down below?

A I can explain. I can't answer that yes or no.

Q You can't answer my question, whether you're going to try to say mobilize should be interpreted differently at that point than later below? You can't answer that question yes or no?

A No, mobilize means to --

Q Doctor, you can't answer that question yes or no?

A No, I'm not defining mobilize differently.

Q Doctor --

MR. MCTAGUE: Your Honor, I --

THE COURT: Doctor, just listen to the question and just answer yes or no. And if you can't answer it yes or no just say I cannot answer it yes or no, but no commentary, please.

BY MR. MCTAGUE:

Q So, are you telling me you can't answer that question yes or no?

A That's correct.

Q Okay. Maybe it's poor phrasing, let me ask it again maybe in a little different way.

Are you going to now try to tell this jury that the term mobilize, down below in that, should be interpreted differently than mobilize as used higher up after Dr. Rogers entered the abdomen, yes or no?

A I'm not telling the jury that, but I

--

Q Doctor --

A I can't answer that yes or no. I could explain.

Q You can't answer that yes or no. It must be me, so let me ask again a different way, maybe, this time.

Is what you want to do next is to explain to this jury, in some manner, that they should interpret the word mobilize differently when it's used in "mobilize the cecum into the wound," than it is used up above when Dr. Rogers said, "We entered the abdominal cavity and attempted to mobilize the cecum into the wound"?

Are you going to attempt to describe that they should interpret mobilize differently in those two sections, yes or no?

A I have a brief explanation. If you won't let me say that then I'll say I can't answer that yes or no. If I

can have a two-sentence explanation I'd be happy to give it.

THE COURT: So, the answer is he cannot answer it yes or no. Next question.

MR. MCTAGUE: Okay.

BY MR. MCTAGUE:

Q Doctor, it then says, as we keep going down, that Dr. Rogers elected to perform an ileocecectomy and he then cut across the cecum with the stapler, correct?

A Yes.

Q So, at this point, what will be handed off to pathology is the cecum with one end of it stapled shut, correct?

A Yes.

Q With the attached appendix?

A Yes.

Q And the other thing that's going to go to pathology is 21 centimeters of the terminal ileum?

A Yes.

Q And what's left in the body would be a stapled end of the ascending colon, just above where the cecum starts?

A Yes.

Q And then this terminal ileum, 21 centimeters missing, correct?

A Yes.

Q And then the doctor will bring these two together and do a side by side anastomosis and you described that, I think, before, correct?

A Yes.

Q Now, if you turn to page 24, this is the pathology specimen requisition, correct? It's a little hard to read up top with the copying.

A Yes, yes.

Q And so this is, "Tissues removed on site." It says, "Terminal ileum and cecum/appendix," just like we discussed, correct?

A Yes.

Q Now, Doctor, what is ileocecectomy?

A It's taking out the end of the ileum and the bottom part of the cecum and leaving the ascending colon in.

Q If we look at page 25, when the pathologist is done with his evaluation, both gross and microscopic, he says one of the samples he received and looked at, he'll make a comment on, is terminal ileum resection, correct?

A Yes.

Q That again refers to that 21 centimeters of terminal ileum?

A Yes.

Q And then the next sentence, "Cecum/appendix, ileocecectomy."

A Yes.

Q Does that indicate to you that he sees some ileum in that sample?

A Yes, it says "terminal ileum resection."

Q No, no. Down in that section where we have the statement, "Cecum/appendix, ileocecectomy."

Does that indicate to you that in that sample that pathologist sees some ileum?

A No, because the gross description on the next page doesn't mention any ileum.

Q Do you know why that pathologist takes a sample as described by the surgical team as "cecum/appendix," and then says "cecum/appendix, ileocecectomy"?

A I believe ileocecectomy is a procedure, not a pathologic diagnosis.

Q So, it wouldn't be in the diagnosis. So, my question remains, Doctor, can you think why the pathologist put that there?

A Just because it was the procedure. Normally it would not appear.

Q Okay. Doctor, if you'd turn to page 26 again.

A Yes.

Q What this indicates is that -- we'll

start with A. There is 21 centimeters of terminal ileum that's provided, correct?

A Yes.

Q And without going through it line to line, I'm sure you've looked at this, can we agree that at some point in the process, when this gross description is being done, that this pathologist opens up the terminal ileum and looks inside?

A Yes.

Q Okay. And when he looks inside, he sees that from the open end into the small bowel, spanning up to 10 centimeters, almost half of that 21, he sees ulcerated and a slightly nodular area, correct?

A That's what he says, yes.

Q And then when he looks at the remaining 11 centimeters, he describes them as mucosal surface which is -- mucosa is just the inside lining?

A Yes.

Q That mucosal surface is described as normal appearing mucosa, correct?

A Yes.

Q Distinct from the 10 centimeters he saw, correct?

A Yes.

Q So, at least by vision -- and we're not talking about microscopic. At least by vision by this pathologist, that first 10 centimeters did not look like normal mucosa, correct?

A I think there are minimal findings and basically normal, but there were some minimal findings. It would not affect the strength of the bowel in any way.

Q Doctor, my question is, can we agree that the pathologist -- well, did you ever -- have you trained in pathology?

A Yes, I had a surgical pathology rotation in my residency.

Q All right. Did you go on to a

pathology residency?

A No.

Q Are you board certified in pathology?

A No.

Q This pathologist who is, described one part of this as normal appearing and then described the 10 centimeters as different, is that fair to say?

A There's a minimal difference, yes.

Q I'm not asking you to quantify the difference. My question relates to what the pathologist said. He described that section of the terminal ileum, one part of it, being normal appearing and the other was described differently, correct?

A Yes.

Q Now, surgeons, Doctor, who create anastomoses, need to find healthy viable tissue to match up and create the anastomosis, correct?

A Yes.

Q Because what you want to make sure of when you're reconnecting things is that the tissues are healthy so that when you create the anastomosis, which is now a new connection, that things will be healing correctly and hopefully you have normal functioning bowel thereafter, correct?

A Yes.

Q Now, Dr. Rogers, by his note, indicates that he found the viable area to be about 21 centimeters up from the opening, correct?

A Well, that's where he resected. I don't think he meant to say the rest was not viable. That's an implication that isn't in the evidence here.

Q Doctor, what's in evidence is his op note, correct?

A Yes.

Q And if you'd look on page 20. In the middle there he says, "A 5-

millimeter linear cutter was used to transect the terminal ileum proximally. This was done in the viable area of the terminal ileum."
First, yes or no, did I read that correctly?
A Yes.
Q So, in this record, there is evidence here that Dr. Rogers made this transection in an area of viable tissue, correct?
A Yes.
Q And he, as a surgeon, is looking to find viable tissue?
A Of course.
Q Okay. Now, Doctor, is it fair to say that there are times where there are damages or injuries to bowels that you can't see from the outside?
A I don't understand the question. I'm sorry.
Q Is it true that, for example, you can't tell by looking and palpating where diseased tissue begins and

ends in the bowel?
A That's very unusual. I don't agree with it.
Q Would you agree that you can't tell by looking and palpating where diseased tissue begins and ends because you might feel, for example, a stricture, but there could be other ischemic changes inside the bowel that you can't visually -- see visually or feel and that's why you have to stay widely around it?
A I don't agree with that.
MR. MCTAGUE: I'm sorry. May I approach, Your Honor?
BY MR. MCTAGUE:
Q I'm going to show you -- there's a question that's asked.
A What is that? What are you reading from, sir?
Q It's your testimony in a case back in 2011.
A Okay.
Q Do you remember that case?

A I do not, no.
Q Do you remember testifying in a case, and maybe this will refresh your memory, where there was an anastomosis performed after problems with the bowel that then broke down?
A I don't recall that, no.
Q Okay. So, I'm going to read you what you said and you'll -- it may sound familiar because that's my question.
The question was:
"Therefore, only Dr. Davis had the opportunity at that point to have access to all the visual and tactile clues that would be available to a surgeon to help identify where the diseased tissue ends and where healthy tissue begins, true?"
And you said, "Yes." And then you went on. You said, "Yes, but you can't tell by looking and palpating where diseased tissue begins and ends because you may feel

the stricture, but the other ischemic changes are inside the bowel that you can't see visually or feel, which is why you have to stay widely around it."
Did I read that portion correctly?
A Yeah, but there's more.
Q I will
A The surgeon was taking out such a minute piece of bowel, I'm remember it now, that he didn't get widely around an ischemic area. It was a logical, tiny resection.
Q Okay.
A So, this has nothing to do with the facts of this case.
Q Okay. So, I'm going to get into how much was taken in a moment. Can you tell the jury how much was too little in this case?
A I don't remember exactly, but --
Q Okay, yeah.
A -- that was the gist of it.

Q My question, Doctor, was about this particular case in where, basically, I asked you -- the question was, "Do you agree that that's why you have to stay widely around it because you can't feel or see sometimes diseased tissue?" Do you agree with that?

A Well, in the facts of that case, I mean, in this case there was nothing wrong with the ileum in the first place except Dr. Rogers tore it off the cecum, then there was something wrong with it.

MR. MCTAGUE: Your Honor, I am, going to make my request.

THE COURT: Okay. That answer is stricken. Doctor, please just answer the question yes or no. Go ahead, Mr. McTague, ask the question again.

BY MR. MCTAGUE:

Q Doctor, in this particular case, when Dr. Rogers is going to take these pieces and reconnect them, he

wants to connect healthy terminal ileum to healthy colon, correct?

A Yes.

Q Now, in a small perforation in healthy bowel, you can take 10 centimeters or less off the terminal ileum, correct?

A That's possible, yes.

Q In fact, that's what you testified in the Stevens case, correct?

A Yes.

Q Do you recall that now?

A I don't recall exactly, but it sounds logical.

Q Dr. Rogers took 21 centimeters here, correct?

A Yes.

Q And then he described where he was taking it from as the healthy viable tissue, correct?

A Yes.

Q That indicates that Dr. Rogers saw something when looking at the terminal ileum, correct?

A Well, he saw he had torn it off. There's nothing else to see.

Q And when the pathologist opened that up, he saw something different, correct, yes or no?

A Yes.

Q The first 10 centimeters as opposed to the next 11, correct?

A Yes.

Q Now, generally, Doctor, in a case involving, for example, ischemic bowel or other problems with the bowel and you're going to do a resection, you would want to resect 6 to 8 inches to be safe, correct?

A Generally, yes.

Q And you would agree that a leak from the anastomosis of a small bowel resection or, in this case, small to large bowel connection is a recognized risk?

A Yes.

Q And a bowel leak can occur even if it's properly reconnected and

performed anastomosis, correct?

A Yes.

Q Now, in this case, the anastomosis broke down, correct?

A Yes.

Q And one of the reasons why an anastomosis can break down after a properly performed anastomosis is that the tissues aren't actually healthy and don't heal, correct?

A At least the edges of the anastomosis, that could be true, yes.

Q I'm sorry. It may be because you've been talking for a while, but you -- I didn't hear you.

A Okay. Yes, the edges of the bowel that are stapled may not have adequate blood supply. It doesn't mean the bowel itself is unhealthy.

Q Doctor, you have testified in the past that where there is a breakdown of an anastomosis, that is evidence of attaching unhealthy tissue

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together, haven't you?
A That can occur too, yes.
Q And you've testified to that in the past?
A Well, in certain cases, yes.
Q You testified to that in the Stevens case, correct?
A I believe so.
Q In fact, Doctor, in that case you believed and testified that the anastomosis that was done had to involve unhealthy tissue because the leak occurred fairly soon after the anastomosis, correct?
A In that case, yes, on different facts, yes.
Q Do you remember how many days afterwards this anastomosis leaked?
A I don't recall.
Q Would it surprise you that it was five days later?
A I don't know.
Q And you told us earlier that sometimes these will break down four

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to six days later, correct?
A That's possible.
Q Now, Doctor, if you could turn to page 9 in that book. That is the first page of the CT scan result?
A Yes.
Q And down at the bottom of the -- well, not at the bottom, but there's -- as you go down there's a history, you can see it in the left-hand column.
A Yes.
Q And a couple lines down it says findings?
A I do.
Q And if we keep going down there's a paragraph that starts, "Bowel peritoneum and retroperitoneum"?
A Yes.
Q The last line of that says, "Small right lower quadrant mesenteric lymph nodes are visualized, likely reflecting reactive change," correct?

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A Yes.
Q What's a mesenteric lymph node?
A They're lymph nodes around the bowel that can enlarge when there's appendicitis or infection.
Q So, what we're seeing is the impact of the appendicitis on those lymph nodes as seen on the CT scan?
A Yes.
Q Okay.
MR. MCTAGUE: Your Honor, I'm about to go into another area.
THE COURT: Are you suggesting the lunch break?
MR. MCTAGUE: I am.
THE COURT: Okay. I think I'll accept your suggestion, Mr. McTague.
(Court is in recess at 12:59 p.m.)
(Court reconvenes at 2:09 p.m.)
THE COURT OFFICER: Jurors entering.
(JURY ENTERS)
THE COURT OFFICER: You may

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be seated.
(SIDEBAR CONFERENCE NOT TRANSCRIBED)
MR. MCTAGUE: I'm sorry.
Are we ready, Your Honor?
THE COURT: Yes.
(CROSS-EXAMINATION OF DAVID A. MAYER, M.D., CONTINUED)
BY MR. MCTAGUE:
Q Doctor, moving ahead, after Dr. Rogers performed the surgery, which is August 22nd -23rd, the patient stayed in the hospital until the 27th of August, correct?
A Yes.
Q Then, on the 28th, he returns, correct?
A Yes.
Q Now, at some point, when he does return, he comes in and he sees Dr. Driscoll who was actually -- had become his attending surgeon at the previous hospitalization, correct?
A Yes.
Q You now understand that?

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A **Yes.**
Q At that time -- have you reviewed these records?
A **Yes.**
Q So, if you could turn to page 43. When Mr. Marciniak returns, he is seen first in the Emergency Department at South Shore Hospital, and they record a history of the patient having been discharged home yesterday from South Shore Hospital.
Do you see where I started to read?
A **I do.**
Q "Today, at 1:30, he passed gas and then felt bloated and felt a leakage of warm stool in moderate amount from his right lower quadrant abdominal incision."
And it goes on to say "He had passed stool yesterday," correct?
A **Yes.**
Q So, it looks like he experienced

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this, the ultimate perforation and what happened due to it, the day he is home after his discharge; is that fair to say?
A **Yes.**
Q And, in fact, if we look at the next -- page 48, which is part of a history and physical, I believe. I don't have page 49. Let me see who wrote that. That's actually Dr. Driscoll.
He writes, as he takes his history from the patient, he writes, because he had been in the doctor in the hospital after the first surgery, "He did reasonably well postoperatively and was discharged 24 hours ago."
Do you see where I am reading?
A **I do.**
Q "At that time, he was reported to have no fever, and his white count apparently was normal. His bowels

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were also moving normally."
"At home this afternoon, he developed fecal drainage from his right lower quadrant incision."
So, again, he is describing that this -- the perforation or the breakdown likely occurred that day, correct?
A **Or at least the symptoms, the clinical symptoms developed that day, yes.**
Q Now, and you touched base with Mr. Grace on this briefly at the end of your presentation.
When you were originally asked to review this case this year, you originally were of the opinion that Dr. Rogers and Dr. Najjar were responsible for prematurely discharging the patient, correct?
A **Yes.**
Q You subsequently received further information from the depositions that indicate that those were not

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the doctors responsible for the patient after --
MR. MCTAGUE: Strike that.
BY MR. MCTAGUE:
Q You know that Dr. Rogers was not responsible after 7 a.m. that morning after the surgery, and that another attending, Dr. Driscoll, among others, attended to the patient thereafter, correct?
A **Yes.**
Q So, I take it that you would be critical of whoever it was that discharged this patient, correct?
A **If they were defendants in this case, but they're not, so I am not offering opinions.**
Q Well, I'm not talking about your testimony. What I am saying is, looking at that discharge, you would be critical of the doctor who discharged the patient?
A **Or who took care of the patient postoperatively.**

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Q Okay.
A **It isn't just the day of discharge. They looked a little better with some antibiotics on the day of discharge.**
Q But, Doctor, you had -- I'm sorry. Had you finished?
A **Yes, thank you.**
Q You had indicated, or at least we heard in the disclosure, that you state that "Mr. Marciniak became febrile." What's that mean?
A **Fever.**
Q Okay. "To 101.7 degrees and, in fact, was 101 degrees the evening before discharge on 8/27/11," correct?
A **Yes.**
Q Now, have you subsequently been able to review records to indicate that the patient was not febrile or with fever the night before discharge?
A **The night before, probably not. I agree with you.**

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Q And, again, originally you thought this was on Dr. Rogers' watch. But when you take on a case and review materials, is it imperative on you as an expert witness to make sure you have enough information and thoroughly review records?
A **Yes.**
Q Now, have you seen in the record, actually, then that this patient did not have fever since the evening of th August 25 , two days before discharge?
A **I believe that's correct, yes.**
Q And you would have known by thoroughly reviewing the records that the temperatures taken by the nurses every four hours after that right through discharge were within normal limits?
A **Yes.**
Q Now, you did have an opportunity to see the discharge summary that was

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in the record when you rendered that opinion about the workup on the patient; is that fair to say?
A **Yes.**
Q And that indicated that over the course of his hospitalization in that first hospitalization, from nd August 22 until the time of th discharge on the 27 , that they had actually followed and worked up the issue of a fever, correct?
A **They did some workup. Didn't do a CAT scan, but did other workup, yes.**
Q Well, they kept track of the temperature, which was important, correct?
A **Yes.**
Q They kept track of what's known as the white blood count, correct?
A **Yes.**
Q And from your review, you know --
MR. MCTAGUE: Strike that.
BY MR. MCTAGUE:
Q And in most infectious processes,

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one would see a rise in white blood cell count with an infection?
A **You would generally, yes.**
Q And for this patient, from the point of surgery on, his white blood cell count was normal, correct?
A **Yes.**
Q And you also saw in this record, also, that in the course of these few days, they ordered a chest x-ray to check for -- on the basis of fever, to check if there is anything going on in the lungs, correct?
A **Yes.**
Q And that was good practice?
A **Yes.**
Q That was done by the doctors under Dr. Driscoll, correct?
A **Yes.**
Q So, there was a fever workup done at that time, correct?
A **Yes.**
Q And at that time, even despite that review, you were of the opinion that

Dr. Rogers was responsible for discharging this patient prematurely?

A Well, my opinion was he was discharged prematurely. I told the jury today that Dr. Rogers had nothing to do with the premature discharge.

Q Well, Dr. Driscoll will be in the courtroom and be asked about this, but that's not my question to you now.

My question is, you were willing, and put it down in writing, to say, based on your review, even of the records we have discussed and knowing those temperatures, that not only was Dr. Rogers responsible, but that he was also prematurely discharged, correct?

A Yes. Generally, a surgeon is responsible for the post-op care of his patient, so that was the assumption I made.

Then I learned that they were working on shifts and I amended my opinion and withdrew any criticism.

Q And in your review of the records, did you see notes signed by attending physicians?

A Yeah, I did.

Q Dr. Driscoll?

A Yes.

Q During the time period after Dr. Rogers' surgery and prior to the time of discharge, correct?

A Yes.

Q And you knew that when you said in your disclosure to Mr. Grace that you're willing to say that Dr. Rogers prematurely discharged the patient, correct?

A I did not know which attending had seen him at that time. I now know it was not Dr. Rogers, so I have no criticism in that manner.

Q My question, Doctor, is did you ask

Mr. Grace to get you more information so you could determine who it was?

A Yes, and we -- we -- he provided it, we talked about it, and I realized Dr. Rogers was not covering the patient during that time.

Q So, in June of this year, you did have the opinion, correct, that Dr. Rogers was responsible?

A That was my initial thought, yes.

Q And at that time, you saw the signatures of Robert Driscoll in the record, correct?

A I guess I didn't appreciate that fact, but I saw the attending notes, yes, sir.

Q You didn't appreciate that fact, but were willing to say Dr. Rogers was responsible, right?

A Well, that's not what I am saying today. So, I am testifying accurately today.

Q Because you know all the records are

here now and you were going to be asked about them, correct?

A That's not the reason. The reason is I ascertained that he didn't participate in the post-op care.

Q And can you show me where in that record there is some evidence of his participation, Dr. Rogers, in the post-op care after the post-anesthesia recovery room?

A I saw notes by, I assume, residents and attendings and I assumed it was him. Because after a disastrous complication, I had never heard of a surgeon not following up his own patient. So, this was a first for me in 40 years of reviewing charts.

MR. MCTAGUE: I have nothing further.

MR. GRACE: Sorry.

THE COURT: Not your turn yet, Mr. Grace.

(CROSS-EXAMINATION OF DAVID A. MAYER, M.D.)

BY MS. KOGAN:
Q Good afternoon, Doctor.
A **Good afternoon.**
Q My name is Jennifer Kogan and I represent Dr. Najjar.
You told us earlier today that after graduating from medical school in 1974, that you were trained at New York Hospital in a five-year surgery residency?
A **Yes.**
Q Is that correct?
A **Yes.**
Q And you were training to become a surgeon?
A **Yes.**
Q At the conclusion of your residency?
A **Correct.**
Q All right. And when you talk about training, what you're doing in residency is learning how to become a surgeon by observing and participating in surgery with more senior experienced attending

surgeons, correct?
A **Yes.**
Q Okay. And you know in this particular case that Dr. Najjar was a General Surgery resident at the time of Mr. Marciniak's surgery on nd August 22 , correct?
A **Yes.**
Q And do you know what year of his residency he was in?
A **First year.**
Q Okay. And that's sometimes called an intern?
A **Yes.**
Q And, Doctor, he was in his third month of that first year, correct?
A **Yes.**
Q And he participated in Mr. Marciniak's operation on August 22nd as, what we saw in the op note, as an assistant?
A **Yes.**
Q Dr. Rogers was the attending surgeon?

A **Correct.**
Q And he was there. You told us that Dr. Najjar was negligent because he was there. And when you say he was there, he was in the operating room with Dr. Rogers during the procedure?
A **Correct.**
Q Okay. And then if you look at page 16 in your jury book, this is the intraoperative nursing record.
Are you there, Doctor?
A **I am.**
Q And what this page tells us is that, in addition to Dr. Najjar being there, there was a circulating nurse there?
A **Yes.**
Q There was a scrub tech there?
A **Correct.**
Q There was an anesthesiologist there?
A **Yes.**
Q And there was a C.R.N.A. there?
A **Yes.**

Q Certified Respiratory Nurse Anesthetist?
A **Yes.**
Q They were all there for Mr. Marciniak's operation, correct?
A **Yes.**
Q And all of these people in some fashion were actively participating in his operation, albeit doing different tasks?
A **Yes.**
Q All right. Now, did you read Dr. Najjar's deposition?
A **Yes.**
Q When is the last time that you read his deposition?
A **Within the last week.**
Q The last week?
A **Yes.**
Q Okay. And when you read his deposition, did you do that with an eye towards figuring out what Dr. Najjar actually did in the operating room before the avulsion occurred?

A **Yes.**
Q And what I want to do, Doctor, is just take a quick look at his testimony.
MS. KOGAN: Can I approach, Your Honor?
THE COURT: You may.
BY MS. KOGAN:
Q I'm going to give you his transcript just to move this along.
MS. KOGAN: Mr. Grace, page 31.
BY MS. KOGAN:
Q So, this is his deposition, correct?
A **Yes.**
Q And this is what you read?
A **Yes.**
Q And so, I am going to start at line number two. Okay?
A **Sure.**
Q And this is Mr. Grace asking the questions.
"Now, do you recall if the intention was for you, yourself,

with Dr. Rogers' supervision, the intention was for you to perform the appendectomy principally?"
"Answer: I am not quite sure I understand your question."
Mr. Grace's question: "Well, I'm not either, but I know what I wanted to ask. You started the operation, didn't you? Did you make the incision?"
"Answer: I think I made the skin incision, yes."
"Question: Okay. Simpler question: Describe your participation in this operation in detail."
"Answer: Oh, so I believe I made the skin incision."
"Question: The McBurney's?"
"Answer: Correct. I don't recall specifically how we accessed the peritoneum, but I likely would have had Dr. Rogers retract and expose the tissue plane that he

wanted me to Bovie through and I would have Bovied in his direction."
"Once we entered the peritoneal cavity, I do recall performing a finger sweep to try to deliver the appendix up into the wound and being unable to do so, at which point Dr. Rogers attempted to deliver the appendix into the wound."
Did I read that correctly?
A **Yes.**
Q And, Doctor, what's a Bovie, just so the jury understands?
A **That's a cautery that cuts tissue with electric current.**
Q That's used to dissect down into the abdominal cavity?
A **Yes.**
Q Okay. And then, Doctor, if you could turn to page 34, line 20.
A **Yes.**
Q Okay.
"Question: So, is it fair

to say that Dr. Rogers, for lack of a better term, took over the surgery after you were unable to mobilize and visualize the appendix?"
"Answer: Yes."
And then lastly, Doctor, if you could turn to page 40. Actually, I'm sorry, Doctor. I wanted to read one more section. Just go back to page 35. Are you there?
A **Yes.**
Q And then Mr. Grace said, "And please describe in detail what occurred from when Dr. Rogers had to take over for you."
"Answer: I remember him trying to sweep the appendix up and deliver the cecum and appendix up into the wound."
"As part of that process, we'll frequently follow the terminal ileum, down to the cecum to deliver kind of the terminal ileum, cecum

and appendix up into the wound to visualize everything."

"And the terminal ileum, in the course of bringing them up, kind of simultaneously ended up kind of cleanly avulsing off the cecum, which surprised both of us, and it was at that point that the incision was extended and we performed an ileocecectomy with a stapled anastomosis."

Did I read that correctly?

A Yes.

Q All right. So, what Dr. Najjar was explaining there was that after the avulsion occurred is when the extension was made?

A That is correct.

Q All right. And then lastly, Doctor, if you could turn to page 40.

I am going to start at line 22.

"Question: Would you describe please in detail the

position of Dr. Rogers' hands when the ileum was torn off the cecum; what was he doing? As an aside, I assume you weren't manually participating in the surgery at that point, correct?"

"Answer: I was not. I don't remember if I may have been retracting the wound, but I know that I wasn't manipulating the bowel."

Did I read that correctly?

A Yes.

Q Okay. I'll take that back.

Doctor, can we agree -- and when I say we, I am really asking you -- will you agree with me that the skin incision, the initial finger sweep were appropriate actions by Dr. Najjar?

A Yes.

Q Can we agree that he did those things under the supervision of his attending, Dr. Rogers?

A Yes.

Q And as between the attending and the first-year surgical resident, can we agree that ultimate responsibility for the conduct of the operation is with the attending?

A Yes.

Q Not with the first-year surgical resident?

A I agree with that.

Q Will you agree with me that once Dr. Najjar could not mobilize the cecum and the appendix when he was doing his finger sweep, that it was reasonable for him to take his finger out and defer to the attending as to the next step?

A If that's what occurred, yes. It isn't clear from the op-note, but if that testimony is correct, that was reasonable.

Q You would not expect that Dr. Najjar would take his finger out and immediately grab a knife and extend

the incision?

A I would expect that or --

Q You would expect him to do that without --

A That's part of a --

Q -- first finding out what the attending wants to do?

A That's within the knowledge of a resident, to extend an incision when --

Q Without --

A -- a difficult dissection.

Q Without being told to do that by the attending?

A Well, he would discuss it with the attending, of course.

Q That's what I am asking you. What Dr. Najjar did by taking out his hand and then deferring the next step to what Dr. Rogers wanted to do, that was reasonable, correct?

A Yes.

Q All right. And the next step was that Dr. Rogers, as the attending,

put his finger in to assess the situation, correct?
A That's correct.
Q All right. And that's reasonable. You would expect the attending would want to see what was going on inside the incision, correct?
A Yes.
Q And you understand, hopefully now that we went through the testimony, that the avulsion, the point at which the terminal ileum came off the cecum, that occurred when Dr. Rogers was handling the bowel, not Dr. Najjar?
A Well, that's what the testimony says. The op-note kept saying we, and Dr. Rogers says he doesn't remember exactly who did what part of the procedure.
So, there is conflicting testimony. But if Dr. Najjar's testimony is accurate, then he was assisting Dr. Rogers when the injury

occurred.
Q Did Dr. Rogers testify that Dr. Najjar was handling the bowel at the point of the avulsion?
A He did not specifically --
Q He did not, correct?
A That is correct.
Q And Dr. Najjar testified that Dr. Rogers was handling the bowel at the point of the avulsion, correct?
A Yes.
Q So, while Dr. Najjar was there, it was Dr. Rogers who was handling the bowel at the point that the avulsion occurred, correct, Doctor?
A It appears so, yes.
Q All right. And just so I am clear, Doctor, it's your testimony in this courtroom that, with Dr. Najjar standing there, a circulating nurse, a scrub nurse, an anesthesiologist, and a C.R.N.A., that Dr. Rogers, in your words, "grossly ripped the bowel off the cecum with his fingers

inside of the McBurney's incision of several inches?"
A Yes.
Q Lastly, Doctor, you testified that Mr. Marciniak's --
MS. KOGAN: Strike that.
BY MS. KOGAN:
Q You testified, "With Mr. Marciniak's ileum being normal, it's impossible that gentle traction was applied;" do you recall that?
A I do.
Q And hypothetically, Doctor, if there were to be evidence that Mr. Marciniak's ileum was not normal, then is it possible that with gentle traction -- is it possible that gentle traction was applied if there is to be evidence that the ileum was not normal?
A Well, there is evidence that it was normal.
Q But I am asking you if there is evidence that it's not normal, is it

possible that this avulsion occurred because gentle traction was applied?
A You mean in another patient?
Q No.
A In this patient, it's a normal ileum, so I don't know how to answer the question. If you're asking me a hypothetical about another patient, that might be possible, not in Mr. Marciniak. That isn't possible.
Q But if there was evidence that Mr. Marciniak's ileum was not normal, then is it possible that the avulsion occurred with gentle traction being applied?
MR. GRACE: Objection.
BY MS. KOGAN:
Q Can you answer that yes or no?
MR. GRACE: Objection.
THE COURT: Overruled.
A I can't answer that yes or no.
MS. KOGAN: That's all I have.
MR. GRACE: May I approach,

Your Honor?
THE COURT: You may.
(REDIRECT EXAMINATION OF DAVID A. MAYER, M.D.)
BY MR. GRACE:
Q Do you recall being asked by Mr. McTague whether you had read Dr. Najjar's and Dr. Rogers' depositions?
A Yes.
Q In relation to who did what during their operation?
A Yes.
Q In front of you, I have Dr. Rogers' transcript, page 74, line 12.
"Question: Well, are you aware that you never signed this operative report?"
Dr. Rogers answered, "Yes. I mean, until this case, I did not know."
Next question: "All right. On the first page, under" -- and it's referring to the operative note

that's page 19 of 20 of the jury book -- "we made a classical right lower quadrant McBurney incision."
"Of the pronoun we, who actually did that incision?"
Dr. Rogers answered, "I can't recall. When I say we, the surgery is a team support, so I often use a pronoun of the collective we."
"Question: Okay. But you don't know -- you don't remember who did the McBurney incision?"
"I don't remember."
Page 76, line three.
"Question: And, 'We incised the external oblique;' you don't remember whether it was you or Dr. Najjar, correct?"
"Answer: I do not recall."
"Question: 'We split the internal oblique muscle;' you don't recall who did that, right?"
"Answer: That is correct."

