State of Ohio,) SS:
County of Cuyahoga.)

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IN THE COURT OF COMMON PLEAS

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Regina Rushdan,
Plaintiff,
vs.
David Baringer, M.D.,
Defendant.

Case No. 326887
Judge Boyko

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THE DEPOSITION OF DAVID BARINGER, M.D.
THURSDAY, OCTOBER 23, 1997

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The deposition of DAVID BARINGER, M.D., the Defendant herein, called for examination by the Plaintiff, under the Ohio Rules of Civil Procedure, taken before me, Michelle R. Hordinski, Registered Professional Reporter and Notary Public in and for the State of Ohio, pursuant to agreement, at the offices of Howard Mishkind, Esq., Skylight Office Tower, Cleveland, Ohio, commencing at 2:00 p.m., the day and date above set forth.

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APPEARANCES:

On behalf of the Plaintiff:

HOWARD MISHKIND, ESQ.
Becker & Mishkind
660 Skylight Office Tower
Cleveland, Ohio 44113

On behalf of the Defendant:

STEPHEN HUPP, ESQ.
Jacobson, Maynard & Tuschman
1001 Lakeside Avenue
Suite 1600
Cleveland, Ohio 44114

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DAVID BARINGER, M.D.

the Defendant herein, called for examination by the Plaintiff, under the Rules, having been first duly sworn, as hereinafter certified, deposed and said as follows:

PROCEEDINGS

MR. MISHKIND: Let the record reflect that we are here today to take the deposition of Dr. David Baringer in case number **326887**, and the deposition is being taken pursuant to agreement. It previously had been scheduled by notice, but rescheduled by agreement, and that any defects that exist in notice or service are waived.

MR. HUPP: Agreed.

MR. MISHKIND: Okay.

CROSS-EXAMINATION

BY MR. MISHKIND:

Q. Doctor, my name is Howard Mishkind, and I represent Regina Rushdan in the lawsuit that has been filed against you.

I'm going to be asking you a series of questions this afternoon. You've had your deposition taken before, but you and I have never met, *so* I would only ask that, when I ask you a

question, before you start answering the question, make sure that first you wait until I'm done, and secondly you wait until you're certain that you understand what I'm asking you.

A. Okay.

Q. If you don't understand what I'm asking you, would you tell me, I have no idea what you're talking about, or rephrase it, or read it back before you venture an answer?

A. Yes.

Q. And even though we're all well-intentioned in terms of not overlapping, inevitably someone is going to start speaking before the other person is done. I will try to give you the respect, and I would ask equally that you do the same in terms of not responding until I'm done.

A. Okay.

Q. Thank you, good start.

Doctor, tell me where your business address is.

A. One Mt. Sinai Drive, Cleveland, Ohio, 44106.

Q. And how long has your office been there?

A. About 14 years.

Q. Are you affiliated with any other physicians in your practice?

A. I'm just recently forming a group with three other physicians.
Q. Who are they?
A. Dr. Elmer Perse, Dr. Ami Aszodi, Dr. Jeffrey Marks.
Q. Could you spell the second doctor's name?
A. A-S-Z-O-D-I.
Q. And his first name?
A. First name, A-M-I.
Q. This is something that's in the works right now?
A. Yes.
Well, it's actually been formed, but we're not really doing much with it yet. We're in the process of setting up a corporation.
Q. Do you have a professional name for that corporation?
A. Northern Ohio Surgical Associates, Inc.
Q. And are the four of you in an office together at one Mt. Sinai Drive now?
A. We all have an office there, and most of us have offices at different locales, as well, through the eastern suburbs.
Q. Where, in addition to one Mt. Sinai Drive, do you have an office?
A. 26900 Cedar Road, Suite 18 north.

Those other physicians see patients at that address, maybe not in that suite, and Dr. Perse also has an office in Willoughby. But I'm not sure of that address.

Q. Besides the office on Cedar Road which you've just described and your office at one Mt. Sinai Drive, do you have any other offices?

A. I currently see patients in no other places.

Q. When you were seeing Regina, where did you see her other than when she was confined to the hospital?

A. Either at one Mt. Sinai Drive or -- I think I never saw her out at Beachwood. Probably at my office just at the hospital.

(Thereupon, Plaintiff's Exhibit 1 was marked for identification.)

BY MR. MISHKIND:

Q. Before the deposition began, you were kind enough to provide me with a four-page document that has curriculum vitae of David Baringer across the top. You have a copy of it in front of you, as well.

Is this current and updated with regard to all of your professional endeavors?

A. Yes.

Q. Were you successful, Doctor, in becoming board certified by the American Board of Surgery back in 1984 on your first attempt?
A. Yes.
Q. And what about recertification?
A. First attempt.
Q. What's involved in becoming recertified?
A. The recertification examination is strictly a written examination of two to four hours. I honestly forget how long it was. But there is no oral examination for recertification as there is for certification.
Q. Do you have an area of specialty within surgery?
A. I'm a general surgeon and do generally all aspects of general surgery.
Q. Do you find yourself doing more of a particular type of surgery than others just by circumstance?
A. Not necessarily. I do breast surgery, trauma surgery, thyroid, parathyroid surgery, biliary tract and abdominal and colorectal surgery.
Q. Are you still the director of the trauma service?
A. No.
Q. You used to be the director?
A. I used to be the director, and then we actually --

maybe my CV doesn't reflect that. Then I essentially became co-director with Dr. Marks.

Q. When did that take place?

A. Oh, probably by attrition within the last year or year and a half.

We brought on a young surgeon, and generally the younger surgeons will do a lot more of the trauma work.

Q. While you were seeing Regina, am I fair in concluding that you were a solo practitioner at that point?

A. Yes.

Q. So that all of the outpatient care at the very least was your ~~dog~~ doing

In other words, when she would come to the office, she would only see you or perhaps a nurse in your office?

A. Absolutely.

Q. Okay.

None of the doctors that we've talked about were in any way involved in her care from February of '94 through August or so of '95?

A. No, other than the fact that I did ask Dr. Aszodi to give me a hand on a couple of the operations that we performed on Ms. Rushdan.

Q. At the hospital?
A. At the hospital as a professional courtesy.
Q. Okay.
At your office, though, he wasn't involved in seeing her in follow up, was he?
A. Correct.
Q. Do you do all of your surgeries currently at Mt. Sinai?
A. Also at the Integrated Medical Campus on Cedar Road and now at Richmond Heights, also.
Q. When did you start doing surgeries at Richmond Heights?
A. Last six months or so.
Q. The type of surgeries that you do at the integrated campus, are they outpatient procedures?
A. Yes.
Q. All of your in-patient and some of your outpatient are done at Mt. Sinai?
A. Uh-huh, yes, as well as a little bit at Richmond Heights now.
Q. Prior to six months ago, though, you were either doing -- all of your in-patient work would have been at Mt. Sinai Hospital?
A. Correct.
Q. Do you do any teaching currently?

A. Yes.
Q. You're presently an assistant professor of surgery?
A. Yes.
Q. Is that a general surgical course, or is that a specific area within surgery that you're teaching?
A. That is a general surgery course through the Case Western School of Medicine and Department of Surgery.
Q. You're licensed in the State of Ohio, and it looks like you've been so since 1983?
A. Correct.
Q. And have maintained your license continuously, I presume?
A. I have.
Q. You've never had your license suspended or revoked, have you?
A. No.
Q. Ever had any hospital privileges at Mt. Sinai, Richmond, or any other hospital suspended, revoked, or brought into question?
A. No.
Q. Have you ever practiced outside of the State of Ohio?

A. No, except for a three-month fellowship in 1980 in Massachusetts for which I did obtain a temporary Massachusetts license. I was in intensive care.

Q. In looking at your CV, starting with the publications, do any of the publications that you have authored have any relevance to what I would describe the issues surrounding the diagnosis and repair of colorectal injuries?

A. No.

Q. This laparoscopic repair of diaphragmatic laceration, does that talk at all about iatrogenic injuries to the colon or anything that would have anything of relevance to Regina Rushdan's case?

A. No.

That has to do with gun shot wounds and stab wounds to the diaphragm in trauma situations.

Q. Okay.

Tell me about the research activities that you're involved in in the colorectal trauma area.

A. Basically those are continuing to follow through our trauma registry the way we handle colorectal trauma at our institution and have handled it in the past.

I've presented a -- actually one of the residents presented a paper on colorectal trauma back in 1983 or '84, I believe, at the Cleveland Surgical Society where we talked about colorectal trauma. And essentially using a trauma registry, we occasionally will go back over and review our data. But we've not published any papers on that data.

Q. In preparation for the deposition today, did you review any of the abstracts, presentations, or any of your publications?

A. No.

Q. You have been named in the past as a Defendant in a medical malpractice case, correct?

A. I have.

Q. Excluding Regina Rushdan's case, on how many other occasions have you been named?

MR. HUPP: Continuing objection to relevance. Go ahead.

MR. MISHKIND: That's fine.

A. Six or seven, I believe.

Q. Are any of those cases still pending?

A. One.

Q. What's the subject matter of that case?

A. Inguinal hernia repair and nerve entrapment

syndrome.

Q. What's the name of the Plaintiff in that case?

A. Denise Nohra, N-O-H-R-A.

Q. Has your deposition been taken in that case?

A. Yes.

Q. Is Mr. Hupp your attorney in that case?

A. Yes.

Q. Do you recall the name of the attorney offhand?

A. No.

Q. Okay, that's all right.

Plaintiff's lawyers names are easy to forget.

A. I won't comment.

Q. Okay.

A. LaPore.

MR. HUPP: Dapore?

BY MR. MISHKIND:

Q. Dapore, okay.

A. Dapore.

Q. The other cases that you have been named in as a Defendant, two of those cases involved complications associated with sponges being left in?

A. That is correct.

Q. And how did those cases resolve? Did they --

A. They were settled without trial.

Q. What type of surgery was done that precipitated the sponge being left in?
A. One of them was an open colicystectomy. The other was a bowel resection for Crohn's disease.
Q. What was the subject matter of the other cases that you've been named as a Defendant in, as best as you can recall?
A. One of them was a neurological complication after gastric stapling procedure for morbid obesity necessitating eventual re-operation. And the last -- the other one was a pelvic abscess that developed after laparoscopic lysis of adhesions.
Q. Was that the Weiland case?
A. Correct, W-E-I-L-A-N-D.
Q. The neurological complication case, what was the outcome of that?
A. That was settled out of court.
Q. Was there also a case involving postoperative nutritional problems?
A. That was the same case.
Q. That's the neurological complication?
A. Correct.
Q. Any other cases where you've been named as a Defendant?
A. Several others.

