

1 VOL. I
 2 PAGES 1-83
 3 EXHIBITS None
 4 IN THE COURT OF COMMON PLEAS
 5 CUYAHOGA COUNTY, OHIO
 6 ANGELA R. MATTIO,)
 7 Plaintiff,)
 8 vs) No. 433190
 9 DINA A. DiCENZO, DO,)
 10 et al,)
 11 Defendants.)
 12
 13
 14 TELEPHONIC DEPOSITION of HENRY M.
 15 LERNER, M.D., taken on behalf of the defendant,
 16 pursuant to the applicable provisions of the
 17 Ohio Rules of Civil Procedure, before Katherine
 18 Henry-Sexton, a Notary Public in and for the
 19 Commonwealth of Massachusetts, at the offices of
 20 Dr. Lerner, Newton-Wellesley Obstetrics and
 21 Gynecology, PC, 2000 Washington Street, 768
 22 Green Building, Newton, Massachusetts, on
 23 Tuesday, August 13, 2002, commencing at 1:35
 24 p.m.

1 APPEARANCES:
 2 Sindell, Young, Guidubaldi and
 3 Sucher, (by Cathleen M. Bolek, Atty.), 1020
 4 Illuminating Building, Cleveland, Ohio 44113,
 5 for the plaintiff (by telephone).
 6 Bonezzi, Switzer, Murphy and
 7 Polito, (by Anthony P. Dapore, Esq.), 1400
 8 Leader Building, Cleveland, Ohio 44114, for the
 9 defendant, D. DiCenzo, DO (by telephone).
 10
 11 I N D E X
 12
 13 Deposition of: Page
 14 HENRY M. LERNER, M.D.
 15 Examination by Ms. Bolek 3
 16
 17 CERTIFIED QUESTIONS 27, 29, 64
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1 HENRY M. LERNER, M.D., a witness
 2 called on behalf of the defendant, first having
 3 been duly sworn, on oath deposes and says as
 4 follows:
 5
 6 Examination by Ms. Bolek:
 7 Q. Good afternoon, Dr. Lerner. My name
 8 is Cathleen Bolek, and I represent Angela Mattio
 9 in the case she filed against Dr. Dina DiCenzo.
 10 I understand you are in your office in
 11 Massachusetts?
 12 A. Yes, I am.
 13 Q. And you are the only other person
 14 present with the court reporter?
 15 A. That's correct.
 16 Q. Please state your full name?
 17 A, Henry Michael Lerner.
 18 Q. What is your current business address,
 19 sir?
 20 A. 2000 Washington Street, Newton,
 21 Massachusetts.
 22 Q. Who is your current employer? What is
 23 the legal entity that employs you?
 24 A. Newton-Welleslev Obstetrics and

1 Gynecology, PC.
 2 Q. How long have you been employed by
 3 that entity?
 4 A. We incorporated in 1995 or
 5 thereabouts, so it would be seven years employed
 6 by that entity.
 7 Q. Is that the entity that is responsible
 8 for billing when you perform procedures on
 9 patients?
 10 A. Yes.
 11 Q. Are you affiliated with any other
 12 legal entities for billing purposes?
 13 A. No.
 14 Q. And when you do medical/legal
 15 consulting work, is that the entity that the
 16 check is made to?
 17 A. No.
 18 Q. Who is that check made to?
 19 A. Me personally,
 20 Q. Doctor, I was provided with a
 21 curriculum vitae prior to the deposition. As
 22 far as you know, is that CV current and
 23 up-to-date?
 24 A. If it has my last publication in

5

1 Hospital Medicine, which will be on the next to
 2 last page, then it is up-to-date.
 3 Q. The publications that are listed on
 4 this CV are Radical Surgery for the Treatment of
 5 Early Invasive Cervical Carcinoma. There's one
 6 for Pre-hysterectomy Curettage, Prior --
 7 A. It doesn't have the hospital medicine
 8 article?
 9 Q. No.
 10 A. That would be the only change. 1999,
 11 I believe, I wrote an article which was
 12 published in Hospital Medicine entitled,
 13 Pre-pregnancy Counseling for General
 14 Practitioners.
 15 Q. That is the only change to your CV?
 16 A. Yes.
 17 Q. Can you tell me everything you
 18 reviewed in preparation for your deposition?
 19 A. I reviewed medical records on Angela
 20 Mattio from Southwest General Hospital, from
 21 Parma Community Hospital. I reviewed office
 22 records on Ms. Mattio from Dina DiCenzo's office
 23 and Timothy Klatt's, K L A T T, office. I
 24 reviewed a letter written by Dr. Austin. I also

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1 A. No, These are all matters that I'm
 2 familiar with from my 22 years of practice.
 3 Q. Do you intend to conduct any research
 4 prior to testifying in the trial of this case?
 5 A. I do not intend to, no.
 6 Q. Can you tell me other than the medical
 7 records and depositions that you've described,
 8 what else is in your file on this case?
 9 A. Nothing.
 10 Q. Do you have any correspondence or have
 11 you ever received any correspondence from any of
 12 Dr. DiCenzo's attorneys?
 13 MR. DAPORE: Objection. That's work
 14 product. You don't answer that question,
 15 Doctor.
 16 MS. BOLEK: Tony, I cannot disagree
 17 with you more strongly, If you've written this
 18 expert letters, then you have violated the
 19 privilege. He's not your client.
 20 MR. DAPORE: I didn't say it was a
 21 privilege. I said it was work product.
 22 Communications between myself and experts,
 23 that's work product,
 24 MS. BOLEK: Do you have a case cite

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1 have reviewed deposition transcripts on Dr.
 2 DiCenzo, on Mario Mattio and from Angela Mattio.
 3 I also have a letter from an expert witness, a
 4 Dr. Bruce Rosenzweig. And I believe that's it.
 5 Q. The letter from Dr. Austin, what is
 6 that letter, sir?
 7 A. Please repeat the question about Dr.
 8 Austin's letter?
 9 Q. You indicated you reviewed a letter
 10 from Dr. Austin?
 11 A. Yes.
 12 Q. What is the date of that letter?
 13 A, September 15th, 2000.
 14 Q. And Dr. Austin is one of Angela
 15 Mattio's care providers?
 16 A. Yes.
 17 Q. Did you request any information that
 18 you were not provided relative to this case?
 19 A. I requested to make sure that I had
 20 all the depositions that were available at the
 21 time I made the request, and I was told I had
 22 them.
 23 Q. Did you research, conduct any medical
 24 research, at any time relative to this case?

8

1 on that Tony? I've researched that issue
 2 extensively, and I can tell you there isn't
 3 any --
 4 MR. DAPORE: That is work product.
 5 MS. BOLEK: Because you say so?
 6 MR. DAPORE: Yes.
 7 MS. BOLEK: I guess it will be an
 8 issue to take up with the court.
 9 MR. DAPORE: Okay.
 10 Q. Doctor, are you refusing to answer
 11 that question?
 12 A. Absolutely, on the advice the attorney
 13 just mentioned.
 14 Q. Have you ever met Dr. DiCenzo?
 15 A. I have not.
 16 Q. Have you ever spoken with her?
 17 A. I have not.
 18 Q. Doctor, what is your understanding of
 19 the size of the cyst that Angela Mattio had th t
 20 Dr. DiCenzo attempted to remove?
 21 A. The dimensions were four-and-a-half by
 22 three-and-a-half by three-and-a-half
 23 centimeters,
 24 Q. What is the size of the instrument

9

1 that she attempted to pull the cyst through?
 2 A. I don't understand that question.
 3 You said the size of the instrument she
 4 attempted to --
 5 Q. She attempted to pull the cyst through
 6 an instrument?
 7 A. Through an instrument - as opposed to
 8 an incision?
 9 Q. Yes.
 10 A. There was an endo bag. There is a
 11 trocar that is used. The trocar is 11
 12 millimeters, at least the one that was in the
 13 lower quadrant on the left,
 14 Q. Did Dr. DiCenzo attempt to pull the
 15 cyst through the trocar?
 16 A. She attempted to get the bag
 17 containing the cyst through that.
 18 Q. You know that Dr. DiCenzo prepared two
 19 operative reports?
 20 A. I do.
 21 Q. You know that in the second operative
 22 report she says the trocar was ten millimeters?
 23 A. Please hang on a second. I'm looking
 24 for somethina in the record, In the first

11

1 A. Well, she used that to put in the
 2 laparoscope in the sub-umbilical incision.
 3 Q. So what size was the trocar that she
 4 attempted to pull the endo bag through?
 5 A. It looks from the note like the 12
 6 millimeter port.
 7 Q. And will a three-and-a-half centimeter
 8 cyst fit through a 12 millimeter port?
 9 A. Depends on the compressibility of the
 10 cyst, If you think of the cyst as a small
 11 fluid-filled sac, if you pull it through and the
 12 wall is strong enough, the sac can change its
 13 shape to fit through a smaller opening. If the
 14 cyst wall is too fragile, at some point during
 15 the changing of shape of the cyst, it can
 16 rupture.
 17 Q. Or a third option - if you try to pull
 18 the cyst, a three-and-a-half or four-and-a-half
 19 centimeter cyst through a 12 millimeter port,
 20 the endo bag may break; is that correct?
 21 A. That falls in the category of
 22 potential equipment failure. We all the time
 23 remove cysts this size through one to
 24 one-and-a-half centimeter incisions, The cvst

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1 operative report - I'll answer your question in
 2 a second. In the first operative report it says
 3 that the incision was extended to accommodate a
 4 12 millimeter trocar.
 5 And I'm looking for the second
 6 operative report you're referencing. I believe
 7 your question supposes an incorrect reading of
 8 the second operative report. You said 11
 9 because what I see is that the cyst was then
 10 free in the pelvis, and an endo catch bag was
 11 placed through the 12 millimeter port. And then
 12 in looking further, in that report, the second
 13 op report where you said something about an 11
 14 millimeter trocar, I do not see that,
 15 Q. So in her first operative report she
 16 said that she used a 12 millimeter trocar?
 17 A. Right, and she says the second thing
 18 in the second operative report.
 19 Q. Which is what?
 20 A. The cyst was then free in the pelvis,
 21 and an endo catch bag was placed through the 12
 22 millimeter port.
 23 Q. Do you know that in her deposition she
 24 says that she used a ten millimeter trocar?

