IN THE COURT OF COMMON PLEAS
OF CUYAHOGA COUNTY, OHIO

Rimma Bezyakin, Executrix, et al.,
Plaintiffs,
v. Case No. 280232
Ami Aszodi, M.D., et al.,
Defendants.

VIDEOTAPED DEPOSITION OF RICHARD BASSIN, M.D.

Taken at Clark, Perdue, Roberts & Scott
471 East Broad Street
Suite 1400
Columbus, Ohio
October 28, 1995
10:15 a.m.

SPECTRUM REPORTING II, INC.
155 W. Main Street, Suite 101
Columbus, Ohio 43215

A P P E A R A N C E S

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REPRESENTING THE DEFENDANTS MOUNT SINAI MEDICAL CENTER, DR. MEYER TENENHAUS, AND DR. CARL JACKSON:

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Cleveland, OH 44114

ALSO PRESENT:

Stephen Gibson
Renee Schepis

Saturday Morning Session
October 28, 1995
10:15 a.m.

S T I P U L A T I O N S

It is stipulated by and among counsel for the respective parties that the videotaped deposition of RICHARD BASSIN, M.D., a witness herein, called by the Plaintiffs for direct examination under the statute, may be taken at this time by the Notary pursuant to notice and stipulations of counsel; that said deposition may be reduced to writing in stenotypy by the Notary, whose notes may thereafter be transcribed out of the presence of the witness; that proof of the official character and qualification of the Notary is waived; that the signature of the witness to the transcript of said deposition is expressly waived by counsel and the witness; said deposition to have the same force and effect as though signed by the said RICHARD BASSIN, M.D.

RICHARD BASSIN, M.D.,
being by me first duly sworn, as hereinafter certified, testifies and says as follows:

MR. BECKER: Let the record reflect that this is the evidentiary deposition of Dr. Richard Bassin on direct examination on behalf of the Estate of Roman Vayl. The record should further reflect that this deposition is being taken by videotape and stenographic means.

Before we begin, may we gain a stipulation from defense counsel that this evidentiary deposition is being taken pursuant to appropriate notice?

MS. REINKER: Correct.

MR. DAPORE: Correct.

MR. GROEDEL: Yes.

MR. BECKER: And may we have a further stipulation that the filing requirements of this videotape and stenographic deposition are waived?

MS. REINKER: Okay.

MR. DAPORE: Yes.

MR. GROEDEL: Sure.

DIRECT EXAMINATION

BY MR. BECKER:

Q. Good morning, Doctor.
A. Good morning.
Q. Would you tell us, please, your full name.
A. Richard Bassin.
Q. And what is your business address?
A. 112-47 Queens Boulevard, Forest Hills, New York.
Q. And what is your occupation, sir?
A. I'm a physician and a general surgeon.
Q. Doctor, I'm going to ask you some questions about your background and training. Would you -- would you prefer just to answer in general, give us a sketch of your medical history, your education?
A. That's fine. I could do that.
Q. All right. Would you do that for us.
A. Yes. I attended Michigan State University from 1960 to 1963 and then Tulane Medical School in -- from 1963 to 1967 where I received an M.D. degree. Following that, I became an intern at the Mount Sinai Hospital in the field of general

surgery in New York City. I did one year of internship at Mount Sinai Hospital, and then I did one year of residency at Mount Sinai Hospital where I spent half of my time at Mount Sinai and the other half at Mount Sinai Hospital's city teaching hospital, which is called Elmhurst Hospital.
Q. What is a residency and what was that residency in?
A. Well, the residency was in the field of general surgery. As a resident, I supervised interns and taught them various things about surgery. I did preoperative evaluations, did surgery, smaller types of surgery, and then did postoperative management.
Q. Okay. Continue with your background for us.
A. Following my first year of residency, I received a grant from the federal government from the National Institute of Health and did research for two years in the field of shock and trauma. I studied patients who were involved in accidents or injuries or people who had bleeding and wrote several articles on that subject.
After completing my two-year fellowship,

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I continued my residency at Mount Sinai Hospital. I did a third year of residency, a fourth year of residency, and then I was chief resident at Mount Sinai Hospital and also at Elmhurst Hospital. And in that position, I was in charge of the teaching program for interns, residents, and medical students in the field of general surgery.

After completing my residency at Mount Sinai, I became the director of the emergency unit at Elmhurst Hospital, and there I was in charge of the entire teaching program for interns, residents, medical students, physicians' assistant students, and nurses. I taught them emergency care and surgical care in the emergency room. And during that period of time, I was also a professor of surgery at Touro College in New York City where I taught a course in emergency medicine and surgery.

While I was a director of the emergency unit, I also became board certified in general surgery. I took a written examination at Columbia University, which I successfully passed and then, one year later, an oral examination in Boston and successfully passed that. And I became board certified and am a diplomate of the American Board

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of Surgery.