One of them, a fistula that formed to the skin from a ruptured gastric stapling procedure and a postoperative -- what was that case -- a postoperative possible bowel perforation after a catheter had been placed by vascular surgery.

And there was a question whether or not there had been a rupture of bowel or the vena cava. And both of those cases have been dropped.

Q. The leak following the gastric staple procedure was a case that was dropped?

A. Yes.

Q. How long ago was that case, do you recall?

A. Four or five years.

Q. I take it in all of those cases that you've just described for me, your deposition has been taken?

A. Yes -- it was not taken in one of the sponge cases with the gallbladder.

Q. Are you currently scheduled to testify either in a case as a Defendant or as a witness in any other cases?

A. No, except, I believe, a trial date has been set for the hernia case.

Q. You have served on occasion as an expert witness in medical malpractice cases, am I correct?

A. Yes.

Q. Are you currently serving as an expert witness in a medical malpractice case?
A. I am considering reviewing a case, and I have served in the past on several cases which I've generated medical reports, but which have not gone to trial.

The only time I went to trial was to defend a physician in a bowel perforation case during a hernia procedure.
Q. Was that an out of state case?
A. No.
Q. That was here in Cuyahoga County?
A. It was in Trumbull County or Mahoning County. I forget.
Q. Do you remember the name of the doctor that you were testifying on behalf of?
A. I do not.
Q. Was that a PIE case?
A. Yes.
Q. Do you remember the name of the patient?
A. I do not.
Q. You have in front of you a number of documents. I've had a chance before the deposition began to briefly review your original chart, and I would only for purposes of housekeeping request, Mr.

Hupp, that a copy of what is best described as the contents on the inside right --

MR. HUPP: The billing and surgical schedules, it appears to be.

MR. MISHKIND: It starts with a letter from my office dated --

MR. HUPP: 8-8.

MR. MISHKIND: -- 8-8 ninety --

MR. HUPP: Six.

MR. MISHKIND: -- six, and then proceeds back.

MR. HUPP: Sure.

MR. MISHKIND: If you could run off a copy of that. I think everything else you've provided to me.

MR. HUPP: Fine.

BY MR. MISHKIND:

Q. You've had a chance to go through your office records?

A. I have.

Q. You also have a stack of records to your left. Are those part of the Mt. Sinai records?

A. Correct.

Q. What other hospitals are contained in there?

A. Just the Mt. Sinai records.
Q. Have you had a chance to review any of the Cleveland Clinic records on Regina?
A. Only the correspondence I had had with the Cleveland Clinic regarding some of her postoperative events that were sent directly to me by the physicians at the Cleveland Clinic.
Q. And, in fact, in reviewing your records, I see that Dr. Strong sent you notes, and possibly one or more additional surgeons sent you copies of notes as she was going through the treatment at the Cleveland Clinic?
A. Yes.
Q. It seems that the correspondence to you from the Cleveland Clinic at some point in time stopped.

Does that -- is that your understanding, as well? In other words, you're not still continuing to receive correspondence from the Cleveland Clinic on her treatment, are you?
A. Correct.
Q. Do you know -- if you know, tell me what caused that cessation of communication.
A. I do not know.
Q. Okay.

Did you ever talk to Dr. Strong?

A. I did not.
Q. Have you had any correspondence with him other than what's contained in your file, sir?
A. No.
Q. What about any of the other doctors at the Cleveland Clinic? And the scope of my question, just so you're clear, is, prior to the lawsuit, while Regina was no longer your patient, but prior to the filing of the case, did you have any communication either in writing or verbally or in person with any of the doctors?
A. I can't recall any.
Q. When we talk in specifics in a moment, I see there came a time that you made a note about Victor Fazio and a plan to have Victor Fazio participate in some respect in Regina's care.

Can you tell me how that came about?
A. I had recommended to Regina that a referral to the Cleveland Clinic and Dr. Fazio, who I've worked with before on cases, might be a gentleman who might be able to help us out with this difficult problem. And I said I would speak to him.

And I do recall having a conversation with one of his nurses or schedulers and was either told that he would be, you know, willing to see Ms.

Rushdan or one of his associates would, and that they, I believe, requested some records or charts and a referral.

And that's the only conversations I had with them, because I think we sent over some records, and then she got an appointment over there.

Q. Have you had occasion to refer other patients over to Dr. Fazio or any of his colleagues in the past?

A. Yes.

Q. Was there something specific about Regina's recuperation or the status of her condition that prompted the Cleveland Clinic's involvement?

A. I had done as many -- I had made as many attempts as possible to close this very difficult colovaginal fistula and was not getting satisfactory results. And I had dealt with him on another difficult anal sphincter case, and I knew that his reputation would be helpful in maybe helping me get this lady taken care of.

Q. So the referral to the Cleveland Clinic was your idea as opposed to Regina's idea?

A. Yes.

Q. Obviously you discussed it with her before the mechanism was set up for that referral?

A. Yes.
Q. Do you have independent recollection of discussing with Regina why it was that you wanted someone from the Cleveland Clinic to see her? And when I say -- let me interrupt you. When I say independent recollection, not necessarily line and verse what was discussed, but do you recall the general nature of the conversation with her?
A. I do.

I think that the general nature of the conversation is that she had a very difficult clinical and surgical problem that I had attempted to repair along with some of my associates. And we had had significant problems with recurrences of this fistula, and that I thought a second opinion with possible follow-up surgery by another surgeon might be helpful.

Q. What, if you recall, was Regina's reaction to your suggesting that she be seen by physicians other than you and your associates?
A. I perhaps even recall mentioning to her before I attempted the final transrectal repair of the fistula that I would be willing to and would not be alarmed at her seeking a second opinion. And I do that in any and all difficult cases that I am dealt

with.

And I don't recall that she had any difficulty with the initial suggestion by me that she see someone else, and I believe that she said, well, you know, do what you think is best. And what I thought was best was another attempt, because the fistula seemed to be getting better. But when that final attempt seemed to recur, I said, look, let's go see someone else and get another opinion.

Q. I'm going to ask you sort of a global question. And if you can respond, fine. If it's not fair, let me know.

Through the time that you were treating her, back to February of '94 through August of '95, how would you describe your physician-patient relationship with Regina?

A. I felt that I had an excellent physician-patient relationship with Regina Rushdan, and I felt that we were dealing with a very difficult clinical surgical problem and that she was certainly having a tough time of it, but that she seemed to feel that she could call me at any time and get in touch with me at any time.

And the fact that she continued to come back to me after difficult operations made me believe that

we had an excellent physician-patient relationship.

Q. After you set the wheels in motion for the referral over to the Cleveland Clinic, my review of your records would suggest that -- it would appear, Doctor, that Regina did not return to your office any further, is that correct?

A. That is correct.

Q. There's a note on September 6th, '95, someone spoke to the patient.

Who is that someone?

A. My secretary, Sharon.

Q. Sharon, okay.

Were you made aware of the substance of that conversation?

A. Only that, from my recollection, what I wrote down was that the Cleveland Clinic was going to operate on her.

Q. At the time that that conversation occurred, would you likely have been told more substance in terms of how she was doing, or would it just have been as simple as that, that she was having surgery, and that would have been the end of the conversation?

A. Well, I didn't have the conversation with the

patient, *so* I can't comment on that at all.
Q. I understand that.
I'm saying, did Sharon provide you with any greater insight other than what you've just noted, that the Cleveland Clinic was going to operate, such as how she was doing or what they told her the problem was or anything along those lines?
A. Not that I recall.
Q. Okay.
On October **10, 1995**, Sharon apparently sent out a -- or left a message with --
A. I was aware at that time, if I'm not mistaken, that Ms. Rushdan had undergone an operation at the Cleveland Clinic, which that's why I sent her over there, and that I was curious to see how she was doing and to please get back in touch with me when they release her from Cleveland Clinic.
Q. So this would have been a message on a voice mail or with a third party receiving the message by phone?
A. I would assume *so.*
Q. Would any type of a card have been sent out to her requesting that she follow up with you?
A. Well, we do that with patients who need follow up for breast exams and other problems. I don't know

whether a card was sent or not.

Q. Okay.

In looking at your file, I didn't -- and that was one of the things I was looking for, to see whether there was any type of follow-up notice cards or anything of that nature that you keep. And I didn't find any.

A. Yeah.

Q. I'm just wondering whether I missed it.

A. Not to my knowledge.

While you have the chart there, I did want to ask you a question. There is -- in the file, there is a letter from me dated August 8, 1996, to you. And it's marked hand delivered.

Do you know when that was received by your office?

MR. HUPP: Well, there's one other one before that.

MR. MISHKIND: I know. I'm going to get to that next. I'm just going from top to bottom.

A. I don't know.

Q. Okay.

There is a letter also from my office dated July 25, 1996. And then behind that is an envelope

with a post mark -- it looks like July 25, '96.

Do you know when that letter was received by your office?

A. What was the date?

Q. It's post marked from the post office July 25, '96. And the reason I ask is because there is then a Xerox of an envelope with an actual -- it looks like a return receipt card.

A. Uh-huh.

Well, that was to my Beachwood office, so I might not have gotten it for a period of time. Because I'm only out there once a week, and sometimes only every other week.

Q. And the reason I ask you that, Doctor, is because it appears as if the post office actually left a certified envelope with the return card at your office. Because what we're looking at here isn't something that normally would be left with you. This card is something that normally is returned to the person that sent it.

A. Uh-huh.

Q. Do you still have this original envelope?

A. I don't believe so.

Q. Okay.

A. It's not in my chart.

MR. MISHKIND: Steve, do you have the original envelope?

MR. HUPP: Whatever is in there. The only thing I took out was my letters to him, that's it.

MR. MISHKIND: Okay.

BY MR. MISHKIND:

Q. Now, this was sent to your Beachwood office, and is it your testimony you have no knowledge as to when that was received at your Beachwood office?

A. I have no direct knowledge of when that was received in my Beachwood office.

Q. Would there be any type of a record in your office as to the date that this was received?

A. There probably wouldn't be. Because if it's received at the Beachwood office, I don't have a secretary out there. I just receive mail there.