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1 changes shape and then reforms its shape once
 2 it's through the pressure of the opening.
 3 So although the bag can break as an
 4 option, the instrument you're pulling with can
 5 break and leave something inside, The cyst can
 6 break in half. There are many things that can
 7 happen. But the most likely outcome and the one
 8 you expect when you're planning ahead in making
 9 your decision as to what to do is either the
 10 cyst will deform enough to be removed or it
 11 won't, or it will rupture within the bag which
 12 is why you use the bag,
 13 Q. If you're attempting to rupture the
 14 cyst in the endo bag, what do you use to drain
 15 the cyst? How do you do that?
 16 A. If you are intentionally draining the
 17 cyst, are you asking?
 18 Q. Yes.
 19 A. There are a couple of ways to do it.
 20 One would be to attempt to put a needle through
 21 an anterior abdominal wall, watch the needle
 22 with one of your scopes and put the needle
 23 through the bag wall into the cyst, A second
 24 way would be to do the same thina with an

If

1 intra-abdominal laparoscopic instrument with a
 2 needle on the end of it.
 3 Q. If you have an obese patient, is there
 4 any problem with accomplishing either of the two
 5 items you just described?
 6 A. Might or might not be, depends on the
 7 exact thickness of the anterior abdominal wall -
 8 in the obese patient, how long an external
 9 needle you have if you're using that approach.
 10 If you're talking about an intraoperative
 11 approach, if the doctor were able to get
 12 scissors and other instruments inside, it would
 13 seem that that approach would be possible
 14 without too many reasons to think it couldn't be
 15 performed.
 16 Q. So if you have a patient on the table
 17 and you have a cyst in an endo bag and you're in
 18 the middle of the procedure, then there's no
 19 reason why you shouldn't be able to drain the
 20 cyst even if you have an obese patient, if
 21 that's what you're intending to do? There are
 22 instruments to accomplish that purpose, is my
 23 question?
 24 A. I don't know if Dr. DiCenzo had those

15

1 A. Now, you've made a misstatement. You
 2 didn't restate the question, This is a totally
 3 different question. I'm happy to answer it, but
 4 I want to be clear it is a totally different
 5 question.
 6 Should you as an operating surgeon
 7 be able to drain a cyst? It depends on the
 8 instrumentation you have and the thickness of
 9 the patient's abdominal wall. So I cannot say
 10 definitely yes. There are situations when I
 11 cannot always drain a cyst.
 12 Q. My question, Doctor, is whether as a
 13 surgeon you should check to make sure that you
 14 have the appropriate equipment prior to
 15 commencing the procedure?
 16 A. Appropriate equipment for what?
 17 Q. To complete the procedure you're
 18 attempting.
 19 A. If you don't know exactly what you're
 20 going to get into when you get inside a patient,
 21 there's no way you can predict ahead of time
 22 exactly what you're going to need.
 23 Q. Doctor, if you're going to perform a
 24 laparoscopic cystotomy on a patient who is

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1 instruments available at her hospital, one. And
 2 two, there are about three or four or five ways
 3 to do anything in medicine. In all of the
 4 different procedures I do I probably know and
 5 can perform two-thirds of any of those ways, and
 6 probably one-third of those ways I've never been
 7 taught or trained or just don't use on a regular
 8 basis.
 9 So yes, there are multiple other
 10 ways you could drain a cyst in a bag, that I'm
 11 not familiar or Dr. DiCenzo might nor be
 12 familiar with. But: yeah, there are other ways
 13 to do it.
 14 Q. I don't think you answered my
 15 question, Doctor,
 16 A. You asked if you could drain the cyst
 17 during surgery; and I said, yeah, there are
 18 other ways to do it.
 19 Q. If I may please finish my question,
 20 Doctor. If you are intending to perform a
 21 laparoscopic cystotomy on a patient who is
 22 obese, should you as a physician, as a surgeon,
 23 ensure that you have the proper instruments to
 24 complete your procedure?

16

1 obese, and you intend to drain the cyst once
 2 it's in the endo bag and prior to removing it
 3 from the abdomen, should you not as a surgeon
 4 ensure in advance that you have the equipment
 5 with you in the operating room to accomplish
 6 that procedure?
 7 MR. DAPORE: I'm going to object
 8 because the operative plan here was not a
 9 cystotomy. The operative plan was a cystectomy.
 10 Q. Doctor, if you're intending to perform
 11 a laparoscopic cystectomy on an obese patient,
 12 and it's your intention to drain the cyst once
 13 it's in the endo bag and prior to removing it
 14 from the abdomen, should you as the surgeon
 15 ensure you have the appropriate equipment with
 16 you in the operating room when you commence that
 17 procedure?
 18 A. Your question is internally
 19 inconsistent; and I, therefore, cannot answer
 20 it. It was never the intention ahead of time to
 21 drain the cyst. That was --
 22 Q. I'm not asking you what was intended
 23 by Dr. DiCenzo on the day that she commenced
 24 surgery on Angela Mattio.

17

1 A. Will you listen to my answer please?
 2 Your question is internally inconsistent, You
 3 stated that someone is going to perform a
 4 cystectomy and then planning on drain the cyst.
 5 You don't plan to drain the cyst until you see
 6 what goes on during the cystectomy. That's why
 7 it can't be answered.
 8 Q. It's true, isn't it, when you perform
 9 a cystectomy it is not unusual to drain the cyst
 10 prior to removing it from the abdomen?
 11 A. If the cyst appears entirely benign
 12 and you can be sure of that by appearance, what
 13 you say is true.
 14 Q. So once again, should you as the
 15 surgeon when you are performing laparoscopic
 16 cystectomy on a patient, should you as the
 17 surgeon make sure you have the equipment
 18 necessary to perform the procedure in the event
 19 you should drain the cyst in the operating room
 20 if you know the patient is obese?
 21 A. Please repeat your question.
 22 Q. You are performing a laparoscopic
 23 cystectomy on an obese patient. Should you
 24 ensure that you have the equipment with you in

19

1 structure inside a cyst. The more internal
 2 structures there are inside a cyst, whether
 3 septum or other internal structures, the greater
 4 the likelihood that this is not a simple benign
 5 cyst.
 6 Q. When the pathologist reviewed or
 7 inspected the cyst after the surgery, did the
 8 pathologist find any septum?
 9 A. There is no mention of that, no.
 10 Q. Is that the sort of thing that would
 11 generally be mentioned in a pathology report?
 12 A. It depends. A septum is very thin.
 13 The pathologist got the cyst after it had been
 14 collapsed; therefore, a very thin membrane could
 15 well have been adherent to the inside structure
 16 of the general capsule. If a pathologist gets a
 17 structural hole; that is, if you do a laparotomy
 18 directly and remove an ovarian cyst, and a
 19 pathologist gets a non-drained ovarian cyst and
 20 it has septum, yes, I would agree with you the
 21 pathologist would mention that in the report.
 22 Q. So your testimony is in this
 23 particular case there might have been septum and
 24 the pathologist may not have noticed it?

18

1 the operating room prior to commencing the
 2 procedure, the equipment specifically to drain
 3 the cyst in the event that you determine that's
 4 what you should do?
 5 A. Your question cannot be answered in
 6 its form because it presupposes that you know
 7 exactly what you will need. Dr. DiCenzo thought
 8 she had what she needed, a long spinal needle.
 9 It turned out in this case it was inadequate.
 10 She did not and could not know that until she
 11 was trying to drain it.
 12 Q. She couldn't know how long of a needle
 13 she needed for Angela Mattio's abdominal wall
 14 until after the surgery, Doctor; is that your
 15 testimony?
 16 A. Absolutely. She could not know that
 17 the long needle that she normally uses to get
 18 through an abdominal wall would not get to this
 19 cyst in this particular patient until she was
 20 inside the belly and she tried it and it didn't
 21 reach.
 22 Q. What is the significance of the
 23 septum?
 24 A. The septum is an internal dividing

20

1 A. Yes, because the cyst was collapsed at
 2 the time the pathologist got the specimen.
 3 Q. In your opinion, Doctor, was this cyst
 4 the cause of Angela Mattio's pelvic pain on
 5 9/30/99?
 6 A. I think it contributed to the pelvic
 7 pain, but might not have been the sole cause
 8 because there also was scar tissue.
 9 Q. Is there any other cause of the pain
 10 in your opinion?
 11 A. I'm thinking - no, I do not think so.
 12 Q. Doctor, do you agree with this
 13 statement - if a cyst is drained in an endo bag
 14 prior to removal from the abdominal cavity, the
 15 contents of the cyst will not spill into the
 16 abdominal cavity?
 17 A. If the bag remains intact, yes, that's
 18 its purpose.
 19 Q. Doctor, when were you first consulted
 20 in regards to this matter?
 21 A. I only have a rough idea. I imagine
 22 about a year to a year and a half ago.
 23 Q. Tell me what your fee structure is for
 24 your medical/legal consulting?