"Question: And 'We entered into the abdominal cavity and then attempted to mobilize the cecum into the wound;' what did you mean by that sentence? And, again, you don't know who tried to mobilize the cecum in the wound?"
Dr. Rogers answered, "It means you are trying to get the cecum up into the wound, meaning outside of the abdominal cavity up into the field so that you can complete the operation."
Line 22 on page 76.
No, line three on page 77, I'm sorry. I'm almost done.
"You remember you were mobilizing the cecum?" question.
"Answer: That's correct."
"Question: Not Dr. Najjar?"
"Answer: Dr. Najjar may have initiated, but -- may have started doing that, and as he couldn't, I then took over."

"Question: Do you remember that he couldn't or have you looked at some other record that indicates he couldn't?"
"Answer: That is just my assumption, because from when this part of the case, I then took over the conduct of the operation."
Is that what you were referring to when you said you can't tell who did what?
A That is correct.
Q What is the American College of Surgeons?
A That's a -- it's like a fraternity of surgeons where surgeons can join and go to meetings and get continuing education.
You basically, if you're board-certified and a surgeon, you pay an initiation fee and annual dues and can join.
MR. GRACE: May I approach?
THE COURT: You may.

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BY MR. GRACE:
Q Mr. McTague showed you the statement on a physician acting as an expert witness put out by the American College of Surgeons. Does that have any legal authority?
A No. That's just done by surgeons who are putting out what they consider to be expert witness guidelines.
Q And it says it was recommended by the college's Central Judiciary Committee. What is that?
A That's a committee of surgeons. It doesn't have judges or lawyers on it, so it's not really -- judiciary is a -- is not really an accurate name for it.
They are trying to police their members, and it's common knowledge --
MR. MCTAGUE: Objection, Your Honor.
THE COURT: Sustained. Next

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question.
BY MR. GRACE:
Q Well, you were a member of the college for over 30 years?
A Of course.
Q Yeah. Well, what's your understanding of what the college's Central Judiciary Committee; what does it do?
MR. MCTAGUE: Objection, Your Honor.
THE COURT: Overruled.
A Its purpose is to intimidate surgeons in testifying on behalf of patients against other surgeons.
It actually only has that one purpose.
Q All right. And on the second page, I'll read it.
"The physician expert witness is ethically and legally obligated to tell the truth."
That makes sense.
A Of course.

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Q "The physician expert witness should be aware the failure to provide truthful testimony exposes the physician expert witness to criminal prosecution for perjury, civil suits for negligence, and revocation or suspension of his or her professional license."
Is that part of this guideline put out by the Judiciary Committee of the American College?
A Yes, and it's part of the intimidation --
MR. MCTAGUE: Objection, Your Honor.
THE COURT: Sustained. Just answer the question, Doctor.
A It is part of the guideline.
THE COURT: Strike that, jurors. Disregard, please.
MR. MCTAGUE: Your Honor, I am going to make my request --
THE COURT: Doctor, just answer the question yes or no that

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Mr. Grace asks you now if it calls for a yes or no answer.
MR. GRACE: May I --
THE COURT: Go ahead, Mr. Grace.
MR. GRACE: Yes. Thank you.
BY MR. GRACE:
Q Why did you resign from the college?
A I belong to over 20 organizations and the dues were getting over 20,000 a year, so I pared it down.
Q You weren't asked to resign, were you?
A Of course not, no.
Q And how difficult was it to get into this American College?
A Well, once I passed the American Board of Surgery exam, it was very simple to get in. You have to be board-certified, though.
Q Right. Okay. Now, do you recall Mr. McTague asking you about studies that showed how much -- how many pounds per square inch that's

required to tear a bowel --
A Yes.
Q -- and you said you're not aware of any?
A There are certainly no such studies in the surgical literature.
Q Okay. And he didn't show you any, did he?
A He did not.
MR. MCTAGUE: Objection, Your Honor. May we approach? Well, let me state my objection. Redirect, direct. I object to the leading.
THE COURT: Okay. So, the objection is sustained. The last answer will be stricken.
The jury has been here the entire time as far as I can see, so they saw what happened when he testified on direct. So, let's leave it at that, please.
BY MR. GRACE:
Q You testified that Dr. Rogers' story

changed from the operative report, the operative note, from the version there to versions he gave in answers to interrogatories and depositions. Could you explain that please?
MR. MCTAGUE: Objection, Your Honor.
THE COURT: Sustained in that form.
BY MR. GRACE:
Q Do you recall testifying that Dr. Rogers changed the version of events in the operation from what's included in his operative report to what he said in his answers to interrogatories and his deposition?
MR. MCTAGUE: Objection, Your Honor.
THE COURT: Overruled. Just a yes or no answer.
A Yes.
Q Could you explain that?
MR. MCTAGUE: Objection, Your Honor. Can we approach?

THE COURT: That will be stricken. You may approach.
(SIDEBAR CONFERENCE NOT TRANSCRIBED)
BY MR. GRACE:
Q Dr. Mayer, on what do you base your opinion that Dr. Rogers changed his version of the -- what occurred during the operation from what was in the operative note to what was in his answers to interrogatories and deposition?
A Comparing his later answers in the interrogatory and deposition, he indicated he did dissection behind the cecum prior to mobilizing it up in the wound and pulling on the ileum.
In the operative note, it indicates he was putting traction on the ileum and then tried to mobilize the cecum.
So, he pulled first and dissected second, and later he was trying to say he dissected first and

pulled second. I placed more credence in the operative note --
MR. MCTAGUE: Objection, Your Honor.
THE COURT: Sustained. Next question.
DR. MAYER: May I finish the answer? There's --
THE COURT: No. Next question.
BY MR. GRACE:
Q Could you turn to page 26 please?
And gross description, again, what does that refer to in the pathology?
A That's when you look at the specimen with your eyeballs as opposed to a microscope.
Q And after it's looked at under a microscope, where were those conclusions stated?
A Those are concluded -- they would be part of the final diagnosis.
Q On the first page, right?

A Yes, on the first page.
Q On page 25, right?
A Yes.
Q Are there any significant conclusions with respect to specimen A, the terminal ileum, after microscopic inspection?
A After microscopic inspection, there is no change or malignancy.
The vascular congestion and hemorrhage, that's all part and parcel of removing the bowel. That's not an intrinsic disease of the bowel. Basically, it's a normal ileum with minimal gross changes visible.
Of that mucosal ulceration, that means nothing as to the strength or integrity of the bowel wall.
Q What does mural vascular congestion mean?
A That just means, you know, once you remove the bowel, the blood stays in

the bowel because the vascular channels have been cut once you send it to pathology. That's all that means.
Q How about focal mucosal hemorrhage?
A That's from the trauma of surgery and removing it and also the trauma of the avulsion injury.
Q And do you recall questions about how much of the ileum Dr. Rogers removed?
A Yes.
Q Twenty-one centimeters? Do you have an opinion regarding the significance of Dr. Rogers removing 21 centimeters of the terminal ileum and sending it to pathology?
A I remember this question, yes.
Q Yeah. What's the opinion of the significance of that, removing 21 centimeters of the ileum and sending it to pathology?
A Well, once you have created an injury, such as was done here, the

avulsion injury, you're going to create an anastomosis under conditions where you remove bowel widely, so you're a hundred percent sure good healthy bowel is going together.
That doesn't mean to say the 21 centimeters that were removed, there was anything wrong with prior to the avulsion injury.
But the tearing injury causes trauma, so you want to go back from the area of trauma, where it's absolutely safe, to minimize the chance of an anastomotic leak.
Unfortunately, in this case, it leaked anyway, but I have no criticisms of the way the injury was handled. That was handled properly.
Q Okay. Could you turn to page 35 of the jury book, please? That's a General Surgery Progress Note signed by Dr. Najjar on August 26, 2011, the day before Mr. Marciniak was

discharged.
A Yes.
Q Do you see under vital signs?
A I do.
Q What was his temperature the day before he was discharged?
A It was 101, and later in the day went down to 99.4.
Q A hundred and one is febrile, isn't it, low-grade fever?
A No, that's a good fever.
Q That was the day before he was discharged, right?
A Yes.
MR. GRACE: Thank you.
THE COURT: Mr. McTague.
(RECROSS-EXAMINATION OF DAVID A. MAYER, M.D.)
BY MR. MCTAGUE:
Q Why don't we stay on that page, Doctor?
A Yes.
Q What time is that note?
A Six a.m.

Q Now, before I ask you questions about that temperature notation, I want to ask you this question:
Mr. Grace showed you those portions of the American College Guidelines, correct?
A Yes.
Q And you had your opinion on that. But some of them, Doctor, I think you'd agree with.
One would be, for example, that any expert defending -- talking about defending a doctor or prosecuting a doctor needs to be honest, to dig into the facts to be sure what he is saying is accurate and true, correct?
A Yes.
Q So, if we were to do that here, you would know that the notation on August 26th, the one we looked at on page 35, is referencing the high temperatures from the previous 24 hours, correct?

A Yes, we agreed on that before. Yes.
Q We did.
And if you then wanted to get thorough with it, Doctor -- and I am willing to sit here and go through every page with you from our exhibit here, which is the South Shore Hospital; I believe it's Exhibit 8.
If we were to go through there, or, actually, if anyone wanted to look to see am I really right to say that this is true, we could go through the nurses' notes and look at every single temperature and find out exactly when he was 101 degrees, correct?
A Yes.
Q And you know if we did that, he was 101 degrees at midnight on August 25th, two days before he left, right?
A I agree with that.
Q Now, turn to page 20. You have now told this jury that you believe that

Dr. Selwyn Rogers changed his story from when he dictated his operative note to when he then discussed it more fully in deposition and answers to interrogatories, correct?
A Yes.
Q You're essentially saying that he is changing his story to protect himself, that he is actually lying, aren't you?
A I didn't say that. I just said they're inconsistent. The story has changed.
Q And your reference to how it changed is now saying that Dr. Rogers didn't say in his operative note that he had tried to dissect before he pulled, correct?
A He did some limited attempt, but he didn't free the cecum before he attempted to pull it.
Q Doctor, you just told this jury not less than five minutes ago Dr. Rogers originally said through his

operative note that he had not done any dissecting before he pulled, then he changed it to say he dissected before he attempted to pull; didn't' you just say that?
A I think I said he did minimal dissection before he pulled, but it was still adherent.
Q You think you just said that to this jury?
A That's what I -- the meaning of what I said.
Q Doctor, when I ask you questions about going through this operative note and we get to the point where Dr. Rogers describes after the incision being extended laterally and medially, his reference there to mobilizing is a reference to him dissecting out behind the cecum, correct?
A Not necessarily.
Q So, it may be about an hour, two hours ago.

Do you remember telling the jury that, on page 20 of this op-note, when Dr. Rogers referenced "mobilized the cecum up to the wound after extending incision," you didn't tell these ladies and gentlemen that that meant Dr. Rogers was describing this blunt dissection behind the cecum?

A Well, since --

Q They'll remember one way or the other. Just tell them whether you did or didn't.

A Since it didn't come up the first time and he tore the ileum off trying to get it up, once he extended the incision and did the proper dissection and freed it, then it mobilized easily.

MR. MCTAGUE: Move to strike, Your Honor.

THE COURT: It's stricken.

BY MR. MCTAGUE:

Q My question, Doctor, is much simpler

than that. This is clearly in the plainest English I can give you, a yes or no.

Did you tell this jury not more than two hours ago or so that when you were looking at this notation in Dr. Rogers' operative note where he says, "We then turned our attention to mobilize the cecum up to the wound after extending the incision laterally and medially," did you not tell them -- yes or no -- did you tell them that that meant he was dissecting behind the cecum?

A At that point in time you're asking me?

Q Yes.

A Yes, at that point in time, he had to. Otherwise, he wouldn't have freed it up.

MR. MCTAGUE: Again, move to strike the rest of that.

THE COURT: Denied. Next question, Mr. McTague.

BY MR. MCTAGUE:

Q And then, Doctor, you will not accept that the word mobilize means the exact same things by Dr. Rogers when he describes attempts to mobilize the cecum in the wound before this avulsion, yes or no?

A I can't answer that yes or no. I could give a brief explanation.

Q I have been having this trouble with you. We'll see if I can do a little better for a yes or no.

You're telling us -- yes or no -- that the word mobilize is used differently by Dr. Rogers initially than subsequently in this op-note?

A No, I'm not saying that. I can explain.

Q Doctor, I think we have heard quite a bit on that, but let me ask you this:

If you accept, Doctor, that the word mobilize is used in the same fashion, to mean the same thing

throughout this operative note, if that's true, there was no change in what Dr. Rogers stated, correct?

A I can't answer that yes or no. I could explain.

MR. MCTAGUE: I have nothing further.

THE COURT: Ms. Kogan?

MS. KOGAN: No questions.

THE COURT: Mr. Grace?

MR. GRACE: No questions, Your Honor.

THE COURT: All right. Jurors, do you want a five-minute break or do you want to keep going? Show of hands for a five-minute break.

Okay. Let's take a five-minute break and then come right back and we'll keep going. Okay?

THE COURT OFFICER: Court, all rise, please.

THE COURT: Doctor, you may step down after the jury leaves.

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COMMONWEALTH OF MASSACHUSETTS
FRANKLIN, SS SUPERIOR COURT DEPARTMENT
OF THE TRIAL COURT

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SETH DOULL, as Personal Representative of the Estate of LAURA DOULL, SETH DOULL, MEGAN DOULL, and SETH DOULL as next friend of TROY DOULL,

Plaintiffs,

v.

ANNA C. FOSTER, N.P., and ROBERT J. MILLER, M.D.,

Defendants.

* * * * * * * * * * * * * * * * * * * *

BEFORE THE HONORABLE MARY-LOU RUP
DOCKET NUMBER 1478CV00058

Friday, September 29, 2017

Meredith Pollier
Court Reporter

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I N D E X

P R O C E E D I N G S

(Court commences at 9:00 a.m.)

COURT OFFICER: Court, all rise. Franklin County Superior Court is now in session with the Honorable Mary-Lou Rup presiding.

For the record, today is Friday, September 29th, 2017.

Please turn all electronic devices off. Please remain quiet, court is now in session. You may be seated.

THE CLERK: I ask the parties who are members of this session that are being digitally recorded, please state your name and identify the party to which you represent.

Calling Civil Action 2014-058, Doull v. Foster. This matter is on for continuation of jury trial.

MR. SOBCZAK: Good morning, Your Honor. Krys Sobczak for the

plaintiffs.
MR. DUMAS: Good morning, Your Honor. Noel Dumas on behalf of Anna Foster.
MS. DALPE: Good morning, Your Honor. Rebecca Dalpe on behalf of Dr. Miller.
THE COURT: Okay, thank you. Good morning.
MR. NEWTON: Good morning, Your Honor, Andrew Newton on behalf of Dr. Miller.
THE COURT: I'm sorry, I broke in before you had an opportunity to introduce yourself, Mr. Newton.
Okay, so the jurors are all here. Are we ready to proceed?
MR. SOBCZAK: I have couple of preliminary issues, Your Honor, so that we can potentially avoid repeated objections and sidebars during the examination.
THE COURT: Mm-hmm.

MR. SOBCZAK: The first witness the defendants are going to put on is one of their experts. I just wanted to get clarification from the Court and any confirmation of the prior ruling that this is the defendant's expert, and therefore, it's going to be direct examination, regardless of which lawyer does the examination; that the Court is not going to permit one lawyer to cross their own expert.
THE COURT: Which of you wants to respond to that assertion by Mr. Sobczak?
MS. DALPE: Thank you, Your Honor.
As you know, Attorney Sobczak has repeatedly tried to suggest that Attorney Dumas and I are simultaneously representing both of the defendants. That is not the case. We each have our own client.
We have, for purposes of

this trial, agreed to share certain experts. That being said, every party has a different interest, and we are each entitled to perform our own examination.
Attorney Sobczak's plan seems to be in some way to circumscribe the rights of the defendants at the time of trial. I don't think that's warranted or appropriate.
MR. DUMAS: One additional thing, Your Honor.
I can tell you that in terms of a cross-examination, I wouldn't go through what has already been rehashed as duplicative.
The other issue, too, is that I imagine if it's Attorney Sobczak's position, as he has just stated it, that I were to have my own causation expert or hematologist, he would have objected to that as duplicative testimony.

THE COURT: He has already made that motion, as I recall, --
MR. DUMAS: Exactly. So, he can't have it --
THE COURT: -- or something essentially to that effect during the dozens of motions that the Court had to review before the trial started, from both sides, I will say.
MR. DUMAS: Correct. So, he can't have it both ways. And I don't intend to go into -- Attorney Dalpe will be doing the direct of Dr. Miller this morning. I don't intend to cross --
THE COURT: This is the other Dr. Miller?
MR. DUMAS: The other Dr. Miller, the hematologist.
THE COURT: Okay.
MR. DUMAS: I don't intend to ask anything that's covered by direct examination. I may have very

little; I may have nothing, but I do have a right to cross-examine witnesses that are called by any party.

MR. SOBCZAK: And Your Honor, I have no objection to Mr. Dumas questioning the witness, but he's not cross-examining him. He is -- that's his direct witness.

The disclosure that was filed in court before I filed any single motion was a single disclosure, jointly, from both defendants. For Mr. --

THE COURT: Excuse me for a moment. Do you intend to cross-examine this witness, or is he actually part of your expert evidence?

MR. DUMAS: The only caveat is to move testimony along. If I'm making subtle points, I may try to in the furtherance of testimony.

THE COURT: That's perfectly

fine. Everybody does it, including Mr. Sobczak with his own witnesses.

Cross-examination to just get -- move things along and get to the point is perfectly fine.

MR. SOBCZAK: Well, the reason --

THE COURT: All right, thank you. I've ruled on this, Mr. Sobzcak.

MR. SOBCZAK: I know. The reason I'm --

THE COURT: Please, I know you keep insisting on needing to say things over and over again. We lose a lot of time because of that.

Mr. Dumas has just indicated how he will handle the witness. I have ruled that that appears to be appropriate. Next issue.

MR. SOBCZAK: Next issue, Your Honor, is the specific issue of the disclosures. The defendants' disclosures are identical for both.

What I am concerned the defendants will try to do is to basically disregard all rules, and he will try on cross-examination to introduce literature that was never disclosed. There is not a single study that was disclosed by either of the defendants pretrial.

And what they've been doing so far is by pretending to be cross-examining opposing expert, they're trying to sneak in the literature that's never disclosed. That is a violation of every single rule applicable to this Court, and that's what I'm trying to avoid.

Him asking questions, clarifying things within the disclosure, he's got a complete right, but when they try to call it cross-examination, and try to violate the rules of crossing his own expert, that's what I'm trying to avoid, Your Honor.

MR. DUMAS: I don't intend to introduce any articles, Your Honor.

THE COURT: Thank you.

MR. SOBCZAK: The other issue is then, the Court has ruled on keeping it to disclosures. I see that the defendants have article that were not disclosed. There is not a single article disclosed in the disclosure, therefore, I assume that defense counsel will not even try to ask about literature and violate the Court's order.

The third issue is, Your Honor, --

THE COURT: Does anybody want to respond to that assertion by Mr. Sobczak?

MS. DALPE: Your Honor, in my direct exam, I did not ask about any particular piece of literature.

THE COURT: Okay, thank you.

MR. SOBCZAK: The third

issue is, Your Honor, there was a subpoena served on the Doctor.

I request that the documents that were produced responsive to the subpoena be turned over now and marked, because if the Doctor violated the Court's order and did not produce the documents, should be precluded from testifying altogether.

MS. DALPE: Your Honor, the documents that Dr. Miller has include his CV, the list of materials that he has reviewed from the case, including the pleadings, all the depositions, all the records, and also the list of literature that he reviewed in confirming his opinion in this case, and that is all here.

The witness did not have correspondence from the insurance company, which was also subject to the subpoena. I can produce that

now.

MR. SOBCZAK: There was also -- subpoena included issues concerning billing, concerning payment for this case.

There were seventeen elements to the subpoena. The defendants moved to strike some of it. The Court did. What remained are points 1, 2, 3, 6, 8, 10, and 11. And what Ms. Dalpe just described is not nearly responsive to all of them.

THE COURT: Well, it may very well be that the Doctor does not have all of that information. He's only required to produce that which is in his possession.

Do you want to respond, however, as to these other things that Mr. Sobczak says are not among the ones that you have just verbally listed?

MS. DALPE: Yes, Your Honor.

I believe your instruction in this case was quite clear.

That being said, the materials that are responsive to what Your Honor allowed was a CV, a list of the documentation that he reviewed, a list of any literature that he reviewed, and correspondence with the insurance company.

You specifically excluded any and all communications with counsel's office, which would involve any kind of written correspondence between me and the expert.

Dr. Miller, I don't believe, has any of his billing records, however, in the interest of full disclosure, I did ask Covarys to provide me with numbers of what my expert had earned up until this point, although Dr. Miller actually does not remember and does not have any of his billing invoices left.

MR. SOBCZAK: Your Honor, for the record, to correct, the actual court order, the Court precluded any work product concerning opinions.

The Court specifically included Section 8 of the subpoena, which was any and all writings, proposals, documents, or agreements concerning your fees or services rendered in this case.

That would include any communications, any checks, any transfers. Clearly, the Doctor has been paid. If he did not bring his payment information, which is primarily ripe information for cross-examination, and he has disregarded the subpoena, he should be precluded from testifying.

THE COURT: I am not going to preclude him from testifying.

With regard to the payments, you said you've been made aware of

what that amount is, you can tell Mr. Sobczak what you're aware of and he can use the figure.

We're not going to be parading bills and trying to get bills introduced into evidence. What's relevant is, with regard to payments to a witness, is to the extent that the person has been paid, that that may in some way be indicative of a witness's bias toward the person who has paid them. That's all that's relevant.

MR. SOBCZAK: For the record, Your Honor --

THE COURT: I understand what you are saying. I am making that ruling.

Ms. Dalpe has said that the Doctor, as I understand it, doesn't have any billing records, is that correct?

MS. DALPE: Yes, Your Honor.

THE COURT: Okay.

MS. DALPE: Dr. Miller didn't have any -- we figured that the best safest way of getting to the exact amount that he has been paid would be to ask Coverys directly.

THE COURT: All right. So, that information will be provided. We're going to move on. Your objection --

MR. SOBCZAK: That's the whole subpoena. I offer it to be marked for ID, the subpoena and the Court's records -- on the record that the Court is going to --

THE COURT: That's fine. That is fine. Please, let us move on. It's now quarter after 9:00. Once again, a good portion of the morning is being taken up by your insistence on arguing with me about rulings that I have made or am making at this time.

MR. SOBCZAK: And the Court

has just changed those rulings, which is important.

So, I prepared for this morning in anticipation that the Court is going to enforce the law as it said in this case. The Court made a ruling in this case --

THE COURT: All right, well your objection is made. Would you please --

MR. SOBCZAK: -- and the last thing, Your Honor, --

THE COURT: Yes.

MR. SOBCZAK: I request that the witness not have any documents on his stand. This is supposed to be testimony, not reading prepared notes.

The fact that the defense counsel are stacking their experts with cheat sheets on the paper, and they're reading from it, is grossly improper.

If the witness for some

reason cannot testify from his memory, then he is incompetent to give testimony.

If he needs to be refreshed, then that can be done on cross, but for a witness to be sitting on a stack of papers on the stand and reading his testimony, that's not trial, at least not anywhere I've read, Your Honor.

THE COURT: Ms. Dalpe, does your witness intend to utilize notes to assist him in remembering things, or will he be able to testify from memory?

MS. DALPE: I believe he is perfectly competent to testify from memory, but he does have his own jury book here, as well as a page with --

THE COURT: By jury book you mean the one that's been given to the jurors?

MS. DALPE: Yes, Your Honor.

THE COURT: All right.
MS. DALPE: And I believe he also has a note with the proper spelling and pronunciation of Mr. Sobczak's name.
THE COURT: Okay, thank you, that's fine.
MR. SOBCZAK: And Your Honor, in that case, I insist that he uses the one that's been marked, and not something that may have been prepared ahead of time and written notes in. That's why we have Exhibits marked.
Anything the witness has on the stand, it has been marked for ID. If the defense counsel intends to use the jury book, the proper procedure is, they hand him the one that's been in court, and used by everybody else, not something that the witness brings in with him that may contain other notes in there.
THE COURT: I am not going

to make that an order.
MR. SOBCZAK: Thank you.
THE COURT: Is the notebook that will be put in front of the witness the same one that is being -- that the jurors have had?
MS. DALPE: I believe so, Your Honor. He may have extra pages from Tab F, the Women's Compounding, but we're not getting into any of that.
THE COURT: Okay, thank you. All right, can we please --
MR. NEWTON: Your Honor, --
THE COURT: Yes. Oh, I'm sorry, Mr. Newton.
MR. NEWTON: Your Honor, I have one very brief housekeeping matter.
THE COURT: Sure.
MR. NEWTON: We spoke yesterday about adding some pages to the juror book, the agreed-to Exhibit from Women's International.

That's been done. And the book that has been marked for ID has been done. And I believe Your Honor has a copy of the juror book, as well?
THE COURT: I do, and I gather I don't have that.
MR. NEWTON: And if I can approach, I have the same pages.
THE COURT: Thank you. And would that be another tab?
MR. NEWTON: Yes, Tab F.
MR. SOBCZAK: And I offer as Exhibit QQ the trial subpoena that was served to Dr. Miller.
THE COURT: That will be marked.
(QQ for Identification, so marked)
THE COURT: Just one other quick issue. It's my intention to take up before we end the day today as with regard to the issue of Mr. Doull's deposition and designated matters.
Just to let everybody know,

we still need to resolve that at some point today.
Okay, thank you. Would you bring out the jurors, please.
COURT OFFICER: Yes. Jurors now entering. Please rise.
(Jurors Entering)
THE COURT: You may be seated. Good morning.
Members of the jury, before we resume this morning, have any of you read anything about the case, heard anything about the case, discussed the case among yourselves or with anyone else since we recessed yesterday afternoon?
JURORS: No.
THE COURT: Does any juror have anything he or she would like to bring to my attention, or anything you feel should be brought to my attention about your continued service as a juror on this trial or any other matter related to this

case? Thank you.
Ms. Dalpe, I understand you're going to call the next witness.
MS. DALPE: Thank you, Your Honor. We would like to call Dr. Ken Miller to the stand.
(Testimony of Kenneth Miller, M.D., commences at 9:18 a.m.)
(Jury present)
(WITNESS SWORN)
KENNETH MILLER: I do.
THE CLERK: Thank you.
THE COURT: Go ahead.
MS. DALPE: Thank you.
(DIRECT EXAMINATION OF KENNETH MILLER, M.D.)
BY MS. DALPE:

Q Can you please state your full name and address?
A Kenneth Miller, 52 Rangely Road, Chestnut Hill, Mass., 02467.
Q And Doctor, what is your occupation?
A I'm a hematologist.

Q And where are you a hematologist?
A At Tufts Medical Center.
Q And what is your specific position at Tufts?
A Associate Chief of Hematology/ Oncology and full Professor of Medicine.
Q And can you tell me, beginning with college, describe your educational background?
A Undergraduate at NYU, medical school at New York Medical College, residency and chief residency training at NYU, fellowship at Tufts New England Medical Center, and then faculty position at Tufts.
Q And can you tell the jury a little bit about what is a fellowship?
A A fellowship is training that occurs after residency, and where you become a specialist in your specific field.
Q And what specifically did your fellowship consist of?

A Working and treating and evaluating only specific groups of patients, namely, patients with hematologic blood disorders.
Q And how long was your fellowship?
A Three years.
Q And can you describe exactly what the term hematology means?
A Hematology is the study of blood forming organs, and the components of blood, and the function of blood, either as it performs normally or abnormally. It includes malignancies, excess clotting, or deceased clotting.
Q And are you board certified?
A Yes.
Q And what does it mean to be board certified?
A It established an accurate -- my complete training in the field, and I passed a written examination, maintained ongoing further education in the field, and been accepted as

an expert in hematology.
Q And are you board certified in internal medicine and hematology?
A Yes.
Q Okay. Do you hold -- oh, can you tell the jury a little bit more about your faculty appointment, please?
A I am a Professor of Medicine at Tufts Medical Center; primarily, a clinician, a teacher, and academic position.
Q And what types of individuals do you teach in connection with your role as a full professor?
A So, I teach in the medical school, medical students the field of hematology. I teach residents; in other words, those individuals who are training for general medicine in the hospital.
I teach fellows who work in my clinic every day of the week. I teach nurse practitioners. I teach

other doctors who want to learn about my field. That's it.

Q And the hospital that you hold privileges at, where is that?

A Yes.

Q That's Tufts, right?

A Correct.

Q Okay. Are you a member of any professional societies or organizations?

A American Society of Hematology, American College of Physicians.

Q And have you co-authored or authored more than 120 peer review journal articles?

A Yes, I have -- last count, it was more than 120, yes.

Q Thank you. Have you written any books, chapters, or been invited to speak?

A Oh, in excess of 50 to 70 chapters in books, including submitted online articles, it's approximately 100.

Q And have you served as a reviewer of

any peer review journals?

A Yes, I have reviewed multiple peer review journals.

Q And what does it mean to be a reviewer of a peer review journal?

A An author would submit an article, and the journal would look for an expert in the field, to see if this article is worthy of publication. And moreover, if it's not completely worthy, our responsibility is to make it better, and what the author needs to address to make this article acceptable, what they need to address in their article.

Q And can you give the jury examples of the types of editorial boards that you sit on?

A I sit presently on the Leukemia Research -- leukemia; I've served on Cancer -- as a senior reviewer for New England Journal, Blood, Journal of Clinical Oncology, Annals

of Internal Medicine, American Journal of Medicine. I think I may have forgotten a few, but almost every major publication in my field, I've at one time reviewed papers for.

Q Okay. And how many times have you given lectures in your particular field?

A Lecturing is very much a part of what I do, an estimated 50 times a year, but it's really every day, I teach residents and fellows. But lectures at outside hospitals, approximately 50 times a year.

Q And have you been ranked one of America's Top Doctors by U.S. News & World Report?

A Yes, in the top one percent of doctors in cancer in U.S. News & World Report for the last ten years.

Q And can you describe for the jury, what is the selection process? How do you get selected to

be one of the Top Doctors by U.S. News & World Report?

A They're different than most other organizations. One, there is some peer review, and members of my organization have to sort of establish me as an expert. What my publications are and how frequently they're read, who I'm invited to give lectures to, and my general standing in the medical community as being considered a super expert.

Q Have you also received similar recognition from Newsweek and Boston Magazine, as one of the Best Doctors?

A Yes, Boston -- Newsweek, the similar articles, the top ten percent, top one percent. I've been selected as the Best of Boston for the last twenty years.

Q And over the course of your career, have you cared for patients who have

CTEPH?
A Yes.
Q Okay. And in what aspects of care is a hematologist involved with, with a CTEPH patient?
A A patient can get CTEPH -- or some of them are my patients; patients without a spleen, patients with cancer, patients with clotting disorders.
So, the nature of my practice, I see patients who have developed CTEPH.
Q And are you ever consulted on hormone replacement therapy for patients who have blood disorders?
A Yes.
Q Prior to your involvement in this case, have you reviewed cases of potential malpractice over the course of your career?
A Yes.
Q And how often have you served as an expert in a situation like this?