Q. Okay.

So this could have sat for a couple of days?

A. It could have sat for 7 to 10 days, maybe longer.

Q. Okay.

And I will tell you that the reason that you have a second one there is because we never received back the certified card indicating that you had received the first one. And I now know why

we never received it back, because it was never returned. And apparently -- and correct me if I'm wrong, but this may have sat for several days or longer at your Beachwood office before it came into your possession?

A. That's correct.

Q. And you simply have no knowledge as to exactly when or testimony or that time period you actually received this letter?

A. That's fair to say.

Q. Do you remember getting a hand-delivered 180 day letter from my office on August 8th?

A. That I remember.

Q. Okay.

And I actually have a receipt signed by someone from your office acknowledging that it was received.

Were you there on the day that it was delivered to your office?

A. I don't recall, but I know I got it the day that it was -- I'm also positive I got it the day that it came.

Q. You've told me that you did not actually talk with Dr. Fazio, but you had correspondence with Dr. Strong and with one or more of the other doctors as

Regina was being treated.

Aside from those doctors that corresponded with you, have you talked with any surgeons either affiliated with the Cleveland Clinic or affiliated elsewhere with a view toward obtaining an opinion as to whether the care that you provided Regina complied with accepted standards of practice?

A. No.

Q. You use various surgical textbooks for review, study, and teaching purposes, correct?

MR. HUPP: Objection.

A. Correct.

Q. And Schwartz' textbooks of surgery is one of those texts that you use for teaching and review purposes?

MR. HUPP: Objection.

A. I've used that textbook, yes.

Q. And also Corman's textbook on surgery?

MR. HUPP: Objection.

A. I've seen that.

Q. That's another book that you refer to on surgery issues?

A. I have in the past.

Q. And do you still currently refer to Corman's textbook when you have issues that you want

addressed on surgical matters?

A. I will use several different textbooks as well as Corman's.

Q. What other textbooks besides Corman's and Schwartz' do you use for reference purposes?

MR. HUPP: Objection.

A. Rutherford's, Cameron's.

Q. And do you consider Rutherford's, Cameron's, Schwartz' and Corman's texts as good references in the area of colorectal surgery?

MR. HUPP: Objection.

A. Yes.

Q. There's also a book -- is it Celinger or Celinger, C-E-L-I-N-G-E-R surgical text, are you familiar with that?

A. No.

Q. Did we agree that you consider Schwartz', Corman's, Rutherford's texts as authoritative texts in the field of surgery?

A. Those and any other number of texts as well as the literature covering these kinds of problems are all probably considered authoritative.

Q. You subscribe to various journals, correct?

A. Yes.

Q. Which ones do you subscribe to that would have the

most reliable information dealing with colorectal surgery?

A. Probably the Annals of Surgery and SG&O, Surgical Clinics of North America.

Q. Specifically with regard to this deposition, have you reviewed any medical literature?

A. I have not.

Q. Specifically with regard to Regina Rushdan's case and the difficulty that was encountered in the case -- I'm just using that as a generic statement not passing judgment on what that difficulty was attributable to -- but did you refer to any medical literature at all during the course of your treatment of Regina?

A. Oh, I can't honestly recall, but I certainly don't recall anything specific that I read.

Q. It's conceivable that you did to try to get some information, but nothing that comes to mind right now?

A. Absolutely.

Q. Okay.

Did you talk with anyone to try to get some input as to why she was having the difficulty that she was having as you were involved in her treatment?

A. Yes.
Q. Who were you talking with?
A. Well, we probably presented her at several surgical morbidity and mortality conferences as a complication.
MR. HUPP: Objection, move to strike.
A. And I spoke with Dr. Ami Aszodi, a senior colleague on our staff, who offered some insight and help.
Q. Whereabouts in the time period would you have had the discussion with Dr. Aszodi?
A. Well, I believe I had him come into the operating room to help me with the operation that we performed in October of 1994. And I am sure that he helped with one of the mucosal flap advancement procedures that we tried in an attempt to get this closed.
Q. Did you ever ask Dr. Aszodi or any of your other colleagues for an opinion on the cause of the rectal vaginal fistula?
A. For an opinion as to the cause?
Q. Yes.
A. I don't think so.
Q. Now, you said that this case was presented at

surgical M&M meetings, is that correct?

MR. HUPP: Objection.

A. Well, I said that it may have been and perhaps probably was discussed at those courses -- at one of those meetings.

Q. Okay.

A. Because we discuss most or all of the difficult cases at those kinds of meetings.

Q. Before I start talking about the specific surgeries and how you got involved back in February, I want to understand whether there's anything else that you've reviewed prior to the deposition other than what you have in front of you by way of your office records, Mt. Sinai, and minimal correspondence from the Cleveland Clinic.

A. There has been nothing else.

Q. In reviewing the interrogatory answers that you were kind enough to provide to me through your attorney, there was one answer -- I'm sure it was an oversight -- that was left unanswered. I just wanted to see if maybe we could do it by --

MR. HUPP: That's fine. I just didn't -- I didn't bring a copy of those with me. Let's see.

BY MR. MISHKIND:

Q. I'll show you, and I'll just identify it for the record, that that's interrogatory 30. I won't read the interrogatory into the record, but I'll just let you and your your attorney take a look at that interrogatory.

A. This one here (Indicating)?

MR. HUPP: No, this one.

MR. MISHKIND: The one that's highlighted, number 30.

MR. HUPP: I'm going to object, and I think that calls for a legal conclusion. And considering we haven't taken your client's depo, I don't know if we can answer that. But if you want to rephrase it and ask him if he thinks she did in any respect, I'll let him answer that.

Q. Sure, I'll make it real simple.

Is there anything, in your opinion, Regina Rushdan did that caused or contributed to the complications and the difficulties that were encountered during your treatment?

A. I think that it's possible that having intercourse could have added to the problems that we were

having, yes.

Q. Now, you used the term it's possible that intercourse could have added to it.

Can you state to a reasonable degree of medical probability that her having intercourse on whatever occasions you have noted in the record did, in fact, cause or contribute to the difficulties that you had? And if so, then I'm going to ask you a series of questions about that.

MR. HUPP: Cause or contribute to cause, right?

A. I think it could contribute to cause. I think it could -- it contributed -- it may have contributed to the problems we were having with getting that fistula closed. I don't know that I or anyone can say that it was with certainty.

Q. Just so I understand what you're saying, it may or it could or it possibly did, but you can't say here under oath and say to a reasonable degree of medical certainty that it did cause or contribute to the problems that she had, is that an accurate statement?

A. If you'd restate it completely?

Q. Sure.

I've heard you say that it may, it could, it

possibly did affect the healing of that fistula. And I'm asking you, can you state under oath to a reasonable degree of medical certainty that it did affect the healing of that fistula?

A. I certainly thought at the time.

Q. And do you still as you're sitting here now feel that it affected the healing?

A. From what I know about how difficult this fistula was to close, it's possible.

Q. Can you state to any greater degree of certainty other than it's possible?

MR. HUPP: Well, objection.

A. Not -- no.

Q. Okay.

Other than what you've said about intercourse, is there anything else that you feel that Regina, as a patient, did or failed to do that is a factor in the outcome?

A. No.

Q. Dr. Rubinstein -- or is it Rubinstein?

A. Rubinstein.

Q. Rubinstein.

It's still going to be spelled the same way, so -- Dr. Rubinstein brought you into this case back

in February of '94, correct?

A. That is correct.

Q. Do you have any type of a professional relationship with Dr. Rubinstein currently?

A. No.

Q. Is Dr. Rubinstein still in practice?

A. Yes.

Q. Did you have occasion on a regular basis to participate in cases that Dr. Rubinstein was involved in back in '94 and '95?

A. Not a regular basis.

Q. But obviously more frequently than you do now, considering you said -- your answer is no as to now?

A. Well, what kind of a professional relationship? I'm sorry. I mean, you know, we're colleagues, and we consult each other, yeah, certainly.

Q. What I'm saying is, Dr. Rubinstein called you in because there was a complication at the time of his total abdominal hysterectomy?

A. Correct.

He's done that before, and he's done it recently, and he'll probably do it in the future. So we have a professional relationship. I'm sorry, I misunderstood the question.

Q. That's all right.

Again, I wanted -- and that's why I said at the very beginning, if I ask you anything that's confusing --

A. Okay.

Q. Every once in a while I'll do that. Once during a deposition. Steve limits me to one confusing question.

So you still have occasion to consult and perhaps to participate in difficult cases that Dr. Rubinstein may look to you for?

A. Yes.

Q. Okay.

Now, I want to ask you just some straight questions relative to the surgery back in February of 1994. And the first question I have relative to that surgery is whether you've reviewed the operative report for that surgery.

A. Yes.

Q. And we know that we've got the total abdominal hysterectomy, and then we have your surgery involving the Hartman procedure?

A. Correct.

Q. Do you have any criticism, Doctor, at all of Dr. Rubinstein in terms of his surgery relative to the

total abdominal hysterectomy?

A. No.

Q. Do you have any criticism of Dr. Rubinstein in terms of his preparation of Regina for her abdominal hysterectomy?

A. I don't believe that she had a bowel prep for that procedure. I don't recall. Whether or not I remember -- I don't recall whether he did a bowel prep or not, but my feeling was at the time of surgery that it certainly hadn't been adequate.

Q. I'll tell you that, at least based upon what I see in the records, Dr. Rubinstein did not do any pre-operative bowel preparation before her total abdominal hysterectomy.

What are the indications for pre-operative bowel preparation?

A. I believe that any time a potentially difficult pelvic procedure is done, whether or not it's involving the colon, small bowel, or gynecologic organs, that a bowel prep ought to be done.

Q. Is it your opinion that Regina should have had pre-operative bowel prep in view of her pre-operative history of marked pelvic adhesions?

A. Yes.

Q. Was Dr. Rubinstein's decision, for whatever reason,

not to do pre-operative bowel preparation, below the standard of care?

MR. HUPP: Objection.

A. I don't feel that I'm able to answer that, because the gynecologists view this a lot different than I do. And I'm not sure what the gynecological standard of care is.

Q. Can you state to any degree -- so basically you have no opinion on that, correct?

A. Correct.

Q. Can you state to any degree of medical certainty as to whether pre-operative bowel prep would have altered the outcome in this case?