21

1 A. When I review cases on my own time, I
 2 charge \$300 an hour. When I have to take off
 3 time from the office such as I'm doing today,
 4 \$500 an hour.

5 Q. When you get a telephone call from Mr.
 6 Dapore during business hours, do you charge him
 7 \$500 an hour or \$300 an hour?

8 A. Depends on how long the telephone call
 9 is, Usually during the day I cannot take an
 10 unscheduled call because I have patients I'm
 11 seeing. So that situation hasn't come up.
 12 Usually the telephone calls are scheduled in
 13 advance. If Mr. Dapore needs an hour or two of
 14 my time - the situation hasn't come up, but if
 15 he wanted to talk to me for two hours in the
 16 middle of a weekday and I had to see patients, I
 17 would charge my daytime rate.

18 Q. How much time have you put into this
 19 file so far?

20 A. Including my first review?

21 Q. Yes.

22 A. Eight or nine hours.

23 Q. How many reports have you drafted?

24 A. One.

23

1 insurance carrier?

2 MR. DAPORE: Objection. You can
 3 answer.

4 A. ProMutual.

5 Q. Are you active in any organization
 6 that is lobbying or campaigning or working to
 7 bring about court reform or medical malpractice
 8 reform?

9 MR. DAPORE: Objection. You don't
 10 have to answer that question. It's irrelevant.

11 MS. BOLEK: He does.

12 MR. DAPORE: No, he doesn't. It's
 13 irrelevant, not likely to lead to any admissible
 14 evidence.

15 MS. BOLEK: It is admissible, It
 16 goes directly to his bias.

17 MR. DAPORE: You haven't shown that
 18 he has a bias.

19 MS. BOLEK: I don't have to show he
 20 has a bias in order to ask questions to
 21 determine whether or not he has a bias. You're
 22 obstructing my deposition.

23 Doctor, do you remember the
 24 question?

22

1 Q. Did you make any changes to that
 2 report at any time after you submitted it to Mr.
 3 Dapore or anyone from his office or anyone
 4 representing Dr. DiCenzo?

5 A. No.

6 Q. Have you ever worked for Mr. Dapore or
 7 his office before?

8 A. Yes.

9 Q. How many times?

10 A. Mr. Dapore, once. And I may be
 11 looking at a case for another lawyer in his
 12 office because I remember seeing the office
 13 letterhead, but I don't remember the name of
 14 that lawyer right now.

15 Q. Do you remember the name of the case
 16 that you reviewed for Mr. Dapore previously?

17 A. Tiffany Maxwell versus Escheneur
 18 [sic].

19 Q. You know from Dr. DiCenzo's deposition
 20 that she had a number of lawsuits filed against
 21 her, Doctor, Were you consulted with regard to
 22 any of those cases?

23 A. No.

24 Q. Who is your medical malpractice

24

1 THE WITNESS: Mr. Dapore?

2 MR. DAPORE: Do you remember the
 3 question?

4 THE WITNESS: I do.

5 Q. Can you answer the question please?

6 A. There's an organization called the
 7 Professional Liability Foundation that seeks to
 8 ameliorate the current anti-patient and
 9 anti-physician and anti-hospital tort liability
 10 climate in Massachusetts.

11 Q. Is that the organization that's
 12 commonly known as PLUS?

13 A. I do not believe so. I have never
 14 heard of that name, PLUS.

15 Q. It's Professional Liability
 16 Underwriters Service, I believe.

17 A. I have never heard that term before,
 18 ma'am,

19 Q. Does the Professional Liability
 20 Foundation have a Web site?

21 A. Good question. I don't know,

22 Q. Where are they headquartered?

23 A. Well, we don't have a headquarters.

24 We have an executive director, but the meetings

25

1 of the board of that group, which occur a few
 2 times a year, are in different locations.
 3 Q. Who is the executive director?
 4 A. Michael Kelley,
 5 Q. Where is Mr. Kelley or Dr. Kelley
 6 located?
 7 A. It's Mr. Kelley, and he has a private
 8 practice in Boston, Massachusetts.
 9 Q. He's an attorney?
 10 A. Yes.
 11 Q. Does the Professional Liability
 12 Foundation have a newsletter or anything of that
 13 sort?
 14 A. No.
 15 Q. In Angela Mattio's records there is a
 16 note by Dr. Klatt that Mrs. Mattio had a wound
 17 infection for two months; did you see that?
 18 A. Let me find that. I see that note,
 19 Q. Do you agree with that statement?
 20 A. That statement had to have been
 21 obtained from the patient's history, so I agree
 22 that Dr. Klatt heard that from Ms. Mattio.
 23 Q. Do you agree that Mrs. Mattio had a
 24 wound infection for two months?

27

1 statements about the wound.
 2 Q. Did you credit Dr. DiCenzo's
 3 testimony?
 4 A. In what regard?
 5 Q. On the whole did you believe that Dr.
 6 DiCenzo's testimony was credible?
 7 A. I will have to answer it this way - I
 8 saw nothing in Dr. DiCenzo's testimony that I
 9 found internally inconsistent.
 10 Q. That wasn't my question, Doctor.
 11 A. I explained to you that's the way I
 12 have to answer it.
 13 Q. On the whole did you find Dr.
 14 DiCenzo's testimony to be credible?
 15 A. I will only give you the answer I just
 16 gave you.
 17 Q. Is that a yes or no to my question?
 18 A. I'll say it a third time, and I won't
 19 say it again. I found nothing internally
 20 inconsistent in her testimony.
 21 Q. I didn't ask you whether you found
 22 anything internally inconsistent in her
 23 testimony, Doctor, I asked you whether you
 24 found her testimony on the whole to be credible?

26

1 A. I have no basis for judging that other
 2 than what I just mentioned.
 3 Q. How long did Angela Mattio's wound
 4 infection last?
 5 A. I do not know the status of that
 6 beyond November 9th of 1999.
 7 Q. Did you read Angela's deposition?
 8 A. I did.
 9 Q. Do you have any reason to dispute her
 10 testimony with regard to how long her infection
 11 lasted?
 12 A. I do.
 13 Q. What is the basis of that?
 14 A. At one point she claims she had a
 15 greenish discharge from her incision the day
 16 after surgery. That's a clear impossibility.
 17 Therefore, I cannot find totally credible other
 18 statements in regard to the wound.
 19 Q. So based on that statement you've
 20 disregarded her testimony all together with
 21 regard to how long her infection lasted?
 22 A. Based on what I know to be one
 23 incorrect statement describing the wound, yes,
 24 it cast doubt on other otherwise unsupported

28

1 A. I've answered it the best way I can.
 2 Q. But you haven't answered it.
 3 MR. DAPORE: He has, but you don't
 4 like the answer so let's move on,
 5 MS. BOLEK: I'll have to include
 6 that in my motion as well. I ask the court
 7 reporter to certify that question,
 8 Q. Doctor, was there anything about Dr.
 9 DiCenzo's testimony that caused you to question
 10 her skill as a surgeon?
 11 A. No.
 12 Q. Hearing that she may have cut off a
 13 child's toe when she cut its umbilical cord does
 14 not cause you to question her skill as a
 15 surgeon?
 16 MR. DAPORE: Objection, it's totally
 17 irrelevant to this case. We're not going to
 18 answer the question.
 19 Q. Doctor, are you refusing to answer the
 20 question?
 21 A. On the advice of Mr. Dapore. Besides
 22 it was a misquotation from the record. It was a
 23 misstatement.
 24 Q. Her deposition testimony was a

1 misstatement?
 2 A. Your repeating of it was a
 3 misstatement. When asked whether she did or
 4 not, she said, "I don't know", not that she did
 5 cut off the toe. I'd appreciate if you'd use
 6 the right wording in asking your question.
 7 Q. Let me ask it this way - should a
 8 surgeon know whether or not she cut off a
 9 child's toe when she was cutting the umbilical
 10 cord?
 11 MR. DAPORE: Objection, prior bad
 12 acts are not admissible in this case or any
 13 other case.
 14 MS. BOLEK: This is a discovery --
 15 MR. DAPORE: It's inadmissible and
 16 not going to lead to the discovery of admissible
 17 evidence, He's not going to answer the
 18 question,
 19 MS. BOLEK: You can make your
 20 objection. You do not have a right to advise
 21 the expert witness to not answer my question.
 22 MR. DAPORE: Certainly I can.
 23 MS. BOLEK: I will move for costs
 24 and we will adjourn the deposition.

1 Therefore, to the extent that there
 2 was a laparotomy incision, under the
 3 circumstances it statistically is somewhat more
 4 likely to have led to an infection. That by no
 5 means states, one, that there could not have
 6 been infection just from the laparotomy
 7 incision. There are all the time. Q two, the
 8 fact that it's more likely you can get an
 9 infection from a laparotomy incision in any way
 0 shape or form states that laparotomy incisions
 1 sometimes are not the exact appropriate thing to
 2 do.
 3 Q. Doctor, you agree that all other
 4 things being equal the longer the surgery
 5 progresses, the more likely it is that the
 6 patient will develop a postoperative infection?
 7 A. Correct.
 8 Q. And you agree that all other things
 9 being equal a laparotomy is more likely to
 0 result in a postoperative infection than a
 1 laparoscopy?
 2 A. Yes.
 3 Q. You note in your report that Angela
 4 Mattio had persistently elevated sedimentation

1 Doctor, do you remember my
 2 question?
 3 A. I'm not going to answer.
 4 Q. Please do. Did you say you're not
 5 going to or you will answer?
 6 A. I'm not going to answer,
 7 Q. Doctor, in your opinion what is the
 8 cause of the wound infection that Mrs. Matt o --
 9 A. The cause of the wound infection is
 10 the cause of all infections, bacteria.
 11 Q. If Angela Mattio had not had a
 12 laparotomy, do you agree her course of recovery
 13 probably would have been different?
 14 A. Not probably, but might have been
 15 different,
 16 Q. In what way?
 17 A. In Dr, DiCenzo's deposition there were
 18 some questions that you asked that were
 19 reasonable about whether or not the length of
 20 time an operation lasts and whether the more
 21 involved the procedure is, whether that
 22 increases the infection rate. It does not
 23 necessarily do so; but all other things being
 24 equal, it is more likely to.