A Over the last 20 years, probably 30 cases. I have a full-time job, so at any one time, I won't have more than three cases on my plate.
Q Okay. And have you offered opinions to both lawyers representing plaintiffs, as well as defendants in your work as a medical/legal expert?
A Yes.
Q And can you tell us, what percentage of your testimony has been for plaintiffs, versus defendants?
A Two-thirds for the defense; about one-third for the plaintiff.
Q Okay. And you are being paid for the time that I'm taking away from your office today, is that right?
A That's correct.
Q Okay. And over the course of this case, you have reviewed a quantity of materials, is that right?
A Yes.
Q Okay. Do you remember what it is that you have been paid up to this

point?
A No.
Q Okay. If I represent to you that you have earned about $29,000, would that sound accurate to you?
MR. SOBCZAK: Objection, Your Honor.
THE COURT: Overruled.
A Yes.
BY MS. DALPE:
Q Okay. And did you review this case at my request?
A Yes.
Q And did you review the following materials in connection with your testimony today?
The medical records from Dr. Bob Miller's practice, Brigham & Women's Hospital, Baystate Medical Center, Baystate Franklin Center, Dr. Silverman, plaintiff's jury book, Plaintiff's Supplemental Responses to Request for Production?
A Yes.

Q Okay.
MR. SOBCZAK: Objection, Your Honor. Misrepresents -- there is no plaintiff's jury book; it's only the defendants selected records in the jury book.
MS. DALPE: I beg your pardon.
THE COURT: Would you correct that, please, Ms. Dalpe?
MS. DALPE: Absolutely.
BY MS. DALPE:
Q Did you review the jury book that we put together in this case?
A Yes.
Q Okay. And the thousands of pages of materials that have been marked to date in this case?
A Yes, there's greater than 10,000 pages from the Brigham alone, yes.
Q Okay. In addition to all of those materials, did you also read a host of deposition testimony?
A Yes, over 40 depositions.

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Q All right. And just so the jury can hear all of the materials that you have reviewed in this case, have you reviewed the following:

The deposition of Michelle Violi, the two days of deposition of Bob Miller, consisting of 14 hours, the depositions of John Doull, Joan Greenfield, Daniel Hyytinen, Dawn Dorisy, Jane Kane, Robin Pierce, Mr. and Mrs. Johnson, the 16 hours of deposition testimony of Anna Foster, the depositions of Kim Celli, Steven Roy, Mr. & Mrs. Stanley, Mr. Valley, Ms. Doull, Tammy Zelman, Ms. Shinn, Kim Wysk, Dawn Hyytinen, Mrs. Lowinski, Mr. Doull, Kelsey Klerowski, Mr. Emond, Ben Crosby, Kelly Doull, Shirin Morris, Laurie Dulude, Melissa Finn, Mr. Finn, Paul Moyer, Sandy Guzik, Kim Gleason, Dan Gleason, Kelley Goddard, Ira Doull, Joseph Alves, William Fitzpatrick.

Are those all the

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depositions that you have read to date in this case?

A I believe so.

Q Okay. And you have also read the trial testimony of Dr. Genecin, plaintiff's expert, who testified last week, is that correct?

A That's correct.

Q Okay. Based on your review of the deposition testimony and the medical records, did we prepare a report and file that in June of this year?

A Yes.

Q Okay.

MR. SOBCZAK: Objection as to the we.

THE COURT: Overruled.

BY MS. DALPE:

Q Had you read all of the materials, -- other than Dr. Genecin's trial testimony, of course, had you read all of those materials prior to signing off on your disclosure in this case?

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A Yes.

Q Okay. Is it fair to say that you're basing your opinions that you are giving here today on your review of those medical records, deposition testimony, and your education, training, and experience?

A Yes.

Q Okay. Have you ever spoken with Dr. Miller or Anna Foster about this case?

A No.

Q All right. And I'm going to ask. Since you share the same last name, are you related in any way to Robert Miller?

A No.

MS. DALPE: Okay, just a coincidence.

Q Have you ever spoken with Dr. Hill or any of the other experts that were retained for the defense in this case?

A No.

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Q All right. For purposes of my questions about your opinions in this case today, are all of your opinions that you are giving being made to a reasonable degree of medical certainty?

A Yes.

Q To begin with, can you give us a little orientation about what is hormone replacement therapy?

A Hormone replacement therapy, and I think we're defining it for women and not for men.

To begin with, women are hormonally very complicated. There's basically a number of different hormone replacement therapies for women who are relatively deficient in hormones, that are having perimenopausal symptoms from hot flashes, headaches, insomnia, decreased energy, and where appear to approve with supplemental hormone therapy.

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Then there's patients who are -- women who are postmenopausal, to replace their hormones so they don't have the symptoms of menopause, the hot flashes, the fatigue, hair loss, many of the symptoms that go with it.

Then the next group are the individuals who try to maintain a pregnancy, who can't for some reason because they don't make adequate numbers of hormones or have trouble conceiving, or have had chronic miscarriages.

Then the last, who are many of my patients, where it's physician induced, or medically induced early menopause because of the chemotherapy or the radiation that they've received, and addressing their quality of life.

Q Doctor, are there various -- well, have you prepared an illustrative chalk to discuss the different types

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of hormone replacement therapy?

A I have.

MS. DALPE: Okay, Your Honor, I'd like to use a chalk, if I could?

THE COURT: Yes.

MR. SOBCZAK: Objection. Lack of disclosure.

MS. DALPE: To what, Mr. Sobczak?

MR. SOBCZAK: And technically, motion to strike all the previous answer, again, for lack of any disclosure.

THE COURT: Overruled. Can I see you at sidebar, please?

(SIDEBAR CONFERENCE)

MS. DALPE: So, this board is about indications that he has just testified to for hormone replacement therapy.

MR. SOBCZAK: It's not. There is nothing on this board that's been testified to, and more

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importantly, there is nothing on this board that's in the disclosure.

THE COURT: Overruled. Go ahead. Keep telling me what's on this.

MS. DALPE: And this is group two, and this is an outline of the different types of hormone replacement therapy that has been brought up in this case, progestin and progesterone, plus estrogen combinations, and progesterone in general.

And it speaks to, in particular, the list of progesterone that Dr. Miller is disclosed to testify to, which is where it's known. It speaks to progestins, which has already been covered in this case, and it speaks to estrogen, progestins, the kind that have been mentioned, which is associated with this, which is also been brought up in plaintiff's case.

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MR. SOBCZAK: And again, Your Honor, none of this is disclosed. It is a direct examination of their own expert, and there should be some rules in this Court. As a matter of fact, this Court has already ruled --

THE COURT: The Court has quite approval, I would beg to differ with that characterization.

MR. SOBCZAK: One of them being --

THE COURT: Would you please let me finish?

I'm going to look at the disclosure and see if it's in here or not, but I will note that you, yourself, brought in charts without showing it to anybody, marked it up. So, let's not --

MR. SOBCZAK: And for the record, Your Honor, --

THE COURT: Let's not be making --

MR. SOBCZAK: The chart I brought in was verbatim what the witness agreed to.
THE COURT: Well, perhaps this is what this --
MR. SOBCZAK: And it was defendant, not their own expert.
There is a big difference, Your Honor, there's a cross-examination of a party --
THE COURT: All right, your objection is noted.
MR. SOBCZAK: -- and a direct examination of an expert witness, which requires specific disclosures, and in this case, this Court has pretrial ruled the defendants are allowed to stay within the disclosures only.
MS. DALPE: In the second paragraph of Dr. Miller's disclosure, --
THE COURT: Which I'm trying to find right now.

MS. DALPE: I'm sorry.
THE COURT: There's a lot of disclosures.
MS. DALPE: I know, I'm sorry, Your Honor.
THE COURT: No, there's no reason to be -- to apologize. I just want to make sure this is Dr. Miller's.
MS. DALPE: I have Mr. Dumas's copy, if you would like.
THE COURT: Okay, thank you.
MS. DALPE: I believe right in -- somewhere in here, it talks about -- will talk about hormone replacement therapy, in general, and specifically with progesterone cream. So, I think we've covered the general.
MR. SOBCZAK: There is grossly insufficient disclosure to allow jury to see a giant board to provide things that are not in the disclosure.

THE COURT: Okay. Well, your objection is noted, but you may use the chalk.
MR. SOBCZAK: In that case, Your Honor, I move for a mistrial based on this Court's continual of allowance of defendants to disregard all rules of this Court.
THE COURT: Okay, your request is noted, but overruled.
MR. SOBCZAK: Thank you.
MS. DALPE: Thank you, Your Honor.
MR. SOBCZAK: And I move for a fair trial so that the rules apply equally to both sides.
THE COURT: You are getting a fair trial.
MR. SOBCZAK: Not in this Court, Your Honor.
(END SIDEBAR CONFERENCE)
MR. SOBCZAK: Can we mark these non-disclosed boards for ID so that they are part --

THE COURT: Of course they will be marked for identification. Is it RR and SS?
THE CLERK: Yes, Your Honor.
(RR for Identification, so marked)
(SS for Identification, so marked)
THE COURT: And anybody that feels that they need to move over so they can see is permitted to do so. And I'm going to do that right now.
BY MS. DALPE:
Q Doctor, could you step down, please?
Doctor, I think when I broke off, I was asking you whether or not there were different types of hormone replacement therapy.
You've seen the chalk that you've prepared. Can you walk the jurors through the different types of hormone replacement therapy?
MR. SOBCZAK: Objection. Leading, non-disclosed, and --
THE COURT: Overruled.
MR. SOBCZAK: -- in

violation of this Court's orders.
A So, what I did in this chart, which is the various hormonal therapies and their risk of developing a clot, in the chart I put together.
And as you'll notice over here --
THE COURT: Excuse me, would you keep your voice up a little bit more, Doctor, because when you start facing the board, I'm afraid sometimes there's a tendency to talk to the board, and not everyone may be able to hear you.
Can everyone hear him? No? I see some -- okay, just keep your voice up nice and that will be very helpful for all of the jurors. Thank you.
DR. MILLER: I thought I had a booming voice.
A So, I tried to address the different types of hormonal replacement therapy that are currently given to

women, and contrast that with their risk of developing a clot.
As you will notice, the highest risk are women who are pregnant. This is to which everything is compared. Pregnancy really is a prothrombotic state, where the women are at the highest risk of developing a clot during the pregnancy and shortly after pregnancy. So, this should just be one side.
Estrogens, women make every day. There are not just estrogens, many different types; there are pills, topical, there are even injections. And they are meaningfully different if they're given as pills, or if they're given topical, which is transdermal, over the skin.
They are a moderate risk for developing clots. Estrogen, in and of itself, causes clots.

The most common is the combination of estrogen, usually a pill, and progesterone, again in most studies was a pill, but there are many other forms; there could be pills, there's patches, and there is creams and gels. And the combination of the two, in fact, produces a higher incidence of developing a clot than each individually.
The next are the progesterones, and there's basically, there's two types. There's one that's synthetic; these are drugs that are made from the basic formula for progesterone, but they're not exactly the progesterone that women make. Multiple different pills for that, used in many times in women during their menstrual cycle.
And they have very low incidents, and most of them had no

incidents of increased thrombotic events, but in the literature, it would suggest that some of these -- and it's interesting, some of the newer ones do have a mild increase in clotting.
And the last is the natural progesterone, and this is progesterone derived from soy or from yams, which is identical what women make. So, chemically, it's the same as what women make in their body, so-called natural progesterone.
It's available in a pill form; it's available in gels; and it's available in creams, which we'll talk about.
And the literature would suggest these drugs have been available for many years; that there is no increased risk for developing thrombotic events, clots, in women who take natural progesterones.

MR. SOBCZAK: Motion to strike for complete lack of disclosure and violation of this Court's orders.

THE COURT: Overruled.

MR. SOBCZAK: And I offer the disclosure as the next Exhibit, Your Honor.

THE COURT: It will be marked for identification. Overruled.

(TT for Identification, so marked)

MR. SOBCZAK: It's a ten-page undated disclosure --

THE COURT: Please do not comment. I have marked it for identification. Your objection is noted, Mr. Sobczak.

Okay, ask your next question, please.

MS. DALPE: Thank you, Your Honor.

BY MS. DALPE:

Q Doctor, have you prepared another

board in this case, as well -- a chalk regarding the symptoms that hormone replacement therapy is used for?

A **Right. This follows -- this is hormone replacement therapy, that follows up on those in a similar fashion.**

One would be the symptoms of menopause, you know, which can be distressing, and women ask -- require treatment.

So, it may treat the hormonal changes that's seen with menopause; depression, difficulty sleeping, decreased libido. It's all hormonally related, and women's hormones are very complicated.

To treat low bone density. As women go through menopause, their bone density decreases, and these substances try to prevent that.

Also to treat some of the skin changes related to hormonal

changes. As women get older, without estrogen on board, or progesterone on board, there's a change in skin texture; the skin becomes thinner and more wrinkled, and less youthful.

To treat dysmenorrhea, painful periods; those women who now are not menopausal, but still menstruating, and they have prolonged and painful periods, and the hormonal supplementation treats that.

To treat vaginal dryness; these are individuals who don't make enough hormone with that, so dryness, and painful sexual relations, recurrent vaginal infections. It's again, overhaul and changes in the vaginal PA are hormonally needed to mediate it.

And the list can go on, but decreased hormone, there's a decrease in woman's libido, an

interest in sexual activity, trouble sleeping, mood changes. Estrogen and progesterone play critical roles in a woman's day-to-day life.

Q And can you talk --

MR. SOBCZAK: Objection. Motion to strike for lack of disclosure.

THE COURT: Overruled.

BY MS. DALPE:

Q Can you tell me, Dr. Miller, what form of hormone replacement therapy was prescribed for Mrs. Doull?

A **Ms. Doull received a natural progesterone, and it was a cream.**

Q And can you tell me a little bit more -- do you recall what the dosing was -- what the progesterone dose was?

A **It was 100 milligrams.**

Q Okay.

A **It was 100 milligrams applied for the 14 days of her menstrual cycle. It was applied to the skin, it was a**

quarter of a teaspoon.
Q And would she -- do you remember what time of day she was applying that?
A Yes, it was applied in the evening.
Q And what was the significance of that?
A Well, that's generally when progesterone is applied. It is a cream, and if you apply it during the day, it's easy to wipe off, too.
Q And what is the significance of the dosing, 100 milligrams?
A Well, she received 100 milligrams --
MR. SOBCZAK: Objection. Leading.
A -- midway between the --
THE COURT: Overruled. I'm sorry, you can answer the question.
Is the Doctor still needed here at the chalks, or no?
MS. DALPE: The next question calls for this chalk, and then I can have him sit down.

THE COURT: Okay, that's fine. I'm sorry to interrupt. Would you ask the question again, please, Ms. Dalpe?
MS. DALPE: No problem.
BY MS. DALPE:
Q Dr. Miller, I think my question was, what was the significance of the dose that Mrs. Doull received?
MR. SOBCZAK: Objection. Leading.
THE COURT: Overruled.
A She received 100 milligrams, a quarter of a teaspoon, to be applied for 14 days for her menstrual cycle.
That's midway dosing, but the company recommends is between 50 and 200 milligrams of those two weeks.
BY MS. DALPE:
Q And using the board that you prepared for this case, can you tell me, what were the indications for Ms. Foster to prescribe the

progesterone cream to Mrs. Doull?
A She had low libido, she had vaginal dryness, multiple visions for bacterial infections, and painful intercourse.
She had skin changes; she felt there was wrinkles. She had trouble sleeping. She wasn't fully menopausal, but she did have some of the mood changes associated with being perimenopausal.
Q Doctor, let me have you sit down, and I'll ask you a few further questions.
MR. SOBCZAK: Are you done with the boards?
MS. DALPE: I'm going to use one more later.
MR. SOBCZAK: Are you using them now?
MS. DALPE: Maybe.
BY MS. DALPE:
Q Dr. Miller, can you tell me, did Nurse Practitioner Foster discuss

the decision to order progesterone with Dr. Miller -- Dr. Bob Miller?
A In the chart, there was a notation that she did.
Q Okay. Were there other alternatives of hormone replacement therapy available in 2008?
A There were some others.
Q Okay. And among the other hormone replacement therapies available in 2008, how did they compare in terms of a risk of thrombotic event with the progesterone cream that was prescribed?
MS. SOBCZAK: Objection. Leading, lack of disclosure.
THE COURT: Overruled.
A So, what was noted at the time was that the natural progesterones were associated with the least risk of developing thrombotics. And then, topical progesterone was the best tolerated, so -- and there's a more holistic approach than using pills.

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MR. SOBCZAK: Motion to strike for lack of disclosure.
THE COURT: Overruled.
MR. SOBCZAK: At this point, Your Honor, can I just make a motion for the rest of the doctor's testimony?
THE COURT: Yes, you may, of course.
MR. SOBCZAK: Okay. Given the lack of the disclosure.
BY MS. DALPE:

Q In your review of the records, was there any indication as to whether or not Laura Doull had ever indicated a preference for holistic therapies, either in the records or in the deposition testimony that you reviewed?

A Yes. Not only by Laura Doull, but by members of her family, both in person, and in fact, how she sought medical care.

Q And do you remember what timeframe

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Mrs. Doull was taking the progesterone cream for?

A It began in April of 2008. Her compliance of the medicine wasn't complete. First prescription was -- I believe it was in April of 2008; the next one was in 9 of 2009. The prescription was for 15 grams, so she must have run out and not used it for many times.
But also Nurse Foster noted that her compliance with the estrogen cream was an issue.

Q And can you describe how progesterone cream -- natural progesterone cream that is compounded compares to what is actually made in the body by women?

A So, the natural progesterone cream is the same as the estrogen -- that is the progesterone that women make every day, and it's as close to the structure of the progesterone that women make.

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Q And earlier you had touched on the substances that natural progesterone is derived from. Can you tell the jury what those are?

A Yes, they're all from soy and yams.

Q And how was Mrs. Doull's cream applied?

A It was applied -- it comes in a jar, with directions to apply 100 grams, which is a quarter teaspoon, which is provided, and you apply it on the inner aspect of the leg or the abdomen.

Q All right. And did Mrs. Doull report a benefit from the use of the progesterone cream?

A She did. She said that she felt better on the cream. She said she slept better on the cream. One of the issues she had was hair loss; she said that was also improving. Her moods were better.

Q Did Mrs. Doull ever receive a prescription from Nurse Practitioner

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Foster for hormone replacement therapy, other than the progesterone?
MR. SOBCZAK: Objection. Leading.
THE COURT: Overruled.

A There is nowhere in the medical record that I saw that Ms. Doull received a prescription for anything else but the natural progesterone.

BY MS. DALPE:

Q Was there any indication in the materials that you read that indicated that Mrs. Doull applied the cream in any location other than topically on her body?

A No.

Q And there was some reference in some of the records about the change of the format of the cream, from cream to a gel -- a non-alcoholic gel.
Can you speak to the significance of that?

A The pharmacy from which she obtained

the progesterone came essentially in two forms; a progesterone cream that had perfume, a different base.

And there was some skin reaction that Ms. Doull complained with, associated with that product. It was changed to the same dosing, the same instructions, to a non-alcohol based progesterone product, without perfume.

Q And did the change in the base affect the risk of a thromboembolic event at all?

A No.

Q All right. The cream that Mrs. Doull received from Women's International Compounding, did that come with any kind of warnings?

A No.

Q And can you speak to the significance of that?

A This is an over-the-counter product. Matter of fact, there's multiple over-the-counter progesterone

products that are available, none of which are required to carry a label.

Q Prior to 2008, did Mrs. Doull have any history that would suggest that she was at risk for a thrombotic event?

A No, and it's documented by medical records, both by Ms. Foster, Dr. Miller, the physicians at Franklin Medical Center, and the multitude of physicians that had seen her at Brigham & Women's Hospital, that she or any member of her family did not have any evidence of an increased blood clotting disorder.

Q And why is that significant?

A Well, individuals with a prior history tend to have another clot. Individuals who have family history may inherit one of the genetic defects associated, and make them more likely to clot. She had none of those.

Q Was there any reason to suspect that

she would be at risk for a blood clot?

A No, she was a young woman, she was active; went to the gym three times a week; was on no other medicines that increase the risk of clotting.

And outside of her brief period of five years of smoking, which she stopped greater than five years ago, she was at no higher risk for developing a clot.

Q Was there any reason that Mrs. Doull should not have been prescribed progesterone cream?

A No, not medically.

Q And why not?

A Well, she had none of the contraindications, and she had symptoms that were referable to perimenopausal systems that are generally treated with hormonal supplementation.

Q The jurors have heard some testimony in this case regarding warnings

contained in the PDR.

Do any of the warnings in the 2008 PDR apply to the cream that Mrs. Doull was prescribed by Nurse Practitioner Foster?

MR. SOBCZAK: Objection. Again, leading, and lack of disclosure.

THE COURT: Overruled.

A So, there are warnings in the PDR for both estrogens and progesterones, and the combination of the two, based on prior studies done by the Women's Health Initiative.

Those are different products, different concentrations, different routes of administration, and used for different indications. So, those warnings are really not applicable to the cream that she had received.

BY MS. DALPE:

Q And does absorption vary by

application?
A Yes.
Q Okay. And can you elaborate a little bit more on that?
A So, the other products that are available by prescription, that are in the PDR, are vaginal creams, and there are intravaginal creams, and those absorptions are much higher, in contrast to a topical progesterone cream, where the absorptions are less.
And moreover, if one looks at even the other one with estrogen, estrogen administered as a topical agent is associated with a marked increase in clotting.
So, both the type of hormone and its rooted administration affects its risk of developing side effects.
Q Doctor, you should have a jury book in front of you. Do you?
If we turn to Tab E, page 1.

A Tab E, page 1?
Q Yes. Are you there?
A Yes.
Q Okay. Can you tell the jury what this note is?
A This is a GYN consult when Ms. Doull was an inpatient at Brigham & Women's Hospital, questioning what they should do for hormonal therapy.
Q And on the third page of that note, at the bottom, what was the recommendation for hormone replacement therapy?
A Ms. Doull entered -- was transferred to Brigham & Women's Hospital with an ovarian cyst that bled, and it was a very large bleed, and needed to address this to address bleeds in the past.
So, she had a history of ovarian cysts, too. So, to prevent recurrent bleeding a hormonal therapy or suppressing ovarian function is critical.

And they discussed in this note there, there are various options. So, they used the word prophylactic hypothalamic pituitary abscess suppression. What it essentially means is turning off ovaries.
Q Can you just orient the jurors to where you are reading?
A That's in the last paragraph.
Q So, on page 3 of Tab E?
A Right.
Q The paragraph that starts, "In addition?"
A Correct.
Q And because I interrupted you, can you just tell me about the prophylactic hypothalamic pituitary abscess? I'm sorry.
A Okay. In an uncomplicated term, they essentially wanted to turn off Ms. Doull's ovaries from functioning, because that produces a larger cyst and causes the bleeding.

And there are a number of ways to do it. The GYN people said she's not a good candidate for estrogen; estrogen is a too high risk for her.
A single agent progesterone would be ideal, or another agent called Lupron, which is given in an injection, and which totally turns off ovarian function, would be the last option.
Q And so, what does the significance that gynecology at Brigham & Women's Hospital recommends here on this page, progestin?
A All right, so this woman has been demonstrated to have major thrombotic events, life-threatening CTEPH. And which is the best hormonal therapy for her, associated with the least likelihood of developing further clots.
In their mind, and in my mind, it's progesterone-only agents.
Q Thank you. And just to recap,

progestin is the synthetic form of progesterone?
A Correct.
Q Okay. Doctor, you had spoken a little bit about over-the-counter availability of progesterone cream.
Is progesterone cream available by prescription at pharmacies like CVS?
A Yes.
Q Okay. Is it available over-the-counter at pharmacies like CVS?
A The products that are available over-the-counter are the creams, and those are not prescription items.
Q Okay. So, going back, does the pharmacy -- the actual pharmacy at CVS, provide prescription creams?
A Yes.
Q Okay. Are there any differences between the risks of progesterone, whether it's over-the-counter or provided by a compounding company?
A This pregnant pause is because this

area is complicated.
The literature would suggest that progesterone, in and of itself, given both as a pill, and as a cream, and as a gel, is not associated with an increased thrombotic event.
The progesterone gel, which is the intervaginal gel, does carry a warning, based on prior studies from the Women's Health Initiative.
Progesterone cream, which is available over-the-counter at Walmart, CVS, Costco, hundreds of products of which greater than three million women use, is without a prescription, no warning, and does not have an increased risk of thrombotic events.
Q Now, the jurors have heard some testimony from Dr. Genecin about FDA regulation.
What does it mean to be regulated by the FDA?

A So, regulation is a complicated term, too. The FDA really regulates everything, and approve certain items, and therefore has the seal, and they're adamant you can't put the seal on it unless they approve it, which means that that that is presented; they can market it by a company, and it's by prescription.
The FDA also has a surveillance for all of this, which is where the regulation comes in. They don't necessarily approve the product, but they observe if there is any side effects for it.
What colors you add to food; not approved, but regulated.
The best example is ephedra. Ephedra was in multiple products as a diet supplement; not FDA approved, but side effects -- serious side effects were reported to the FDA, and as part of their oversight, their regulatory component, they

withdrew it from the market. So, no products can contain ephedra.
Any products, really, that are sold, purchased for human, and even animal consumption, the FDA does have a surveillance role. So, the answer is yes, there is a regulatory component, but not necessarily an approval component. We all use non-approved FDA products every day.
Q Can you give some examples of non-FDA approved products that are used in medicine?
A Let's see, all the vitamins we use ginko biloba, Tums, Maalox SR, chondroitin sulfate.
All those aisles you walk down in Costco, the hundreds of items that supposedly help your health in many ways, all non-FDA approved. You can buy them -- and while the FDA does watch over them and does regulate what kind of

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colors you can put in, those are all the non-FDA products, and we all use them each day.

Q At some point, after her diagnosis with CTEPH, was Mrs. Doull subject to some blood disorder testing?

A Yes.

Q And what were the results of the blood disorder testing?

A So, she underwent routine studies to see if she had a clotting disorder, and why she would be increased risk for developing CTEPH, both at the Franklin Medical Center and from Brigham & Women's Hospital.

And no abnormality of a clotting profile or genetic defects of the clotting system were determined.

Q And what's the significance of the negative testing in Mrs. Doull's case?

A The significance is that we all try to understand why an individual

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develops a clot. She had none of the medical reasons to develop a clot. She had none of the reasons why any other agent would make her at higher risk for clotting.

She was a young woman, no defect in clotting, no family history of clotting, and unfortunately, this just happens.

Q Does the fact that she had negative blood clotting testing rule out a clotting disorder?

A Well, I wish I could say yes, that all our tests are perfect and we know all of the answers.

The answer is no. We clearly don't have all the tests to define why individuals clot. In fact, the majority of patients who have clotting disorders will have negative clotting studies.

They have clotting defects that we don't understand, or may just have bad luck, too.

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Q Dr. Genecin told the jury Friday that negative genetic testing suggested that progesterone was the cause of the patient's CTEPH.

Do you agree with that opinion?

A No.

Q And why not?

A Topical progestin, natural progestin, is not associated with an increased risk of developing clots.

She was evaluated -- she spent three months at the Brigham & Women's Hospital, seen by a pulmonologist, thoracic surgeon, GYN people, multiple residents.

I had estimated she had interacted with over 40 different physicians. All said that her clots were idiopathic; none of them attributed her clotting disorder to the topical administration of progesterone cream.

Moreover, the literature,

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which I reviewed extensively, there is no controlled trial documenting that topical progesterone is associated with an increased risk of developing clots.

Q Can you just describe, what does idiopathic mean?

A Idiopathic, it means unknown; that we don't know what the etiology is. Sometimes, intellectually unsatisfying, but disorders like that, that's what all of the physicians attributed to why she developed this.

It's a rare, unfortunate disorder that no one -- she had no cause that we can determine why she would develop this, but it was clearly not the progesterone cream that she applied at night.

Q And then as my follow-up question, do you have an opinion, to a reasonable degree of medical certainty, as to whether the

progesterone cream prescribed to Mrs. Doull increased her risk of a thrombotic event?
A I do.
Q And what is that opinion?
A My opinion is that the progesterone cream that Ms. Doull applied did not increase her risk of developing the thrombosis; it did not contribute to her development of her CTEPH.
Q And can you state all the bases for your opinion?
A Basis is on my training and experience in treating patients with hypocoagulative disorders that require hormonal therapy.
And then based on the extensive review of the literature on the use of estrogen and estrogen containing compounds and their development in clots, both in normal individuals and in high-risk individuals.
Q And Doctor, do you have an opinion,

to a reasonable degree of medical certainty, as to whether the progesterone cream prescribed to Mrs. Doull caused her CTEPH?
A Yes.
Q And can you tell me that opinion, and a basis for that opinion?
A So, my opinion is that the progesterone cream did not in any way relate to Ms. Doull's development of CTEPH.
CTEPH is, one, a very rare disorder, and it occurs in a minority of patients who can develop any clots, but there is no association in the literature, and none of the physicians who had experience with CTEPH at the Brigham & Women's Hospital -- she was referred to the pulmonary hypertension clinic and to the thoracic surgeon, and they are very specialized thoracic surgeons who do this surgery, and any way invoked

that the progesterone cream was responsible for her developing CTEPH. There is not a single notation of that in the chart -- in the chart in the Brigham.
MS. DALPE: Your Honor, I have no further questions.
THE COURT: Do you wish to inquire, Mr. Dumas?
MR. DUMAS: No, Your Honor.
MR. SOBCZAK: May I be seen, Your Honor, at sidebar?
THE COURT: Yes.
(SIDEBAR CONFERENCE)
MR. SOBCZAK: Your Honor, as I indicated earlier, I move to strike the entire testimony for disclosed lack of disclosure, violation of the Court's order, and the continued leading questions, use of chalks that were not disclosed, and use of leading questions that were not disclosed in the court ordered disclosures over three

months ago.
THE COURT: Your objection is overruled.
MR. SOBCZAK: Thank you.
THE COURT: Are you ready to inquire?
MR. SOBCZAK: Yes.
(END SIDEBAR CONFERENCE)
(CROSS-EXAMINATION OF KENNETH MILLER, M.D.)
BY MR. SOBCZAK:
Q Good morning, Dr. Miller. You work at Tufts Medical?
A Yes.
Q You never worked with me before?
A No.
Q And have you ever worked with my wife?
A I don't --
MR. DUMAS: Objection.
THE COURT: Sustained.
A The answer is, I don't know. I don't know who your wife is.
BY MR. SOBCZAK:

Q Okay. So, you never heard of Sobczak before?
A No.
Q We never talked before today, correct?
A No, not that I know of.
Q You were served with a subpoena from my office, correct?
A The hospital did, yes.
Q Yes. Before we go there, did you actually make those boards?
A Yes.
Q So, you personally made those boards?
A I personally -- I didn't put the color on the big board, but all of those diagrams are mine, yes.
Q And how long did it take you to make those?
A Two to four hours.
Q And when did you make them?
A A month ago, perhaps.
Q Okay, so after you signed off on the disclosure, a reporting of what you

will testify to this jury?
A That's correct.
MR. SOBCZAK: Okay, may I approach the witness, Your Honor?
THE COURT: Yes.
BY MR. SOBCZAK:
Q I'm going to hand you what's been pre-marked as Exhibit QQ, the trial subpoena, and TT, the disclosure that's been sent on your behalf.
And before we go any further, can we mark what you are reading from, the jury book. That's not the one that's in evidence, correct? That's your own copy?
THE COURT: None of these jury books are in evidence, Mr. Sobczak.
A It's the same book that was given --
BY MR. SOBCZAK:
Q So, there is no difference between this -- you made no notes on it, no extra folders?
A No, no, except my CV.