A. It might have altered what I did surgically at the time that we were consulted in February.

Q. Can you state that to a reasonable degree of medical certainty, that it would have altered what you did, or --

A. No.

Q. So it's might, possible, could have, but you can't say to any degree of certainty whether it would have?

A. Well, the pelvis was very inflamed, and there was a lot of adhesions and a lot of scarring. And it was a difficult dissection even at that time. And I'm

not sure that I would have done any different procedure at the February date if indeed her bowels had even been prepped.

Q. Okay.

So that, had Dr. Rubinstein done pre-operative bowel prep, more likely than not, you would have done the Hartman procedure, assuming there was some injury to the colon at the time of his total abdominal hysterectomy?

A. It was -- the colon was really inflamed. The injury was pretty significant. There was a lot of spillage of bowel contents. And even if the bowel contents had -- even if there had been a bowel prep, I'm not sure I would have gone ahead and done any kind of primary repair at that time. Because I did not like the feeling of and the texture of the bowel at that time. It was an inflamed bowel as well as inflamed pelvic organs.

Q. But obviously inflamed or not, you wouldn't have been called in to participate in the case had there not been some type of a complication during Dr. Rubinstein's total abdominal hysterectomy?

A. Correct.

Q. Okay.

Would the complication that Dr. Rubinstein

experienced more likely than not have been avoided had he done pre-operative bowel prep?

A. No.

The complication that he encountered was not at all related to the bowel prep. It was related to the degree of adhesions between the colon and the uterus and the tubes and ovaries.

Q. So the bowel prep wouldn't have minimized or negated the likelihood of his complication, nor would it have altered the surgical technique that you used once you came into the case?

A. Not -- faced with what I found when I came into the case, I agree with what you said.

Q. Okay.

Is damage to the bowel a common or uncommon occurrence in total abdominal hysterectomies?

A. It's uncommon.

Q. Can you give me any type of a statistic as to the frequency of small bowel injuries at the time of a total abdominal hysterectomy?

A. I would be guessing if I did.

Q. Can you give me --

A. Three to five percent, maybe, probably less.

Q. Obviously she did suffer a small bowel injury at the time of her total abdominal hysterectomy,

there's no doubt about that.

MR. HUPP: Objection.

A. She had colon injury, not small bowel injury.

MR. HUPP: Right.

BY MR. MISHKIND:

Q. Referring to your operative report, Doctor, dated February 1, '94 --

A. Uh-huh.

Q. What I'm going to do is just -- you can use your copy, but I'm going to hand you a copy. It's got some highlighting on it that will direct you to where I'm referring to in the description of the procedure.

A. Yes.

Q. And your copy is better than mine. Mine is sort of running off the copy machine. But I think you can still see where I'm talking about. We helped -- looks like mobilize the colon -- and found a small hole in the colon.

Do you see that?

A. Yes.

Q. Which we expected because of the adherence to the uterus.

Was this, in fact, a small bowel injury or a small hole to the colon, as you've described it

there?

A. Well, if I recall, the injury was probably several centimeters, at least, in length, and perhaps longer. And when you have spillage of colon contents, I don't know that the size of the hole is as important as where it is and what kind of spillage you have.

Q. Let me ask you this *so* that you can respond and explain in whatever manner that you want to, because obviously the purpose of my deposition is to find out why you did certain things, no mystery to that.

With regard to your surgery on February 1, 1994, would you tell me why you didn't close that injury in layers perpendicular to the long axis of the bowel?

A. Yes, because there was a lot of inflammation of the bowel, and there was a spillage of intestinal contents. And the dissection of the remainder of the hysterectomy caused further segment of the bowel to be dissected off.

And I was not pleased with the look of the gut at that point. And I did not think a simple closure at that time was the appropriate operation.

Q. Did you consider using a primary closure prior to making the decision to do the Hartman procedure?
A. If I considered it, I pretty much put it out of my mind very quickly, because I just did not like the looks of the entire pelvis because of the degree of inflammation and adhesions that were there at the time.
Q. You're called in on an emergency basis to participate at this point, correct?
A. Correct.
Q. So you're not in a position to be discussing the risks and benefits of procedures and the alternatives with Regina Rushdan, were you?
A. Correct.
Q. So as far as the decision on what procedure to do and whether to do a colostomy or to do a primary closure, that was Dr. Baringer's decision alone?
A. Yes.
Q. Did you have any input from Dr. Rubinstein or from any other assistants before proceeding to do the Hartman?
A. No.
Q. What other factors influenced your decision, if any, concerning the 'type of surgical procedure that you used in attempting to treat the injury to her

colon?

A. I think we've gone over most of them, the degree of inflammation and adherence of the sigmoid colon to the uterus and the pelvic structures, the fact that there was spillage and unprepped bowel, and the fact that the segment -- the short segment of sigmoid colon was very inflamed looking.

And I can't honestly say whether that was from the primary process or from the dissection for the hysterectomy. But it was not bowel that looked like -- there was not bowel that I would have done any primary closure on. Indeed the bowel looked bad enough for me that I took a small section of it out.

Q. Would you agree that, if you can repair a colon through a primary repair that, from the standpoint of the patient's morbidity and recovery, it's preferable to do that than to do a colostomy?

A. Yes.

Q. And that a colostomy should only be done if other less radical measures are not adequate?

A. In my opinion, a colostomy should be done in any situation where you're not satisfied or where you're not satisfied that the primary repair or any kind of an anastomosis will heal satisfactorily.

Q. When you do a primary repair, how do you normally secure the area of injury?

A. You dissect the bowel out from any surrounding structures as much as you can to free it up *so* that you have excellent tissue to work with and that you have enough bowel length *so* that any kind of a repair primarily or an anastomosis is not under tension and that the blood supply looks adequate to allow for healing.

And indeed in these kinds of situations, you may be able to do that and do the repair, but you still elect not to because of the spillage of intestinal contents or other inflammatory changes in the pelvis that you think would increase the risk of developing a leak, a fistula, or an abscess to develop post-operatively.

Q. You could have done a primary repair, but you were concerned about subsequent infection and subsequent fistula formation?

A. In this situation, I think a primary repair would have probably been difficult. The only way that I think you could have done it differently would have been to do a resection of bowel and a complete total anastomosis at that time. And that I elected absolutely not to do because of all the reasons we

mentioned above.

Q. In reviewing the operative note and reviewing the course of events that occurred at the time of the hysterectomy, are you satisfied in your mind that your surgical decision to proceed with the Hartman colectomy -- the sigmoid colectomy with the Hartman procedure was within accepted standards of practice?

A. Yes.

Q. I wanted to get a couple terms defined, just so I'm clear. I've seen colectomy. I've seen colostomy. What's the difference?

A. A colectomy is a removal of a portion of the colon. It may or may not involve a colostomy.

A colostomy is the creation of a segment of bowel being brought up to the abdominal wall and through the abdominal wall so that the intestinal contents will empty into a bag as opposed to go through the entire system.

Q. And the bag and the collection, that's the Hartman procedure?

A. No.

The Hartman pouch or procedure is the removal of a segment of sigmoid colon, overstapling the rectum, and leaving the rectum as a literal pouch

that will drain a little bit of mucous, but it's not in continuity with the entire colon.

The colostomy being brought out on the abdominal wall is the end of the bowel wall literally sewn through the abdominal musculature onto the skin of the abdomen where a bag is placed in order to collect stool, fecal contents.

Q. There is the use of the term by you on several occasions, and most particularly on May 31, '94, of the term iatrogenic rectal injury.

Would you define for me what you mean by iatrogenic?

A. That an injury occurred to the rectum during an operative procedure.

Q. Can we agree that, when one refers to an iatrogenic injury, that that implies that the affects could have been avoided by proper and judicious care on the part of the surgeon?

MR. HUPP: Objection.

A. No, I can't agree with that.

Q. You disagree with that statement?

A. There are iatro --

MR. HUPP: There's really no question pending.

MR. MISHKIND: There was.

MR. HUPP: What's the question?

MR. MISHKIND: I'm asking whether he disagrees with that statement.

MR. HUPP: He says he disagrees with it. Next question.

A. Why don't you repeat the question?

Q. You've defined iatrogenic -- let me *go* back just *so* that I make sure we're on the same page. I can either have the court reporter --

MR. MISHKIND: Why don't you read back the doctor's definition of iatrogenic?

(Thereupon, a short recess was taken.)

(Thereupon, the record was read.)

BY MR. MISHKIND:

Q. When you use the term iatrogenic to define an injury that occurs during a procedure to the rectum, does that term imply that that injury could have been avoided by proper and judicious care on the part of the surgeon?

MR. HUPP: Objection, asked and answered.

A. I'm not sure that I can sit here and quote you the definition of iatrogenic. In my mind, iatrogenic

means something that occurs during the course of an operation that could be avoided.

But there are certainly instances, in my mind, where, even with an excellent standard of care and judicious procedures, that an injury could occur based on loss of normal tissue planes and difficulty being able to dissect out normal organs.

If iatrogenic means that it occurred during -- you know, that it occurred during the performance of an operation, then this is an iatrogenic injury that I can't necessarily comment on whether or not it is avoidable or not or whether or not it's above or below standard of care.

Q. Okay.

Do you have an opinion whether this iatrogenic rectal injury was avoidable with proper and judicious care on the part of the surgeon?

MR. HUPP: For the record, we're saying Dr. Rubinstein's care?

A. We're talking about Dr. Rubinstein's procedure?

Q. Yes.

A. Based on what I saw in that pelvis, I'm not surprised that a rectal injury occurred.

Q. So your opinion is that it was not avoidable with proper and judicious care on the part of the

surgeon?

A. Yeah, yes.

Q. Okay.

Back in May of '94, did you hold any positions within the department of surgery at Mt. Sinai?

A. In May of 19947 I was probably -- I was head of the section of trauma, as defined by Mt. Sinai Medical Center, and I was an assistant professor of surgery with the Case Western School of Medicine.

Q. Referencing the surgery back in February of '94 for a moment -- I won't keep on going back and forth on the procedures, but had you considered doing a primary closure?

And I know you've explained to me the reasons why you did not, but if you had done a primary closure, would that have been a two-layer silk closure with a metal patch over it?

Would that have essentially been the mechanism?

A. With a metal patch?

Q. Yes.

A. I certainly don't use metal patches in those kinds of repairs. I would have done a two-layer closure with an inner layer of usually absorbable suture

and an outer layer of silk.