1 rate. What significance, if any, does that fact
 2 carry for Mrs. Mattio's course?
 3 A. Let me please find that first, At the
 4 beginning, middle, end of the report? I see it,
 5 okay. The reference to sedimentation rate in
 6 this case was, I believe, part of Dr. Klatt's
 7 looking for an infertility factor. A
 8 sedimentation rate can be raised by any
 9 infection or inflammation,
 0 So given the fact that Ms. Mattio
 1 had incisional infection for some length of time
 2 following her surgery, the sedimentation rate
 3 may still have been raised by the time Dr. Klatt
 4 saw her. On the other hand, sedimentation rate
 5 is classically being looked for in an
 6 infertility patient for conditions such as lupus
 7 or anticardiolipin syndrome.
 8 Q. Angela does not have anticardiolipin
 9 syndrome, does she?
 0 A. Well, it's actually thought that she
 1 did because she had a positive lupus factor.
 2 And at the end of the letter - let me see if
 3 it's by Austin or Klatt, I believe it's by
 4 Klatt. He says that that makes the possibility

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1 of anticardiolipin syndrome is a likely
 2 possibility,
 3 Q. So the answer to my question is you
 4 don't know whether she has anticardiolipin
 5 syndrome?
 6 A. No. The answer to your question was
 7 that the doctor who was diagnosing it says that
 8 it was a likely possibility,
 9 Q. Do you know whether or not she has it?
 10 A. With 100 percent certainty, no. With
 11 probability, yes.
 12 Q. So you believe that to a reasonable
 13 degree of medical probability Angela Mattio has
 14 anticardiolipin syndrome?
 15 A. I can't answer the question the way
 16 you phrase it.
 17 Q. What is it about my phrasing that you
 18 are unable to answer the question, Doctor?
 19 A. As a medical expert witness I can
 20 evaluate medical records, I can evaluate
 21 positive tests, and I can evaluate statements
 22 made by providers who are expert in that area,
 23 You have been trying to take that away from me
 24 just now because I've answered you twice that

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1 laboratory studies,
 2 A. I have it. Thank you. January 19th,
 3 2001, under assessment and plan there's a first
 4 assessment and plan then there's No. 2. "If she
 5 would like to attempt pregnancy, we will refer
 6 her to reproductive endocrinology. She has a
 7 positive lupus anticoagulant in addition to
 8 multiple miscarriages. This gives her a
 9 diagnosis of antiphospholipid antibody syndrome.
 0 Q. Doctor, does that fact play any role
 1 in the question of what caused Angela Mattio's
 2 postoperative infection?
 3 A. No.
 4 Q. Does it play any role in the manner in
 5 which her surgery was carried out by Dr.
 6 DiCenzo?
 7 A. No.
 8 Q. Does it play any role in her
 9 postoperative course?
 0 A. Only to the extent at one time it was
 1 claimed that part of Ms Mattio's current
 2 inability to get pregnant was related to the
 3 surgery,
 4 Q. Who claimed that, Doctor?

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1 the expert evaluating thought that this was a
 2 likely syndrome.
 3 Me reading the medical records and
 4 seeing the positive test, that's a reasonable
 5 conclusion, So I think what the doctor thought
 6 as reasonable is reasonable. But you want me
 7 independently somehow to answer your question,
 8 and I can't do that,
 9 Q. Your testimony is that based upon your
 10 review of his record, Dr. Klatt believes that it
 11 is more likely than not that Angela Mattio has
 12 anticardiolipin syndrome?
 13 A. Yes, and I am looking to find that
 14 passage which I saw last night. Let me see if I
 15 can do that,
 16 MR. DAPORE: In the January 19th,
 17 2001, dictated and typed note.
 18 THE WITNESS: 2001?
 19 MR. DAPORE: Yes, that's what it
 20 says at the top. It's probably in error.
 21 THE WITNESS: One of the ones that
 22 says University Hospital Health Systems?
 23 MR. DAPORE: Correct. In my set of
 24 records it's the last clinical note before the

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1 A. I can't locate that right now, It was
 2 a general impression I have had from the
 3 documents I read.
 4 Q. From the what?
 5 A. From the documents I read.
 6 Q. Could that have been something you got
 7 from Mr. Dapore?
 8 A. The only thing I got from Dapore is
 9 that those claims are no longer being made.
 0 Q. My question, sir, is - did you learn
 1 from Dr. Dapore that that claim was ever being
 2 made?
 3 MR. DAPORE: My only doctorate is
 4 being a juris doctorate so --
 5 A. I believe I have heard it from him. I
 6 believe I have also seen it in the records, but
 7 I cannot put it my finger on it now.
 8 Q. Have you ever broken an endo bag
 9 removing a cyst?
 0 A. No.
 1 Q. Approximately how many procedures have
 2 you done where you've used an endo bag to remove
 3 a cyst over your career?
 4 A. 15 to 20.

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1 Q. Have you done laparoscopic
 2 cystectomies where you've not used an endo bag?
 3 A. Many times.
 4 Q. Approximately how many times?
 5 A. A hundred,
 6 Q. When you'd perform a laparoscopic
 7 cystectomy without using an endo bag, please
 8 describe what procedure you'd follow?
 9 A. I perform a normal laparoscopic
 10 approach to getting the camera part of the
 11 laparoscope in under the belly button, and I
 12 usually will make two lower abdominal incisions
 13 through which I will put in either a five or ten
 14 millimeter trocar. Through that I will put
 15 instruments - one a grasper, one a cutter of
 16 some sort. I will free up the structure.
 17 If the structure looks absolutely
 18 benign - that is, totally clear and thin walled
 19 - I will allow the structure to rupture so I'm
 20 only taking out membranes. If it is a
 21 relatively small cyst, somewhere between two and
 22 four centimeters, and the membrane looks tough
 23 such as a dermoid cyst, I will attempt to grasp
 24 it with an instrument through one of my lower

1 abdominal incision trocars, bring it up into the
 2 incision, take off the trocar and then grasp the
 3 structure directly from the outside of the
 4 abdomen with a strong clamp such as a Kocher,
 5 K O C H E R, clamp and ease it through the
 6 incision in the abdominal wall,
 7 Q. And please describe for me the
 8 procedure that you use when you use an endo bag?
 9 A. When I use an endo bag, I free up the
 10 cyst. I wrap the bag in a trocar, place it in
 11 the abdomen, manipulate the structure into the
 12 bag, bring - it depends which bag you have. The
 13 one we currently use has a string. Bring the
 14 string through the trocar, lift the trocar with
 15 the string and bag attached into the skin
 16 incision, and then directly grasp the string and
 17 bag and bring that through the incision. If I
 18 have to, I will sometimes enlarge the incision
 19 in order to do that.
 20 Q. Are you sure Dr. DiCenzo had enlarged
 21 the incision to pull the bag through when she
 22 performed surgery on Angela Mattio?
 23 A. It's my impression that before she had
 24 a sense of whether or not the structure could

3s

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1 fit through the incision she had, the bag
 2 ruptured. And that with the trial of the second
 3 bag an attempt initially was made to drain the
 4 cyst, and then a definitive attempt was made to
 5 bring the structure through. And that caused
 6 the second rupture.
 7 The situation where I'm describing
 8 is where I have gotten the bag or its handle up
 9 through the skin incision and am already trying
 10 to pull it out of the belly, I have already
 11 grasped it from the outside, and I see after the
 12 application of a modicum of force that it's not
 13 going to come, then I would enlarge the
 14 incision,
 15 My sense from reading the note is
 16 that only in the very initial stages of getting
 17 the bag up through the incision did the bag pop,
 18 and it was not at the stage where she was
 19 exerting lots of pressure and it wasn't coming.
 20 And that's the point where the incision would
 21 have been enlarged,
 22 Q. Doctor, it's not your testimony that
 23 the endo bag that broke was defective in some
 24 manner, is it?