Q Do you need this for examination?
A No. Well, in case you want me to refer to it.
Q Well, I'll hand you the one that's actually been marked, so we are on the same page.
A Okay.
Q Looking at Exhibit TT, that's the 10-page disclosure? Yes?
A Yes.
Q And if you turn to the last page, is that your signature?
A Yes.
Q And when did you sign it?
A Somewhere about a month ago, six weeks ago.
Q Six weeks ago would be --
A There is no date on this.
Q Do you agree that dating stuff is important in the medical field?
A I asked Ms. Dalpe if she wanted me to date it.
Q Oh, so on instruction of the defense counsel, you specifically left it

ambiguous, so it has no date?
MS. DALPE: Objection, Your Honor.
THE COURT: Sustained as to the form of the question.
BY MR. SOBCZAK:
Q Your belief is that you signed this about six weeks ago?
A Correct.
Q So, that would have been sometime in August of 2017?
A I don't recall the exact date.
Q If I represent to you that the defendants filed that in June of 2017, would you want to change your testimony?
A Yes.
Q Okay. One of the things that you were required to bring by the subpoena are any and all writings concerning your fees, correct?
A Yes.
Q And you have been paid in this case?
A Yes.

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Q Did you get paid by check?
A Yes.
Q And when was the first check you received?
A I don't recall.
Q Was it a week ago, a year ago?
A I was contacted by Ms. Dalpe approximately two years ago, so it probably was about two years ago.
Q So, since then, you would have even filed taxes concerning the payments you received on this case, correct?
A Yes.
Q So, you still have those documents?
A I still have my old tax forms.
Q Which would include all the checks that you received in this case?
MS. DALPE: Objection, Your Honor.
A I don't save the checks.
BY MR. SOBCZAK:
Q Did you save your W-2's?
A I send it to my accountant.
Q Okay. And you keep your taxes?

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A I keep my taxes.
Q So, you chose not to bring documents that were required of you to, to this case?
MS. DALPE: Objection, Your Honor.
THE COURT: Sustained as to the form of the question.
BY MR. SOBCZAK:
Q You did not bring the documents you were required to bring with you, correct?
A I believe --
MS. DALPE: Objection, Your Honor.
THE COURT: Overruled. Can you answer that question?
DR. MILLER: Should I answer the question?
THE COURT: Go ahead.
A In discussing with counsel, she has copies of the statements I sent to her. I don't keep records of my prior billing. I did also have a

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computer meltdown. I have a real job. This is not what I do for a living.
BY MR. SOBCZAK:
Q But you have done this before, correct?
A I have done it.
Q And you understand that part of you giving testimony, to be fair to both sides, I get to ask you some questions, correct?
A Yes.
Q And in order to answer those questions, I can ask you to bring some documents, and the Court required you to bring those, and you chose not to?
MS. DALPE: Objection.
MR. DUMAS: Objection.
THE COURT: Sustained.
BY MR. SOBCZAK:
Q You said Ms. Dalpe --
THE COURT: Please move on, if you would.

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BY MR. SOBCZAK:
Q Did you just say that Ms. Dalpe had those documents that you were asked for?
A She has my billing statements that I sent to her.
Q And in response to the subpoena, did you ask for those back so you can comply with the court order and bring them here?
MS. DALPE: Objection, Your Honor.
THE COURT: Please, would you please move on, Mr. Sobczak.
BY MR. SOBCZAK:
Q Well, all you brought was these two little stacks of documents, correct?
A Correct.
Q Did you even bring those, or did Ms. Dalpe bring those for you?
A I brought them. She sent them to me.
Q All right. So, she made those for you?

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A Yes.
Q So, the list of things that you claim to have reviewed, you didn't prepare -- defense counsel prepared it for you?
A Correct.
Q Did you prepare anything in this case concerning Ms. Doull?
A I prepared the statement that was presented in court, and that was subsequently filed by Ms. Dalpe. And she assisted in filing it.
Q Which statement are you talking about? Oh, the 10-page disclosure, you prepared?
A Yes.
Q You drafted all of it?
A Not all of it. The key parts are mine, and Ms. Dalpe prepared some of it.
Q Well, what would you consider key parts? Would you consider the patient's history to be key parts?
A Yes.

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Q And that was done by you?
A That was done by me.
Q So, any errors in the patient's history, that would have been your mistake?
A I accept that responsibility.
Q Okay. And any errors in not disclosing what you're going to talk about, that would be your mistake or Ms. Dalpe's mistake?
MS. DALPE: Objection, Your Honor.
THE COURT: Sustained.
BY MR. SOBCZAK:
Q Did you put in your report all the things on the board that you talked about to the jury here?
If you need to look at it, feel free to. I want to be fair to you.
MS. DALPE: Objection, Your Honor.
THE COURT: While the witness is looking at the document,

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I will see counsel at sidebar.
(SIDEBAR CONFERENCE)
THE COURT: I will just note for the record, the purpose for expert witness disclosures is to put on notice everybody as to the topic matters that a particular witness is expected to testify, and for expert opinions to be rendered, those opinions are to be disclosed in sufficient detail.
There is absolutely no requirement that every single word that a witness may use on the witness stand be written out verbatim in the disclosures.
So, let's move on, please.
MR. SOBCZAK:
There is a requirement of sufficient detail, Your Honor, and that's why I'm making the record.
THE COURT: Sufficient detail is not word-for-word.
MR. SOBCZAK: Correct.

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THE COURT: Please move on.
(END SIDEBAR CONFERENCE)
BY MR. SOBCZAK:
Q So, you were going to answer, Doctor? I didn't want to cut you off. What was your answer?
THE COURT: Perhaps you can ask the question again, Mr. Sobczak. We've had a little bit of an interruption here.
BY MR. SOBCZAK:
Q Did you put in your disclosure that you claim to have partially written all the different types of hormone therapy?
A I referred to specifically the progesterone and the synthetic progestins, which is -- Ms. Doull had received progesterone.
I did not address estrogens in my report.
Q Okay, so the portion about estrogen -- estrogen and progestin was stuff that was added after you disclosed

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what you were going to talk about here?
A Yes, as an educational component.
Q And you've decided that that would not be important to put in your report as to what you were going to disclose here?
A I believe, to address the question at hand, did the progesterone cream, which is what I was asked --
Q Doctor, the question was, you decided that it was not important for you to put the issues from the boards into your report, correct?
MS. DALPE: Objection, Your Honor. Can the witness answer his questions?
THE COURT: The witness is permitted to answer. Go ahead. Can you answer that question, Doctor?
DR. MILLER: Yes, I can answer it.
A The answer would be -- can you repeat the question?

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BY MR. SOBCZAK:
Q Sure. You decided it was not important for you to put what you were going to talk about here in the report, specifically concerning the different types of HRT's?
MS. DALPE: Objection, Your Honor.
A I decided that it was not important to include all the material on that board in my report.
BY MR. SOBCZAK:
Q And one of the questions Ms. Dalpe asked you was concerning literature and studies, correct?
A Correct.
Q Did you review plaintiff's disclosed literature, the sixty different published peer review journals, books, and studies in this case?
A Yes.
Q And do you find them to be authoritative and applicable in this case?

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MS. DALPE: Objection, Your Honor.
THE COURT: Overruled. Can you answer that question for sixty listed documents?
A Authoritative is -- I find that those published in peer reviewed journals were peer reviewed articles, and there is no one article that is authoritative.
Q Okay. Did you find any of them authoritative in your thorough review in preparation of this case?
A Not to get into a debate, but authoritative has a different connotation, meaning that it's immutable, unchangeable, and that it's something we all believe.
And there is no one article that's authoritative in that context.
Q And did you review the literature disclosed by the defendants?
A Yes.

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Q You did? Because it's zero, correct?
A I had some articles reviewed by the defendant.
Q You saw documents disclosing literature by defendants?
A A paper from Dr. Potter?
Q That was disclosed?
I'll represent to you, Doctor, that there has been zero literature disclosed by defendants.
A Okay. The only reason is, I saw one e-mail to me on an article that I think -- oh, I correct -- that Dr. Porter liked.
Q So, you communicated with Dr. Porter, or with Ms. Dalpe?
A Ms. Dalpe.
Q So, that was via counsel, Doctor; you didn't communicate directly with Dr. Potter?
A No.
Q But you saw some communications about article that Dr. Potter liked,

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but you agree that you saw zero articles disclosed by the defendants, they would be talking about in this case?

MS. DALPE: Objection, Your Honor.

THE COURT: Sustained.

BY MR. SOBCZAK:

Q You did not see any disclosed literature studies, peer reviewed articles, books, by defendants, relative to this case, correct?

MS. DALPE: Objection.

THE COURT: Can you answer that question? Are you able to answer that question?

A There is a list of articles that you have there. I don't know if the other defendants have used similar articles, and therefore, the list was put together.

I do not see specific articles, however, from other defendants. I saw this list, and

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there may have been some redundancy on it. So, I cannot state categorically that they didn't provide the same articles.

BY MR. SOBCZAK:

Q And when did you see this list?

A Last week, a month ago. There's a number of versions of it.

Q Oh, so you saw different versions throughout the time, in communication with counsel?

You didn't see anything that was actually filed in Court, correct?

MS. DALPE: Objection, Your Honor.

THE COURT: Sustained.

BY MR. SOBCZAK:

Q You reviewed documents in preparation for this case, including medical records, correct? Yes?

A Yes.

Q And you reviewed the forty or so depositions when the defense counsel

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subpoenaed all friends and family of the Doull family, and brought them in here and asked them questions, correct?

A Yes.

Q And you reviewed the deposition of the pharmacist from Wisconsin, correct?

A Correct.

Q That's the one that the jury heard yesterday, but we'll get into it later.

And you also reviewed some filings in this case, correct?

A Correct.

Q You have reviewed the list of articles that plaintiffs filed, that they intend to use at trial, correct?

A Correct.

Q And you did not review a list of articles that the defendants filed, because they did not do so, correct?

A I did not know of any of them -- the

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articles that I submitted were also submitted by the other defendants.

Q And those articles were submitted by you to defense counsel only?

A Correct.

Q And those were the sort of documents that you were asked to bring with you, but you did not -- all the communications regarding payments --

MS. DALPE: Objection, Your Honor.

THE COURT: Sustained.

Please move on.

BY MR. SOBCZAK:

Q Now, Doctor, how long have you been at Tufts?

A Thirty years or so.

Q And you've been there for a long time, and you're affiliated with the leadership. In fact, you are featured in numerous videos on Tufts' website, correct, including the one under patient safety and care website?

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A I'm not sure it's a patient safety and care website, but I think -- yes, there is a movie about me, but I haven't seen it.
Q You know that Tufts has a quality and safety committee and subsection?
A No.
Q You're not aware of that?
A I'm aware there is a committee, that's all.
Q So, are you aware whether or not the institute of which you've been for twenty-plus years has a patient safety committee?
A I'm aware there's a patient safety committee.
Q Because patient safety is an important aspect of medical care, correct?
MS. DALPE: Objection, Your Honor.
MR. DUMAS: Objection.
THE COURT: Can you answer that question?

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A That is not what physicians do. Our role is not to provide safety. Our role as a physician is to provide care, diagnosis, and treatment.
The safety committee is to provide and make sure that the hospital is a safe environment.
And clearly, I'm concerned about my patient safety, but as a physician, my role is to help diagnose, improve his state of health, and treat his illness.
BY MR. SOBCZAK:
Q So, you would disagree with Tufts saying, "We are committed to keeping our patients safe by adhering to strict standards?
A Well, I think Tufts, as a hospital, as a medical center, is committed to make sure patients are safe in the hospital.
The halls are clean, they're not slippery, the elevators work, the stairs are clean, the bathrooms

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are fixed, there's police onsite. There are rules and regulations of what nurses can do. We all have to wear badges.
So, the environment of the hospital, which I believe that's what we all interpret it, is safe, and I think we all strive -- if you see a wet spot in the hall, to call the appropriate person to clean it. If the bathrooms aren't clean, they should be cleaned. The towels are washed.
So, I think a safe environment for a patient to be in is important. But as a physician's role, we care for patients; we diagnose their illness and we treat them.
Q And are you testifying here, Doctor, that as part of caring for patients, you are not concerned for the patient's safety and wellbeing?
A Oh, I'm concerned about the

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patient's safety, but that's not my primary role as a physician. Oh, I'm concerned with patient safety. I won't send a patient home if they've had a narcotic or something that would interfere with their driving. That would be unsafe.
However, I still would give that agent to the patient if I believed that it was critical, but not let the patient drive home.
My primary role, however, is to diagnose, treat, within the patient. My role is to make people well.
Q And would you agree that sending a patient home undiagnosed is also unsafe?
A No. I wish I could diagnose all patients on their first visit. I'm not a deity; we're human.
I work with a great number of other people that help in the diagnosis of complicated cases.

No one physician feels that they, at the first visit or any time, make the diagnosis on every patient alone.

MR. SOBCZAK: May we be seen just briefly?

THE COURT: Please, over here.

MR. SOBCZAK: It's a white board.

THE COURT: It's just a plain white board? Okay.

MR. SOBCZAK: I am assuming there would be no objection to that.

THE COURT: That's fine.

I'm interrupting only because there have been a number of issues of people bringing out things that others claim not to have seen, so I wanted to be sure we aren't in that position here, as well.

So, a white board is fine.

BY MR. SOBCZAK:

Q So, Doctor, in this case

specifically, we're talking about pulmonary emboli and blood clots, correct?

A Part of the case is pulmonary emboli and blood clots.

Q Pulmonary emboli is shortened for PE?

A PE.

Q And during direct, you testified about several likely causes for PE's, correct?

A Correct.

Q One of them was cancer, correct?

A Correct.

Q Another one was blood disorders, or history of blood disorders, correct?

A Correct.

Q Is there a shortening for this disorder that you use?

A No, that's fine.

Q In that area?

A Blood diseases.

Q Blood diseases? One of them is hormone replacement therapy,

correct?

A Correct.

Q Including progesterone, correct?

A Natural progesterone does not cause blood clotting disorders.

Q You testified, Doctor, that progesterone has no likely cause of PE's?

A Yes, natural progesterone has not been associated with at all PE's.

Q I'm asking you progesterone.

A Yes.

Q Just progesterone. You are a hematologist, you understand?

A Yes.

Q Progesterone?

MS. DALPE: Objection, Your Honor.

A Well, I'll make it very clear, which I did --

THE COURT: Overruled. Go ahead, you may answer the question.

BY MR. SOBCZAK:

Q Is this progesterone one of the

likely causes of PE's?

A So, I --

Q Yes or no, Doctor?

A No, that's not a yes or no question. I'm sorry, counselor.

As the picture showed, and why I brought that is, there's different types of progesterone. There is natural progesterone, which is what Ms. Doull had received; there is synthetic progesterone, which is a different type of progesterone.

And I documented on the board that synthetic progesterone is sometimes associated with the clotting, but --

Q So, --

A But within -- the question, is it broadly progesterone, I can't answer that.

Q So, your position is that non-bioidentical progesterone is associated -- a likely cause of

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PE's, correct?
A I did not use that term. I said no natural progesterone.
Q Natural, okay. So, have you ever used the term bioidentical?
A I have.
Q And you reviewed the testimony from the Wisconsin pharmacy, where they were asked specifically what drug was Laura being prescribed, and she said no, she wasn't getting the natural one, correct -- she was getting the bioidentical one?
Do you remember that part of the testimony?
A No.
Q So, if the jury recalls that she was asked specifically about there are two types of progesterones she could probably use, natural and non-natural, and the answer was, she was not getting the natural, because that would say "NC Progesterone," but then she did say --

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MS. DALPE: Objection.
THE COURT: Sustained.
You're testifying, please. You may ask him if he recalls what the deposition testimony indicated.
MR. SOBCZAK: I'll rephrase it.
BY MR. SOBCZAK:
Q In your careful review of all of the materials for this case, do you recall reviewing the deposition testimony of the Wisconsin pharmacy rep, wherein she was asked specifically whether or not the drug that was being shipped to Ms. Doull was natural or the non-natural one?
Do you recall that, Doctor?
A Yes.
Q And do you recall that the answer was that it was not the natural one; it was the non-natural one, because otherwise, the RX order would say "NC Progesterone?"
MS. DALPE: Objection.

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THE COURT: Sustained.
BY MR. SOBCZAK:
Q Do you recall the answer to that question?
A No.
Q But, do you recall that it was identified as bioidentical?
A Yes.
Q Okay. And, it's your position that bioidentical hormones, specifically progesterone, have different risks than synthetic ones?
A Yes. As I alluded in the chart, to make it clear.
Q So, in your chart, you were referring to bioidentical, the one you called natural?
A Yes. Not a term that we all like to use, bioidentical.
Q Well, the literature uses that term, correct?
A What's the question?
Q The literature uses the term bioidentical?

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A The literature is very controversial with the word bioidentical.
Q You were asked about FDA, correct?
A Yes.
Q And, you've given lengthy answers about what the FDA does and does not do.
Did you review the FDA's bulletin, specifically addressing bioidentical hormone drugs?
MS. DALPE: Objection, Your Honor.
A A number of them.
BY MR. SOBCZAK:
Q Did you review the FDA bulletin from 2008; right around the time that Ms. Doull was --
THE COURT: Would you show him the article, 2008?
MR. SOBCZAK: I'm just asking the question first, Your Honor.
THE COURT: Well, show him the article, so you don't have to read it aloud. Go ahead, show it to him, and ask if he read --

MR. SOBCZAK: Am I ordered to show him this first?
THE COURT: I am asking you, so that we don't have to go through a lot of questions, to just show him what you're referring to, state on the record what the identifying letter is, and then you can ask him, did he see this article.
MR. SOBCZAK: May I approach, Your Honor.
THE COURT: Yes.
BY MR. SOBCZAK:
Q I'm going to hand you Exhibit L, the FDA Bioidentical.
Is this one of the articles you reviewed in your careful preparation for this case?
A I am familiar with this article.
Q Okay. And, in fact, it's done by the FDA, correct?
A Yes.
Q And, it addresses the differences between FDA regulated drugs and those

that are not, that they just have oversight of it, correct?
A Correct.
Q Precisely what you were testifying to on direct, correct?
A Yes.
Q Okay. And, you find FDA to be a reliable authority on the issue of the drugs they regulate or oversee, correct?
A Can you rephrase your -- what the question is?
Q You agree that FDA is a reliable source and authority on the issue of regulating drugs, or supervising the drugs that are not subject to regulation?
A The FDA's role is to approve drugs, to regulate -- to approve drugs. They have a regulatory issue with regards to all products that are consumed. And they have a surveillance control for drugs that they don't approve. So, a blanket statement is hard to give a yes

or no to, counselor.
Q That's not a blanket statement. It's a question. Whether or not you agree that FDA is an authority in dealing with drugs?
A I would have to say the answer to that is no.
Q You do not agree that FDA is authority that controls drugs?
A For the drugs that they approve, yes.
Q So, you do --
A The drugs that the FDA approves, they're authorities.
Q Okay. So, when they're addressing the drugs that they approve and how they differ from the ones that they are not approving, they're still an authority?
A They are authorities in the drugs they approve.
Q Okay. And, do you agree that bioidentical hormones are also known as bioidentical hormone replacement therapy, BHRT?
A Yes.

Q And, would you agree that FDA is concerned that the claims made by these BHRT's may mislead women and healthcare professionals, giving them false sense of assurance about using potentially dangerous hormone products?
A That statement, yes.
Q Okay. And you agree with that statement?
A I believe there's a great deal of controversy about that.
Q And, you agree that as of 2008, FDA is not aware of any credible scientific evidence to support claims regarding safety and effectiveness of compounded BHRT drugs?
A That's a statement that's made by the FDA, more of that.
Q And, you agree with that?
A There's a great deal of controversy about that.
Q There was a controversy, but as of 2008, there wasn't enough scientific evidence to claim that they are safer.

You agree with that?
MS. DALPE: Objection, Your Honor.
THE COURT: Overruled.
A **The FDA offered an opinion that they did not have scientific evidence with regards to compounding products, correct.**
BY MR. SOBCZAK:
Q And just because -- they are not safer just because they are neutral, and neutral is in quotes, correct?
A **They don't comment on they're not safer or more safe.**
Q Really? Can you read the next sentence? Go to the next page.
A **This isn't the first article.**
Q Oh, I know. We'll go through all the other ones, don't worry, Doctor.
A **Okay.**
Q Can you go to Page 2?
You see the statement by the Director of FDA's Office of Women's Health; "They are not safer just

because they're neutral?"
A **Yes.**
Q And, you agree with that, correct?
A **Yes.**
Q You agree that FDA approved hormone replacement drugs are sold by prescription only?
A **That's true.**
Q And, FDA advises women to choose those hormones at the lowest dose in the shortest period of time?
A **Yes.**
Q Okay. And, would you agree that FDA warns that the women should be informed of all risks and benefits of the drug they're being prescribed, including the ones that have not been proven to be safe and effective?
A **That's true. And the reason for these arguements are is because over three million women use over-the-counter non-FDA approved products every day.**
Q And, has Ms. Doull used over-the-counter progesterone in this case?

A **Essentially it was an over-the-counter product, though it was prescribed through a compounding pharmacy.**
Q So, it wasn't over-the-counter, it was by prescription, correct?
A **Correct.**
Q It was -- in fact, in your careful preparation, you read the Wisconsin Pharmacy deposition where they said it can only be done by prescription, correct?
A **That's correct.**
Q And, you've read the testimony from the defendants, where they say, "This is only a prescription drug," correct?
A **Yes.**
Q So, over-the-counter drugs have nothing to do with the ones that were prescribed for Ms. Doull in this case, correct?
A **They share the same component, but they're not FDA approved.**
Q And, they share the same active ingredient?

A **So, the studies have addressed this, counselor.**
Q Yes or no, Doctor?
A **No, no, no.**
Q They don't?
A **The studies have addressed this --**
Q Can you answer the question, please?
THE COURT: Would you please stop interrupting?
A **There are over-the-counter products that have been reviewed -- and I do have a scientific background -- have been demonstrated to contain the active ingredient that the company says.**
BY MR. SOBCZAK:
Q So, the question was, same active ingredient or not?
A **Yes.**
Q Yes? So, they all have the same active ingredient, progesterone?
A **Well, I can't comment on all.**
Q Because they're not approved?
A **Right.**
Q And they're not regulated, they're not

tested. So, you are aware of the fact that many of the products that are not regulated have issues with them?

In fact, you testified about one of them --

THE COURT: Excuse me. Would you just ask one question at a time, Mr. Sobczak?

BY MR. SOBCZAK:

Q Your testimony is that you can't say they're all the same because they're not FDA approved, correct?

A With regards to the studies which are done by the FDA, sampling products that are over-the-counter; do they contain what the products purportedly obtain? The studies have documented they do.

Q And, those are studies that you read in the disclosure by the defendants, the zero ones?

A No.

MS. DALPE: Objection.

MR. DUMAS: Objection.

THE COURT: Sustained as to

the form of the question.

BY MR. SOBCZAK:

Q Are those the studies that you have identified in your lengthy disclosure?

A I hope so, yes.

Q Okay. Then why don't you go take the time, review those pages, and point out where you have identified a single study in your disclosure.

A I need my disclosures.

Q Say again?

A I'm sorry.

Q In your disclosure.

A In my disclosure, no. In the list of articles I gave, that's what I thought you were referring to.

Q Okay. So, what you're saying is, in the disclosure that you had to sign as accurate, what you will testify here, you did not disclose a single study?

A True.

Q And, that is what you're coming here and let the other side -- the plaintiffs know what you'll be

testifying to.

What you signed for, saying this is what I'm here to talk about, correct.

MS. DALPE: Objection, Your Honor.

THE COURT: Sustained.

BY MR. SOBCZAK:

Q This is what I'm being paid to come here to talk about?

MS. DALPE: Objection.

THE COURT: Sustained.

BY MR. SOBCZAK:

Q Can you turn to the last page of the disclosure? What did you actually certify, Doctor?

A Are you referring to my last paragraph?

Q Yes. Well, you actually didn't fill out a certificate.

It's just the last sentence, correct? If you read the last paragraph before your signature.

A In my disclosure?

Q Yes.

A "Dr. Miller is expected to testify that there was no delay in the diagnosis" --

Q No, Doctor, the last one. The last, last sentence.

A This is the last sentence.

Q It says, "I had reviewed." Right above the signature.

A "I have reviewed the foregoing expert disclosure, and I hereby certify that the expert disclosure accurately states the subject matter and the substances of facts and opinions, and a summary of the grounds for each opinion, which I expect to testify at the trial in this case."

Q Okay. And, in your disclosure, you elected not to include the boards you were going to use; you also elected not to identify a single study, peer review journal, book, anything, correct?

MS. DALPE: Objection, Your Honor.

THE COURT: Sustained.

BY MR. SOBCZAK:

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Q Did you identify a single study, peer review journal, article, or a book in your disclosure?
A I provide no references in my disclosure.
Q Now going back to the FDA one. You dispute that at the time of 2008, there was no known scientific studies to show that the bioidenticals are safer, correct?
MS. DALPE: Objection, Your Honor.
BY MR. SOBCZAK:
Q You dispute the FDA's statement? Fact, dispute in the minutes, that as of that timeframe, there is not enough scientific evidence to prove that bioidenticals are safer?
A That's true.
Q Okay. So, if they're not safer, the assumption is, the risks are the same, correct?
A I'm not sure you can make that extrapolation. Are they un-safer? No.

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Q No, that's okay. So, you can have same, you can have safer, or you can have less safe, correct?
All the FDA is saying is that they're not safer. So, at a minimum, they are the same as the ones that are FDA approved, correct?
A It's not addressed by the FDA. They don't comment on that.
Q They do; they say they are not safer. So, I'm asking you, Doctor, the only other two options are --
THE COURT: Excuse me. That's a statement on your part.
MR. SOBCZAK: That's my question.
THE COURT: Would you please ask questions.
Members of the jury, please disregard that last question by Mr. Sobczak.
BY MR. SOBCZAK:
Q Okay. So, Doctor, you agree that something can be safer, same, or less

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safe, correct?
A Or, unknown.
Q Or, unknown. Lack of studies? And, all that FDA is saying is they're not safer, correct?
A They're unknown.
Q No, they're saying there is no studies to show that they're safer? Did you read that again?
A They're unknown, right.
Q So, either they're potentially even less safe, or at minimum, they're the same, correct?
A They're essentially unknown -- their safety, because they're not evaluated by the FDA.
Q So, as a prudent safe practitioner, you make an assumption -- they're either worse, or at a minimum, they are the same?
A I don't assume they're any worse. I assume they're either the same or less.
Q Okay. So, they're the same or less. And, are you familiar with

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ACOG?
A Yes.
Q And, in your extensive preparation for this trial, did you review ACOG's 2005 opinion, reaffirmed in 2007, concerning compounded bioidentical hormones?
MR. SOBCZAK: May I approach?
THE COURT: Yes.
MR. SOBCZAK: Exhibit K.
BY MR. SOBCZAK:
Q Did you review that prior to coming here?
A Yes.
Q Okay. And, that's because it falls in the applicable timeframe when Laura Doull was being prescribed compounded bioidentical hormones, correct?
A Yes.
Q And, you found ACOG to be an authoritative source of the issue on women's health?
A Yes.
Q So, do you agree or disagree --
MR. SOBCZAK: May I take that

back? Please let me see that for a second.
Q Do you agree that compounded bioidentical hormones are plant-derived hormones that are prepared, mixed, assembled, packaged, or labeled as drug by pharmacists and can be custom-made for patient according to a physician's specifications?
A Yes.
Q In fact, that's what you testified on direct. They're often made from soy or yams, correct?
A Yes.
Q And, just so we're in the realm of this case, in addition to the physician specification, they also can be made to a nurse practitioner's specifications, correct?
A Correct.
Q Because nurse practitioners have a prescriptive authority in Massachusetts?
A Correct.

Q And, in this case, Nurse Practitioner Foster is the one that prescribed this by prescription only drug for the duration of Laura Doull's care, correct?
A Correct.
Q And, do you agree that most compounded products have not undergone rigorous clinical testing for safety or efficacy and issues regarding purity, potency, and quality are a concern?
MS. DALPE: Objection, Your Honor.
THE COURT: Overruled. Can you answer that question?
A Can you repeat that question?
BY MR. SOBCZAK:
Q Sure. It's right on the board, second sentence.
Most compounded products have not undergone rigorous clinical testing for safety or efficacy, and issues regarding purity, potency, and quality are of concern?

A Yes.
Q Do you agree that compounded hormone products have the same safety issues as those associated with hormone therapy agents that are approved by the U.S. Food and Drug Administration, and may have additional risks in intrinsic to compounding?
A Yes.
Q That was a yes?
A Yes.
Q And, there is no scientific evidence that supports the claims of increased efficacy or safety for individualized estrogen or progesterone made products?
Do you agree with that statement?
A Yes.
Q And, you would agree that the drugs that are in the Physician's Desk Reference are the ones that are FDA approved?
MS. DALPE: Objection, Your Honor.

THE COURT: Overruled.
A The FDA has really expanded and includes some non-FDA approved products in there, as well.
BY MR. SOBCZAK:
Q As of 2008, did you review the 2008 version of the PDR, in your preparation for this trial this morning?
A No.
Q Did you see it in both Nurse Foster's deposition testimony and Dr. Miller's testimony, when they said that the only reference they had in 2008 was the PDR?
A Yes.
Q And, you did not find it relevant for you to get the book that the defendants who are paying you to be here have only available in the office.
MR. DUMAS: Objection.
THE COURT: Sustained as to the form of the question.
MR. SOBCZAK: I'll rephrase.
BY MR. SOBCZAK:
Q You did not find it relevant to get the

only book that Dr. Miller and Ms. Foster identified as having in their office?

A No. The information is available without the book.

Q It's available online, correct?

A Most of us don't keep old PDR's.

Q I understand. That's fine. So, in fairness, this book is updated every year, correct?

A Correct.

Q And, every year, new information becomes available and new information comes out?

A Correct.

Q So, as a practicing doctor with all these different patients, you don't waste space keeping old ones because you have the new information available there, correct?

A That's correct.

Q But, you would agree that information about drugs may have changed just slightly from 2008 to 2017, correct?

A Specific drugs do change, and we do get updates about those, specifically.

Q So, that's why for the purpose of this case, we actually are using the 2008 version, because that would be information that was available, and should have been available to both Dr. Miller and Nurse Foster, as Ms. Doull was their patient, correct?

A Correct.

Q Okay. And, as you just agreed, the compounded form of products have the same issues as those associated with hormone therapy agents that are approved by the U.S. Food and Drug Administration?

Those would be the ones in this book, correct?

A Correct.

Q And, you didn't review Dr. Miller's trial testimony, did you?

A No.

Q Okay. I'll represent to you that when he was asked to find the drugs that he

was prescribing to Laura Doull, he went into this book and went to Page 979.

MS. DALPE: Objection, Your Honor.

MR. DUMAS: Objection.

THE COURT: Sustained.

BY MR. SOBCZAK:

Q I'll represent to you that when Dr. Miller was on the stand, he went over three different drugs --

MS. DALPE: Objection.

THE COURalloudedT: Sustained.

Why don't you just ask him specific questions, please.

BY MR. SOBCZAK:

Q The warnings, the safety issues, the precautions that are dealing with progesterone in this book, according to ACOG and you, are the same for compounded form of drugs, correct?

A No. The FDA does not rule on compounded drugs, as you eluded to. They don't evaluate compounded drugs.

Q Correct, Doctor. We agree FDA doesn't

regulate them, but both the ACOG, FDA, and now you, agree that the risks are the same?

A Counselor, not to sidetrack your question; I'm not a pharmacologist. Ms. Doull received cream, which is not an FDA approved product in any form. There is no progesterone cream that's FDA approved.

Q You don't believe there's an FDA approved cream?

A Topical progesterone cream.

Q Are you familiar with the Mayo Foundation for Medical Educational Research?

A Not specifically.

Q Are you familiar with Drs. Julia Files, Marsha Ko, and Sandra Prudie?

A No.