Q. Okay.

You would not have used a metal patch?

A. No.

Q. And doing that, from what you told me before, would have had the disadvantage of increasing the likelihood of fistula formation and infection?

A. Fistula, infections, abscesses, stenosis or scarring down of the anastomosis or repair would be the major things that I was concerned about occurring if I would have done a primary repair.

Q. Somewhere in your records, or in the hospital records, perhaps, I thought I saw some indication that you were not planning on doing the reversal of the colostomy as early as you ultimately did it.

I may be mistaken, but was May, '94, the original period of time that you had envisioned the reversal?

A. My standard of practice is generally to tell patients after a difficult initial pelvic procedure where a colostomy and a Hartman's pouch is formed, that it will be anywhere between three and six months before we do a closure.

Q. So in Regina's situation, it was at the early end of that spectrum?

A. Yes.
Q. Okay, let's talk about the operation on May 31st, '94.
My understanding of this EEA stapling device is that it's like an anvil with a donut, a round donut on the end.
Is that a fair description of how it appears?
A. Generally, yes.
The anvil, or the head of the stapler, is essentially a receptacle in a donut shape, or a round shape, to accept staples from the other end of the EEA device.
Q. And the EEA stands for end-to-end anastomosis?
A. Correct.
Q. Is that a brand name, or is that just sort of a --
A. I believe it's a brand name. I can't recall whether it's Ethicon or U.S. Surgical. The wars between those companies are allegiant.
Suffice it to say that most surgeons describe and use the term EEA when they're using a circular stapler designed to create an anastomosis.
Q. Who chose the number 29 EEA stapling device?
A. I did.
Q. Did you have various devices to choose from?
A. Various sizes, but not various devices.

Q. How many various sizes did you have?
A. Three.
Q. Tell me --
A. Sure, a 27 -- I believe in this series it's a 27, 29, and 33 millimeter diameter.
Q. So that 29 represents millimeters?
A. Yes.
Q. How is it that you chose a 29 millimeter in Regina's case?
A. Generally after we take down the colostomy, or any bowel -- it does not have to be colon -- we have metal sizers that look like large sounds that correspond to the size of the stapling instruments that we use, and you simply put the device into the colon to see where it fits nicely or whether or not it's too small or too large.
Q. Whose responsibility is it to maintain that stapling device in good operating condition?
A. These are disposable instruments, so they are essentially brought to the operating room in packages fashion from the storage area and are sterile at the time and are opened in the operating room based on what size I ask for.
Q. And after it's used, then, is it disposed of?
A. Yes.

Q. Do you know whether the 29 millimeter EEA stapler that was used in Regina's case, whether that was disposed of?
A. I'm pretty sure it was. I certainly don't recall asking for it to be saved.
Q. What had been your experience in using these three different sized EEA staplers in the past before Regina?
A. Like all surgeons, these instruments sometimes don't fire the way you think they're going to fire, don't fire at all, perhaps cut tissue too sharply or not enough, and generally are capable of having anything mechanical go wrong with them that can go wrong with anything.
Q. Have you had, prior to Regina's case, an EEA stapler misfire?
A. Yes.
Q. On how many occasions had you had an EEA stapler misfire?
A. One or two.
Q. Did you have any complications secondary to the misfiring?
A. Not that I recall.
Q. Are you aware of the frequency in the literature that EEA staplers, or this type of an end-to-end

anastomosis stapler, misfire on average?

A. No.

Q. But from what you're describing, it doesn't sound like it is a rare occurrence. It sounds more like an infrequent, but not rare occurrence?

A. That's -- I'd agree with that statement.

Q. If it happens infrequently, but yet enough that it's not considered to be an isolated or rare occurrence, why continue to use this device in the process?

A. Because it enables us to do anastomoses down in the pelvis and lower in the pelvis than we were able to do sometimes before these devices were brought out. We're able to do lower anastomosis and anastomoses in the pelvis that sometimes the rectum itself is hard to dissect out of.

I think most surgeons would agree with that statement. I think that these instruments function very well in most instances and have enabled us to do different kinds of procedures and procedures lower in the pelvis than the surgeons in the past were willing to do.

Q. Was there any degree of problems that Mt. Sinai was having back in 1994 with this brand of EEA staplers?

A. I really don't recall. I think we have switched back and forth with regard to the kinds of staplers we've used. I think most of it has generally been based on surgeons' preference and availability. Sometimes it's hard to get these things into your hospitals. But I'm personally not aware of any problems.

Q. In Regina's case, can you tell me what the cause of the misfiring was?

A. I think at the time I didn't know what caused the misfiring. And it wasn't a complete misfiring, because we could see that there was an opening where it didn't cut through the tissue, which was my impression at that time, and complete the staple anastomosis.

So that we were left with an area that was still open. And upon removing the instrument from the rectum, you could see a good bit of the area stapled to the -- the tissue stapled together in a donut fashion like you like to see, but that it wasn't complete.

And we were readily able to identify that the anastomosis wasn't completely circumferential. And in doing so, I elected to make a little ante-mesenteric cut on the anterior surface of the

proximal colon to give me a little bit more length and then create a hand-sewn anastomosis sewing up the defect in my stapled anastomosis.

Then we checked that to make sure that it seemed to be completely circumferential and everything was closed.

Q. So that when you use the term misfiring, it was really just an incomplete --

A. I would say that incomplete firing would be better terminology.

Q. So you were able to use the product of that firing, but you then had to, by hand, finish the anastomosis?

A. Fair statement.

Q. Okay.

And what happens from time to time, that you have to complete the anastomosis by hand?

A. Yes.

Q. And has that happened to you in the past?

A. Yes.

Q. Have you seen circumstances where the misfiring of an **EEA** stapler is caused by substandard surgical technique?

A. Have I personally seen cases of that?

Q. Yes.

A. No.
Q. Are you aware from the literature, aware for whatever reason, the skill of the surgeon or other factors, that the misfiring of the EEA stapler is a component of less than acceptable surgical technique on the part of the surgeon as opposed to just one of those things that happens?
A. I'm not sure that I know that from the literature.
Q. Do you know that from your practice?
A. Well, I can envision it, okay?
Q. Okay.
So certainly a misfiring, even though you may not be able to cite me to any particular literature, you can see how a surgeon could misuse the EEA stapler and cause a true misfiring of the stapler at the time of an attempted anastomosis?
A. I could envision that happening.
Q. Okay.
I take it in this case your opinion is that you did not misuse the EEA stapler causing the misfiring to occur, is that correct?
A. Well, I don't think that the -- you know, we recognized that the instrument didn't perform the way I wanted it to perform. And based on what I saw and what we examined at that time, both in the

abdominal cavity and from below with a flexible sigmoidoscope, it appeared that it just wasn't a complete donut formation, which I have seen in the past, and which I have dealt with in the past.

And that, once we repaired with hand-sewn technique the remainder of that anastomosis, checking around, it appeared to me that we had satisfactorily dealt with the problem.

Q. Do you have an opinion as to why it didn't perform the way that you had expected it to perform?

A. I formed that opinion later on, but not at the time of the operation.

Q. What was the opinion that you formed?

A. That the rectovaginal septum had been caught in the EEA stapler, and a portion of the vagina was in the staple line of fire.

Q. Why was it in the line of fire?

A. Looking back at the operation that we later had to do in order to try to fix this, it was -- and at the time of that operation, even, there was a lot of dense adhesions in the abdominal pelvic cavity, and that it was difficult to dissect the rectum from the vagina even at that time.

Those two organs were really tightly adherent. And passing the EEA gun through the rectum, and

then advancing the receptacle through the rectum, and then hooking up the colon, anvil side, to the receptacle, that as you screw that down, the mucosa of the rectum and vagina were so closely adherent that some vaginal mucosa got caught in there.

Q. You as a surgeon must exercise care in advancing the EEA gun into that area so as to minimize the potential for injury to the mucosa and to --

A. Any surrounding organs.

Q. Okay.

And that's your responsibility, correct?

A. Correct.

Q. And can you tell me why, in this case, you weren't able to avoid causing some type of injury?

A. It's my opinion that those two -- that the rectum and vagina were *so* tightly adherent from adhesions from the previous surgeries and from whatever pathological processes she had had even in the past, that it was difficult to tell those tissues apart, that I was obviously through the rectum with the staple gun, and that I was quite satisfied at the termination of the procedure -- not at the termination of the firing of the gun, but at the termination of the procedure, that we had connected colon to rectum as we had planned.

Q. You apparently didn't appreciate the fact that there had been an incidental injury to the mucosa --

A. Of the vagina at that point, correct.

Q. -- of the vagina, okay.

Certainly if you had the ability to perceive that, can we agree that that's something that you should have attempted to avoid?

MR. HUPP: Objection.

A. You're always trying to avoid injuries to surrounding structures whenever you do surgery and whenever you do anastomoses. So I would absolutely attempt to avoid any kinds of problems like that.

Q. And I suppose that sort of was an obvious question with an obvious answer, but let's assume that the injury occurs.

Do you also agree with me that you have a duty to promptly recognize and to treat any incidental injuries that may occur that are taking place before the patient leaves the operating room?

MR. HUPP: Objection.

A. One should try to satisfy oneself that the procedure went as planned. And if it doesn't *go* as planned, satisfy yourself why it didn't go as

planned.

And in this case, it was my opinion at the termination of the procedure that we had done an appropriate anastomosis between the colon and the rectum. We checked it out with a flexible sigmoidoscopic exam. We blew in air, and we had a widely patent anastomosis with no obvious injury to any other structures.

Q. And all of these things in terms of making sure that you do not have any air or fluid escaping, that's your responsibility as the surgeon, correct?

A. Yes.

Q. And can we agree that, if you fail to make sure that the area isn't -- if you fail to make sure that there is no leakage of air or fluid, that would be a violation of the standard of care?

MR. HUPP: Objection.

A. If there is -- you better state it again.

Q. Want me to rephrase it?

A. Yes.

Q. I can sort of tell the way you were looking -- and after I said it, I was wondering whether it was clear.

If there is a leak of air or fluid, and you do

not recognize it and correct it, that's a violation of the standard of care, correct?

MR. HUPP: Objection.

A. I would say that, if you recognize a leak of air or fluid, you should satisfy yourself why that occurs. And if you don't satisfy yourself why that's occurring, that might be a violation of standard of care.