1 A. I have to answer I don't know that.
 2 It's not my testimony that for 100 percent
 3 certainty the bag was defective, no. But I
 4 think there was a possibility that it was.
 5 Q. You think it was a more than 50
 6 percent possibility that the bag was defective?
 7 A. I can't answer that just because I'm
 8 unable to assign a number to the possibility.
 9 Q. You're aware that Dr. DiCenzo
 10 testified that there was nothing wrong with the
 11 bag or the instrument?
 12 A. Could you point that out to me please?
 13 Q. Page 68, line 13, Dr. DiCenzo
 14 testifies, "The bag broke because the cyst
 15 didn't fit through the incision, not because
 16 there was anything wrong with the bag or
 17 anything wrocg with the technique being used."
 18 A. I see that, yes.
 19 Q. If the bag didn't fit through the
 20 incision, should Dr. DiCenzo have enlarged the
 21 incision?
 22 A. I think if the bag had remained intact
 23 and not fit through the incision, as has been
 24 the case in all the situations where I found the

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1 incision wasn't big enough, then that would have
 2 been the appropriate thing to do.
 3 Q. And in that case if, in fact, she had
 4 the bag to the incision and started to pull the
 5 bag through the incision, if that's, in fact,
 6 what happened, the standard of care would have
 7 required Dr. DiCenzo to enlarge the incision to
 8 pull the bag through; is that correct?
 9 A. No, ma'am. As I said before, it
 10 depends at what point in the pull-through
 11 process the bag ruptured. If it was at the
 12 point where she was certain she had used all
 13 reasonable force to get the bag out, and the bag
 14 was still intact, then you're right, that would
 15 have been the standard of care to enlarge the
 16 incision.
 17 If, however, in the initial stages
 18 of trying to determine if the bag with the cyst
 19 could be removed from the given incision with
 20 moderate force, if during that determination
 21 process the bag ruptured, then it would be ex
 22 post facto reasoning to assume she would have
 23 known she had to enlarge the incision.
 24 Q. Doctor, can you describe for me how

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1 A. Younger age would make malignancy less
 2 likely, The fact that the cyst persisted for a
 3 ten-week period would make it more likely. The
 4 fact that there's a septum makes it slightly
 5 more likely. The fact that there may be
 6 thickening of part of the wall would make it
 7 more likely. In a woman this wage the odds of
 8 there being a malignancy are low but,
 9 unfortunately, not zero.
 10 Q. You say the odds are low. Can you put
 11 any range of numbers on that?
 12 A. Malignancy in a persistent cyst in a
 13 woman this age would likely be present half to
 14 one percent of the time,
 15 Q. And Doctor, is there anything that you
 16 could or anything that would factor into your
 17 determination if you consider that the cyst has
 18 been present and has not changed over a period
 19 of time, size has not changed?
 20 A. I'm sorry, I'm not following your
 21 question.
 22 Q. You know that an ultrasound was
 23 performed six weeks prior to her surgery?
 24 A. Let's see, an ultrasound was performed

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1 you can tell whether the cyst is benign, as you
 2 described earlier - if it were benign, you would
 3 rupture it and pull the membrane through the
 4 trocar?
 5 A. That's an active point of debate among
 6 gynecologists, so it's a very good question.
 7 You can't be 100 percent sure, but you can be
 8 very, very sure. If you have a thin-walled
 9 translucent cyst that you can see all the way
 10 through, you see no evidence of thickening on
 11 the inside of the cyst wall, and it appears
 12 totally clear, then you make an educated
 13 assumption that it is very, very likely to be
 14 benign. But you cannot know for 100 percent
 15 certainty. And if I do a thousand of those, a
 16 few times I will be wrong, and I will
 17 potentially ruptore a cancer.
 18 Q. Doctor, is there anything that you can
 19 determine based upon the patient's age,
 20 preoperative course, that would assist you in
 21 determining whether a cyst is benign?
 22 A. You can't determine that, but you can
 23 get some probabilities one way or the other.
 24 Q. What factors would you consider?

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1 - no, I don't think that's correct ma'am. An
 2 ultrasound was performed ten weeks prior and
 3 four weeks prior to her surgery.
 4 Q. Okay, And you know that the size of
 5 the cyst did not change between those two
 6 ultrasounds, correct?
 7 A. Correct, it did not dissolve, did not
 8 go away.
 9 Q. Or change in size?
 10 A. Correct.
 11 Q. Is there anything to assist you in
 12 your determining whether or not the cyst was
 13 benign by the fact that over an eight-week
 14 period the size did not change?
 15 A. Rather the opposite. The fact that it
 16 did not go away makes it much more likely this
 17 is a neoplasm - I'll define that in a second -
 18 as opposed to a functional cyst. A functional
 19 cyst of the ovary is the sort of cyst in which
 20 an egg gets made every month and resolves every
 21 month. A neopiasm is any sort of abnormal
 22 growth - can be benign or malignant,
 23 The fact that over an almost
 24 two-and-a-half-month period this cvst had not

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1 resolved makes it more likely to be a neoplasm
 2 of some kind, Once you get into the range of
 3 neoplasm as opposed to a functional
 4 ovulation-related cyst, then the odds for
 5 malignancy go from being roughly zero to being
 6 some number depending on the age of the patient.
 7 Q. What is a paratubal cyst?
 8 A. A paratubal cyst is an entirely other
 9 structure than what was reported being seen. It
 10 is an embryologic remnant of the Wolfian duct,
 11 W O L F I A N, structures, The Wolfian duct
 12 structures are the embryologic urologic system
 13 that develops in males and fades away in
 14 females. These small cysts, usually between
 15 half to one-and-a-half centimeters in greatest
 16 dimension, can be seen in the area of the distal
 17 fallopian tube in women.
 18 Q. You understand that Dr. DiCenzo
 19 describes this as a thin-walled smooth-walled
 20 cyst, correct?
 21 A. Let me check one thing, please. At
 22 which point is she describing it thusly that
 23 you're saying?
 24 Q. In her deposition, page 59, line 25

4;

1 And the rest is about some markings.
 2 Q. Doctor, can you tell me what medical
 3 textbooks that you have in your office that
 4 would address the issues in this case?
 5 A. If you're talking about laparoscopic
 6 procedures, there are chapters in the Telinde,
 7 T E L I N D E, textbook. There are textbooks on
 8 laparoscopy by San Phillipio [sic], and there are
 9 a few others whose main authors I do not know,
 10 If you're talking about ovarian cysts, then,
 11 again, the Telinde book would be one that a
 12 general gynecologist would often have available,
 13 Other issues - any other issues you
 14 want to ask about in that regard?
 15 Q. Do you have anything on postoperative
 16 infection?
 17 A. Sure, the Telinde book, again, would
 18 be a source for that.
 19 Q. My question, actually, Doctor, was
 20 what you had in your office?
 21 A. Same answer.
 22 Q. How many depositions have you given
 23 this year?
 24 A. Three, I think.

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1 going to the next page, "Okay, so you agree the
 2 cyst was thin walled, but it was thicker than
 3 you believe a typical cyst is; is that correct?
 4 Answer: Yes. Question: And you agree it was
 5 smooth walled, but not as smooth as other cysts
 6 you've seen, correct? Answer: True."
 7 A. She says that in reference to having
 8 seen the cyst postoperatively. This is not
 9 information she had going into the surgery, She
 10 also says that it was semi-opaque.
 11 Q. What did the pathologist say?
 12 A. In regard to what?
 13 Q. The cyst,
 14 A. Their diagnosis is serous cyst with
 15 surface fallopian tube mucosa, and then they
 16 have a gross description.
 17 Q. What is the gross description?
 18 A. "Received in formalin, designated
 19 Mattio, is a 4.5 by 2.6 centimeter intact
 20 thin-walled cystic structure that has a smooth,
 21 gray semi-opaque wall containing fibrous
 22 attachments. It averages 0.2 centimeters in
 23 thickness. Unremarkable lining, free of
 24 excrescences and contains clear watery fluid."

4E

1 Q. And last year?
 2 A. Three or four.
 3 Q. And can you tell me over the past five
 4 years?
 5 A. Probably given about 17 or 18
 6 depositions.
 7 Q. And how many times have you testified
 8 at trial in the past year?
 9 A. I think three.
 10 Q. And last year?
 11 A. Either four or five.
 12 Q. And in total over the past five years?
 13 A. Somewhere between 16, 18, getting
 14 close to but not quite 20 yet,
 15 Q. How many times in the past year have
 16 you provided a report that you have not
 17 testified?
 18 A. Five or six times, mainly for
 19 plaintiffs.
 20 Q. Last year?
 21 A. Probably about the same frequency.
 22 Q. I asked you about how many times you
 23 testified for Mr. Dapore and his office. Had
 24 you testified for or performed any consulting

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1 for the Jacobson Maynard law firm?
 2 A. In the old days when they were
 3 Jacobson Maynard, yes.
 4 Q. Approximately how many times did you
 5 testify for Jacobson Maynard?
 6 A. Never.
 7 Q. I'a sorry, I thought you said yes that
 8 you had testified for them?
 9 A. I thought you used the word
 10 consulting,
 11 MR. DAPORE: She did.
 12 Q. How many times did you consult for
 13 Jacobson Maynard?
 14 A. Probably about 15 or 16 cases over the
 15 years,
 16 Q. Were you on a board for the now
 17 defunct TIAA Insurance Company to review cases
 18 for them?
 19 A, T I - no,
 20 Q. It was the insurance company that got
 21 robbed by its owners?
 22 A. I got one or two checks from them, but
 23 I never had - my role with them was that of
 24 supplicant.