Q In your preparation, did you happen to review the article on the bioidentical hormone therapy that was published in 2011?

A Yes.

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Q Okay. And did you read in there that there are bioidentical drugs that are available on the market ---

MS. DALPE: Objection, Your Honor.

Q -- that are FDA approved?

THE COURT: Sustained as to the form of the question. You may show him the article.

BY MR. SOBCZAK:

Q Are you aware that there are bioidentical --

A Yes.

Q -- progesterone drugs that are FDA approved?

A Right. But, are no bioidentical -- going back to the question that I was addressing.

There are no bioidentical creams. There are no non-bioidentical creams. There are no FDA approved creams. We're talking different products.

Q There are FDA approved gels, correct?

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A Intravaginal gels.

Q And did you also --

A Which is a totally different drug.

Q And did you also review that portion of Wisconsin's Pharmacy deposition, where they said that their progesterone can come in creams, gels, pills, suppositories.

It comes in multiple different forms, correct.

A Yes.

Q And, in the end, although the route of application, and as you testified earlier, the absorption rate may be different, the active ingredient is still progesterone, correct?

A According to them, that's what they said.

Q So, Wisconsin said active ingredient is the same, Dr. Miller said progesterone is progesterone.

Is it your position that progesterone is progesterone?

A I hate to report my question, but

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progesterone is not progesterone, progesterone.

There is natural progesterone, closest to what a woman make each day. There are multiple synthetic progesterones, which are different. The route of absorption is much different between intravaginal, topical, pill, and intramuscular.

So, this blanket statement that you're asking me to agree to is not biologically or clinically relevant.

Q You're saying -- okay.

Do you agree that currently the FDA requires manufacturers of products approved by the FDA that contain estrogen and progesterone to use a class labeling, black box warning, reflective of the finding of Women's Health Initiative?

Do you agree with that?

A That estrogen and progesterone, there is a black box warning on that, yes.

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Q Okay. Would you agree that, however, because compounded products are not approved by FDA, and have no official labeling, i.e. package inserts, they are exempt from including the contraindications and warnings required by the FDA in class labeling for hormone therapy?

Do you agree with that?

A Yes.

Q That's what you, in part, were just talking about, that these compounded drugs or over-the-counter drugs have no requirement for labels; that's why they don't include them?

A That's right.

Q It's not that they're saying there is no risk to them, they're not saying anything because they don't have to. They're just marketing stuff, correct?

A They don't require a label.

Q Do you agree, given the lack of well-designed and well-conducted clinical trials of these alternative therapies,

compounded hormone products should be considered with the same safety issues as those associated with hormone therapy agents that are approved by the FDA?

A There is a controversy about compounded pharmacies and their products, yes. But, I'm not a pharmacist; that is not my field of expertise.

Q And, if it was not your field of expertise, the safer approach would be following the recommendations --

MS. DALPE: Objection.

Q -- and give the same warnings, correct?

THE COURT: Sustained.

A Excuse me?

Q If you are --

MS. DALPE: It's sustained.

THE COURT: I've sustained the objection.

MR. SOBCZAK: Sorry, I'll rephrase the question.

BY MR. SOBCZAK:

Q The safer approach when you're not

certain if the risk applies or not, is to give the patient the information about the risk, correct?

A If there's no statement about the risk provided by the manufacturer, there is nothing else to give.

Q If, as you just testified, there is controversy, just like it's here -- some people say it's safer, some people say it's not.

If there is a controversy, and there is not enough sufficient scientific data to prove that it's safer, as a practitioner, the safer approach for you is to give the patient the information about the risk, so then the patient can make the decision whether or not they want to take it, correct?

MS. DALPE: Objection.

THE COURT: Overruled. Are you able to answer that question, Doctor?

A So, I have to answer this question in a

number of parts.

For one, the patient was prescribed topical cream. There is no FDA approved topical cream product period. So, there is nothing you can compare it to.

Is there literature? Extensive literature; The Women's Health Initiative, follow-up literature just recently published is that; is progesterone in its current form safe? And, the answer in my extensive review of the literature, to which I provided you, definitively, without question, documents that that product is not associated with an increased thrombotic risk.

Following up on the Women's Health Initiative, since you introduced estrogen and progesterone -- the Women's Health Initiative recently updated their data on 27,000 women and found no increased mortality for women who received estrogen and progesterone

products on their studies.

So, that is the most recent data, counselor. I'm only commenting on the product that she had received. And, there is no FDA approved topical natural progesterone product that is FDA approved or not approved.

BY MR. SOBCZAK:

Q Are you done, Doctor?

A Yes.

Q Okay. Now, just to answer my question and to correct you. I did not inject estrogen progesterone -- so

THE COURT: Please do not argue with the witness. You may ask questions.

BY MR. SOBCZAK:

Q You're board injected progesterone and estrogen. That's not in your disclosure, is it?

THE COURT: Asked and answered.

BY MR. SOBCZAK:

Q Yes?

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A It is not in my disclosure, correct.
Q And, in the disclosure that you signed, the only thing you signed, you didn't talk about any these studies, including the updated studies, correct?
A Correct.
MR. SOBCZAK: Your Honor, we're approaching 11:00 and I've still got awhile.
THE COURT: All right. We'll take our recess at this time. We will resume at fifteen after the hour, please.
(Court in recess at 11:00 a.m.)

(Court reconvenes at 11:26 a.m.)
(Jury not present)
THE COURT OFFICER: Court, all rise. This court is now in session. You may be seated.
THE CLERK: Your Honor, you are back on the record.
THE COURT: So, when the jurors are brought back in, it's my

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intention to -- in case the jurors are confused by all this language about disclosures and treatises, I am going to read from the actual Superior Court Rule, the relevant parts of Superior Court Rule 30B on expert disclosures.
And indicate that we also have a statute with regard to learned treatises; in other words, treatises, periodicals, books or pamphlets on particular statements and the way in which they have to be disclosed or not disclosed.
Okay. Anything else? I'm sorry, did you want to --
MR. DUMAS: Your Honor, two brief things.
THE COURT: Mm-hmm.
MR. DUMAS: One is, I notice that Mr. Sobczak during the break brought up his boards again about patient safety goals. I just want to continue our objection to that.

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Changing the word from rules to goal doesn't change the meaning, and this witness specifically has disagreed with the statement about patient safety. And he has not been asked about any of this, which relates to my next issue, which is just an observation.
THE COURT: Mm-hmm.
MR. DUMAS: Mr. Sobczak described his cross as having quite a bit more. He has already covered the FDA, he has already covered disclosure, he has already covered the PDR, he's covered the literature.
I am just concerned. We do have fact witnesses that we subpoenaed here today. And, obviously, Dr. Miller is here for a limited time, but just an observation about what the length and scope of the cross-examination may be.

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But primarily, I do strenuously object to these boards. And we saw a little bit of it this morning. It's the reptile theory. It's safety is the standard of care.
And they put the doctor in the untenable position of saying don't you want your patients safe, isn't that your goal? And having a PE is not safe, is it?
Therefore, you have breached the standard of care. It's a completely fictitious standard of care. And we even heard it this morning when the doctor was asked, and failure to diagnose isn't safe, is it?
This is just a different way, as Mr. Sobczak tends to do: take something that the Court has already excluded, twist a couple words, while the meaning remains the same, in an attempt to get it into evidence.

And I just want to continue our objection to these types of tactics to steer away from the standard of care.

THE COURT: Well, I will say, I thought that the doctor was able to answer actually during cross-examination and explain where safety comes into play.

So, perhaps that will be helpful to jurors. Okay. So, let's bring up the jurors, please.

MR. SOBCZAK: And for the record, Your Honor, just to correct Mr. Dumas' misstatement, the Court did not exclude those words. They specifically allowed -- the only thing that was excluded was covered up, and then the witness on the stand admitted to everything except for the word rule.

THE COURT: Well, and you wrote in the rest of it, but --

MR. SOBCZAK: From the doctor's

mouth, Your Honor.

THE COURT: We'll see what this witness has to say about the language on there.

MR. SOBCZAK: That's the plan. Correct. That is my plan, Your Honor.

As for length, Your Honor, I would just say for the record my direct of Dr. Genecin took 40 minutes, and the defendants' cross took three-and-a-half hour.

Here, we have direct examination of hour and a half, and I have only been crossing less than an hour. I do have a few things more to go.

THE COURT: I'm sure everybody has a lot more to ask of this doctor, but I would just point out that it's now 11:30 almost. We have until 1:00 and then until three.

And, you know, if you're not

getting anywhere, Mr. Sobczak, perhaps you should move onto the other parts of your intended cross-examination instead of repeatedly asking the same questions. All right. So, can we bring the jurors, please?

THE COURT OFFICER: Yes.

THE COURT: I am just going to point out that we have quite a bit of work this afternoon, including an arraignment in a homicide case, which is going to take some time.

So, we cannot drift much past three o'clock today.

MS. DALPE: We understand, Your Honor.

THE COURT: That's fine. I stand corrected. We have moved the arraignment to 1:30, so hopefully that will be finished before two.

THE COURT OFFICER: Jurors entering.

(JURY ENTERS)

THE COURT: And actually, jury, you may be seated.

Before Dr. Miller resumes his testimony, because you have heard quite a bit this morning about questions about disclosures, and I put that in quotes because that's the particular word that's been used and you may have heard this language used earlier in the trial as well, but I think it might be helpful for jurors to understand what this is.

So, in civil cases, here in Massachusetts and more specifically for purposes of this word disclosure here in the Massachusetts Superior Court, there are certain rules of procedure so that the attorneys know when they're permitted to do some certain things, what things they are required to do or permitted to do before a case actually comes to trial.

And among those things are what we call discovery. That is where the parties are expected to exchange the information that each of them has to support their position so that once the case actually comes to trial, both sides know what is expected to be introduced during trial.

With regard to that idea of discovery, in certain cases, as I told you at the beginning of the trial and I will remind you of it later today before we recess for the day, because there are certain matters that are outside the understanding of ordinary jurors, people who have expertise, training and education in a particular area are permitted to testify and are permitted to offer their opinions on matters.

These are so-called expert witnesses. And I put that in a

quote as well. That's just a term of art that is used to talk about what kind of witnesses they are.

These witnesses are generally speaking not people who have any personal knowledge in the case in the sense that they weren't personally involved with the person who claims to have been injured in a case such as this one.

They are not doctors who personally treated, diagnosed or saw the person who allegedly was injured in some way. But instead, they're permitted to testify in order to assist the jury, whom we expect probably don't have knowledge about these particular areas, but assists the jury in understanding the evidence that is being presented to them and to assist the jury in being able to decide the facts, which you are ultimately going to have to do.

So, with regard to these

expert witnesses, in the Superior Court, in order to make sure that both sides understand exactly what kind of opinion these types of experts are expected to give during the trial, and I say exactly and I'll rephrase that somewhat.

There is a rule in Massachusetts Superior Court which is called expert disclosures it's Rule 30B of the Massachusetts Superior Court Rules.

So, I am going to read to you the pertinent part of the rule so you understand what the lawyers are talking about when they talk about disclosures and what may or may not be required to be included in a disclosure.

So, the rule reads, in pertinent part, "Each party" -- so that means the plaintiff or plaintiffs on the one hand, the defendant or defendants on the other

hand -- "Each party shall set forth the following information in the pretrial conference memorandum:" -- and this is something that is filed with the Court before the trial -- "the name, address and qualifications of each expert a party intends to call, the subject matter on which the expert is expected to testify, the substance of all facts and opinions expected, and a summary of the grounds on which each expert's opinion as detailed, as would be expected in an answer to an expert interrogatory."

And, again, interrogatories are those written questions that are sent to witnesses and that they're expected to answer in writing under oath.

"The information as set forth in the pretrial memorandum must be signed by that expert."

So, again, it's a summary of

what the expert is expected to say, the substance of facts and opinions upon which the witness is expected to testify, and the subject matter on which the witness is expected to testify.

"Furthermore, the" -- I am reading further from the rule, "the signature of the expert is a certification that the disclosure accurately states the subject matters on which the expert is expected to testify, the substance of the facts and opinions to which the witness -- the expert is expected to testify, and a summary of the grounds for each opinion to which the" witness be -- I'm sorry -- "the expert is expected to testify at trial."

So, to the extent you're hearing about disclosures, that's what it is. It is something set forth, filed with the Court prior to

trial during a pretrial conference.

And that is what it set forth in that disclosure and the disclosure -- there is no requirement that a particular person write out the disclosure, but the expert is actually required to read it and certify it by signing it that this is an accurate disclosure of the expected testimony.

You have also been hearing over the course of the trial and more specifically in the context of these questions so if it's about the disclosure today about a number of different articles and books.

You have heard testimony at various points about it. But just so that there is no confusion about disclosure and the need to include within that disclosure any indication of any article or treatise or book or pamphlet on an area of, in this case, medical

terminology or medical opinions, that is not required to be included in expert disclosure as such.

It may be part of what would fit within what I have just described, but it is not required that that be disclosed.

Furthermore, with regard to our rules, we have both a statute, a law on our books. We have hundreds of these chapters and sections. And, also, you may have heard me refer earlier, perhaps not, to the Massachusetts Guide to Evidence.

That also explains the nature -- the manner in which if a particular party is expecting to use such treatises or pamphlets or booklets on a particular area of science and to utilize them with expert witnesses as they examine expert witnesses, if the party who is offering the expert, so, in other words, if the defendant calls the

expert, the defendant would be required to do this.

If the plaintiff calls the expert, the plaintiff would be required to do this.

And that is to give a list of any of these particular scientific journals, let's say, or books or treatises to the other party in advance and to indicate I intend to ask my expert questions from these materials.

On the other hand, if it is the other party, so, in other words, if the plaintiffs' or the defendants' expert witness is testifying, when the other party is entitled to cross-examine the witness, they are not required to disclose those names.

So, you only have to disclose the particular documents in advance if you, as the offering party, the person who has called

that witness as your expert, has -- is expected to testify during your questioning, direct questioning of the witness about these particular documents.

For cross-examination purposes, it is not required that the party that is either offered as a witness, because, obviously, they don't know if the other side is going to cross-examine about, or the person who is -- the party that is cross-examining, it is not required that they put out this particular list.

So, hopefully that will clarify in some ways the nature of the questioning that is going on here right now. I'm sorry.

JUROR: A specific question. In scientific journals of particular --

THE COURT: I can't answer questions about the facts like that.

JUROR: No, it's not about facts. I'm just saying if they list the name of a journal, they have to have the specific issue of the journal.

THE COURT: I am not going to answer that question. I just want you to understand the procedure that's being discussed here. Okay? All right. So, we're ready to resume.

MR. SOBCZAK: Thank you, Your Honor. Yes, Your Honor. And in light of the Court's instruction, at this point, plaintiff would offer into evidence, I think it's for ID, plaintiffs' notice of the articles.

THE COURT: Yes.

MR. SOBCZAK: May I approach the witness?

THE COURT: Yes.

(CROSS-EXAMINATION OF KENNETH MILLER, M.D., CONTINUED)

BY MR. SOBCZAK:

Q Doctor, is this one of the lists -- is this the only list of arguments that you saw in preparation for your testimony today?

A This is the only thing I saw signed by you.

Q You did or didn't?

A Yeah.

Q So, you saw that part?

A I believe so, yes.

Q Okay. And it includes entire books, such as the PDR, as well as sometimes the single article, like a one-page flier, correct?

A Yes.

Q So, it has sometimes entire volumes and sometimes very specific articles on a particular issue, correct?

And during the break, did you get a chance to review your disclosure and make any of those changes or no?

A I didn't make any changes to anything, no.

Q Okay. Well, because, I asked you about the typos and you said you're going to make -- you made some and you have to understand that you drafted it.

I want to be fair to you if you want to make any changes to your typos, because you have disclosure --

THE COURT: Excuse me. There is no evidence of any typos. Let's please move on.

MR. SOBCZAK: Okay. May I approach, Your Honor?

THE COURT: Yes.

BY MR. SOBCZAK:

Q If you could turn to your disclosure, Doctor? And turn to page six. Are you there?

In the paragraph in the middle that starts with "Laboratory studies," do you see where you put the date 6/18/11?

A Yes.

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Q But then the evaluation was on 6/20/2012?
A Yes.
Q This all talks about the 2012 visits. So, the 2011 is just a typo, correct?
A That is a typo.
Q Okay. And I only bring this up -- it's not relevant. Your opinion doesn't change in any way. It's just in fairness to you.
I am concerned, though, if you could turn to the third page of your disclosure, where you specifically address the history of Ms. Doull as she was being cared for by the defendants. And your testimony is that you prepared the history, correct?
A Yes.
Q And you talk about a visit on March 2, 2011, correct?
A Yes.
Q I am going to hand you what's been

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marked as Exhibit 1, and it's a copy of the chart. That's one of the things that you reviewed in preparation for this case, correct?
A Correct.
Q Did you review it before or after Ms. McCann was able to uncover the covered-up areas?
A Before.
Q Before. So, you were in the same position as Dr. Genecin. You did not see what's behind the White Out?
A I did not see.
Q And is there a visit on March 2, 2011? I'll represent to you it's on page ten, so it will be faster.
A Counsel, there is a page here that is not readable.
Q These are copies of the -- on the bottom of each page, there should be a tiny little Bates number. If you go to page ten.
A Yeah.
Q Are you there?

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A I have page ten.
Q So, there is a visit on March 2nd, correct?
A Correct.
Q Then there is a March 7th T/C, correct?
A Yes.
Q So, it's not an inpatient visit, it's just a phone call. Then you talk about a March 10, 2011 visit.
A Excuse me?
Q In your disclosure, the next paragraph down, the one that you prepared, you talk about March 10, 2011, "Mrs. Doull was seen in followup for her asthma."
Please point to the jury where is the record for this March tenth visit?
A It's April 10th.
Q Yes. I mean April 10th, sorry. April 10, 2011.
A Are these the records of chiropractor Dean?

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Q No, these are the records of --
A Because that's what that sentence implies, not that she was seen by --
Q You're saying that when you wrote on March 10, 2011, "Mrs. Doull was seen in followup for exacerbation of her asthma," are you saying that that was at the chiropractor, not with --
A So, the next line is, "She was seen by K. Dean for acupuncture."
Q Okay. So, are you saying that's the same thing, not --
A That's what I assume.
Q Well, it's you who wrote this. I don't want you to assume. If that's' what you mean --
A There is no note.
Q Because there is no records, correct?
A I don't see one in the material here. I --
Q I will represent to you that there has been no records from the chiropractor in this case.

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A **Excuse me?**
Q There has been no records from the chiropractor in this case concerning this visit.
So, I am trying to find out if you had a different version of the chart that may have additional visits that we don't have.
MS. DALPE: Objection, Your Honor.
THE COURT: Sustained.
A **Counsel, my understanding is that, in somewhere in this chart, there is a reference that on that day she was seen by a chiropractor for -- K. Dean, but I didn't -- I have no preferences on specific dates.**
Q Can you find it?
A **I can't find it in the material here.**
Q Okay. Well, that's the only chart.
A **Right. Is it referenced somewhere later that she is seen on that date? I can go through all the records by**

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this afternoon, but --
Q Okay. Well, that's fine. I am trying to find out if there is more records. So, you're not certain, but you're pretty certain --
A **Well, I'm not saying who said this. I'm not saying that the --**
MS. DALPE: Objection, Your Honor.
A **-- physician said it. All I am saying is --**
THE COURT: Sustained.
A **-- it's a fact.**
Q Hold onto the chart, because we'll use it. And in preparation for this deposition, did you also review the Endocrine Society position standing with bioidentical hormones?
MR. SOBCZAK: May I approach, Your Honor?
THE COURT: Yes.
BY MR. SOBCZAK:
Q Did you review that?
A **I reviewed this.**

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Q Okay. And do you agree with their position?
MS. DALPE: Objection, Your Honor.
A **What specifically about this do you want me to agree or disagree?**
Q Well, do you agree that bioidentical hormones, particularly estrogen and progesterone, have been promoted as safer and more effective alternatives to more traditional hormone therapies --
MR. DUMAS: Objection.
BY MR. SOBCZAK:
Q -- often by people outside the medical community?
THE COURT: I'll see you at sidebar.
(SIDEBAR CONFERENCE)
THE COURT: What is the objection? Is this one of the articles that was listed in -- included in the list of the plaintiffs' -- all right. So,

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that's not your objection.
MR. SOBCZAK: I.
THE COURT: Would you please let them tell me why they're objecting?
MR. DUMAS: There has been no foundation established by this witness that this is an authoritative source as required by Sneed.
THE COURT: Okay.
MR. SOBCZAK: And I am asking you about something here as in addition to being listed in the disclosure, this was also an exhibit in Ms. Foster's deposition.
THE COURT: Well, you still have to, before you can question him on it, ask him whether or not he accepts the society or the articles' authors as being authoritative.
MR. SOBCZAK: Okay.
(END SIDEBAR CONFERENCE)
BY MR. SOBCZAK:

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Q Dr. Miller, are you familiar with what the Endocrine Society is?
A No.
Q So, you don't know that it's the largest professional organization of doctors dealing with --
MR. DUMAS: Objection.
THE COURT: Sustained.
You're not to testify about it. You may ask him if he is familiar with it.
BY MR. SOBCZAK:
Q Do you find them to be authoritative in the --
A I am not an endocrinologist. I don't know which subspecialty of endocrine is authoritative or not authoritative. It's outside my area of expertise.
Q And that particular position statement was attached to Ms. Foster's deposition, correct?
MS. DALPE: Objection, Your Honor.

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THE COURT: Sustained.
A I don't recall reading this attached to her deposition.
Q Well, you reviewed Ms. Foster's deposition and you know that there were three statements that were introduced as exhibits and she was asked about them, correct?
A Yes.
Q And you coming here testifying about this looked up those three articles and prepared, correct?
MS. DALPE: Objection, Your Honor.
THE COURT: Sustained.
BY MR. SOBCZAK:
Q In preparation for this testimony here at trial, did you take the steps to review the three articles that were used at Ms. Foster's deposition?
A I reviewed more than 20 articles in reference to this material, which I provided on my list, dealing with

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the controversy that you're addressing.
Q Okay. Doctor --
A I don't think it's relevant. This is not my area of expertise. It is -- I reviewed this as a balance presentation and because it was brought up.
Q Doctor, --
A So, it's -- I supplied you more definitive articles and the references.
Q Doctor, can we focus on the question? This is not your first time testifying, correct?
A Correct.
Q The question is, you reviewed Ms. Foster's deposition transcript, correct? You certainly are not saying that what Ms. Foster testified to is not relevant to your testimony, correct?
A No.
Q In fact, because of the extremely

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limited notes in the medical records, --
MR. DUMAS: Objection.
THE COURT: Would you please not characterize things in that way? You're arguing your case again, you're not asking questions.
BY MR. SOBCZAK:
Q You would agree that majority of your opinion is based on what Ms. Foster testified happened, not what's actually documented happened, correct?
A No.
Q So, everything you testified to on direct you will be able to point to the jury in the chart?
A Yes. This does talk -- there is progesterone produced an increased incidences of thrombotic events, that caused this patient's CTEPH. I can document and definitively say the answer is no.
Q The question --

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A And is there literature documenting, which I supplied, worldwide, overwhelming, with no other points of view saying that? The answer is yes.

Do these representable societies, including what you have quoted from your other expert, documenting that progesterone in any form, even though this is not the form we're discussing today, is associated with increased risk of thrombotic events? The answer is no.

And that's the part which I consider relevant. With regards to acupuncture and other things in the chart, with regards to biosimilars, I am not an expert on that.

But I am an expert on clotting disorders and blood disorders. Progesterone does not cause an increased thrombotic event, and I supplied the jury, hopefully

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to you, hundreds of articles in hopefully a balanced way.

MR. SOBCZAK: Your Honor, move to strike. And would you please instruct the witness to actually answer the questions posed?

THE COURT: Well, I am not going to strike the answer except for what he might have supplied. You are not to consider that, but will you just listen to the questions, Doctor?

BY MR. SOBCZAK:

Q Doctor, the question is simple. What you testified to, you are going to be able to point in Mrs. Doull's chart for every single thing that you blamed, correct?

MS. DALPE: Objection.

MR. DUMAS: Objection.

BY MR. SOBCZAK:

Q Or did you rely on Ms. Foster's testimony for many of the parts?

MR. DUMAS: Objection.

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MS. DALPE: Objection, Your Honor.

THE COURT: Sustained.

A I relied primarily in the charts.

MR. SOBCZAK: Sustained.

BY MR. SOBCZAK:

Q Okay. So, you relied on the charts?

THE COURT: Sustained.

BY MR. SOBCZAK:

Q So, it's your position that Ms. Foster's testimony was not relevant to your review?

A I did not say that.

Q So, it was relevant?

A Yes.

Q And in preparation, you reviewed her testimony and all the exhibits that were marked at her deposition?

A I reviewed the deposition. I don't know if I reviewed all the marked items as well.

Q Okay. So, you don't recall if you reviewed this, but looking at it now, your memory is that you

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probably did not?

A I reviewed this article. I am not sure I reviewed it as far as an attached deposition.

Q Okay. So, you have reviewed it prior to today and do you agree with their holding?

MS. DALPE: Objection, Your Honor.

THE COURT: With regard to this, you need to lay the foundation.

BY MR. SOBCZAK:

Q Did you read it?

A Yes, I believe so.

MS. DALPE: Objection, Your Honor.

THE COURT: He has already --

BY MR. SOBCZAK:

Q Okay. Did you understand it?

A Yes.

Q And did you agree with it?

MS. DALPE: Objection, Your

Honor. Foundation.
A Counsel, there were multiple statements in this article. What do you want me to --
THE COURT: Excuse me. Doctor, sustained at this time. You have to lay a foundation. And the proper procedure, Mr. Sobczak, is to specifically point to the statement or statements --
MR. SOBCZAK: Okay. I'll break it down.
THE COURT: -- that you wish. But the foundation is necessary first.
BY MR. SOBCZAK:
Q Did you read the first introductory paragraph?
THE COURT: That is not the foundation. Would you please lay a proper foundation?
MR. SOBCZAK: That is a foundation for the document that eh reviewed in preparation, Your Honor.

I am not using Sneed.
MR. DUMAS: May we be heard?
MR. SOBCZAK: I am using documents in preparation for trial testimony.
MR. DUMAS: May we be heard briefly?
THE COURT: Yes.
(SIDEBAR CONFERENCE
MR. SOBCZAK: I am not using Sneed, Your Honor.
THE COURT: It doesn't matter. You are using something that's a nature of a learned treatise while cross-examining an expert witness. You have to follow the rules, which means you need to first -- and I am reading from the Massachusetts Guide to Evidence, Section 803, 18B.
"To the extent called to the attention of an expert witness upon cross-examination, statements," not the entire published treatise,

etcetera, but "statements established as a reliable authority by the testimony or admission of the witness."
MR. SOBCZAK: Or other experts or the Court. Dr. Genecin already maintained it reliable. If the Court is going to make a ruling now that it's not reliable, then I will move on.
But there's two or's in there, Your Honor.
MR. DUMAS: Sshhhhhh.
MR. SOBCZACK: You can't focus on one and ignore the other two. So, therefore, Dr. Genecin has already established it as credible. I am again moving for the Court to determine if it's credible or not.
THE COURT: Well, I am not finding from that specific finding. But this witness has already said he's -- you can certainly show it to him, but he has already acknowledged

that he doesn't know because he is not an expert in this particular field, Endocrinology.
MR. SOBCZAK: And Sneed does not require the actual witness to acknowledge it. That's why there's two or's in there. It's the witness, it's any other expert, or Court.
It's already been established by another expert.
THE COURT: I'll let you ask him, but go ahead Mr. --
MR. DUMAS: Your Honor, just one comment on this.
THE COURT: Mm-hmm.
MR. DUMAS: He is again trying to circumvent Sneed by saying it was something that he looked at in a deposition as an exhibit.
Nurse Foster specifically testified when she was shown it at her deposition she had no idea what it was. She doesn't know what the

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Endocrine Society is. It's just improper.

THE COURT: Well, I don't consider the mere fact something is attached to a deposition of another witness as getting it in through the back door.

MR. SOBCZAK: Your Honor, the part that you have read, you stopped at or. The second part is "or another expert or Court."

THE COURT: Well, relevance is --

MR. SOBCZAK: Dr. Genecin has already established --

THE COURT: Well, you may ask the question, but we need to move on. You keep beating the same horse.

MR. SOBCZAK: Because I am asking the Court to follow the rules.

MR. DALPE: Your Honor, Dr. Genecin did not admit that it was

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authoritative. It did not come in through the 40 pages of the very abbreviated direct exam.

THE COURT: Well, I'd have to look back at Dr. Genecin's testimony. I will do that during the break. I am not going to do it now.

MS. DALPE: Thank you.

THE COURT: Move onto another topic.

(END SIDEBAR CONFERENCE)

BY MR. SOBCZAK:

Q So, Doctor, just to be clear, you do not find Endocrine Society authoritative, correct?

A I didn't -- I just -- I'm not aware of the Endocrine Society.

Q Never heard of them?

A No.

Q Okay.

A I am not -- each society has multiple organizations, some of which represent their society and

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some of which just their name.

Q That's fine.

A I'm not an endocrinologist.

Q In fairness, I will not ask you about that. I'll take it back.

MR. SOBCZAK: Can we mark this for ID, Your Honor?

THE COURT: Yes.

BY MR. SOBCZAK:

Q You are familiar --

THE COURT: Is that SS or are we farther along?

THE CLERK: VV.

THE COURT: VV. I'm sorry.

BY MR. SOBCZAK:

Q You are familiar with the JAMA, correct?

A Yes.

Q In fact, you're a reviewer for them, correct?

A In the past, yes.

Q And you find it to be a credible journal?

A Yes.

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Q And did you review the article in JAMA about informed decision-making in outpatient practices?

MS. DALPE: Objection, Your Honor.

MR. DUMAS: Objection.

THE COURT: I'll see you at sidebar.

(SIDEBAR CONFERENCE)

THE COURT: And what is your objection?

MS. DALPE: Well, to start with, Your Honor, this is a very specialized expert in Hematology. The article just on the face of the title sounds like it is a standard or is an attempt to get the expert to comment.

THE COURT: Well, the article itself cannot be admitted into evidence. The statements from it can. You may show it to him.

If he has acknowledged -- he has acknowledged that JAMA is

authoritative -- well, he hasn't actually said that, but he said he's been in the past been a reviewer for them.

But you may show him, point his attention to a particular statement in here. Go ahead.

MS. DALPE: As the statement to plaintiffs' attorney opens the door to standard of care, then I will not be precluded from asking this expert standard of care questions.

So, my meaning is plaintiff has specifically requested that I not present duplicative evidence, and I am trying in good faith not to do that. But should he open the door to standard of care.

THE COURT: Absolutely. If he opens the door to standard of care on redirect, you may address that.

MR. SOBCZAK: And it will be

redirect with the scope of the de-disclosure.

THE COURT: No, it will be redirect within the scope of your cross-examination. So, if you're going in that direction, you're treading on thin ice.

(END SIDEBAR CONFERENCE)

BY MR. SOBCZAK:

Q So, going back to my question, Doctor. You are familiar with JAMA?

A Yes.

Q And you find them to be an authoritative journal?

A Yes.

MR. SOBCZAK: And may I approach, Your Honor?

THE COURT: Yes.

BY MR. SOBCZAK:

Q And in your preparation, did you review the article by Dr. Berwick et al?

THE COURT: After the doctor finishes reviewing it, this is may

be marked as WW.

A I did not specifically review this article prior.

Q You did not. Okay.

Did you review the article by Dr. Leape about What Practice Will Most Improve Safety: Evidence-Based Medicine Meets Patient Safety?