Q. And if there is a leak of air or fluid, would you agree that there is an increased likelihood that there is going to be the development of a fistula?

A. Not necessarily a fistula or abscess or a stenosis or scarring of the anastomosis -- I mean, complications can occur, but they don't necessarily have to.

Q. Is there an increased instance of abscess formation or fistula formation where there is air or fluid leaking at the time that a procedure of this nature is completed?

A. Probably.

Q. Is it okay under any circumstance not to repair a leak of air or fluid at the time of colon surgery?

MR. HUPP: From an anastomosis cite?

MR. MISHKIND: Yes, uh-huh.

A. Is it okay not to?

Q. Yes.

A. No. I think you should repair it if you can find it.

Q. Looking at the operative report again, and I'll -- if you can look on yours, and I'll direct you to the specific areas that I'm referring to.

On page 4 of the operative note, toward the bottom in the highlighted area, I'll read it into the record. It says, air did not leak out through the anastomosis. There was a very small amount of leakage of the Methyline Blue dye when this was irrigated into the rectum.

Would you explain to me what the cause of that leakage of the dye was at that time?

A. It was my opinion at that time that there was a little bit of leakage through the hand-sewn anastomosis area.

Q. Okay.

A. That when you do this -- when you put Methyline Blue under pressure, you sometimes can see that kind of a leakage. And in my opinion, and in my experience, even more so with a hand-sewn anastomosis.

It's my recollection that this was a very small, little leakage with -- my technique is to put some dry tapes down in the pelvis and irrigate out with Methyline Blue in some instances to see if you have any leakage that would be picked up on the tape.

Once we did that, we couldn't find any further sites. And I have had more success with using the insufflation of air for an anastomosis, because, frankly, the pressure is even higher with air.

What you do in that situation is fill the pelvis with saline, clamp the bowel, and blow air in it at very high pressure through the flexible sigmoidoscope. And if you don't see any bubbles coming up, that generally, in my experience, has been satisfactory that there is not any clinically significant leak.

The Methyline Blue, if it's picked up, you look and see where it might be coming from. And in the pelvic cavity and at the anastomosis, I could not, to my recollection, find any oversights where it was leaking. And because we had a good bowel prep, I proceeded to go ahead and leave a drain in place in the pelvis, which I do after all of these low anastomoses.

Then I was satisfied that the anastomosis wasn't under tension and the tissues were healthy, so I elected to not do anything else, like a diverting colostomy.

Q. Doctor, we can certainly agree, can we not, that inserting a drain does not substitute for the surgeon's responsibility to make sure that leaks of air or leaks of fluid are resolved before closure?

A. It does not substitute for finding a possible site of a leak.

Q. And as I look at your operative note, I don't see any evidence that, at the time of closure, that you had satisfied yourself that the Methyline Blue leak that was described in the operative report had been resolved by further intervention to sew up the area or to resolve the point of leakage.

A. If I would have seen a site where Methyline Blue was obviously leaking out of an anastomosis, I would have repaired it. It has been my experience that at times you get a little leakage of dye, and you re-irrigate and re-irrigate, and you can't see it leaking out. This is in the peritoneal cavity. And you're dealing with an anastomosis fairly low in the pelvis.

I satisfied myself that there was not a clinically significant leak by insufflating the air and using that technique. I am sure -- although it may not be dictated that I looked around for any area where the Methyline Blue may be leaking. And if I would have found it, I would have repaired it.

It was pretty clear from the operative note that I was satisfied with the anastomosis, that there was no tension there and that the bowel was healthy enough that a leak would be unlikely.

Q. While you were satisfied that there was no clinically significant leak, you could not and cannot at this particular point say that you were satisfied that there was no leak that continued to exist at the time of the closure, can you, Doctor?

MR. HUPP: Objection.

A. Well, I don't think anyone can.

I satisfied myself clinically that the anastomosis was satisfactory.

Q. And the fact that you had a leak of Methyline Blue dye then or at any time in the future, did you arrive at an opinion as to the cause of the leak?

A. It had nothing to do with the formation of a

colovaginal fistula, in my opinion. If we saw Methyline Blue in the pelvis after insufflation of Methyline into an anastomosis, and the Methyline Blue dye is in the pelvis, it would mean to me that the anastomosis between the colon and the rectum had a leak somewhere and that it was spilling out into the pelvis, not into the vagina.

And that's different, because you've got -- you've got one-fourth or one-fifth of your anastomosis that is in conjunction with the vagina. You've got four-fifths of it that is freely sitting in the pelvis peritoneal cavity.

And if I've got a tape down in the pelvis and saw some Methyline Blue on the tape -- and I don't recall that, but if we did, we would have looked all around wherever the anastomosis was visible from the pelvis to see if we could find a site of leakage.

And in our dictation, we obviously didn't find that. And we elected to close.

Q. Going back to my original question, though, can you tell me what the cause of the leakage was of the Methyline Blue dye?

A. If you're injecting saline or dye through an area that has just been sewn closed, you can have

sometimes leaks of fluid through that area. You depend on the body to do some healing. You can't sew things together so tightly that you have no healing, because sometimes you'll cause stricturing and scarring and ischemia to a segment of bowel.

If you sew two pieces of bowel together and put them -- put clamps on each end of the bowel, and then inject fluid through that piece of bowel that's got an anastomosis, if you will reach a point where you'll get leakage through there, a small amount of fluid through there, that may or may not have any clinical relevance, because, one, there is never any -- hopefully not any significantly high pressures through that area for a while. And two, you've got to depend on the body to do some healing between your sutures. Sutures do nothing more than hold the tissues together so that they heal.

Q. So your opinion in this case is that this Methyline Blue leak that's described on May 31, 1994, has no clinical correlation at all to the colovaginal fistula that we know 17 days later you were operating on?

A. I can't see how it does.

Q. Okay.

After discovering that there was a small amount of leakage of Methyline Blue at the time that you irrigated the rectum, did you, from your memory or from what's noted in the operative report, take any further efforts to reinforce the anastomosis?

A. I don't recall. If it's not dictated, I don't recall it.

Q. Would the standard of care in order to minimize the likelihood of an abscess or a fistula developing . require that measures be taken to reinforce the anastomosis where there is evidence of a small amount of dye leaking from the rectum?

MR. HUPP: Objection.

A. I think certainly if you see the site where you have some leakage, and with Methyline Blue, you often will, because it will stain the tissues, as well, then I would reinforce that area.

There's no point in this dictation where I noted that there was any staining of tissues. Because if I did see that, I would have reinforced it. I have had the experience of seeing both dye leakages and air leakages noted after a completely satisfactory stapled anastomosis.

And you look and look and try to find the area

of your leakage. And if you do not find that area of leakage, and it is sometimes impossible to find, then you have other alternatives. And those alternatives are take the anastomosis down and redo it, which sometimes is difficult if you're working low in the pelvis, or create a proximal diverting colostomy in order to give that area a time to heal.

And it is my contention and dictation that we were satisfied that the anastomosis was satisfactory, without tension, and that there was no leakage of air. And putting a scope through the anastomosis, everything looked fine. And I had a good bowel prep, and I elected to not perform a proximal colostomy.

Q. Okay, let's move to the June 17th surgery now.

MR. HUPP: Can we see yours for a second? When we copied it, it made a black mark.

(Thereupon, a discussion was had off the record.)

BY MR. MISHKIND:

Q. On June 17th, again, the operative note that I've handed to you has some highlighting on it. And on June 17th, 1994, we know that we've got a rectal vaginal fistula, correct?

A. Correct.
Q. Did Regina develop an abscess that led to the fistula?
A. No.
Q. What caused the fistula?
A. A partial stapling together of the vaginal wall and the rectal wall with the EEA stapler.
Q. And from a physiological standpoint from May 27th -- I'm sorry, May 31st to June 17th, what process or processes occurred that caused, if, in fact, you are correct, the misfiring of the stapler to lead to the fistula formation?
A. Well, I think that what happened is that part of the wall of the vagina, posterior wall of the vagina, was caught with the anterior wall of the rectum in the stapler, and that, when the instrument was fired, that it didn't complete an anastomosis probably in that area, because it was a a different tissue consistency.

And that, when we were examining the bowel where the anastomosis wasn't completed, we saw -- I saw good rectal and colonic tissue and fastened the remainder of the anastomosis by hand, and that for a week or so before she started to have significant flow of stool through the area, that that wasn't a

problem. But then when she started to have significant amount of gas and stool come through the area, that it probably gradually anatomically broke down, and the fistula was created.

I don't have any clinical evidence that she had an abscess that led to that formation. So that's what I think must have happened.

Q. And that's why you used the language in your operative report that she developed a rectal vaginal fistula with a staple line through the vaginal wall no doubt resulting from the EEA stapler?

A. Yes.

Q. Whose fault is it, if you are correct, that she developed the fistula no doubt resulting from the EEA stapler?

MR. HUPP: Objection to the form of the question.

A. Well, the surgeons who put the staple gun together and fired it are at fault.

Q. And who was that surgeon?

A. That is me.

MR. HUPP: Objection, move to strike.

BY MR. MISHKIND:

Q. Doctor, the Methyline Blue dye, the small amount that was seen back on May 31 --
A. Yes.
Q. -- was that in reality a leakage from what was soon to be the fistula?
A. That's speculation.
Q. Is it in the same location?
A. I can't recall. I don't know where the -- you know, there's no point in the dictation where it says where the leakage was coming from. I would expect that, if there was a large enough hole created between the vagina and the rectum initially, that you would see blue dye in her vagina when you're inserting that into her rectum. And that was obviously not the case. That if any dye showed up, it showed up on a tape down in her pelvis and that that is -- it's impossible for me to -- and I think impossible for anyone to say whether or not the Methyline Blue leakage, minor though it may have been, was a precursor of or harbinger of a colovaginal fistula.
Q. Was it surprising to you that she developed a rectal vaginal fistula based upon what transpired at the time of the surgery on May 31, 19941
A. When I got the pathology report back, which was

about the same time that she started to pass a little stool per her vagina, it was clear to me what happened. Because the pathology report had some squamous mucosa in it, and the rectum doesn't have squamous mucosa. The vagina did.

So I didn't even have to put a finger in or a scope up there. I knew what happened.

Q. You knew she had a fistula?

A. Yes.

Q. But that doesn't tell you what caused the fistula?

MR. HUPP: Objection.