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1 or ambiguous.
 2 Doctor, do you --
 3 A, I don't understand the second part.
 4 You're supposing negligence, and you want me to
 5 answer whether there should be special laws, So
 6 the answer to your question is that it's an
 7 inconsistent question. You can't suppose that
 8 somebody has committed negligence before the
 9 whole apparatus has gotten started.
 10 Q. I understand that, Doctor. Do you
 11 believe there should be caps that limit
 12 liability for doctors even if they're found
 13 negligent?
 14 MR. DAPORE: Caps on what?
 15 MS. BOLEK: Damages.
 16 A, First of all, let's not raise voices,
 17 You might have used that technique effectively
 18 the last deposition, but I'm not going to allow
 19 it here.
 20 I believe that society would be
 21 well-served if compensation for medical injuries
 22 resulted in more than one-third of the dollars
 23 put into the system going to patients and not
 24 have an average of a five- to seven-year delay,

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1 Q. You were insured by them?
 2 A. No. I had reviewed the cases for
 3 Jacobson and Maynard; and when everything went
 4 belly up, they were the payer that paid some of
 5 the last bills I sent in.
 6 Q. Doctor, do you personally believe
 7 there should be special laws protecting doctors
 8 from liability if they injure patients with
 9 malpractice?
 10 MR. DAPORE: Objection,
 11 Q. You may answer the question, Doctor.
 12 A. No, not special laws.
 13 Q. You believe there should be laws
 14 protecting doctors from liability if they're
 15 negligent and injure patients?
 16 MR. DAPORE: You want to define what
 17 you mean by protecting from liability?
 18 Q. Doctor, do you not understand my
 19 question?
 20 MR. DAPORE: I want to understand
 21 your question so I can object to it if I need
 22 to.
 23 MS. BOLEK: You can make your
 24 objection that you believe the question is vague

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1 Q. Doctor, do you believe that there
 2 should be caps on the amount of damages that a
 3 doctor whose negligence injures a patient should
 4 be ordered to pay?
 5 A, In some cases, yes.
 6 Q. And are you a proponent of laws that
 7 would limit the rights of injured patients from
 8 bringing lawsuits against physicians?
 9 MR. DAPORE: Objection,
 10 A. Not at all. I oppose or, rather, I
 11 advocate conditions which would limit the means
 12 that the current system has, including 30 and 40
 13 percent contingency fees, and length of the
 14 current system that makes it more difficult for
 15 injured patients to collect monies they need
 16 when they're injured.
 17 Q. Do you believe that there should be
 18 special tribunals to decide medical malpractice
 19 cases instead of civil juries?
 20 MR. DAPORE: Objection,
 21 A. I can't say I believe that as the best
 22 solution for getting better compensation for
 23 injured victims, no. I am very much in favor of
 24 looking into no fault-type solutions or

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1 arbitration-type solutions.
 2 Q. Both of which would put the decision
 3 making into the hands of someone other than a
 4 civil jury, correct?
 5 A. No fault would put the decisions in
 6 the hands of the injured parties, which I think
 7 would be a better solution than in the hands of
 8 plaintiff or defense lawyers, judges or a jury.
 9 Q. Do you believe that the decision as to
 10 whether or not Dr. DiCenzo was negligent and
 11 whether her negligence injured Angela Mattio
 12 should be in the hands of someone other than a
 13 civil jury?
 14 MR. DAPORE: Objection.
 15 A. I believe that there are alternative
 16 arrangements that in situations where there is
 17 somebody injured and they make a claim of
 18 negligence, that it could be adjudicated more
 19 rapidly, more fairly, to all parties involved.
 20 Q. So you believe that the ultimate
 21 decision-making authority should be in the hands
 22 of someone other than a civil jury?
 23 MR. DAPORE: Objection, asked and
 24 answered.

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1 A. I think that for patients to have an
 2 opportunity to arrive at satisfaction of their
 3 claims directly on their own much more quickly
 4 would be in many cases a superior alternative.
 5 Q. That wasn't my question, Doctor. I'll
 6 ask my question again, Do you believe that the
 7 ultimate decision-making authority when there's
 8 a dispute as to whether or not the doctor was
 9 negligent and the doctor's negligence caused
 10 injury to her patient - do you believe the
 11 ultimate decision-making authority should be
 12 placed somewhere other than on a civil jury?
 13 MR. DAPORE: Objection, asked and
 14 answered. Don't answer, Doctor.
 15 Q. Doctor, you haven't answered my
 16 question. Please answer my question.
 17 MR. DAPORE: He's answered your
 18 question three times now.
 19 MS. BOLEK: He hasn't answered my
 20 question yet. Doctor, please --
 21 MR. DAPORE: You don't like his
 22 answer, but he's answered three times,
 23 MS. BOLEK: He has told me that in
 24 certain situations there may be, could be,

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1 possibly some other way to handle the system in
 2 general. That's not my question.
 3 MR. DAPORE: And your question is
 4 all cases. Clearly he's saying not all cases.
 5 In some cases it is.
 6 MS. BOLEK: He can speak for
 7 himself, Tony.
 8 MR. DAPORE: He has said that.
 9 Q. Doctor, once again, do you believe
 10 when there is a dispute with the doctor and
 11 patient in the situation that you've described -
 12 in the dispute when there is a question as to
 13 whether the doctor was negligent and whether the
 14 patient is entitled to recover, do you believe
 15 that the ultimate decision-making authority
 16 should lie in the hands of other than a civil
 17 jury?
 18 MR. DAPORE: Objection, asked and
 19 answered. Answer one more time, and then we're
 20 moving on.
 21 A. I believe in some cases it is better
 22 for the injured party to make the decision than
 23 a jury, yes.
 24 Q. It is better for who to make the

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1 decision? You think that the injured party
 2 should be the ultimate decision maker?
 3 A. In many cases in no fault, absolutely.
 4 Q. When you're talking about arbitration,
 5 who would make the decision in that scenario?
 6 A, Depends which of the multiple
 7 arbitration plans you're discussing, but you
 8 asked --
 9 (I. You believe in arbitration over a
 10 civil jury?
 11 A. Not uniformly, I'd have to know what
 12 arbitration plan you're talking about.
 13 Q. Doctor, have you ever testified on
 14 behalf of an injured plaintiff against a doctor
 15 in a medical malpractice case?
 16 A, In court, no, because I've never been
 17 asked to.
 18 Q. What about in deposition?
 19 A. Yes.
 20 Q. How many times?
 21 A. Twice.
 22 Q. And over what period of time?
 23 A. Last five years.
 24 Q. So you've testified between 17 and 18

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1 times in total, and two of those times were on
 2 behalf of an injured plaintiff; is that correct?
 3 A. No, ma'am. You asked about
 4 depositions just now. I've given two
 5 depositions over that period of time for
 6 plaintiffs, but I will tell you I've testified
 7 100 percent of the time when plaintiffs have
 8 asked me to testify in court.
 9 Q. Doctor, you testified that over the
 10 past five years you've given between 17 and 18
 11 depositions?
 12 A. Yes.
 13 Q. And two of those times were on behalf
 14 of an injured plaintiff; is that correct?
 15 A. Yes.
 16 Q. Do you know Dr. Bruce Rosenzweig?
 17 A. No.
 18 Q. Doctor?
 19 A. I'm sorry, I said no.
 20 Q. I didn't hear you, sorry. Has anyone
 21 told you what he has testified to in this case?
 22 A. I have a letter dated May 2nd, 2002,
 23 listing some of his views,
 24 Q. That is a letter from Mr. Dapore?

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1 A. No. He mentioned that the deposition
 2 was given when I pointed out this apparent error
 3 to him.
 4 Q. Do you know who Dr. Michael Baggish
 5 is?
 6 A. I do.
 7 Q. You agree he is a pioneer in the field
 8 of laparoscopy?
 9 A. Yes.
 10 Q. He is a respected OBGYN surgeon?
 11 A. Yes.
 12 Q. He's the editor and chief of the
 13 Journal of Obstetrics and Gynecologists?
 14 A. I don't know that,
 15 Q. Do you receive the journal?
 16 A. Yes, I do, but the editors change
 17 periodically. Last time I knew it was Roy
 18 Pitkin from Iowa.
 19 Q. I'll represent to you that Dr. Baggish
 20 is currently the editor and chief.
 21 A. Okay.
 22 Q. Are you familiar with his book, Pelvic
 23 Anatomy and Gynecologic Surgery?
 24 A. I have seen it.

5E

1 A. Or someone from his office. It's a
 2 letter addressed to you.
 3 Q. A letter from Dr. Rosenzweig?
 4 A. Yes, sir,
 5 Q. Dr. Rosenzweig was deposed in this
 6 case. Has anyone told you what he said in his
 7 deposition?
 8 A. I heard that he has withdrawn some of
 9 the statements he made based on errors in his
 10 reading of the chart.
 11 Q. Who did you hear that from?
 12 A. I asked Mr. Dapore about an error in
 13 the letter from Dr. Rosenzweig, and Mr. Dapore
 14 told me that during the deposition Dr.
 15 Rosenzweig withdrew the opinion based on that
 16 incorrect reading of the chart.
 17 Q. What opinion is that?
 18 A. That Dr. DiCenzo did not wait long
 19 enough after the first laparoscopy to perform
 20 the ovarian cystectomy surgery.
 21 Q. You mean after the first ultrasound?
 22 A. Correct, after the first ultrasound.
 23 Q. Did Mr. Dapore tell you anything else
 24 about Dr. Rosenzweig's testimony?

6C

1 Q. You understand it's used in medical
 2 schools to teach surgical procedures that are
 3 detailed therein?
 4 A. I'm sure somebody somewhere uses it to
 5 teach.
 6 Q. Do you teach medical school?
 7 A. No, I do not.
 8 Q. Do you work with medical residents in
 9 a teaching capacity as their teacher?
 10 A. No.
 11 Q. Other than your work with the
 12 Professional Liability Foundation and ProMutual
 13 Insurance Company and the Massachusetts Medical
 14 Society, do you do any other work in the medical
 15 community by way of reviewing articles, serving
 16 as an editor or work of that nature?
 17 WR. DAPORE: I'll object because you
 18 said that he does work for ProMutual. Your
 19 question to him was who was his insurance
 20 carrier, and that's who he identified.
 21 MS. BOLEK: Tony, I suggest you read
 22 his CV before you object.
 23 Doctor, do you remember the
 24 question?