A I did not review Lucian's article.

Q Are you familiar with the IOM studies in patient safety?

A No.

Q Are you familiar with the IOM?

A No.

Q Are you familiar with the Institute of Medicine from the National Academies?

A Excuse me?

Q The Institute of Medicine from the National Academies. Are you familiar with their initial study, To Err is Human?

MR. DUMAS: Objection, Your Honor.

A No.

Q No? Are you familiar with their publication, Patient Safety: Achieving a New Standard of Care?

MR. DUMAS: Objection.

MS. DALPE: Objection, Your Honor.

A May I see it?

THE COURT: Well, he may either say, yes he is or no he is not.

A No.

Q In your practice, you don't deal with patient safety studies and --

MS. DALPE: Objection, Your Honor.

THE COURT: He's already --

A No, I don't write patient safety.

Q Say again?

A I don't write articles and lecture about patient safety.

Q And do you review them in your CMEs?

MS. DALPE: Objection, Your Honor.

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A Somewhere, there may be some line about patient safety. I don't recall.
Q You're not a member of the Patient Data Safety Committee?
A No. Different -- I am a member of the Safety Data. That's a different organization. I have been a member of two international studies. I was a chair and a member of the safety committee. That has nothing to do with what you're discussing.
Q What does your safety committee have to do with?
A Evaluating critical studies and to see if there are adverse events.
Q Adverse events as in, like, when patients get hurt, correct? Adverse events are when patients get harmed?
A Associated with the treatment.
Q And so, this is something that you have been a member of?
A Yes, I chair and I am a member of prior committees evaluating those

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reports.
Q And you are familiar that, as of most recently, more than 400,000 patients die each year according to --
MR. DUMAS: Objection.
THE COURT: Sustained. The jury will disregard that question. That is not a proper question. Please move on.
BY MR. SOBCZAK:
Q Are you familiar with the results of the committee that you're a member on?
A I'm familiar with what has been published, yes.
Q And this is --
A But I'm not familiar with everything that's been published by committee -- my committee.
Q You're don't review everything, but you're familiar with the major findings of the committee of which you are a member of, correct?

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A Council, I was part of a specific study, I know the study results of the study. And it has nothing to do with what we're talking about here, but --
Q Okay. What was the specific study that you were talking about?
A There were two specific studies looking at chronic lymphocytic leukemia, looking for minimal residual disease with randomization between a certain drug and a non-drug.
It was a very, very technical study. It was a European trial.
Q Okay. So, it's very, very niche. It wasn't a global patient safety study?
A Yes.
Q You were focused on a particular issue? Nothing to do with progesterone?
A It had to do with my field of

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expertise.
Q Looking at that. And that's your specialty of --
A Right.
Q -- videos all over the Internet, correct?
A No, leukemia is one of my areas. Hematology is my specialty.
Q Do you agree, Doctor, --
MS. DALPE: Objection, Your Honor.
MR. SOBCZAK: Your Honor, may I ask the question before I get objected to? What's the objections that you agree to so we can get the record straight?
THE COURT: I think perhaps that's a worthwhile observation.
MR. SOBCZAK: What's your objection?
THE COURT: There was an objection. The question hasn't been asked. The question may be asked before there is an objection.

BY MR. SOBCZAK:
Q Doctor, do you agree that doctors and their extenders must disclose to their patients all material information about their care so the patient has the right to know and make a fully-informed decision?
A I can't -- no, I don't agree completely with that statement.
Q You don't. Okay. Doctor, do you agree that doctors and their extenders must timely investigate and diagnose their patients' causes of pain or complaints?
A Say that again.
Q Do you agree that doctors and their extenders, such as nurse practitioners, must timely investigate and diagnose their patients' causes of pain or complaints?
A I really don't know what that statement means to agree or not agree.

Q That's fine if you can't agree. Did you review Dr. Miller's deposition testimony and Nurse Foster's testimony when they agreed to those statements?
A Yes.
Q But you didn't understand what they meant, so that's why you can't agree to it?
MR. DUMAS: Objection.
THE COURT: Would you please not make comments? You may ask questions, Mr. Sobczak. The jury will disregard that comment.
BY MR. SOBCZAK:
Q Your position is that you cannot agree or disagree to the statement because you don't understand it?
A I can't agree these statements are general statements. Out of context, do doctors do good things -- try to do good things? Yes.
Do we try to evaluate our patients correctly? Yes. These

blanket statements, difficult to say I agree or disagree, but --
Q Okay. So, you're saying it's too global, it's off context; you need to focus specifically on Ms. Doull, correct?
A I deal with the sickest patients in the hospital, so.
Q Okay. So, let's go back to Mrs. Doull. One of the things that the defendants asked you on direct is about Tab E. Could you go to the book, please?
A Excuse me?
Q The jury book.
THE COURT: There is a black book to your left.
BY MR. SOBCZAK:
Q Whichever one you feel is easy, that's fine, yours, the Court's.
A They're the same.
Q Tab E, echo. This is the June 20, 2012 note from the gynecologist, correct?

A No.
MS. DALPE: Tab E, not Tab B.
BY MR. SOBCZAK:
Q E.
A E.
Q As in echo. Sorry.
A I'm in B.
Q No, E, E. The GY one.
A Yes.
Q And this is the note that was brought to your attention specifically on direct examination because you say that this gynecologist recommended the use of progestin, correct?
A Yes.
Q Correct?
A Do you want me to read the line?
Q No. I'm just asking you if that's what the note is.
A The line says, which is what I agreed with, "Patient not a good candidate for estrogen. However, a

progestin, or Lupron may be of benefit."

Q And the next line?

A "Once the patient is stable, will plan to discuss options with her."

Q Okay. So, at this point, the doctor has not made any orders for the patient, correct?

A He is a consultant. He makes a recommendation.

Q He is making a recommendation for the patient and acknowledges that the patient is still unstable and they have not discussed it with this patient, correct?

And it was your position on direct that at the time this recommendation was given, this doctor obviously must have known about Mrs. Doull's prior progesterone use, correct?

A No.

Q Okay. So, this doctor still had an incomplete picture; would you agree

with that?

MS. DALPE: Objection.

A I don't know if --

THE COURT: Go ahead. You may answer the question.

A What is the question?

Q The question is, is it your position that at the time, this doctor, that was specifically asked of you on direct, was specifically put into the defendants' selected jury book, had a full picture of Mrs. Doull's health and that's why he was able to recommend progestin or Lupron?

A Yes, present health.

Q Okay. Point to the jury where on those three pages it identifies that this doctor was aware of the history of progesterone use by Ms. Doull?

A It's not. It's irrelevant. How this patient is at this time and what is the role, which is her best agent to prevent further ovarian cysts, you have a choice of

estrogen, estrogen plus progesterone, or Lupron.

Which is the best for the patient at this time? Her past -- I don't know. Her past history outside of her having CTEPH, pulmonary emboli, and an unstable high-risk patient.

The consultant said overall the safest agent is not estrogen. The safest agent is progesterone or Lupron.

Q And what did the consultant actually recommend to the patient once the consultant had spoke with the patient? Is that in the defendants' jury book?

A Discussed with the patient?

Q Yes. You understand that this is --

A Right. So, it's those two options for the patient. He left it at that.

Q That's it? So, it's your testimony that this is where this doctor left

it at?

A He thought Lupron was a good choice and progestin was a good choice.

Q And what happened next, Doctor?

A The patient declined. She did not want to receive hormonal therapy. And the consultant then referred her back to her primary care to probably receive Lupron, though talked to them about the side effects of Lupron.

Q And that's not in the jury book, correct, that's --

A No.

Q But that's one of the records that you did review --

A That's a separate note.

Q Okay.

Q You reviewed a different version from today?

A Yes.

Q Is that the note you're referring to, Doctor?

A Yes.

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Q Yes?
A **I received this note.**
Q So, in fact, progestin was never ordered for Ms. Doull at Brigham and Women's, correct?
A **Yes.**
Q Okay. And in fact, progestin or progesterone was never ruled out as the cause of Ms. Doull's PE and CTEPH at Brigham and Women's, correct?
A **It wasn't addressed.**
Q It was never ruled out, correct? You reviewed all of the records?
A **Well I thought it was the safest product for her considering that she had prior embolic events, had CTEPH, that progestin was the safest product. It was not addressed.**
Q It wasn't addressed anywhere in the 5,000 plus pages of Brigham and Women's?
A **Oh that was a remarkable thing,of the 10,000 pages of 200 Doctor's**

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seeing this patient, extensive review of her history, not one physician thought that progesterone cream was implicated in the development of her PE.
Q Doctor, the question is did -- of those 10,000 pages, 200 plus doctors, did one physician document ruling out progesterone?
A **No.**
Q Okay. And you understand, that's how differential diagnoses works? When you're dealing with a specific patient, like Laura Doull, and you have a list of likely causes, you rule them out. And in your review of the 10,000 pages of records, 200 plus doctors, did a single doctor rule out hormone therapy or progesterone as the cause of the PE?
A **No.**
Q But you did review those 10,000 pages, 200 plus doctors, and they did rule out blood disorders,

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correct?
A **Correct.**
Q And they did rule out cancer?
A **Correct.**
Q And your position is that nobody potentially even considered progesterone as the cause of PE, in your review of 10,000 plus pages, 200 plus doctors, correct?
A **No, that's not what I said.**
Q Okay. So, you are aware of multiple doctors that ruled in progesterone as a likely source, correct?
A **No.**
Q Doctor, I'm going to go to Exhibit 8, which are the records from Dr. Landis. You're familiar with Dr. Landis, correct?
A **Yes.**
Q He was the pulmonologist that actually saw Ms. Doull for several months?
A **Yes.**
Q And those are some of the multiple

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thousands of pages of records that you saw, correct?
A **Yes.**
Q And this is the office note from June 13, 2011. Is that the newer jury book that you have in front of you?
A **What? I'm near a document but what is in my jury book?**
Q I said, is this note in your jury book?
A **I, I ---**
Q It's not?
A **I don't know.**
Q So, that's fine, we'll go through the records. Do you see the letter that Dr. Landis wrote to Ms. Doull's new PCP?
A **Yes.**
Q Could you please read that to the jury?
A **Well --**
Q Could you please read what's been admitted as Exhibit 8 and of all the

documents that you reviewed in preparation for coming here and giving testimony?

A **"Dear Stephanie, Laura Doull was seen today. Her Factor V Leiden was negative, and I suspect the reason for her hypercoagulability has been the progesterone agent that she has been taking."**

"She has stopped that and I informed her of her INR today. It was on the low side, so I had her take 7.5 milligrams of Coumadin today and continue with 5 milligrams for the rest of the week and have her INR repeated on Friday."

Do you want me to read more?

Q No, that's enough. So, you agree, at least Dr. Landis, suspected the progesterone agent, correct?

A **Well, he thought she was taking pills.**

Q Where do you see pills?

A **In one of his notes he said she was**

taking pills.

Q In the letter he wrote --

A **It doesn't say she was taking progesterone agent, period.**

Q In your --

A **She was taking --**

Q -- review of all these extensive medical records, how many hormone therapy agents did you see Laura Doull was taking in this case?

A **One.**

Q What was that?

A **Progesterone cream.**

Q And you didn't see any references to estrogen in the chart?

A **Well, there was a misprint by Dr. -- by Nurse Foster.**

Q So, you are basing your opinion that it's a misprint according to Ms. Foster's testimony, correct?

A **And the records from the pharmacy.**

Q That would be the records from which pharmacy?

A **The Women's International Pharmacy,**

the compounding pharmacy.

Q And the note in September of 2009, where it says "stay with by S," is right after this year plus gap of no records from the Wisconsin pharmacy, correct?

A **Correct.**

Q So, at that point, Ms. Foster did not send any scripts or prescriptions, which are necessary, to Wisconsin to order the progesterone, correct?

A **Correct.**

Q In fact, if you look at the chart that's in front of you, there isn't a single document of a prescription order in the chart, correct?

A **Correct.**

Q You reviewed all the testimony and all those have been misplaced, correct?

MR. DUMAS: Objection.

BY MR. SOBCZAK:

Q They're not kept?

THE COURT: Sustained.

BY MR. SOBCZAK:

Q All of these prescription orders from Dr. Miller's office have not been kept?

A **I didn't see any prescriptions, yes.**

Q Yeah. All we have are the singular, here and there, notes and the progress notes and the records from other pharmacies, correct?

A **That supplied -- that other -- the records from the other pharmacist that supplied the product to Ms. Doull.**

Q And those records were obtained from the pharmacist based on Ms. Foster's statement that that's the only place she ordered them from, correct?

A **Correct.**

Q Did you review the records from the Springfield pharmacy to see if estrogen was ordered from there?

MR. DUMAS: Objection.

MS. DALPE: Objection.

THE COURT: I'll see you at sidebar.

(SIDEBAR BEGINS)

THE COURT: Did you say records from the Springfield Pharmacy?

MR. SOBCZACK: Yes.

THE COURT: Where are we going here?

MR. DUMAS: Nurse Foster said she used two compound pharmacies for patients who needed compound medication.

THE COURT: Huh-hmmm.

MR. DUMAS: A pharmacy in Springfield and the Post Womens' International. A supeona was issued to the compound pharmacy in Springfield and they're are no records, this is grossly misleading to astray that they're are missing records or that there's some indication based upon on a lack of

evidence that she may have gotten something from somewhere else.

THE COURT: So, is the response to the subpoena that there are no records for a Laura Doull?

MR. DUMAS: They have no record of a Laura Doull getting a prescription from there.

THE COURT: Well, unless you have an offer of proof that there was such records.

MR. SOBCZACK: No, no I don't.

THE COURT: Well then you should not be asking about the Springfield Pharmacy because it suggests that there is something there that's not being produced.

MR. SOBCZACK: There is nothing there, that's the point. That's the point.

THE COURT: You know why you're asking that question. Stay away from things unless you

have a offer of proof that backs up even asking about another pharmacy, I think I'm going to instruct the Jury that there is absolutely no evidence that anything has ever been prescribed to Laura Doull in the pharmacy in Springfield.

MS. DALPE: Thank you.

(SIDEBAR ENDS)

THE COURT: Members of the jury, just so there's no confusion, there's no evidence that there was ever any medication prescribed to Laura Doull from a pharmacy in Springfield.

BY MR. SOBCZAK:

Q Do you know of any other pharmacies that Ms. Foster used?

A She used CVS, Walgreens, that's the only things I recall specifically.

Q And the only thing you can talk to are the ones that Ms. Foster testified to during her deposition, because her medical records are

completely silent as to any other pharmacies, correct?

MS. DALPE: Objection, Your Honor.

A What's the question?

THE COURT: Overruled.

BY MR. SOBCZAK:

Q The medical records are silent as to the all prescriptions that -- where they were sent, to what pharmacy?

A There are notations in the medical records that pharmacy was sent to CVS or Walgreens. So, there is documentation of that.

Q There's some references to Baker's?

A Yes, Baker's, yes.

Q Baker's. But there is no -- a prescription log or copies of the all prescriptions. All we can -- all we have -- all you had, for your review, is the limited information that's in the medical record, correct?

A I don't like the adverb. All I had

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from my review is the medical records.

Q Well, I'm getting -- we're starting it. Just like Ms. Dalpe went through with you the list of things you reviewed --

THE COURT: Would you please not refer to what other people have done?

MR. SOBCZAK: Okay.

THE COURT: Would you refrain from that sort of commentary? Please just ask a question of the witness and answer.

MR. SOBCZAK: Okay.

BY MR. SOBCZAK:

Q So, Doctor, I'm going to ask you a multi-part question. In order to be fair, I'm going to stop after each step. I am not done yet, okay?

So, in your preparation, what you had to review is the chart which has limited notes about where prescriptions were being sent to,

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correct?

A I can't answer that question because the word "limited" implies a negative tone. What I reviewed was the charts and the medical records and the documentation, period.

Q Okay.

A Sorry Counselor.

Q Okay, that's fine. I will not use the word limited. You reviewed the chart. You agreed that there is an -- I'll go back. You testified that Laura Doull was prescribed progesterone on April 2008.

Do you remember that from your direct testimony?

A Yes.

Q Now, that's, again, just a small mistake. It was August of 2008.

A I'm sorry. That's correct it's August of 2008.

Q And you agreed that the only way --

A And even my note says August of 2008.

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Q Correct. So, it's the same, right?

A In my deposition it was 2008 and in the chart it was 2008.

Q Correct.

A There's a lot of dates. I apologize.

Q April was just a misstep.

A Yeah.

Q But all that's in the record is the August of 2008 note that says progesterone 100 milligrams h.s. 14 to 28, correct?

A Correct.

Q There is no copy of a script that would include how to be applied, whether it's topically or any other way, correct?

A Correct.

Q There is no copy of a script that would have been faxed to a pharmacy, correct?

A Correct.

Q All you had is that note, and on the subsequent page, the actual notation

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when it was called to the patient on 8/11/08, correct?

You don't have a subsequent script on September of 2009 where -- what was prescribed specifically for Ms. Doull, correct?

A Right -- .

Q You don't have a copy of a --

THE COURT: Would you permit him answer the question before you move on to the next one?

MR. SOBCZAK: He said no, but I'll slow down. I apologize. I do talk fast.

THE COURT: If you don't mind. Thank you.

BY MR. SOBCZAK:

Q You don't have a copy of a script from September of 2009 that specifically is written out with drug name, dosage, and how to be applied, correct?

A Correct.

Q All you have is, again, a tiny note

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in a chart that references Biest, correct?
A Again, I just -- the adverb. I have a note in the chart.
Q Okay. All you have is a note in the chart that says "Stay with Biest," correct?
A Correct.
Q And you understand Biest to mean bioidentical estrogen, correct?
A That's what that abbreviation means --
Q Yes.
A -- but she mentioned she did not receive -- there's no notification that she ever received estrogen.
Q Because from thereafter, there are records from Wisconsin pharmacy that she was being sent progesterone cream, correct?
A Correct.
Q And she was being sent progesterone cream every time the practitioner would fill out a script, correct?

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A Yes.
Q And on your direct, you made a comment about Ms. Doull being noncompliant with her drugs, but you reviewed the Wisconsin pharmacy deposition, didn't you?
A Yes.
Q And you saw that the times when Ms. Doull was being noncompliant is because the provider failed to send over the new script, correct?
A Sometimes, but the initial gap between August and the following September, I'm not sure that was due to the failure to send the script.
Q Well, you reviewed the deposition transcripts, didn't you?
A Right, but some of times was the failure of -- I'm not sure that long interval was.
Q Well, we'll get to that next. You remember that Ms. Foster swore that Ms. Laura Doull was on progesterone cream that entire year, correct? In

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fact -- yes?
THE COURT: Would you finish - let him?
MR. SOBCZAK: Yes.
BY MR. SOBCZAK:
Q Was that a yes?
A Yes.
Q Yes. And in fact, she was picking out individual notes in the record in which she claims she specifically addressed progesterone cream, even though there was no reference of it, like the one in June of '09, correct?
A Correct.
Q That was before the records from Wisconsin pharmacy were obtained and showed that it was impossible for her to be on progesterone, correct?
A Yes.
Q So, to you, as a doctor that has been involved in multiple review of cases, when somebody has -- is telling you that they are doing

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something, there's no documentation of it, and then the documentation shows up and proves the opposite --
MS. DALPE: Objection, Your Honor.
BY MR. SOBCZAK:
Q -- what does that mean?
THE COURT: Sustained as to the form of the question.
BY MR. SOBCZAK:
Q In your review of cases, and when you have an issue where you have a practitioner telling you that they're doing something, there is no record of them actually doing it --
MS. DALPE: Objection on standard of care.
MR. DUMAS: Objection.
THE COURT: Sustained.
MR. SOBCZAK: It's the cross-examination of an expert and he's -- and he did testify about --
THE COURT: Well, as I said, it may open up the issue of standard

of care with this witness. Go ahead.
MR. SOBCZAK: And Your Honor, on direct he was asked about the gaps --
THE COURT: Please don't make arguments in front of the jury.
MR. SOBCZAK: I'm exploring the gaps issue.
THE COURT: You may --
BY MR. SOBCZAK:
Q So, Doctor --
THE COURT: Why don't you ask a question more specific to that and not extend it to what it means.
MR. SOBCZAK: Okay.
BY MR. SOBCZAK:
Q So, Doctor, you would agree that on the totality of evidence, the gaps were Ms. Foster's fault not Ms. Doull's fault?
MR. DUMAS: Objection.
MS. DALPE: Objection.
A I don't know.

THE COURT: Overruled.
BY MR. SOBCZAK:
Q You don't know?
A I can't answer that question.
Q Well, you have. It was the testimony from the pharmacist that tells you we can only send what we have orders for, correct?
A Correct.
Q What you have are the contemporaneous business records from the pharmacy showing that, each time there was a prescription that was due, they faxed the provider and asked him for a record, correct?
A Correct.
Q What you have is the testimony from Nurse Foster claiming that she's doing it all along the way, correct?
A Yes.
Q And what you have is your opinion that it's Ms. Doull being noncompliant with taking the cream that she couldn't get?

A On the documentation in the record that she said she was noncompliant.
Q That was the one -- the only time in the record that mentions noncompliance is in March of 2011, correct?
A Correct.
Q And if you recall reviewing the transcript from the Wisconsin pharmacy, that's one of the gaps, when they faxed the request for script in January and it wasn't until March 2nd that the script was sent in, correct?
A Yes.
Q Would you agree, Doctor, that you cannot take a drug for which you have no prescription for?
A That's a very broad statement. You can't take a drug from the compounding pharmacy without a prescription, yes.
Q Okay. And that's --
A What it's eluded to is available

over the counter. It -- yeah.
Q So, what you're saying is that Ms. Doull, although she was given a script by her provider, when her provider failed to refill the script, she should somehow, on her own, decide what is the compatible drug available somewhere else and get it on her own so she can continue the --
MR. DUMAS: Objection.
THE COURT: Sustained.
BY MR. SOBCZAK:
Q -- treatment that was ordered by --
MR. DUMAS: Objection.
THE COURT: Sustained.
BY MR. SOBCZAK:
Q That's not what you're saying. You're not saying that Ms. Doull should, on her own, decide how to replace the prescription that was not being refilled, correct?
A Of course not.
Q Okay. And in addition to that note

from Dr. Landis, you also reviewed the records from Greenfield Hospital, didn't you?
A Yes.
Q And that would be Exhibit 2. And did you review the note from August 9, 2011?
A Yes.
Q And did you read the history when Ms. Doull was apparently in good health until May 20, 2011? And you agree with that based on your review of the records, correct?
A Yes.
Q And then she was previously active and was going to the gym three times a week. You agree with that based on your review of records, right?
A Including in my records, yes.
Q And would you agree that somebody that is active and goes to the gym a lot and runs a lot, generally have a lower heart rate than a person that may be out of shape?

MS. DALPE: Objection, Your Honor.
THE COURT: Sustained.
BY MR. SOBCZAK:
Q As a doctor, do you deal with patient's heart rates?
MS. DALPE: Your Honor, I'd like to object on the issue of opening the door on pulmonology expertise.
THE COURT: Sustained.
BY MR. SOBCZAK:
Q You are an internal medicine doctor first, correct?
A No, I don't do general internal medicine.
Q But you did before you specialized. You are -- if you look at the board certifications, your first certification is internal medicine, correct?
A Correct.
Q And then you subspecialized, correct?

A Yes.
Q So, when you subspecialize, you don't forget everything you learned in med school as an internal medicine doctor, correct?
A Ultimitely not.
Q Okay. So, you are competent to testify on the issues that Dr. Miller is facing, who was just an internist, correct?
A I'm not testifying as an internist. I'm testifying as a specialist in hematology.
Q That's what the defendants called you for, but I asked you a question about internal medicine.
MS. DALPE: Objection, Your Honor.
BY MR. SOBCZAK:
Q Do you feel confident answering --
THE COURT: I will see you at sidebar, please.
(SIDEBAR BEGINS)
THE COURT: MR. SOBCZACK if

you continue to go down this road with this witness who says he's here to testify as a Hematologist, you resist on asking him questions about his expertise also as an internist. I will permit if, the defendants request, down to open up the standard of care for an internist with this witness. You are opening a front door, it may not be in the disclosure, it may not be what the witness was disclose to testify about but in redirect that may very well be a topic area that I will permit the defendants to go into. You're forewarned.
MR.SOBCZACK: That's fine Your Honor, this court has already let this go beyond disclosure anyway so it really makes no difference Your Honor. He is already testifying beyond the disclosure.
THE COURT: Well that's your Opinion. Go ahead.

MR.SOBCZACK: That's a fact Your Honor we have this disclosure marked for exhibit.
THE COURT: Please, continue Your questioning.
(SIDEBAR ENDS)
BY MR. SOBCZAK:
Q Do you agree that after initial admissions, she was worked up for genetic testing and she was being seen by Dr. Landis, correct?
A Excuse me? Can you say that again?
Q Sure. I'm just -- in order, so I don't ask you too many questions about what you are not disclosed for, I'm just moving along.
So, I'm going down to later on. She was worked up for pulmonary embolism, you testified to that on direct, correct?
THE COURT: Maybe you can point to him where on the chart.
A Right. Where are you?
Q I'm looking at the fourth line from

the bottom of the paragraph you can see.
"She was worked up for a pulmonary embolism and continuous and genetic testing has been done."
Yes?
A Yes.
Q And she's being followed by Dr. Landis at Baystate medical and he thinks the etiology for her pulmonary embolism was the progesterone cream, which she had been using two weeks during each month, correct?
A Yes.
Q So, that's in the medical records that you reviewed?
A Yeah. In this record, yes.
Q Yes.
A In other records he says she was taking oral progesterone. And also he was the physician who said she didn't have CTEPH.
Q So, are you telling this jury that

Dr. Landis was negligent in the care of Laura Doull?
A No.
Q What you are saying is that, somewhere throughout this record, he may have talked about a different form of progesterone, correct?
A Correct.
Q Just like the defendants pointed out to Dr. Genecin, whose testimony you reviewed, that in his initial disclosure, he said that the progesterone was to be applied vaginally not topically, correct?
A I can't comment on what --
Q Well, you did read his deposition?
A Not what he thought, but I --
Q You saw that line of questioning in preparation for today, correct?
A What's the question for that?
Q You saw --
A I saw that.
Q -- the line of questioning where the defense Counsel was questioning Dr.

Genecin opinion because he mentioned that the cream was applied vaginally and not topically, correct?
A I saw that.
Q And then you saw in the transcripts, as well as with your own eyes, that the record doesn't say how the cream was to be applied, correct?
A Correct, except from the information provided by the compounding formula gives clear instructions about how it's to be provided.
Q It's not, is it? And did you actually review the information that was provided by the compounding pharmacy?
A Yes they provide a picture, it comes with a certain spoon and it tells how much of the spoon to be applied. It shows the container. It shows you even how to take off the container top.
Q The picture that you saw was of the generic warning for all topical

applications, correct?
A Provided by the company.
Q And that was something that you saw that was provided from Wisconsin about three or four months ago, correct?
A Yes.
Q So, at the time, when Dr. Genecin was giving his initial review in 2013, all that was available was the limited pages from the chart that you have in front of you there, correct?
MS. DALPE: Objection, Your Honor.
THE COURT: Sustained --
BY MR. SOBCZAK:
Q You know --
THE COURT: -- as to the form of the question.
BY MR. SOBCZAK:
Q You know that at the time that the initial disclosure was made, all that was available were the select

pages from the defendant's chart, correct?
MS. DALPE: Objection, Your Honor.
THE COURT: Sustained. Do you know anything about what was provided to Dr. Genecin?
MR. MILLER: No.
THE COURT: Okay.
BY MR. SOBCZAK:
Q So, you did not review his trial testimony --
A I did reviewed the Doctor's -- and I did review that he thought -- in his deposition he thought it was vaginally, this compound can't be given vaginally.
It comes in a container. It's impossible to give vaginally. And anatomically, it's just not possible.
Q And my question to you, Doctor, is you know that now that you've seen the deposition from two months ago.

How can you tell that based on what's just in the defendant's records?
A The products cannot be given vaginally.
Q How do you know that based on what's in the records? Where does it say in the record that it is a topical only cream? Does it say anywhere in the record of the Miller/Foster records that it's a topical only cream?
A The product as provided, it can't be given any other way.
Q Doctor, can you answer the question posed?
A Was it specifically in the record, no.
Q Okay. In fact, it doesn't even say what type it is. It doesn't say that it's bioidentical or synthetic, correct?
MS. DALPE: Objection, Your Honor; asked and answered.

MR. SOBCZAK: No. That question was not asked yet.
THE COURT: He may answer the question. Can you answer that question, Doctor?
A It is not specifically addressed if it's bioidentical or synthetic, but in prior comments, the -- as Ms. Foster pointed out, that the patient was very interested in holistic, natural agents.
Q And that's based on Ms. Foster's testimony, because that's also not in the records, correct?
A It's based on her testimony and family member's testimony.
Q And Doctor, you agreed --
A At least three others.
Q And you agreed that the most reliable source is what's actually in the records, correct?
A That's correct.
Q Yes?
A Yes.

Q And in the records, there is no reference to what type of cream it is, correct? There is not even a reference whether it's bioidentical or synthetic, correct?
A Yes.
Q And you reviewed the deposition testimony of Dr. Miller, who testified that he doesn't know the difference between synthetic and bioidentical and progesterone is progesterone, correct?
A Yes.
Q So, as far as what's in the record and everything that existed until Ms. Foster was sued, all you have is progesterone 100 milligrams q.s. 14 to 28, correct?
A Correct, except we know where it was supplied from.
Q Subsequently?
A We know where she sent the prescription to.
Q Subsequently?

THE COURT: Are you arguing with the witness or are you asking --
MR. SOBCZAK: I'm asking.
THE COURT: -- him a question?
BY MR. SOBCZAK:
Q How do you know, based on the record alone, where the prescription was sent to? Specifically, go to page 43, I believe. That's the August of '08 note.
A Page? Where is it?
Q I gave you the wrong page. I think it's 44. 45 the August of '04 note, please tell the jury where do you see where this drug is coming from?
A It's not there. The prescription sent.
Q Say again.
A There's another note after this that a prescription was sent.
Q So, you're talking about the corresponding C4 that addresses it

being called in, correct?
A And since this prescription was sent, it was -- it had to be sent a compounding pharmacy.
Q Well, so this is the corresponding one. I want to be fair to you. So, are you talking about this note?
A I think that we had discussed before that prescriptions were sent and she documents she sent the prescription.
Q Where? Point for the jury. That's what I'm asking you, Doctor. You are here testifying that the record is mightier than the testimony, which I agree with you.
MS. DALPE: Objection.
BY MR. SOBCZAK:
Q Please point to the jury.
A I have all the record. There's a note here that says consent, and I thought we discussed that prescriptions weren't sent. And then I had records from the prescription company that it was

sent.
Q Doctor --
A And this is not a prescription item that you would send to CVS.
Q The question is --
A It's the only place to get it --
Q The question, Doctor, is since you testified it's in the records, point to the jury where it's in the records. I know you just went through your disclosure, so you have everything before you now.
You have the chart, you have your disclosure. Point to the jury the evidence behind your statements.
A Well, there's no record in the chart, that I see, of a sent prescription.
Q Okay. So --
A I had the records and prescription documentation from the compounding pharmacy, that they received the prescription, and this is the order that they filled.

The only -- it's only available by prescription from a compounding pharmacy, not from CVS, but I don't have a direct copy of the prescription.

Q Okay. So, in the defendant's records, no evidence that it was sent and to where?

MR. DUMAS: Objection.

THE COURT: Sustained.