A. Well, I'm a clinician, and I know what caused the fistula. It was either a stapling together of the partial wall of the vagina with the rectum, or it was a major leak -- not major, but a significant leak at the anastomosis that eroded into the vagina.

Q. Do you need, in fact, a major leak to have led to the size fistula that she had 17 days later, or would a small leak --

A. A small clinical leak could do the same.

Q. Okay.

So those are two possible explanations for why she developed the fistula?

A. Yes.
Q. Are there any other possible explanations other than those two?
A. Not really.
Q. And can we agree that, if the leak was at the site of the anastomosis, and it had nothing to do with the misfiring of the EEA gun, and there was clinical evidence of a leak, that it was your responsibility to have re-approximated the anastomosis so as to minimize the likelihood of fistula formation?
MR. HUPP: Objection.
A. If I would have been able to determine that Methyline Blue was leaking from an area of the anastomosis, then I would assume that I would put a stitch or two in that area to close up that area of leakage.
Q. Okay.
A. I am sure that I saw no specific area that was leaking Methyline Blue.
Q. Hypothetically, if you didn't put a stitch in, and you had clinical evidence of a leakage of Methyline Blue at that point, we can certainly agree, can we not, that that would have been a violation of the standard of care?

MR. HUPP: Objection.

A. Well, you know, I'm not sure what you're asking me. I mean, are you asking me if I saw -- if I had a little leakage of Methyline Blue, and I looked all around and tried it again, or did whatever, but could not find where it was leaking, and I had other mechanisms at my disposal that I used, and that is putting air in and filling up the peritoneal cavity and the pelvis with saline and looking to see if any bubbles of air leaked through, and you visualize to the best of your ability what the anastomosis looks like, and if all of those parameters tell me clinically that my anastomosis is secure, I'm not sure what else you want me to do or, you know, where you would expect me to make another movement or another step in order to improve the situation where I saw no problems.

Q. Certainly if there is --

A. If I saw a major -- I'm sorry to interrupt.

Q. That's okay.

A. If I saw a leak that was clinically -- that was visible to my eye, and -- I would reinforce it.

Q. And if you saw a leak that was clinically visible to your eye, and you didn't reinforce it, instead

you put a drain in and closed the patient up, that would be a violation of the standard of care, correct?

MR. HUPP: Objection, hypothetical, go ahead.

A. Yes.

Q. If the anastomosis was both water and air tight, more likely than not would Regina have developed this fistula?

A. Based on what I know in retrospect looking over this whole case, if the anastomosis at that time was air and water proof, would she have developed a fistula?

Q. Yes, sir.

A. Yes.

Q. She would have?

A. Yes.

Q. Explain to me.

MR. HUPP: We've been over this a couple times. It's the gun. He keeps telling you it's the EEA.

A. The EEA stapler had vaginal and rectal mucosa within it. The vagina had to be pulled up into part of the anastomosis. And when the gun fired, it probably misfired at that area, because that's

different tissue consistency.

And the idea of the gun is that it usually needs the right consistency. Now, that's in retrospect, because at that time I looked and visually inspected and tried to fix this hole that was not -- you know, part of my anastomosis that wasn't completed.

And when I visualized that and looked all around and freed up the tissue some more, making a little incision on the colonic side to give myself a little more length and less tension, I was satisfied at that time that I was sewing rectal mucosa to colonic mucosa. And I'm convinced that I did that, because I looked with the flexible sigmoidoscope and saw a wide open anastomosis with no obvious leaks. I put air in there and saw no leaks.

If I put in some Methyline Blue and saw a little bit of blue show up, but couldn't find where it was coming from, so be it. But I do not think that that heralded -- that that Methyline Blue leak necessarily at all heralded the possibility of the formation of a fistula

(Thereupon, a discussion was had off the record.)

BY MR. MISHKIND:

Q. did you see Regina at any time between her discharge from the hospital on May 31st and when she came back into the hospital?

A. This is discharge May --

MR. **HUPP:** 31st.

MR. MISHKIND: I think it's May 31st.

A. Exploratory lap, discharge on **6-23**, yes, I have a couple of office notes here from -- you know, I saw her on July 7th.

Q. No, I'm sorry. We have the procedure on May 31st.

A. **Yes.**

Q. Then did she remain in the hospital?

A. According to my chart, she was discharged on June 23rd.

Q. Okay.

So she was in the hospital when the fistula was discovered?

A. Yes.

Q. Now, do you have the pathology report?

A. I should.

MR. **HUPP:** I haven't been able to find it. He told me that he remembered seeing it, but I couldn't find

it.

MR. MISHKIND: Now, is this from the May 31 procedure?

MR. HUPP: Yes --

A. No, it would be from the --

Q. June 17th?

A. No. It would be for the May 31st procedure.

Q. Okay.

A. It's got to be in with the hospital records, then.

Q. I think it's right -- is that what you're looking for (Indicating)?

A. Yes.

MR. HUPP: There you go. Is that in -- it's in his?

THE WITNESS: Yeah, I've got it. No, that's not it. That's not it.

MR. HUPP: Let me see this.

THE WITNESS: That's the June operation.

MR. HUPP: Go ahead. We'll keep going. Use that thing, but --

BY MR. MISHKIND:

Q. This may be from a copy of --

A. It's from the hospital records, probably.
Q. Right, which is right here (Indicating).
Okay, now, we were talking about the pathology report, which you looked at. And this was about the same time that the fistula --
A. Became symptomatic.
Q. Okay.
And what is it about the pathology report that is of significance to you in terms of the diagnosis?
A. That there is non-carotenizing squamous mucosa with mild nonspecific chronic inflammation.
Q. Okay.
A. That's vagina mucosa. That's not colon or rectal mucosa.
Q. And of what significance is that in terms of the cause of the -- or the inciting event, if you will, that precipitated the --
A. That my EEA stapler caught a little bit of the posterior wall of her vagina, whether at the vaginal cuff or a little bit lower down, but it was caught up in that process of bringing the EEA stapler and its anvil down together, a process that involves screwing down the stapler as the tissues are pulled together to this certain position where

the gun is then fired.

You make every effort to put your hand around and feel and satisfy yourself that no other tissues are caught when that happens. And I did that.

Q. Okay.

A. And I've seen bladder, vagina, small bowel, and ureters get caught in these kinds of staple guns, Have I done all those? Absolutely not. But those are all reported complications of using these kinds of instruments.

Q. If it's reported happening, why, then, do they continue to use these guns?

A. Well, I said this earlier. It still makes operating in difficult situations easier a great percentage of the time. I am sure that there are surgeons out there who, if they saw what I saw, the original operation, would have told Ms. Rushdan, as horrible as it sounds, to live with the colostomy the rest of your life. Because trying to put you back together may be hard.

And there are a lot of folks walking around out there, certainly not many young people, but there are a lot of older folks out there walking around now with colostomies that the older general surgeons don't put back together and didn't put

back together, because it's hard. It's technically difficult surgery.

So the advent of these instruments has enabled us to go down into the pelvis relatively low with a lot of inflammation and a lot of difficult dissection and generally improve our ability to put people back together so that they don't have to live with the colostomy.

Q. Did you tell Regina what was causing her to pass stool through her vagina?

A. Yes.

I told her that there was a connection between her rectum and her vagina and that it probably occurred from the staple gun. Because I wasn't sure at that time. I only found out that when we re-operated on her the second -- when we operated on her and did the colostomy and we looked in there. And then I said that we've got this fistula now. There's some staples and sutures in there that we took out. But because it was such a difficult operation initially, I don't want to try to re-operate on you now. I'll give you a colostomy, and we'll see if this fistula will close down over time.

Q. Is it your testimony that you told her at that time

that, more likely than not, the fistula was caused by the stapler misfiring as opposed to --

A. I don't think it's -- it's not caused by the stapler misfiring. It's caused by the tissues getting caught in there.

And it's my recollection that I explained to her that, when the tissues are that close together, that you can get tissues caught in there and cause these kinds of fistulas to form.

Q. I'll withdraw the term misfiring and just --

A. Okay.

Q. From the approximation of those tissues, but is it your recollection that you explained that to her at that time?

A. I thought that she understood what happened, yes.

Q. Do you remember how she reacted to that?

A. I don't recall her being necessarily upset. She was always pretty much of the altitude, well, how long is it going to be until I, you know, can get repaired and fixed and back to work, et cetera. I don't recall her having any untoward responses to a complication.

Q. How many operations did you then perform over the course of time after June 17th?

MR. HUPP: Before I let him

look at this, I'm going to just tell you, I put together a little time line. I don't want to necessarily produce it, but I'll let him look at it to speed things up.

THE WITNESS: It'll save time.

MR. HUPP: All it is is my handwriting, but go ahead.

MR. MISHKIND: I have no problem.

A. My recollection is we did the transverse loop colostomy.

So you're asking after that time?

Q. No. You have to say the dates. We left off on 5-31.

June 17th?

A. June 17th is the transverse loop colostomy procedure where we also took out some sutures in the area of the fistula with the hopes of planning for it to close.

We did an operation on October 18th, 1984.

Q. You don't mean '84?

A. 19 --

MR. HUPP: '941

A. -- 94. November --

Q. What was the nature of that surgery?
A. That was an operation where we went back into the abdominal cavity, because this fistula wasn't closing with conservative therapy and tincture of time.
Q. So thus far the surgeries you've described, the June 17th surgery and the October surgery, were necessitated as a direct result of the fistula?
A. Yes.
Q. Okay, continue.
A. We then operated on her on November 29th, 1994, where we tried a local procedure through the rectum in order to close this persistent colovaginal fistula.

I then became aware again that it was opening up and not closing again, and I attempted again from both the vaginal and rectal side on February 28th, 1995, to close this fistula.

Q. Back up for one second, if I might, Doctor.

In reviewing one of the operative notes, I think the October 18th note, there appears -- and this was the point in time when -- I think it was an attempt to -- the take down procedure.

A. Yes.
Q. Where there was a nicking of the bladder?

A. Yes.
Q. Is that an incidental finding that --
A. When we went back in that pelvis, it was continually as inflamed as it ever had been. And the tissue planes were even as bad or worse than they were before.

She had intense inflammatory response to any and all surgical procedures done in her abdominal cavity with a lot of adhesion formation. And it was a technically very difficult procedure to mobilize the colon, try to get down to the area of the anastomosis, get the bladder, vagina, and rectum all separated out.

In doing so, we made a small hole in the bladder that we immediately recognized and closed.