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1 A. I do, I am not an editor for any
 2 refereed [sic] medical journal,
 3 Q. But do you review submissions for any
 4 medical journals?
 5 A. No, that's what an editor would do, I
 6 do not.
 7 Q. And you have published five articles?
 8 A. And a book that's coming out in two
 9 months, yes.
 10 Q. And what is that book?
 11 A. After Miscarriage, Why Miscarriages
 12 Happen and How Best to Prevent Them.
 13 Q. There isn't anything in your book that
 14 addresses treatment of ovarian cysts?
 15 A. No,
 16 Q. Or postoperative complications?
 17 A. Not in terms of wound infection. I
 18 think there are a couple of sentences where I
 19 discuss what effect surgery might have on
 20 somebody having a subsequent miscarriage.
 21 Q. Would you consider Dr. Baggish's text,
 22 his last released text, Pelvic Anatomy and
 23 Gynecologic Surgery, to be a reliable source?
 24 MR. DAPORE: What year was the

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1 publication please?
 2 MS. BOLEK: Either 1999 or 2000,
 3 Tony.
 4 MR. DAPORE: It makes a difference.
 5 Q. Doctor, do you consider it to be a
 6 reliable source?
 7 MR. DAPORE: Objection, don't have a
 8 date.
 9 Q. Doctor, you can answer the question.
 10 A. Okay, Baggish is well-known in the
 11 field. As I have heard him speak and read othe
 12 articles that he has written, I think it likely
 13 that his book contains very good information;
 14 but I can't answer your question from direct
 15 knowledge because I have not perused his book in
 16 any detail.
 17 Q. Doctor, are you paid to serve on the
 18 board of directors of ProMutual?
 19 A. Yes.
 20 Q. What are you paid?
 21 A. I'll decline to answer that.
 22 MS. BOLEK: I'm asking the court
 23 reporter to instruct the witness to answer the
 24 question.

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1 MR. DAPORE: What's the relevance?
 2 MS. BOLEK: Goes to his bias.
 3 MR. DAPORE: What's the relevance?
 4 MS. BOLEK: Goes directly to his
 5 bias, Tony. He's being paid by a medical
 6 malpractice insurance carrier.
 7 MR. DAPORE: And your expert is
 8 being paid by plaintiffs' lawyers, That has
 9 nothing to do with --
 10 MS. BOLEK: And you asked him
 11 exactly how much he's being paid.
 12 MR. DAPORE: It's irrelevant and not
 13 likely to lead to admissible evidence.
 14 MS. BOLEK: I ask the court reporter
 15 to instruct the witness to answer the question,
 16 (Discussion off the record.)
 17 A. I've stated I'm paid to be a board
 18 member. I'll decline to answer the question for
 19 a variety of reasons, including internal
 20 politics.
 21 Q. I will give you a stipulation of
 22 confidentiality that will continue up to the
 23 date of trial, and the judge can decide on the
 24 date of trial, if that will resolve the problem.

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1 Otherwise, I'll go to the judge, and there will
 2 be a public record of --
 3 MR. DAPORE: He's not --
 4 MS. BOLEK: Can the court reporter
 5 certify that question.
 6 Are you paid to serve as the
 7 chairman of the risk management committee of the
 8 Risk Management Foundation?
 9 A. It falls under board compensation.
 10 Q. So you do not receive an additional
 11 fee?
 12 A. No. The sum of our compensation is
 13 for specific meetings. So that meetings we have
 14 are compensated, but I have no specific fee for
 15 being committee chairman,
 16 Q. What does your work as chairman of the
 17 risk management committee involve?
 18 A. We develop protocols to improve care
 19 for patients in Massachusetts. For instance, we
 20 develop protocols for better dealing with breast
 21 masses found by general medical practitioners,
 22 obstetricians, gynecologists. We develop OBGYN
 23 protocols for prenatal screening. We develop
 24 protocols for anesthesiologists and emergency

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1 room physicians, things like that.
 2 Q. Has your committee developed a
 3 protocol for the treatment of ovarian cysts?
 4 A. I don't think we have on laparoscopy.
 5 We usually target those items that are most
 6 problematic to physicians practicing on a
 7 state-wide level.
 8 Q. I didn't ask if you had one
 9 specifically on laparoscopy. I asked if you had
 10 a protocol specific to the treatment of ovarian
 11 cysts?
 12 A. That nitpicky question I'll answer -
 13 no, we do not.
 14 Q. Have you served on the malpractice
 15 tribunal in Massachusetts?
 16 A. I have volunteered to serve twice.
 17 Q. And did you serve on a tribunal twice?
 18 A. Yes. There is no one organization,
 19 Tribunal. You go and meet with a judge and a
 20 lawyer at a tribunal on individual cases, and I
 21 have gone through that process twice as a
 22 volunteer.
 23 Q. In those cases what was the decision
 24 of your panel?

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1 A. The decision of the panel was
 2 determined solely by the fact that a letter had
 3 been submitted by a physician on the plaintiff's
 4 side, and with that letter present our ability
 5 to make a decision was taken away from us
 6 because that letter is the standard by which one
 7 can get through a tribunal in Massachusetts.
 8 Q. So the decision of the tribunal was
 9 that the case could proceed to trial?
 10 A. It was the decision of the judge
 11 because the criteria for proceeding to trial had
 12 superseded votes of the other members of the
 13 tribunal. So it was not the decision of the
 14 tribunal.
 15 Q. Did you have a decision that differed
 16 from what the judge decided?
 17 A. Certainly.
 18 Q. Did not think the case should proceed
 19 to trial?
 20 A. In one of the instances, yes, that's
 21 correct.
 22 Q. Doctor, have you ever been a defendant
 23 in a lawsuit?
 24 A. Of course, I'm a busv obstetrician,

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1 Q. How many times have you been sued?
 2 MR. DAPORE: Objection. You can
 3 answer.
 4 A. Three times,
 5 Q. What were the dates of those suits,
 6 roughly?
 7 A. 1989, 1992 and 2000.
 8 Q. How was the '89 case resolved?
 9 MR. DAPORE: Objection. You can
 0 answer.
 1 A. A settlement.
 2 Q. How much was the settlement?
 3 MR. DAPORE: Objection. You can
 4 answer.
 5 A. \$200,000.
 6 Q. How was the '92 case resolved?
 7 MR. DAPORE: Objection. You can
 8 answer.
 9 A. A settlement.
 10 Q. How much was that settlement?
 11 MR. DAPORE: Objection. You can
 12 answer.
 13 A. Same amount.
 14 Q. How was the 2000 case resolved?

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1 MR. DAPORE: Objection, You can
 2 answer.
 3 A, I'm probably going to wind up
 4 dismissed from that as I was on vacation the
 5 entire time the case was taking place,
 6 Q. That case is still pending?
 7 A. Yes.
 8 Q. Did any of those cases involve a
 9 laparoscopic procedure you performed?
 0 MR. DAPORE: Objection. You can
 1 answer.
 2 A. Yes.
 3 Q. Which one?
 4 A. The second one,
 5 Q. The 1992 case?
 6 A, Yes.
 7 Q. What was the procedure?
 8 A. It was a laparoscopic evaluation of an
 9 ovarian cyst in a woman who as a child had a
 10 Wilm's tumor cancer.
 11 Q. What was the name of the plaintiff in
 12 that case?
 13 MR. DAPORE: Objection. You can
 14 answer.

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1 A. McLaughlin.
 2 Q. Spell that please?
 3 A. I believe M c L A U G H L I N.
 4 Q. And where was that case filed?
 5 A. Middlesex County.
 6 Q. Did you give deposition testimony in
 7 that case?
 8 A. i don't recall that.
 9 Q. Sorry?
 10 A. I don't recall that.
 11 Q. So you don't know if you testified?
 12 A. i testified, I don't recall if i gave
 13 a deposition.
 14 Q. The case did not proceed to trial,
 15 correct?
 16 A. it did proceed to trial. It was
 17 settled during trial,
 18 Q. So you gave trial testimony?
 19 A. Correct.
 20 Q. Do you recall the name of the judge?
 21 A. I do not.
 22 Q. Did any of the other cases involve any
 23 of the issues involved in this case?
 24 A. No.

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1 A. Millimeters? I wouldn't be able to
 2 see three-and-a-half millimeters, You mean
 3 centimeters?
 4 Q. Yes.
 5 A. Well, if the pedicle was easy to get
 6 at and it was easy to separate the cyst and
 7 there was not a lot of internal bleeding, the
 8 patient might be able to go home after a two- to
 9 four-hour observation period.
 0 Q. How long would such a procedure
 1 actually last?
 2 A. Probably the range would be a half
 3 hour to an hour and 15 minutes depending on how
 4 hard it was to remove the cyst.
 5 Q. What are your general postoperative
 6 instructions and restrictions for a patient who
 7 has had a laparotomy cyst removal?
 8 A. No lifting anything heavier than a bag
 9 of sugar for two bags, no driving by yourself
 0 for one week, nothing in the vagina until your
 1 final postoperative visit, which would either be
 2 four to six weeks out depending on what the
 3 procedure was. And then as i mentioned, they
 4 get an instruction sheet talkina about callina

7c

1 Q. Doctor, when you perform a
 2 laparoscopic cystectomy, what are your general
 3 postoperative instructions and restrictions for
 4 your patients?
 5 A. No lifting for two weeks, no driving
 6 for 24 hours and nothing in the vagina for one
 7 week,
 8 Q. Anything else?
 9 A. The patient - my instructions to the
 10 patient, no. The patient is given a more
 11 detailed instruction sheet by the postanesthesia
 12 recovery room.
 13 Q. How long does a patient generally
 14 remain in the hospital when you perform a
 15 laparoscopic cystectomy?
 16 A. it depends how extensive the
 17 cystectomy is and whether there are any
 18 procedures accompanying it such as extensive
 19 lysis of adhesions.
 20 Q. You have a simple laparoscopic
 21 cystectomy, and you are not performing other
 22 procedures,
 23 A. How big is the cyst?
 24 Q. Three-and-a-half millimeters,