BY MR. SOBCZAK:

Q Did you also review the records from Springfield Hospital, in your preparation for coming here today?

A I did.

Q And let's look at your report. And did you review the note on page 999. I think I pulled up the wrong records. It's 299. And you reviewed that note.

A I have --

Q I'm sorry. Did you review that?

A Yes.

Q And your testimony earlier was that

there was no evidence that Ms. Doull was exhibiting symptoms of PE prior to May 21, 2011, correct?

MS. DALPE: Objection, Your Honor.

THE COURT: Sustained.

BY MR. SOBCZAK:

Q Do you recall testifying that Ms. Doull had no risks for PEs and she exhibited no evidence of anything even remotely associated with PEs?

MS. DALPE: Objection, Your Honor.

THE COURT: Did you testify in that way?

A I said she had no history predisposing her to a PE. I never said the second sentence.

Q Okay. So, you agree that since mid-March she was experiencing shortness of breath, which is in fact a sign and symptom of PEs?

MR. DUMAS: Objection, Your Honor.

MS. DALPE: Objection, Your Honor.

MR. DUMAS: That's not what he testified --

MR. SOBCZAK: He did.

THE COURT: Well, did you -- was that your testimony?

A I don't think she -- the truth is she did not demonstrate any signs and symptoms of a pulmonary embolus prior to this event. Is shortness of breath a symptom of a pulmonary embolus, yes.

But, did she have any of the symptoms where you would think that she had a PE, no.

Q In your opinion, correct?

A Yes.

Q In the opinion of others, for example, like the doctor that saw her on the 22nd. The question that primary care providers alternate theory of shortness of breath, correct?

They put in the record that she has a history of progressive dyspnea since January of 2011 and did not seek attention at Bay State until May.

Her primary care physician had an alternate diagnosis of shortness of breath, correct?

A What did you say? That she had a prior pulmonary embolus in here?

Q The question, Doctor, is in the records I told you, she --

A I said the patient --

Q She had a history --

A -- progressive dyspnea and some right upper quadrant discomfort.

THE COURT: Could you point to the particular part of the record.

A I don't recall anyone else documenting a pulmonary embolus before this.

Q Right. There's no dispute. Nobody is saying that she -- anybody

diagnosed a PE.
A So, none of the people at the Brigham thought she had a PE before? None of the people at Franklin thought she had a PE before, nor did Dr. Silverman thought she had a PE before.
Q No. Nobody says that she was diagnosed with PE. Everybody over there thought she was exhibiting signs and symptoms of a PE.
THE COURT: Please don't make speeches. You may ask the witness a question.
BY MR. SOBCZAK:
Q Doctor, you agree that PE was never diagnosed prior to May 22, 23, 2011, correct?
A Correct.
Q In fact, you reviewed the testimony of Nurse Foster and Dr. Miller, who stand by the position that she never had a PE until she dropped that one night, correct?

A Correct.
Q What you see is the records from Springfield and Greenfield, that you reviewed, where doctor after doctor question whether the history of shortness of breath from March to May or, in here, from January to May, may in fact have been PEs, correct?
A I don't see that.
Q When a doctor puts in her note that the other physician had an alternate diagnosis, is that your --
A Can you point that out to me where it says that?
Q The last line.
A "The patient had progressive dyspnea and right upper quadrant discomfort." There's not PE in there.
Q Do you see the last line of the first paragraph you can see here? "Her primary care physician had alternative diagnosis including

shortness of breath." Do you see that?
A No.
Q You don't see that?
A What line is that? "Her primary care physician had alternative diagnosis for her shortness --." Yeah, I see that. That doesn't --
Q In your --
A -- but that doesn't say -- yeah, I see that line.
Q Okay. And in your business, calling something an alternative diagnosis is a polite way of saying they were wrong, correct?
MR. DUMAS: Objection.
MR. DALPE: Objection.
THE COURT: Sustained.
A No, the statement stands the statement.
Q And this is another record that makes the progesterone, correct? Do you see that where it says, "She was apparently initially evaluated

by a pulmonologist in May and felt to have multiple pulmonary emboli as the cause of her shortness of breath that has been ongoing since 1/21?
A Yes.
Q Do you still stand by your earlier testimony?
A Yes. There's no evidence in the medical records to justify that statement.
Q And the reason why there is no evidence is because --
A No, she never had --
Q -- is the defendants never ordered any tests. They never took full physicals. They never documented anything that was --
MR. DUMAS: Objection.
MS. DALPE: Objection.
THE COURT: This is argument, this is not a question, Mr. Sobczak. You may ask the witness a question.
BY MR. SOBCZAK:

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Q Now, I can go through all of the other ones, but you agreed then, in the Greenfield records and the Bay State records and Dr. Landis records, there are multiple instances where progesterone is linked as the likely cause of Ms. Doull's emboli, correct?
A No, it's from Doctor Landis, period.
Q That's it?
A And references are made to his opinion, by others.
Q So, then --
A Dr. Silverstein. But there was not a single record at Brigham and Women's Hospital, by any of their physicians, which is fathered rather remarkable considering it's mentioned before.
Q So, your position is that Dr. Landis is wrong and nobody else is right is ruled out for this correct? --
MR. DUMAS: Objection.
MS. DALPE: Objection; asked

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and answered.
THE COURT: Sustained. This question has been asked and answered. Please move on.
BY MR. SOBCZAK:
Q Your position is that you don't know what caused Laura Doull's emboli, correct?
A I know what didn't. I don't know what did.
Q No. Doctor, the question is, your position here, as this expert with great vast knowledge, body of experience, who has reviewed thousands of pages of documents, you cannot tell the jury what definitively caused Laura Doull's pulmonary embolism, correct?
A Yes.
Q And in medicine that happens often. Medicine is not an exact science. That's why you have things like likely causes, correct? And in the process of differential diagnosis --

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THE COURT: Would you please ask questions and not make speeches, Mr. Sobczak.
MR. SOBCZAK: It's a question, Your Honor.
BY MR. SOBCZAK:
Q You agree --
THE COURT: No, it's not a question, it's a speech.
BY MR. SOBCZAK:
Q You agree that in medicine, when you can't say something with 100 percent certainty, you are using the process of differential diagnosis, correct?
A That's in the - no, I -- no.
Q No? You don't rule out possible conditions?
A The differential diagnosis is a non-sequential in what we do sorry.
Q So, you don't use differential diagnosis in your practice?
A Differential diagnosis is upon the evaluation of a patient. You don't use it.

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Q It's a system, correct? It's a systematic approach to thinking. When you have a problem or you have a question and you're trying to get the --
THE COURT: Again, you're making a speech, Mr. Sobczak.
MR. SOBCZAK: Okay.
BY MR. SOBCZAK:
Q Doctor --
THE COURT: Please ask a question of the witness.
MR. SOBCZAK: Okay. I'll make it into a question.
BY MR. SOBCZAK:
Q Doctor, do you agree that differential diagnosis is a system of thinking, of solving a potential problem? It can be used in medicine or it could be used in everyday life, correct?
A Yes.
Q And when you have a question you're trying to answer, sometimes the

answer is black and white and right in front of you and sometimes you have to deduct, correct?

A Yes.

Q And your testimony is that in cases of Laura Doull, you cannot definitively deduct what caused her PE because those things are sometimes hard to do, correct?

A What was the last part?

Q Sometimes it's hard to do. You can't diagnose everything?

A Hard to do is not the correct term.

Q Okay. Sometimes --

A Sometimes we can't figure it out. There's no reason in current medical thinking. All you know is based upon current medical knowledge, she had no family history of a hypercoagulable, she was not receiving a drug associated with a hypercoagulable disorder or thrombosis, progesterone has been documented in the literature as not

causing it, so --

Q Okay. So, to add to your --

A And when you're done with -- no hypercoagulable, no family history, no agents known to cause it, then that is in the chart, by multiple authors at the Brigham, as idiopathic, unknown, unclear, those are the words we can use.

Q So, to add, you say "history." History is also a potential cause and, in Laura Doull's case, it's been ruled out, correct?

A Correct.

Q So, all that's left is HRT, hormone replacement therapy, and progesterone. And your testimony is that progesterone never causes the risk of blood clots.

And if the jury believes the reference book --

MR. DUMAS: Objection.

BY MR. SOBCZAK:

Q -- or anything else --

THE COURT: Would you, again, please not make speeches? You may ask a question.

BY MR. SOBCZAK:

Q So, your position is that everything's been ruled out except for progesterone but, in your opinion, progesterone has no risks of blood clots, correct?

A That's an incorrect statement.

Q Okay.

A It is a fact, progesterone has no implications in blood clots is used individually.

Q And that's the opinion you will stand by and that's what the 29,000 dollars bought the defendants, correct?

MR. DUMAS: Objection.

A And I provided the literature and documentation and I think you read it into the medical record and Dr. Nathan's testimony. It's not my opinion, it's a fact and my opinion.

Q Okay. You agree there's a controversy, correct? Because you read -- you agreed with ACOG, you read the --

THE COURT: Sustained this is asked and answered.

MR. SOBCZAK: Okay, that's fine.

BY MR. SOBCZAK:

Q It's your opinion that progesterone has no risk for blood clots?

A Natural progesterone is not associated with any increase instances of blood clots, period.

Q Okay, that's fine.

A It's documented in the literature it's clearly defined at all the visits to Brigham and Women's --

Q Doctor --

A -- where this was not even mentioned.

Q Doctor, that's fine. That's your opinion. We'll just agree to disagree and the jury will see all

the evidence.
MR. SOBCZAK: That's all I have, Your Honor.
THE COURT: It's 1:00. I'm sorry, unless you have just a few questions?
MS. DALPE: If I can keep it to five minutes, Your Honor?
THE COURT: Well, that may require some follow-up. Go ahead. I'll give you five minutes. Does the jury mind waiting five minutes? Okay, thank you.
(REDIRECT EXAMINATION OF KENNETH MILLER, M.D.)
BY MS. DALPE:
Q Dr. Miller, you were asked questions about how you know that this cream was applied topically. Did you read Seth Doull's deposition?
A Yes.
Q Okay. And did Seth Doull, in his deposition, talk about how Laura applied her medication?

A Yes.
Q And what did he say?
A Applied the container and applied it to the skin on the abdomen.
MS. DALPE: Your Honor --
A And looking at the bottle, there's no other way you -- the vaginal cream comes in a syringe or a tablet. It's not possible.
MS. DALPE: Your Honor, may I request permission to read in a portion of Seth Doull's transcript for completeness sake?
MR. SOBCZAK: And Your Honor, this is specifically the issue the defendants tried to redact it yesterday and the Court has not ruled on it yet.
THE COURT: Well, I'm going to overrule the objection and permit the doctor -- the doctor can at least refer to that portion of the deposition.
MR. SOBCZAK: Yeah. He can

read whatever you want, but for the defendants to try to do something that the Court previously prohibited yesterday, that's what I'm objecting to.
THE COURT: Please, no speeches. The issue was opened up, the defendants are entitled to show evidence to explain the reason for the doctor's opinion that this was applied topically to her skin.
MR. SOBCZAK: But that's not a question in dispute, Your Honor. Nobody disputed that point. The issue is it's not in the record.
THE COURT: Please, would you just allow the question to be asked.
BY MS. DALPE:
Q Dr. Miller, you were asked several questions about there being no documentation in the record regarding a method of application; is that right?

A Yes.
Q Okay. And am I showing you the deposition of Seth Doull taken on Monday, November 7, 2016?
A Yes.
Q Okay. And let me just read. The question I posed was: "Did you ever see your wife using the cream?"
The answer was: "Yes."
Question: "And tell me what you observed."
"She is pretty good about reading the instructions on things and paying attention to stuff like that because she cares about it. She would rub it on the inside of her thighs, a lot of times when she was putting it on, because apparently that's where it's absorbed the most."
Question: "Your memory is that she was applying the cream to her legs; is that right?"
Answer: "Yes."

Did I read that correctly?
A Yes.
Q Okay. So, all the questions that Mr. Sobczak just posed to you about there being no documentation about where the cream was applied, you knew that the cream was applied because Mr. Doull said so, right?
A Yes.
Q Okay. And the fact that there's no documentation, does that change the risk at all?
A Nothing -- no. No. it's hard to envision the cream getting anywhere out -- any other orifice. It just --
Q Thank you.
A -- technically, it would be very difficult.
Q Doctor, you were asked about references to literature in your disclosure --
A Yes.
Q -- on the very first page, second

paragraph. Did we talk about the fact that you were going to speak of literature on hormone replacement therapy in general and specifically with respect to progesterone cream?
A Yes, and that generated in the picture.
Q Doctor, you were shown an article called "Bioidentical: Sorting Myths and Facts." Does this article at all reference or pertain to the cream that Mrs. Doull was taking?
MR. SOBCZAK: Your Honor, before we go any further, this is redirect. It sounds like not only cross, but it sounds like interrogation.
THE COURT: Well, this is your witness.
MS. DALPE: I'm sorry, Your Honor. I will try not to lead.
THE COURT: Thank you.
A It refers to bioidentical creams so it does relate to the cream she was

taking.
Q Okay. Does it specifically reference progesterone cream?
A No.
Q Okay. Next, you were asked about an ACOG opinion from 2005. Is there a disclaimer on the article that Mr. Sobczak read to you?
A Yes.
Q Okay. And what does the disclaimer say?
A "This document reflects emerging clinical and scientific advances of the date issued and is subject to change. The information should be construed as dictating an exclusion course of treatment or procedure to be followed."
Q Okay. And does that sentence, does that mean that this article should not be used for planning definitive care?
A Yes.
Q Okay. And you've agreed that ACOG

is a reliable source, correct?
A Yes.
Q And what --
MR. SOBCZAK: Your Honor, she's crossing her own witness.
MS. DALPE: I'm sorry.
THE COURT: This is your witness, please.
MS. DALPE: Thank you.
BY MS. DALPE:
Q Doctor, is ACOG a reliable source?
A It is.
Q Were you shown, on cross examination, the article from 2013, reaffirmed in 2015?
MR. SOBCZAK: No, he was not and I object, Your Honor.
THE COURT: Would you please not --
MR. SOBCZAK: Objection. The Counsel is lying. I have never --
THE COURT: Members of the jury, you will disregard that

comment by Mr. Sobczak. Please, you may ask a question, I will then rule on whether or not to sustain the objection. Thank you.

MS. DALPE:

Q Doctor, have you reviewed with Mr. Sobczak the article that I just placed in front of you called, "Postmenopausal Estrogen Therapy Route of Administration and Risk of Venous Thromboembolism"?

A It has been reviewed and -- yes.

MR. SOBCZAK: Objection; misrepresents what actually happened, Your Honor. And the fact that the defense --

THE COURT: Overruled.

MR. SOBCZAK: May we be heard because this is --

THE COURT: No more speeches, Mr. Sobczak.

(SIDEBAR BEGINS)

THE COURT: You be asked to Keep your voice down.

MR. SOBCZACK: Yes, Your Honor, I did not show a and 1113 article ever during any of my cross examination, the defendants know this. She subpoenaed perjury, that in of itself -

THE COURT: Will you please keep your voice down.

MR.SOBCZACK: It's Perjury.

THE COURT: She is not under oath, she is asking him.

MR.SOBCZACK: She is asking him. Not once did I agree.

MS. DALPE: I think my question was did you review this with Mr.Sobzcack and his answer was I reviewed this article.

MR. SOBCZACK: And her question was actually false because she knows that I never agreed with him. So she is subpoenaed perjury.

THE COURT: He did not -- He testified that he reviewed it.

MS. DALPE: Your Honor, --

THE COURT: Let's please move on. All right then we're going to stop and we will resume at 2'oclock.

MS. DALPE: Okay.

(SIDEBAR ENDS)

THE COURT: Members of the jury, we're going to recess until 2:05 because I have about an hours' worth of unrelated matters that are waiting to be heard right now. Thank you. Doctor, you may step down for the moment.

THE COURT OFFICER: Jurors, please rise.

(Jury exits)

THE COURT: Doctor, you may step down.

MR. SOBCZAK: Your Honor, may we continue? I need to put this on the record.

THE COURT: I will make a statement. Suborning perjury is not

asking a witness a question. So, let's move on.

MR. SOBCZAK: Your Honor --

THE COURT: What is your objection?

MR. SOBCZAK: My --

THE COURT: You say you didn't show it to the witness, all right.

MR. SOBCZAK: My objection is two-fold. One, what Ms. Dalpe is trying to do is somehow show an article that is not disclosed, that is not mentioned during cross, that's not in any of the listings, on a redirect of her own witness. That's just grossly inappropriate by Sneed.

And two, the way she approached it and by falsifying stating her questions that I reviewed this with the doctor, the only article I reviewed with the doctor, and the records will be

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perfectly clear, are the ones that have been marked; the ACOG from 2007, the endocrine society one, the FDA.

The 2013 article never mentioned my lips, was never shown to the doctor, and was never in my cross examination.

And for Ms. Dalpe to just gallant over there with the article and say, "Is this what you reviewed with Mr. Sobczak?" and the doctor says, "I reviewed some article."

She's asking for the doctor to lie on the stand. That is grossly inappropriate. And unfortunately, all the time, I have to say, and I find this unprofessional and the Court should finally do something about it because this is getting to the point where this is not even remotely close to being a fair trial.

THE COURT: Thank you for

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your speech, Mr. Sobczak. The question was, in my view, proper. She was simply asking the witness if among the things, among the articles, that he reviewed with you during your examination, cross examination, was this article among those.

He didn't actually answer yes or no, but he said he reviewed the article. That is not suborning perjury.

I'm sorry. Now, what do you say with regard to his contention that this was not disclosed?

MS. DALPE: Your Honor --

THE COURT: Yes.

MS. DALPE: -- Mr. Sobczak specifically solicited evidence from this witness on his direct exam that ACOG was authoritative. Mr. Sobczak's questioning pertains to ACOG, which pertains to this article.

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I am going to ask this pert if this is reliable and then ask for him to read portions of the article and then move to put the article into evidence because Mr. Sobczak has qualified my expert and this literature and this literary body.

THE COURT: But is this -- under the statute --

MS. DALPE: What does that mean?

THE COURT: -- notice this as a learned treatise?

MS. DALPE: Not under 79C, Your Honor.

THE COURT: Okay.

MR. SOBCZAK: And Your Honor, just to follow up, this applies to cross of opposing experts. What Ms. Dalpe just represented to the Court that she intends to do, is cross her own expert, which is grossly improper.

And for somebody with that

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many years of experience, either -- it smells like deliberate violation of the rules.

THE COURT: All right. Well, I thought I had a copy of it here with me in the courtroom, but I do not. So, we'll pick up this issue after I resolve the other matters that are scheduled for shortly after 1:00. Thank you.

(Court is in recess at 1:10 p.m.)

(Court back in session at 2:06 p.m.)

THE COURT OFFICER: Court, all rise. Superior session is now in session, you may be seated.

THE CLERK: Your Honor, we are back on the record.

(JURY NOT PRESENT)

THE COURT: Again, very briefly, the defendants, more specifically, Ms. Dalpe is seeking to -- through this witness -- use a journal article? I gather that's what it is, Ms. Dalpe?

MS. DALPE: Yes, Your Honor.
THE COURT: That's the best way to describe it? That was not noticed by the defendants under 233 79c. Yes, 79c.
The cross-examination of this witness, however, there was -- as I recall -- cross-examination from an article by the same organization or medical group. Can you just state for the record again the name of the group.
MS. DALPE: The name of the group is called -- usually referred to as ACOG.
THE COURT: ACOG, okay. But the article to which Mr. Sobzack referred and examined the witness was from an earlier date, I believe around 2008 or 2009, and the article you're seeking to use is 2013.
And your suggestion is that because he raised the other article on cross-examination, you should be

permitted to show this later article to the same witness.
MS. DALPE: Yes, Your Honor.
THE COURT: Do you want to say anything beyond that?
MS. DALPE: Not beyond what I've already mentioned.
THE COURT: Okay. So, as I said when we recessed, although, it was already after 1, I wanted to talk another look at Sneed with regard to the procedure.
Sneed does, of course, say by way of footnote: "In fairness, portions of a learned treatise not called to the attention of a witness during cross-examination should be admitted on request of the expert's proponent in order to explain limit or contradict a statement ruled admissible under rule 803, 18."
So, this particular article is not from the same treatise, obviously. But from the same

organizations, ACOG, is that correct?
MS. DALPE: Exactly right. Both articles are from the same institution, they are both committee opinions.
THE COURT: All right. But they are different dates five years apart?
MS. DALPE: Yes, Your Honor.
THE COURT: All right. I just don't see that Sneed or the rule -- of course I've left, oh, here it is. Or the guide to evidence specifically address this issue, and I'm just not persuaded that it's permissible, so I'm not going to permit you to use it.
All right. Can we please move on. Your objection is noted.
MS. DALPE: Thank you, Your Honor. I would like to ask for a protective order.
THE COURT: Sure. Go ahead.

MS. DALPE: To keep Plaintiff's counsel from making any other personal attacks against me or my clients for the future duration of the case.
THE COURT: Yes, I think that's absolutely appropriate for everybody. This is a civil proceeding. Attorneys are expected to conduct themselves in a professional manner, and in a civil manner toward not only each other, but everybody else involved in the courtroom proceedings.
I will say that there had been a number of instances in this case in which it's been pretty clear to me that those professional -- professional conduct has been less than admirable.
And so, Mr. Sobczack, your calling names to any of these other parties using language such as perjury, which, as I said earlier,

was absolutely off base with regard to the manner in which Ms. Dalpe asked a question. I heard the question, and it was not in my view in any way suggesting anything in the nature of perjury.

So, forewarned is forearmed.

Can we bring out the jurors, please?

MR. SOBZACK: Your Honor, I'd like to state on the record, just to - about objection and join the motion. The Court order applies to both sides. It's the defendants that have been doing all of the mudslinging so far; and for the record, Your Honor, I do have to ask that the Court issue sanctions to Ms. Dalpe. And ask her what was her good faith basis to ask this doctor whether or not I showed him an article that I never showed him.

That in and of itself is a violation of rule 3.3 of

professional conduct, and there is a duty to it report to BBO.

Ms. Dalpe is correct, and then subsequently admitted that the only article that I showed him was the 2008 one, and then her argument, which also it violates the rule is that somehow showing one article means that all articles is open game. She specifically --

THE COURT: Please, counsel, I've already addressed this issue. If you feel it's a violation, so be it. I do not view it as such. We're going to resume with the jury right now.

MR. SOBCZACK: Is the Court going to inquire to the good faith basis --

THE COURT: You've made your speech.

MR. SOBCZACK: Is the Court going to inquire to the good faith basis for the question posed?

THE COURT: No. Please.

MR. SOBCZACK: Thank you, Your Honor, for the record.

THE COURT: Could we bring in the jurors.

MR. SOBCZACK: Your Honor, given what happened last time, can Ms. Dalpe pre-announce what she's about to show to make sure that's admissible.

THE COURT: That's not necessary.

MR. SOBZACK: So, we can just flop anything we want in front of the jury without good faith basis for it?

THE COURT: Mr. Sobzack, please, let us just proceed. There's no need to insert additional conflict into this trial beyond what is necessary for the jury to be able to adequately assess the evidence as being presented, in a way that is not fraught with other problems

about arguments between counsel.

MR. SOBZACK: -- evidence --

THE COURT: Would you please. I'm not going to insist that she do it. Ms. Dalpe, I assume, just like Mr. Dumas, I assume, just like Mr. Newton, and you understand that when you're about to ask questions of a witness what not to show the witness a particular document or other thing that they are about to refer to. So, I will leave it at that. No further arguments.

The jurors are on their way in?

THE CLERK: Yes, Your Honor.

THE COURT: I saw them lining up as I was coming in, so I assumed that they would be here right away.

THE COURT OFFICER: We are just waiting on one or two more.

THE COURT: Oh, they are not

all back yet?
THE COURT OFFICER: No, they are.
THE COURT: Okay.
THE COURT OFFICER: Jurors now entering.
(JURY ENTERS)
THE COURT: You may be seated. Thank you. Ms. Dalpe?
(REDIRECT EXAMINATION OF KENNETH MILLER,MD)
BY MS. DALPE:
Q Dr. Miller, just a few other couple of quick questions from me. Earlier you were asked on cross-examination about Dr. Landis and Dr. Landis's notes. I'm going to direct you to what's on the screen. Is this one of Dr. Landis's notes?
THE CLERK: Hold on, one second. We have some jurors --
THE COURT: They can't hear. Ms. Dalpe, I think you have to speak up.

MS. DALPE: I will. I will. I'm sorry.
THE COURT: I'm not sure there's a microphone over there.
MS. DALPE: I don't think that there is. I will try to and project.
(BY MS. DALPE)
Q Dr. Miller, before we took the lunch break, on cross-examination, you were asked some questions about Dr. Landis. Do you remember those questions?
A Yes.
Q Okay. And, the document that I've put on the screen, is this one of the notes that Dr. Landis, where he speaks specifically to his thoughts on the reason behind Ms. Doull's hypercoagulability?
A (non-verbal response)
Q Can you just answer verbally.
A Yes.
Q And, can you read that third

sentence there, that I'm pointing to on the screen?
A "I suspect the reason for her hypercoagulability may have been the progestational agent that she was taking."
Q Okay. Does that statement of Dr. Landis use definitive language?
A No.
Q Okay. And, what is the exact word that he's using?
A May, may have been.
Q Okay.
A I mean, this is a speculation a query.
Q And, Dr. Landis ultimately referred the patient to Brigham and Women's Hospital; is that correct?
A Yes.
Q And, why did he refer the patient to Brigham and Women's Hospital?
A The patient had severe pulmonary hypertension.
Q Okay. Is Brigham and Women's

Hospital a different type of facility compared to Bay State, in terms of dealing with CTEPH patients?
A Yes. In fact, she referred her to Dr. Waxman, whose specialty is pulmonary hypertension, it's a tertiary care center.
Q Okay. And so, Dr. Landis referred the patient to people who had expertise in Ms. Doull's actual disease; is that right?
A That's correct.
Q Okay. And, you had mentioned earlier that there was some confusion about Dr. Landis and his original diagnosis. Can you explain that to the jury?
A So, initially when he saw her in the emergency room, he, in fact, said he doubted that this was CTEPH, which is just a pulmonary embolus and treated her for that; and clearly it was CTEPH.

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Q And, do you happen remember, just off the top of your head, how long it was before Dr. Landis saw the patient and he then referred the patient into Boston?
A I think it's about three months.
Q Okay. And, Doctor, you were also asked questions about the type of progestational agent that the folks at Bay State thought Mrs. Doull was taking. I put in front of you a note from Bay State dated -- let's see. That's part of the discharge package, of 08/23/2011. Can you see that?
A Yes.
Q Okay. And the sentence that I've highlighted on the screen. Can you please read that for the jury?
A "Etiology of pulmonary embolus appears to be secondary to her progesterone tablet use."
Q And, what is significant about that statement?

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A That she wasn't on a progesterone tablet. She was on topical cream.
Q Okay. Fair to say that Bay State -- there was confusion about what she was taking and the cause for her CTEPH?
A Correct.
Q Okay. And, ultimately that's why she was referred to the Specialty Center at Brigham and Women's Hospital in Boston?
A Correct.
Q Okay. Thank you.
MS. DALPE: I have no further questions.
MR. DUMAS: Just briefly, Doctor. A couple questions, Doctor.
(RECROSS-EXAMINATION OF MILLER, MD)
BY MR. DUMAS
Q Do you recall being asked questions about what documentation existed with respect to where and what was filled in terms of Mrs. Doull's prescription of progesterone?

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A Yes.
Q Okay. And, you were shown the note, which is on Tab A, page 47 of the juror notebook, or maybe you weren't shown it, but let's look at it.
I have it on the screen here. From this note, it appears that on August 11th, 2008 was the first discussion with the patient to start the progesterone cream. In other words, when the prescription was made; is that fair?
A Correct.
Q Okay. And, if we look at the International Women's National Pharmacy, can you tell me when the first record of filling the order and sending the order is?
A 8/15/2008, shipping charge order, and 08/16, credit card payment.
Q Okay. So, within four days of the note in Ms. Foster's note, there's a record from the compounding pharmacy that shows that the prescription was

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filled, right?
A Yes.
Q And, to be clear, tells you what was filled and that was what?
A Progesterone C, C progesterone 100-milligrams.
Q Okay. And, to be clear, Doctor, the evidence that we do have from the Women's International Compounding, was Ms. Doull ever prescribed a medication with estrogen in it?
A No.
Q Okay. You were also asked some questions about what I think were called, "gaps" in the prescription that she received at Women's International Compound?
A Yes.
Q And that was from 2008 to 2009?
A Yes.
Q Is it fair to say, Doctor, if a drug carries with it risks, you have to take the drug in order for those risks to materialize?

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A Yes.
Q Okay. So, if you do take a medication that does have risks, if you're not taking it regularly, or not taking it at all, what does that do in terms of the chance of those risks materializing?
A It attenuates any risk.
Q Thank you. The list that you written here, for you, with respect to PE, there's one missing, isn't there, Doctor? We have PE, likely cause, cancer, blood disorder, HRT, but you also heard, or you testified -- pardon my handwriting, idiopathic, right? What does that mean?
A Unknown, unfortunately is the most likely.
Q Okay. And, can you explain again to the jury what an idiopathic cause of pulmonary embolism is?
A That means you document the pulmonary embolus, but the reason

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the patient develops it is unknown and cannot be determined.
Q And, the note that we looked at, or you looked at from -- this is Tab E in the jury notebook, from Brigham and Women's, the GYN note. On the second page, what does the gynecologist document, in terms of the etiology of her pulmonary embolism?
A Pulmonary embolus, unprovoked. That means there's no reason for her to have it, unknown etiology.
Q Okay. And, Doctor, you were asked some questions this morning about, I think it was an article or some questions about informed consent. Do you recall that?
A Yes.
Q Okay. And, I want you to assume for me that Nurse Practitioner Foster prescribed 100-milligrams of progesterone bioidentical topical cream and that she had a discussion

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with Mrs. Doull about the benefits, but did not discuss the risks of blood clots.
Do you have an opinion to a reasonable degree of medical certainty as to whether or not that's appropriate informed consent?
MR. SOBCZAK: Objection, beyond the scope.
THE COURT: Sustained.
MR. SOBCZAK: So, we're opening up this now, Your Honor?
THE COURT: I've sustained the objection.
MR. DUMAS: I have nothing further. Thank you.
MR. SOBCZAK: Your Honor, may we briefly be heard for a very short time. I have that I need to address with you.
THE COURT: Yes.
(SIDEBAR CONFERENCE)
MR. SOBCZAK: I have to address to Mr. Dumas marking up my

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exhibits without permission without asking the Court first.
THE COURT: He didn't mark an exhibit.
MR. SOBCZAK: He did. He marked up my chaulk. So, am I allowed to take up his chaulks and start crossing stuff out?
THE COURT: These are not my chaulk and your chaulk. It happens all the time. If a witness is asked a question, people can -- it's just been written on a board.
MR. SOBCZAK: So, am I allowed to -
THE COURT: If you want to take the board down, you're free to do so.
MR. SOBCZAK: Thank you.
(END SIDEBAR CONFERENCE)
(RECROSS-EXAMINATION OF KENNETH MILLER,MD)
BY MR. SOBCZAK:
Q Dr. Miller, I'll be brief. Earlier

when I asked you about likely causes, the reason why you did not mention idiopathic is because idiopathic is not a cause. It's the lack of information, correct?

A Idiopathic means we don't know the cause --

Q Yeah.

A -- if fact, that should be counted as a definitive statement --

Q So, --

A -- that means you've ruled out other causes and you accept that the the patient developed this for no known etiology. So, it should be it is listed in perceived positions as aligned ---

Q So, your position is that's the answer the Almighty, just, out of nowhere, correct? It's an unknown cause?