Q. Can we agree that that complication would not have occurred had you not had to be in there taking care of a fistula problem?
A. If I hadn't have been in there, that complication wouldn't have occurred.
Q. And I want you to continue with the operations, but can we agree that all of the surgeries that you performed through August of 1995 were directly necessitated as a result of the fistula formation

that occurred back in the May and June, '94 period?

A. Yes.

Q. Okay, please continue.

A. After a failure of the repair, both transvaginally and transrectally on February 28th, 1995, we tried one more time in June of '95, June 27th, to repair the fistula, again just from the rectal side.

And most of these local attempts at closure, we essentially removed any residual foreign bodies, granulation tissue, and if there were any residual sutures or staples there, and then tried essentially mucosal advancement techniques in order to get the fistula closed.

Q. When you say mucosal advancement techniques, what were you doing?

A. These are local operations where the fistula site is identified, generally speaking, from the rectal side, and a flap of tissue encompassing the fistula site at the mucosal level is lifted off of the fistula's tract. That enables us to dissect surrounding normal mucosa that isn't as inflamed, mobilize it a bit, and then close normal mucosa over the fistula site.

We then used that little flap of remaining

tissue to sort of pants and suspenders our repair by taking that over the repair of the fistula.

Q. Throughout this period of time, she has the continued colostomy?

A. Correct.

Q. Your ultimate aim was to resolve the fistula and to be able to reverse the colostomy?

A. Absolutely.

Q. In reality, based upon the degree of the fistula and the complications that she had as time was going on, did you believe that you would ever be able to get to the point where you would be able to reverse the colostomy?

A. Absolutely.

Q. Okay.

Thus your continued efforts at surgical intervention?

A. Correct.

Q. Please continue with the --

A. That's really the end of the procedures, June 27th, 1995.

Oh, we did a flexible sigmoidoscopy, took a quick look inside again when she started to have further drainage. I mean, I was convinced by August of 1995 that the fistula was re-opening

again.

Q. Notwithstanding the mucosal flap?

A. Uh-huh.

Q. And why wasn't it maintaining its integrity? What was it that was causing --

A. I have several theories.

She had very difficult scarring and a lot of inflammation down in her pelvis. And this fistula was right at the junction, essentially, of her cul-de-sac, which is an area in the pelvis where the vagina and the rectum -- and even indeed eventually the bladder were all stuck down in her peritoneal pelvic cavity.

And operations down there had been very difficult on her because of the previous inflammation and surgery. And even indeed in Dr. Rubinstein's initial operation, this woman had a lot of scarring in the pelvis.

I don't pretend to know why that is, but she obviously had had pelvic problems in the past, and maybe even some colonic problems. Because she had diverticulosis in the segment of colon I took out. An inflammatory process in the pelvis made dissections difficult.

And the more you have to dissect in these

tissue planes, the more likely you are to locally interfere with the blood supply. So that perhaps if we have a poor blood supply in the area, tissues just don't heal as well. And she incites an inflammatory response that's almost exaggerated in certain instances.

There was foreign body -- there was still some suture material around that is very difficult to see when you have so much inflammation. And every time we saw it, we tried to remove it. Because a foreign body is certainly contributing to keeping her fistula open.

There was one instance, you know, she had sexual intercourse shortly after one of these repairs. We're trying to keep tissues in the vagina and rectum -- get them healing. And that was perhaps a problem, as well. I think there are multiple reasons why this fistula was difficult to get closed.

Q. Did you advise against sexual intercourse?

A. I did.

Q. Now, as I look through your handwritten notes, there appeared to be two occasions where you document sexual intercourse. That's not to say there may not be others. I just was able to pick

up on -- December 5, '94, do you see that?

A. Correct.

Q. And then I see a situation of May 8th, '95?

MR. HUPP: Right.

A. Yes.

MR. HUPP: Right there.

BY MR. MISHKIND:

Q. Again, I'm not suggesting that I've read -- it appears that those are the two occasions where you note sexual activity?

A. Right.

I think my exclamation point on 12-5-94 was, oh, no, had intercourse. I think when I noted it in May of '95, I was more hopeful that she was having intercourse. She had been out a bit from the repair, and that she didn't seem to be having problems. So that at that point in time, I was hoping, and it seemed clinically, that that fistula may be closed.

That's my recollection from the way the notes look.

Q. And the procedure, the last procedure you did, is the August 8, '95 procedure where you did the flexible sigmoid --

A. Sigmoidoscopy, yes.

Q. Easy for you to say.

If Regina didn't have sexual intercourse in May of '95, would she not have developed the recurrence of the fistula?

A. It's possible. I don't think anyone can say with certainty.

Q. At this point, she's got a track record with regard to the complications in that area, and that's why you can't say that that one episode is the most substantial factor causing the recurrence of the fistula, correct?

A. That's a fair statement.

Q. I asked you before about talking with different people, and specifically about calling over to the Cleveland Clinic.

Did you consult with anyone else to see whether there might be some other surgical modalities that you could consider to try to help this woman out?

A. I don't -- not that I recall. I knew what the next surgical modality was going to have to be.

Q. And that was --

A. And that was to do an even lower dissection and totally take out her distal rectum and to do an anastomosis between her colon and her anus.

Q. Is that what they ultimately did at the Cleveland

Clinic?

A. Yes.

Q. The photos that are in the file that I have Xeroxes of, are those from the sigmoidoscopy?

A. Various sigmoidoscopies.

Q. And are they of any significance as we discuss this case, that --

A. Well, they show --

MR. HUPP: Hold on. He wasn't finished with the question.

A. Sorry.

Q. As we discuss this case just in terms of showing the location of the fistula or any of the complications associated with the various operations?

How is that for a general question?

A. They show areas of inflammation, some sutures and some staples at times before we would remove them. And indeed the last set of pictures from the sigmoidoscopy on August 8th really shows what I think is a great looking anastomosis and what shows some probably residual persistent fistula, but no foreign bodies any more.

So at this point in time, I'm thinking that we've got the foreign body situation even taken

care of. And I can't see any more sutures. But her fistula is obviously opening up again.

And that's when I said, maybe you ought to get another opinion again. So that's the relevance of these pictures.

MR. MISHKIND: What I'd like to do, even though it's not going to be as good as getting actual prints, but I'd like to at least get laser --

MR. HUPP: Do you want prints? We could do that.

MR. MISHKIND: Yeah.

MR. HUPP: We could do that. I'll agree to make the color prints for this, sure.

MR. MISHKIND: That's fine, thanks.

MR. HUPP: Because I may want those copies made, as well.

BY MR. MISHKIND:

Q. You've not seen all of what's gone on at the Cleveland Clinic, so I suspect you're not even fully cognizant of what Regina's current condition is, are you?

A. I am not.

Q. Are you satisfied from what you've seen from Dr. Strong, what little information you've gotten over a period of time, that the surgical approach to continued efforts trying to resolve her problem were appropriate at the Cleveland Clinic?

A. Well, it's certainly what I had planned next, was a very radical pelvic procedure in order to resect any and all possible inflamed tissue, including the old anastomosis, dissect it off of the vagina, close the vagina, and do an anastomosis very low, most likely nearly to her anus, in order to get a --yes, that was the procedure that I felt was going to need to be done.

Q. So you certainly don't have any criticism of what was done for her at the Cleveland Clinic, do you?

A. Not from the very little information that I've seen, no.

Q. Regina had to have Visiting Nurse's Association come out in between her various hospitalizations, I dissected from some of your records?

A. I would imagine so for enterostomal colostomy care.

I don't recall any significant wound infections, but there might have been some local wound care, as well. But more likely it would be

for colostomy and enterostomal therapy.

Q. Can you explain in simple terms what's involved in terms of the hygiene or the care that a visiting nurse would be doing to a patient of this nature?

A. They would be teaching her how to take care of the colostomy bag itself, how to put on a wafer of adhesive material -- it's not hopefully too bothersome to the abdominal wall -- and then to attach to that a colostomy bag, plus or minus venting techniques in order to keep down any odor, and then how to change that.

It's generally a snap-on type of procedure. It does take some time to learn those sometimes, but generally it's a relatively straight forward process. But people take lessons at home in order to learn how to deal with that. They would teach her how to shower and how to completely remove the wafer, et cetera, and reassure her that, you know, you don't have to have your colostomy bag on every second, that you can get in the shower and bathe and do a lot of other normal activities.

It's basically both technical teaching and reassurance.

Q. I take it from what you said in terms of the next course of treatment that would have been provided,

that you have the surgical expertise and training to do what the doctors did at the Cleveland Clinic?

A. Yes.

Q. But just because of what went on with Regina, it was probably a healthier situation that she have a different surgeon treating her?

A. It's my opinion, yes.

Q. Okay.

Did your decision to have her get a second opinion from the Cleveland Clinic have anything to do with your feeling that you were responsible for the situation that Regina was going through?

MR. HUPP: Objection.

A. No. I liked Regina Rushdan. I was having difficulty with a difficult clinical situation. I wanted her to get a second opinion. And then she could make the decision whether or not she would undergo any further surgery with me or someone else.

Q. Did there arrive a point in time with the communication between you and Regina where Regina seemed to get frustrated with you in terms of your telling her that the next procedure, you're optimistic that things are going to improve, and

then you would be -- or she would be back at a point where she was taking one giant step forward and then one giant step backward?

A. It is my recollection with regard to my physician-patient relationship with Regina Rushdan that we both were equally frustrated and concerned about a difficult situation.

MR. MISHKIND: Let me take a look at my notes, Doctor. I believe I may be done.

I am done.

MR. HUPP: We'll read it if it's ordered.

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David Baringer, M.D. date

(DEPOSITION CONCLUDED)

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STATE OF OHIO,)
COUNTY OF CUYAHOGA.) SS:

CERTIFICATE

I, MICHELLE R. HORDINSKI, a Registered Professional Reporter and Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness, DAVID BARINGER, M.D., was by me first duly sworn to tell the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by him was reduced to stenotypy in the presence of said witness, and afterwards transcribed by me through the process of computer-aided transcription, and that the foregoing is a true and correct transcript of the testimony so given by him as aforesaid.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified.

I do further certify that I am not a relative, employee or attorney of either party, or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 5th day of November, 1997.

Michelle R. Hordinski, RPR and Notary Public
in and for the State of Ohio
My Commission expires January 25, 2001.