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1 if pain gets worse instead of better, if there's
 2 elevated temperature, if there's heavy vaginal
 3 bleeding, if there's persistent nausea or
 4 vomiting, and a list of other items like that.
 5 Q. How long do you keep a patient in the
 6 hospital?
 7 A. 48 to 72 hours depending on the size
 8 of the abdominal incision. If it's a small cyst
 9 that I'm able to remove through what i call a
 0 mini-laparotomy - that is, a two-inch or so
 1 incision - that patient might go home the next
 2 day,
 3 Q. Do you know how big the abdominal
 4 incision was that Dr. DiCenzo made in Angela
 5 Mattio's abdomen when she performed her
 6 laparotomy?
 7 A. I've heard two versions of it.
 8 Q. You know that the urgent care that
 9 Angela Mattio went through recorded that it was
 0 eight inches long, correct?
 1 A. I do. I also know from Dr. DiCenzo's
 2 deposition that she said it could not possibly
 3 have been that long.
 4 Q. Did you credit Dr. DiCenzo's testimony

1 or the urgent care record?
 2 A. I had no basis for crediting one or
 3 the other in that two-fact dispute,
 4 Q. Is an eight-inch abdominal incision
 5 for a laparotomy a fairly large incision in your
 6 experience?
 7 A. Hang on, let me get my ruler out, It
 8 depends on the size of the abdomen. This was an
 9 obese patient, so you have to make a larger
 10 incision with a thicker, wider anterior
 11 abdominal wall to get into the abdomen.
 12 Q. Now, I had two questions here that if
 13 you'll answer we don't have to go to the judge.
 14 I asked what was in your file, and you told me
 15 you didn't have any letters from Mr. Dapore.
 16 When I asked whether you had received any
 17 letters from Dr. Dapore, you refused to answer
 18 the question. Now, if, in fact, you never
 19 received any from him, we can solve the problem
 20 right now,
 21 THE WITNESS: I think I could answer
 22 that, Tony, without any problem.
 23 MR. DAPORE: Sure.
 24 A. I have received cover letters

1 accompanying documents saying that this is
 2 thus-and-such a document.
 3 Q. But you have not received any letters
 4 that contain any sort of narrative information
 5 from Mr. Dapore's office?
 6 A. Correct. Narrative information about
 7 the facts of the case, if that's what you mean,
 8 correct.
 9 Q. But you have received narrative
 10 information from him regarding something other
 11 than the facts of this case?
 12 A. It depends what you mean by narrative.
 13 This is so-and-so's deposition. We may have a
 14 deposition date scheduled on thus and such a
 15 date, It's been that sort of communication,
 16 Q. Did you receive any information
 17 regarding Dr. DiCenzo other than what was
 18 contained in the chart and in the depositions?
 19 A. I have not.
 20 Q. Did you receive any information
 21 regarding the plaintiff Angela Mattio other than
 22 what was contained in the chart and in the
 23 depositions?
 24 A. No.

1 Q. Now, you told me that you disregarded
 2 the plaintiff's testimony because you believe
 3 she said something that you did not find
 4 credible, and I asked you whether or not you
 5 found the defendant's testimony credible; and
 6 you refused to answer that question. Can you
 7 answer that question for me please, Doctor?
 8 A. The problem is your statement just now
 9 is again a misstatement. I didn't refuse to
 10 answer. I answered three times with what I
 11 thought was a very comprehensive answer to your
 12 question, but you didn't like the terms of that
 13 answer. So I'm not sure how to get around that,
 14 It's hard for me to comment on a general
 15 statement.
 16 Do I find the defendant's testiaony
 17 credible? I find it generally credible. I'd
 18 have to go through every line to answer that
 19 comprehensibly. What I said was directly in
 20 response to the reason why I have doubts about
 21 the plaintiff's testimony, that there was a fact
 22 mentioned by the plaintiff which I think is
 23 impossible; that I found nothing in DiCenzo's
 24 testimony that was internally inconsistent like

1 that, So I had no reason to have the same sorts
 2 of doubts as I did with Mattio's testimony.
 3 Now, I think that's a pretty clear answer, but
 4 somehow you didn't buy into it.
 5 Q. Doctor, the problem I'm having is the
 6 term "internally inconsistent" which implies
 7 that in one place somebody says one thing and in
 8 another says something else. I'm not asking you
 9 on that basis alone. I'm asking you whether
 10 there was anything else in Dr. DiCenzo's
 11 testimony that would cause you to doubt her
 12 testimony?
 13 MR. DAPORE: Objection, He's
 14 answered it several times. What he said is that
 15 he did not have anything that contradicted
 16 itself that he can recall to say that he would
 17 discredit her testimony. He said there was a
 18 specific reference in your client's deposition
 19 to her wound that was inconsistent with another
 20 statement she said, and that is why he found he
 21 could not rely on those statements because
 22 they're inconsistent, That's all he's going to
 23 tell you.
 24 Q. Doctor, you didn't say you found

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1 something in Angela Mattio's testimony that was
 2 inconsistent. You said that you found it
 3 impossible to believe, correct?
 4 A. I said inconsistent with medical
 5 science, what would be the case.
 6 Q. So it wasn't that she said something
 7 in one place in her deposition and something
 8 different somewhere else; it was that she said
 9 something you as a doctor believe is impossible
 10 to be true?
 11 A. Correct.
 12 Q. So when I ask you about Dr. DiCenzo
 13 and you bring up internal inconsistencies --
 14 A. That's what I meant by internal
 15 inconsistencies - a statement that cannot be
 16 correct by its nature, I can use a different
 17 phrase for that if it will satisfy what you're
 18 trying to get it. There was nothing I saw in
 19 Dr. DiCenzo's statements in her deposition that
 20 seemed untrue, implausible or impossible. How
 21 does that do?
 22 Q. That completes my question, Doctor,
 23 thank you. And again, I will offer a
 24 confidentiality agreement with respect to your

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1 Q. Doctor, I understand your concern
 2 about the information being used, and we can
 3 correct that situation because this portion of
 4 your testimony can be placed under seal by the
 5 court reporter,
 6 A. This makes no sense. You know I'm
 7 getting paid. You know it's a substantial
 8 amount. I've given you the range. Why do you
 9 need to know if it's 22,000, 62 or \$44,000? I
 10 don't get that.
 11 MR. DAPORE: He's not going to
 12 answer the question. He told you that. If you
 13 want to go to the court, go to the court.
 14 MS. BOLEK: I have no alternative,
 15 Doctor, I've asked in every way I can to make
 16 it as palliative to you as possible. In the
 17 case we go to court, the judge may or may not
 18 order that it be maintained as confidential.
 19 I'm offering you a guarantee of confidentiality.
 20 MR. DAPORE: You're not offering a
 21 guarantee of confidentiality because you can't
 22 guarantee that. So he's not going to do it.
 23 He's told you that.
 24 MS. BOLEK: I guess I'll take the

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1 income from ProMutual Insurance Company with the
 2 stipulation that I will have the opportunity to
 3 bring the matter before the court, and I will
 4 not reveal the information to anyone unless the
 5 judge orders that I may ask the question in open
 6 court,
 7 With that offer of a
 8 confidentiality agreement, I will ask you again,
 9 Doctor - what is your income as a member of the
 10 board of directors of ProMutual Insurance
 11 Company?
 12 MR. DAPORE: Objection.
 13 A. I've been in too many situations where
 14 depositions that I've given in the past have
 15 been retrieved by different attorneys and used
 16 for a variety of purposes. Plus, your "offer"
 17 is subject to the whims of the judge. What I
 18 can say, if it's helpful to you, is that based
 19 on findings of - I'm forgetting the name of the
 20 accounting firm - DeTouche --
 21 MR. DAPORE: Touche, Deloitte.
 22 A, Our board compensation is the 30th
 23 percentile for that among all the TIAA insurance
 24 companies.

8C

1 matter up with the court, Subject to the
 2 court's decision on that matter, I have no more
 3 questions for you at this time,
 4 MR. DRPORE: I recommend you read
 5 the transcript, Doctor.
 6 THE WITNESS: I'll read the
 7 transcript,
 8 (Whereupon, the deposition was
 9 concluded at 3:20 p.m.)
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CERTIFICATE 81

1
2
3 I, HENRY M. LERNER, M.D., do hereby
4 certify that I have read the foregoing
5 transcript of my testimony, and further certify
6 under the pains and penalties of perjury that
7 said transcript is a true and accurate record of
8 said testimony.
9 Dated at _____
10 this _____ day of _____
11 2002.
12
13
14
15 _____
16 HENRY M. LERNER, M.D.
17
18
19
20
21
22
23
24

CERTIFICATE 82

1
2 Commonwealth of Massachusetts
3 Middlesex, ss.
4
5 I, K. Henry-Sexton, Registered
6 Professional Reporter and Notary Public, in and
7 for the Commonwealth of Massachusetts, do hereby
8 certify:
9 That HENRY M. LERNER, M.D., the
10 witness whose deposition is hereinbefore set
11 forth, was duly sworn by me and that such
12 deposition is a true record of the testimony
13 given by the said witness.
14 IN WITNESS WHEREOF, I have hereunto
15 set my hand and notarial seal this 16th day of
16 August, 2002.
17
18
19
20
21 _____
22 K. Henry-Sexton.
RPR
23 My commission expires
24 on April 19, 2007

ERRATA SHEET 83

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