MR. DUMAS: Objection.

Q You never ruled it out. It's a complete lack of knowledge, correct?

A But that is a definition meaning that we have evaluated and for many illnesses, unfortunately, which is bad luck, and we don't know the cause.

Q So, it's not a cause, it's the lack of knowledge of cause, correct?

A But, it's attributed to be a cause because --

Q Doctor, --

A -- it implies ---

THE COURT: Would you let him answer the question.

Q If you can answer the question asked, we can move along. It's not a likely cause, it is the absence of likely cause, correct?

A No. It implies that the cause is unknown and that's a cause.

Q So, if you're saying, "unknown" is the cause of everything?

MR. DUMAS: Objection.

Q Every diagnosis you make, the unknown is something that is one of

the options, correct?

A No.

Q Or, it's as you quoted in your direct, "just bad luck", correct? Those were your words? Bad luck? So etiologic --

THE COURT: Would you let him answer the questions?

Q -- is unknown, correct?

A Yes. Unknown, known reason --

Q Yeah.

A -- that's really what it is.

Q Or, as you did on direct, it's, "Bad luck"?

A Well, bad luck implies that good things happen to bad people.

Q Are you saying, Ms. Doull was bad people?

A I'm sorry. Bad things happen to good people.

Q Okay.

A There's no reason for it.

Q But, your answer on direct was it's just bad luck?

A It's unfortunate.

Q Okay. So, what's left is bad luck, or the hormone replacement therapy, because neither one of those two have been ruled out, correct?

A No. This is poor thinking, because you have -- for most patients there is no known etiology. We don't know why things occur.

Q Doctor, --

A It's an untoward event and that's what idiopathic means.

Q -- if you answer question posed we can move along.

MS. DALPE: Objection.

THE COURT: Would you please not make speeches?

MR. SOBCZAK: Would you --

THE COURT: He has answered the question. Go ahead.

(BY MR. SOBCZAK):

Q You went to the record, all 10,000 pages of it and you agree cancer is ruled out, blood disease is ruled

out, (inaudible) were ruled out. What's left was ---

THE COURT: You're making a speech. You may ask a question.

Q What was left in your total review of all the medical records is that HRT was never ruled out and then the one you added, "bad luck", correct?

A No. HRT should not be considered on that board. Progesterone therapy as I eluded to, does not cause this, as does any other reasons that comes into your imagination. It does not cause this. And, that's why all the physicians at the Brigham, that is not their consideration. There's not a single line about it and everyone assumes that it's idiopathic, meaning unknown cause. And that is a diagnosis in and of itself.

Q Point in the records where HRT was ruled out?

MS. DALPE: Objection, Your

Honor.

THE COURT: Sustained. This has been asked and answered. Let's move along.

MR. SOBCZAK: Your Honor, at this point, I offer the chart into evidence.

THE COURT: The chart is already in evidence. All right. Go ahead. Next question.

MR. SOBCZAK: It is?

THE COURT: That chart?

MR. SOBCZAK: Yes.

THE COURT: That's a chart.

MR. SOBCZAK: Okay. Then, I offer it in as a chart.

THE COURT: It is not going to be admitted. It may be marked for identification.

(Identification YY, so-marked)

BY MR. SOBCZAK:

Q And, then the only thing that Mr. Dumas asked you about is about all the confusion in Bay State's records

about the form of progesterone, correct?

A Yes.

Q And, are you blaming Bay State for their diagnoses because they may have been confused in some places about whether the progesterone was a pill or a cream?

A No. I think, as I -- had nothing to do with her illness. Even though Bay State didn't diagnosis her with CTEPH, it was very clear that that's what she had. The progesterone had nothing to do with her development of her PE'S or CTEPH.

Q Well, you saw in the records that, st Dr. Landis initially, on May 21 he didn't notice her CTEPH, but as he saw her the second time, he started leaning toward it and that is, in fact, why he sent her to Brigham, because he was --

MR. DUMAS: Objection.

THE COURT: The

objection is sustained. That's an argument.

Q Did you see in the records where Dr. Landis did consider CTEPH and that's why he sent Ms. Doull to the Brigham and Women's?

A Yes.

Q So, he initially, having only seen the patient once, did not think it was CTEPH, because he had one day's worth of data, correct?

A Yes.

Q And, subsequently, as he learned more he considered CTEPH decided it's beyond my facility here and sent her to Boston, correct?

A Correct.

Q And, this diagnosis of likely the etiology of progesterone was never undone? At no point, did Dr. Landis ever say it's not progesterone, correct?

A Correct. No one at the Brigham Hospital, the medical, surgical, or

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anyone sitting on the house staff continued that thought, because it is not accurate.
Q They couldn't find anything else?
A They never once entertained that thought because it doesn't do it.
Q Well, they did entertain that thought because you saw it in the GYN records that when they considered progesterone without the proper history, once they were informed of what's happened to patient before, they went with lupus, correct?
MR. DUMAS: Objection.
THE COURT: Sustained.
Q You saw in the notes that's not in the jury book that progestin and progesterone was considered at Brigham and Women's and the fact of the patient's prior history changed the prescription that the gynecologist suggested, correct?
A No. The gynecologist still

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recommended progestin or Lupron.
Q On June 20th, Doctor?
A And, --
Q On June 22nd --
A Based upon the patient's preference that she did not want to take oral hormonal therapy, they let it go at that. Those were the two options. But, clearly suggesting progesterone does not induce hypercoagulability, therefore, is not contraindicated, therefore not related to her disorder.
Q In your opinion.
A It was based upon the patient's preference.
Q Okay.
A That the side effects that they eluded to, which sounded very extreme, are all the side effects associated with Lupron; the hot flashes, that's due to Lupron.
Q And, Lupron is the least of the two options initially, absent for

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patient history, Lupron is the lower option choice, correct? It's the least desirable one because it has the more negative side effects?
A It has more side effects for the women, not dangerous, but more unpleasant.
Q But, in fact --
A It's more unpleasant.
Q But, --
A Because women go through menopause symptoms of that time.
Q But, two days later, the GYN's only recommendation was Lupron, having considered what happened with progesterone before, correct?
A No, no. That's not -- I'm sorry. They presented both options to the patient and they thought progesterone because it does not induce hypercoagulability, does not induce a prothrombin state, is an option.
The other option is Lupron,

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which turns off ovarian function by an injection, a IM injection. With the patient's preference to not take a hormonal therapy, Lupron then became the only option available for her. But, both were equally safe. One has slightly more side effects, because Lupron induces a menopausal state.
Q Okay. Going back to Dr. Landis, you don't think of his opinion any less or any more, because in few instances in the record, the reference to progesterone is cream versus pill or tablets, correct?
MS. DALPE: Objection, Your Honor.
MR. DUMAS: Objection.
THE COURT: Sustained.
Q You are not challenging Dr. Landis' opinion just because in the records there's a reference to pill versus tablets versus cream, correct?
MS. DALPE: Objection.

THE COURT: Overruled.
A No. My opinion is not based because he confused the two. It's based because progesterone does not cause an increase in thrombotic events, PE's, or prothrombotic --
Q Estrogen does, correct?
A -- progesterone does.
Q Estrogen does?
A Estrogen does.
Q And, Nurse Foster, confused those two, correct?
MR. DUMAS: Objection.
MS. DALPE: Objection.
THE COURT: Sustained as to the form of the question.
Q You are aware that Nurse Foster confused those two, estrogen and progesterone?
A I'm aware there's a note that she used biestrogen, which is an estrogen containing compound, but I see no records that the patient ever received estrogen.

MR. SOBCZAK: That's all I have, Your Honor.
THE COURT: Anything else? Thank you very much, Doctor. You can go ahead step down.
MR. SOBCZAK: Your Honor, before the defense calls the next witness, could we briefly be seen at sidebar, regarding your prior rulings.
(SIDEBAR CONFERENCE)
MR. SOBCZAK: The defendants next five witnesses are friends of families of the Doulls. I did not talk to them. I did not subpoena them; therefore, I did not inform them of your court orders. I presume the defendants did since they subpoenaed these witnesses, so if and anything these witnesses say is beyond my control. They are not my witnesses.
THE COURT: Well, then I will take each of them in turn and

explain to them they are not to say anything. And you are not to ask them --
MR. SOBCZAK: I know what questions I can't ask.
THE COURT: -- such as the one you asked Ms. Doull yesterday about why did you file this lawsuit, no doubt understanding expecting that she would say "so this never happens to another family" is absolutely improper.
I didn't hear an objection from either of the attorneys. I think, perhaps, they thought they would just leave well-enough alone. That's an example of the way in which things are coming out. So, I am just simply going to indicate that if any these witnesses whip out with anything - have you spoken to any of them?
MS. DALPE: No, Your Honor. We've issued subpoenas. They've

been here. We have advised some of the witnesses that they made need to come back another day because of the length of the cross-examine, and that's the extent of my conversation with them.
THE COURT: All right. So, how many do you think you'll get through between now and three o'clock?
MS. DALPE: I'm not quite sure, Your Honor.
THE COURT: It's about a half an hour or so.
MS. DALPE: Yeah. Without knowing what Mr. Sobczak is going to do I would estimate two, probably at the max, we'll get done before -
THE COURT: So, why don't we excuse the others.
MS. DALPE: Okay.
THE COURT: Until Monday or Tuesday whenever you think to call them back.

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MS. DALPE: I'm wondering, Your Honor, if you want to a wholesale instruction while they're all in the same place.
THE COURT: I'd have to look at all of my instructions.
MS. DALPE: Okay, okay. The first witness is - I'm not expecting her to give any difficult language in particular. I'm alright with excusing them but I'll need to talk to them all anyways, so might as well keep them till 3.
THE COURT: My preference would be -

MS. DALPE: Start?
THE COURT: Well, to go, yeah, but if I'm going to instruct everybody to have the precise language so I'm not sort of stumbling through and because there were several different motions -
MS. DALPE: Yes, I

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understand. Witness number 1 is primarily being called because of the location of the cream issue.
THE COURT: Okay.
MR. SOBCZAK: And, Your Honor, just for the record, these are their witnesses so this is going to be direct examination, not leading.
THE COURT: That's correct.
MS. DALPE: They are all friends and family --
THE COURT: but they're in line. You'll be permitted to cross-examine them, but if you even remotely tread in the area of eliciting any of the types of language that has been kept out, which includes "this should not happen to any other family", which is improper, absolutely improper, I will step in, and I do not like having to conduct myself in this manner as a judge, continually

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giving instructions of this sort that I found myself in the awkward and uncomfortable position but I feel necessary position of repeatedly interrupting, instructing jurors on things they've heard, and that these things are improper, particularly with regard to witnesses who are not professionals, who might not really expect to hear that sort of thing, whereas a professional witness may be more inclined to -- not inclined but may have heard that sort of thing in the past. So, you just bear that in mind, with regard to whatever plans you have with cross-examination.
MR. SOBCZAK: I have no -
THE COURT: Let's proceed.
(END SIDEBAR CONFERENCE)
MS. DALPE: Your Honor, may I call Ms. Dusek to the stand?
THE COURT: Yes.
(SANDY DUSEK, Sworn)

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MS. DUSEK: I swear.
(DIRECT EXAMINATION OF SANDY DUSEK)
BY MS. DALPE:
Q Good afternoon. Can you please state your name for the record?
A Sandy Dusek.
Q And, can you tell us the town that you live in?
A Colrain, Mass.
Q And, tell me a little bit about your education?
A I graduated high school.
Q And, how is that you knew Laura Doull?
A We were good friends. I've known her since 1994.
Q Okay. And, what is your occupation?
A House cleaning.
Q And, prior to Laura becoming sick in May of 2011, did you have regular contact with her?
A Yes.
Q And, can you describe what that consisted of to the jury, for that

time-period, namely the five years before May of 2011?
A We'd get together here and there to catch a movie or go out to eat, maybe go shopping. A few times a year, maybe four to six times a year.
Q Did Mrs. Doull ever tell you that she was using progesterone cream?
A She mentioned some kind of cream that, yes, she was using.
Q And, do you remember where it was that she told you she applied the cream?
A I believe she said her abdomen.
Q Okay. Do you remember whether or not Laura ever told you about any of the symptoms that she was having that led to her taking the cream?
MR. SOBCZAK: Your Honor, this is direct?
THE COURT: Well, close, but I think it's a way of directing this witness toward particular topic area

that Ms. Dalpe is seeking to take her attention to, so I will permit it. But, I do remind you, this is your witness.
MS. DALPE: Thank you.
(BY MS. DALPE)
Q Do you remember Mrs. Doull ever expressing that she was having any perimenopausal symptoms to you?
A I believe that's what she thought it was, yes.
Q And, do you remember what any of those were?
A I don't recall exactly.
Q All right. Do you recall whether or not Laura ever indicated to you that she was having any changes in health prior to the year 2011?
MR. SOBCZAK: Objection, again leading.
THE COURT: Overruled. I don't know if the interruption may have --- would you ask the question again, Ms. Dalpe?

MS. DALPE: Sure.
Q When Mrs. Doull was hospitalized in May of 2011, what was your reaction?
A I don't remember.
Q Okay.
A I was just surprised, I guess.
Q Okay. And, why is it that you were surprised?
A Well, she's always been such a strong woman.
Q Had you been aware of her feeling unwell at any time prior to her hospitalization?
A No.
Q At any time, did Laura ever inform you that she was planning to get a divorce?
A It was talked about. I don't know if it was going to be for sure, but it was mentioned.
Q And, did she ever tell you the reason that she was thinking about divorce?
A Just unhappy, I guess. I don't

really recall everything.
Q Did Laura Doull ever suggest to you that she felt abandoned in her marriage?
A Maybe at sometimes. He's a big hunter, and he would go, you know, away maybe here and there you know to go hunting. If he was away, she might have felt that way sometimes.
MR. SOBCZAK: Your Honor, I object to the leading form of these questions.
THE COURT: Overruled.
BY MS. DALPE:
Q Did Laura ever make any complaints about her spouse's involvement in Troy's care?
A Any complaints?
Q Yes.
A No. He seemed fine with Troy.
Q Okay. Did Laura ever make any complaints about the amount of time that Mr. Doll was in the household?
A Maybe, I can't give an exact answer.

Probably.
Q Did Mrs. Doull ever complain about whether or not she felt Mr. Doull was keeping up with his responsibilities in the household?
A Again, I mean, maybe sometimes, you know. If he was working or something, or hunting.
Q Do you remember those complaints occurring prior to 2011?
A Probably some.
Q Did Laura Doull ever express to you, at any time, that she experienced relief when Mr. Doull was out of the house?
A I guess after a while there was --- you know, they had been together a while sometimes. It was maybe nice to have a little break once in a while.
Q Did Laura ever talk to you about her difficulties with her intimate relationship with Mr. Doull?
A Not really. I mean, it seems it was

good.
Q Do you remember whether or not she ever indicated to you that they were having issues with their intimate relationship prior to her getting sick?
A Prior, no.
Q Okay.
MS. DALPE: I have no further questions.
THE COURT: Mr. Dumas, are you going to ask any questions?
MR. DUMAS: Just a couple questions, Your Honor.
(CROSS-EXAMINATION OF SANDY DUSEK)
BY MR. DUMAS:
Q In terms of the discussion about divorce that you had recalled, do you recall that Laura had told you that the reason was Seth wasn't very supportive?
A Supportive with?
Q That he didn't help around the home?
A I mean he did. I don't think it was

-- no, I don't think so, not all the time.
MR. DUMAS: Your Honor, may I approach?
THE COURT: Yes.
MR. SOBCZAK: There's no question. This is direct. There's no question pending. Your Honor, I object.
THE COURT: But there's no question.
MR. SOBCZAK: Correct, approaching the deposition of non-party. There's no reason to refresh. The deposition cannot be used ---
THE COURT: Why don't we wait for him to ask his question, Mr. Sobczak.
MR. SOBCZAK: Okay. Be that way.
BY MR. DUMAS:
Q And, if we look Page 49 and 50, talking about your conversation with

Laura about the divorce ---
MR. SOBCZAK: Objection, Your Honor. Now, he's pointing to a testimony with that question pending and need to refresh. There should be some rules as how to treat ---
THE COURT: Could we please ask the question. I will rule on the admissibility of the question once I hear it.
MR. SOBCZAK: Well, the question shouldn't include pointing out testimony.
BY MR. DUMAS:
Q The question was, tell me the ways in which she thought he, Seth, was unsupportive and your answer was, "Wasn't home all the time --
MR. SOBCZAK: Objection.
Q -- to help her out.
THE COURT: Sustained.
Q Does that refresh your memory of that conversation?
A Yes. Yeah. It's hard to recall

everything.

MR. DUMAS: Okay. That's all I have. Thank you.

(CROSS-EXAMINATION OF SANDY DUSEK)
BY MR. SOBCZAK:

Q Good afternoon, Ms. Dusek. So, you were subpoenaed here by the defendants, correct?

A Yes.

Q And, you got another subpoena about a week ago sending you to a wrong place, correct?

MR. DUMAS: Objection.

THE COURT: Sustained. Please, that's not a proper question. Could you please ask proper questions?

Q Were you subpoenaed also about a year ago by the defense for a deposition, correct?

A For a deposition, yes.

Q And, either prior to that deposition for this trial, have you spoken with anyone from my office?

A No.

Q So, all your testimony is based on what you remember of what you saw with Laura, your friend of a long time?

A Yes.

Q And, you said that she complained about sometimes having marital issues?

A Yeah, just like everybody else.

Q I was going to say, nobody has a perfect marriage.

A Ups and downs.

Q Okay. And, when the defendants asked you was she complaining before she got sick, your answer was no?

A Mm-hmm.

Q In fact, when they asked you about issues with intimacy, you said it was good.

A Yes.

THE COURT: Please don't repeat her answers or her testimony. You may ask her questions, please.

Q Laura talked about sex a lot, correct?

A Well, I wouldn't say a lot, but she talked to me about it, yes.

Q Do you recall saying that Laura basically, as far as, Seth gave her food on the table, money at home, and sex; she was satisfied?

A Yes.

Q And, that was all prior to 2011?

A Yes.

Q And, that's what their relationship was like?

A Yes.

Q And then, she got sick?

A Yes.

Q And that all changed?

A Yes.

Q She couldn't do the things that they used to do for nearly 20 years?

A Yes.

Q And, it got more difficult?

A Absolutely.

Q To the point where in the end, she

even contemplated divorce?

A Yes.

Q And, that's all because she got sick after the treatment with the defendants?

A Yes.

MS. DALPE: Objection.

THE COURT: Sustained. As to that question, the jury is disregard that question and answer.

Q Now, did you hear Laura complain about any other things, like the care she received?

A I don't remember, no.

MR. SOBCZAK: That's all I have, Your Honor.

THE COURT: Anything else, Ms. Dalpe?

MS. DALPE: Very quickly.

(REDIRECT EXAMINATION OF SANDY DUSEK)
BY MS. DALPE:

Q Ms. Dusek, have you talked anyone or communicated with anyone in the Doull family since your deposition

of last year?
A Just to check in and see how they were doing.
Q Okay. So, the answer is yes?
A Yes.
Q Okay. When's the last time you remember Laura commenting in a positive way on her intimate relationship with her spouse? Do you recall?
A Well, it was before she got sick, so before 2011.
Q Okay. So, the last time she told you anything positive about her sexual relationship with her husband was prior to 2011?
A Well, no. I mean, it was okay for a while beyond that.
Q Ms. Dusek, after you deposed, did I send you a copy of your transcript?
A Yes.
Q Did you read that before coming in today?
A Yes.

Q And so, you remember that I asked you that same exact question last year?
A Yes.
Q Okay. And, you remember that your answer last year was that the last time Laura ever commented positively about her relationship with Seth was prior to 2011?
MR. SOBCZAK: Your Honor, is this direct, or cross, or interrogation?
THE COURT: Well it is redirect.
MR. SOBCZAK: Redirect, yes.
THE COURT: It's redirect, this is your witness.
Q Ma'am, is your testimony here today any different from your deposition testimony?
A No. But, it's probably hard to recall everything.
Q Okay. This is a year later, and so, it's tough to remember what you

testified to last year?
A I'm trying to remember everything I can.
Q Okay.
MS. DALPE: I don't have any other questions.
THE COURT: Mr. Dumas?
MR. DUMAS: No questions.
THE COURT: Mr. Sobczak?
MR. SOBCZAK: I'm content.
THE COURT: All right. Thank you very much, Ms. Dusek. You may step down. Your next witness please?
MS. DALPE: May I have Mr. Stanley.
LEE STANLEY, Sworn
(DIRECT EXAMINATION OF LEE STANLEY)
BY MS. DALPE:
Q Good afternoon, Mr. Stanley. If you can't hear me at any point in time, you let me know. Can you tell the jury your full name and address?
A Lee Stanley. 34 Church St.,

Colrain, Mass, 01340.
Q Mr. Stanley, can you tell the jury your level of education?
A I got my high school education when I was in the service.
Q Okay.
A But, that was --
Q You know what I might have you do, is just pull the microphone a little closer, just in case.
A This one?
Q Yes.
THE COURT: Right. If you pull it closer. Actually, Mr. Sumanski (phonetic) will do it for you. That should help keep your voice up. But, if you move your chair in a little bit closer that would help even more. Thank you very much. We just want to be sure everyone can hear you.
BY MS. DALPE:
Q Mr. Stanley, what was your former occupation?

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A My what?
Q What did you used to do for work?
A I used to work for the railroad.
Q All right. And, you remember when Laura was hospitalized in May of 2011; is that right?
A I really don't know when she was hospitalized.
Q Okay. If you think about that time in your mind, are you able to tell me whether you were seeing your daughter regularly in 2011?
A Yes, I would say. I tried to see my girls.
Q And, how often were you seeing Laura in 2011?
A I don't know, maybe once a week.
Q And, during that time in the first six months of 2011, did she ever indicate to you that she was feeling unwell?
A No.
Q Did you ever observe her to be unwell?

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A No.
Q Did you ever see her using an inhaler or anything like that?
A No.
Q Okay. Did she have any trouble going upstairs that you can recall?
A I don't know -- what do you mean? Before she was sick or after she was sick?
Q The first six months of 2011?
A That don't do much for me.
Q Okay. When she was hospitalized for the first time in May of 2011, did it come as a surprise to you?
A Absolutely.
Q All right. And, why was it a surprise?
A Because she was so healthy.
Q Do you still regularly see Troy?
A Yes.
Q And, how is he doing?
A He's doing fine.
Q Okay. And, what do you think of Seven Hills and what they're doing

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for him?
A I think it's excellent.
Q Okay. And, how is Megan currently?
A Who?
Q Your granddaughter?
A How is she?
Q Yes.
A Oh, she's fine.
Q Okay.
A I hope.
Q She just graduated from school, right?
A Yes, she did.
Q Okay. And so, she's doing well as well, correct?
A Yeah.
Q Do you have any knowledge of any tension between Seth and Laura at any time?
A No.
Q All right. That's not something that she ever talked to you about?
A No.
MS. DALPE: Thank you. I

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have no other questions.
THE COURT: Mr. Dumas?
MR. DUMAS: I have no questions, Your Honor.
THE COURT: Thank you. Any questions?
MR. SOBCZAK: Yes, Your Honor. Thank you.
(CROSS-EXAMINATION OF LEE STANLEY)
BY MR. SOBCZAK:
Q Good afternoon, Mr. Stanley. I will speak up so you can hear me.
A Thank you.
Q So, prior to Laura going to the hospital, you would see her about one time a week?
A Yes.
Q And, for how long would you see her?
A It all depends on what we were doing. I don't know. We might go to Walmart. We go out to eat, whatever.
Q So you didn't see her continuously, correct?

A **No, no.**
Q So, if she was having trouble breathing an hour before she saw you or an hour afterwards, you wouldn't know?
A **Oh, no. Not at all.**
Q Laura didn't talk to you about her relationship she had with her husband?
A **Not at all.**
Q She didn't talk to you about the details of her medical history?
A **No.**
Q You were there as her father ---
A **I'm just a dad, that's all I know.**
Q --- spend time with your daughter and spend times with your grandkids?
A **Exactly.**
Q So, you wouldn't consider yourself a person to describe Laura's medical history?
A **Not at all.**
MS. DALPE: Objection.
THE COURT: Overruled.

Q Now, since Laura's passing, you see your grandchildren still, frequently?
A **Sure.**
Q How has Laura's passing effected Megan?
A **It was terrible. I mean, the girl lost her mother. I mean, what am I supposed to say.**
Q It's hard to describe, right?
A **Yeah.**
Q It's her own mother, she's a teenage girl and she lost her?
A **That's right.**
Q And, how about Troy? You continue seeing Troy at Seven Hills, correct?
A **Yes.**
Q And, it's a great place? They're taking care of him there?
A **Yes, they are.**
Q Because Laura's no longer around?
A **Pardon?**
Q Because Laura's no longer around, so she can't do it?

A **That's right.**
Q Prior to Laura getting sick, Laura's the one that did everything for Troy?
A **Yes, she certainly did.**
Q She was managing his care, seeing him 24/7 the whole --
A **A hundred percent.**
Q She lived for her children?
A **Absolutely.**
Q And then, she got sick and then was taken away from her children?
A **Yes, it was.**
MR. SOBCZAK: Your Honor, may I approach?
THE COURT: Yes.
Q The photograph I just showed you, do you know what that's of?
A **Do I know what it's of?**
Q Yes.
A **Absolutely.**
Q Is that the depiction of the stone where Laura's buried?
A **Yes.**

Q Is that a fair and accurate depiction?
A **Pardon?**
Q Is it a fair and accurate depiction of the stone?
A **Yeah, it looks exactly like it.**
MR. SOBCZAK: Your Honor, I'd like this to go into evidence?
THE COURT: Any objection?
MR. DUMAS: No objection, Your Honor.
THE COURT: All right. Exhibit 33.
(Exhibit 33, so-marked)
BY MR. SOBCZAK:
Q Do you wish Troy would be able to come back and live with Laura?
MR. DUMAS: Objection.
THE COURT: Sustained.
MR. SOBCZAK: That's all I have, Your Honor.
THE COURT: Anything else?
MR. DUMAS: Two brief questions, Your Honor.

(CROSS-EXAMINATION OF LEE STANLEY)
BY MR. DUMAS:
Q Sir, Mr. Sobczak asked you some questions about when Laura got sick. The phrase sick. Do you recall testifying in your deposition that you recall, although you don't remember the timeframe that Laura was first hospitalized when she had a seizure?
A Yeah, she was hospitalized, yes.
Q And, in the times that you saw her before she had her seizure, you never saw her short of breath; is that fair?
A I would say, yes. I don't ever remember seeing her short of breath, because she was so healthy.
Q Okay. Thank you.
MR. DUMAS: That's all I have.
THE COURT: Anything else, Ms. Dalpe?
MS. DALPE: No thank you,

Your Honor.
THE COURT: Anything else, Mr. Sobczak?
MR. SOBCZAK: No, Your Honor.
THE COURT: Okay. Thank you very much, Mr. Stanley. You may step down. You are excused. So, we're reasonably close to 3 o'clock and rather than starting another witness, members of the jury, I remind you that next week we should be all full days and for purposes of trying to at least estimate, just try to keep your calendars clear through at least Thursday.
There was one slight change in what we're going to be doing next week, at least the first two days. And, that is this, so by way of background, the highest court in Massachusetts is the Supreme Judicial Court and they use sit in Boston, but once a year or so they

go out to a different county to sit for a day and make their appeals of cases. Nothing to do with this case whatsoever.
And, so this year, they have chosen to come to Franklin County. They're going to be here on Tuesday and they're going to be using two courtrooms, one of which they're going to be sitting in. There's a number of judges, they all sit up on the bench and they have a full day, so about 2 o'clock worth of work and because of the number of people who are expected to attend, they're going to need two courtrooms.
So, one courtroom will be the one which the judges will be sitting and hearing arguments and the other courtroom will be essentially for overflow of people who can watch the proceedings before the Supreme Judicial Court on video camera.

And, fortunately or unfortunately, one of the rooms they will use is ours. So, on Monday, even though they're not coming until Tuesday, because there has to be some things set up technically, wires and whatever else, we're going to move over to another courtroom here, on Monday and Tuesday, to the farther end of the building, same floor.
I think we also have to move your jury room, yes. Because, I'm told that the Supreme Judicial Court is going to use the room that you're using right now, before they come out on the bench and when they come off the bench, after hearing the cases they'll be hearing.
So, that's just by way of 53:04. The court officers will show you today, before you leave, the next room you're going to be using. So, if any of you are leaving stuff

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in the room you're using presently, I'm just telling you all this, so you'll pick it up and either move it down there and leave it down there for Monday.

And, the other difference in the other courtroom is there is two differences. One of which is there's -- it probably won't interfere with looking at moved screens and whatever, but there is a window that's right behind the jurors. I think we can screen out the sunlight, but sometimes that type of thing causes some reflection on the screen, so hopefully that won't be a problem.

And, the other thing is that the room is actually intended for jury trials in which there's six jurors or maybe up to eight jurors. So, quite fewer seats. But, what we're going to give you the same kind of seats, just that four of you

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are going to be a little bit like down a step from the others. No reflection on anybody's importance. Hopefully, it won't interfere with anything, but I just wanted to give you all an idea of the fact that this is going to happen for the first two days, so nobody's thrown off base on it.

It's got nothing to do with the case at all. We're just accommodating the Supreme Judicial Court for their visit on Tuesday.

So, unless there's anything else, we will see you all on Monday morning and I remind you of this, we're going to be session until 4:30 at the latest for those days.

MR. DUMAS: Do we keep these on 54:39, still?

THE COURT: We provide the seats, we'll have everything moved to the other area.

MR. SOBCZAK: Your Honor, it

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may impact parking as well on Monday and Tuesday.

THE COURT: Oh, that's true. Yeah, what about parking. I don't think Monday will be problematic, Tuesday may, so ---

MR. DUMAS: Tuesday might, yes.

THE COURT: So, don't worry about Monday. On Monday, we'll tell you what accommodations we're going to make sure you don't --- I know parking is already a bit of a nightmare here. But, we want to make sure that our jurors have adequate parking. So, we'll take care of that between now and Monday, and we'll tell you what to do on Monday. Thank you.

MR. SOBCZAK: Thank you, Your Honor.

(JURY EXITS)

MR. SOBCZAK: Do we need to move this stuff now, Your Honor, or

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Monday morning, or just for logistic purposes?

THE COURT: Well, it probably makes more sense to do it today.

MR. SOBCZAK: Okay.

THE COURT: I have other matters. So, they're supposed to start in about 15 minutes or so.

MR. SOBCZAK: If you can give me about 15-20 minutes, Your Honor?

THE COURT: You tell me when you're ready for me.

MR. SOBCZAK: All right. Perfect. Thank you.

(Court concludes at 3:00 p.m.)

C E R T I F I C A T I O N

I, MEREDITH POLLIER, A PER DIEM COURT REPORTER, DO HEREBY CERTIFY THAT THE FOREGOING IS A TRUE AND ACCURATE TRANSCRIPT FROM THE RECORD OF THE COURT PROCEEDINGS IN THE ABOVE-ENTITLED MATTER.

I, MEREDITH POLLIER, FURTHER CERTIFY THAT I NEITHER AM COUNSEL FOR, RELATED TO, NOR EMPLOYED BY ANY OF THE PARTIES TO THE ACTION IN WHICH THIS HEARING WAS TAKEN, AND FURTHER THAT I AM NOT FINANCIALLY NOR OTHERWISE INTERESTED IN THE OUTCOME OF THE ACTION.

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