Also, during that period of time, while I was a director of the emergency room, I became the editor of a journal called Hospital Physician and another journal called Physician Assistant or Health Practitioner journal where I reviewed the articles that were submitted by various physicians and determined whether they should be published or not.

After that, I left Elmhurst Hospital in the mid '70s and entered the private practice of general surgery which I've been in since the mid '70s.

Q. Okay. Before we get into the details of your private clinical practice, Doctor, you're licensed to practice medicine in the state of New York?

A. Yes, I am.

Q. Any other states, sir?

A. I have been licensed in New Jersey and Louisiana, but I've never practiced in those states. So those licenses, I assume, have lapsed.

Q. Would you tell us how your clinical practice since the mid '70s has evolved in surgery.

A. Yes. When I entered the private practice

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of surgery in the mid '70s, I was asked to -- initially to become the director of their emergency room at Physicians Hospital, and I ran that emergency room for them and admitted the surgical patients and operated on them. I also became the associate director of surgery at a hospital called Hillcrest Hospital where I was in charge of the teaching program there. That hospital then was purchased by the New York Osteopathic Hospital and Medical School, and I was in charge of the teaching program for interns and residents and medical students in the field of general surgery.

I had a very active practice. I probably did between four to six hundred operations per year with my partner who was also a general surgeon. So I had -- I operated when I first started every day, did -- saw patients in the morning on rounds, and had office hours in the afternoon.

I continued in that practice until about two and a half years ago when my partner retired. I continue to run that practice, except now it's just one person. I operate almost every day. I have office hours three days a week. I have two offices. I see patients at my Queens address, and I

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also have another office in Brooklyn where I'm the medical director of a very active walk-in center and a surgical consultant. So I see surgery patients there. And I typically do various types of surgery, which would include hernias, gallbladder surgery, colon surgery, stomach surgery, surgery on the thyroid, and surgery on the breast. And that makes up most of my surgical --

Q. Doctor, can you point to one specific type of surgery that you do most often, or is it generally mixed?

A. The most common surgeries that I do are hernia operations and gallbladder operations.

Q. And speaking of gallbladder operations, Doctor, could you estimate for us, excluding at this point your residency, approximately how many gallbladder surgeries you have performed during your career.

A. Well, in almost 20 years in practice, I probably have performed four or five hundred gallbladder operations excluding my -- my residency.

Q. Okay. Doctor, do you spend at least 50 percent of your professional time in the clinical

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practice of medicine or teaching?

A. Yes.

Q. And, Doctor, have you authored or co-authored any medical journal articles?

A. Yes. I've -- I've written 19 articles, including a chapter in a book, on various subjects.

Q. And are those the kind of articles that are read by other physicians to assist them in upgrading their clinical skills?

A. Yes.

Q. Now, you mentioned earlier that you have served as an editor or medical editor for a journal publication. Would you just kind of tell us a little bit more about that, what that entails.

A. Yes. Well, one of the journals was called Hospital Physician magazine, and that goes to every resident and intern in the United States. And I used to -- I was considered a contributing editor to that journal. I contributed articles, and I also reviewed other articles in the field of surgery to check on their accuracy and to determine whether they should be published or not. I also ran a series of -- I did a quiz section where I would put in x-rays every month and then give the answer to

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what the x-rays showed, in other words, show interesting cases.

And then the other journal, which is called Health Practitioner/Physician Assistant, that goes to all physicians' assistants in the United States. I was the medical editor. So I was in charge of all the medical content of that journal. And I held those positions for several years at -- at those journals.

Q. All right, Doctor. I want to move now to the -- to the subject matter of medicolegal -- your medicolegal experience, specifically acting as an expert in medical negligence cases.

You have had previous experience in this area; is that correct?

A. Yes, for many years.

Q. Would you tell me -- tell us approximately how many years you've been doing medicolegal work.

A. Yes. When I was a director of the emergency unit at Elmhurst Hospital, one of my responsibilities was to meet on a monthly basis with the attorneys for the hospital. They were called the corporate counsel for the City of New York. And

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I would meet with several of those attorneys, and we would present all the cases that they had where they suspected that something was done wrong in -- in the emergency room. And I would meet with them and give them my opinion. If I felt we had done something wrong, I would suggest that they settle the case. And if I felt that we hadn't done anything wrong and explained it to them, I would say that I would be willing to testify or they could find an expert who would be willing to testify. And I did that regularly with the corporate counsel, and sometimes more than once a month, I would meet with them.

After I left that position, those same attorneys hired me as a consultant then and paid me on an hourly basis to review cases. And the first time I testified in court was for the City of New York probably in the mid '70s. After I testified at that time, the attorney who I testified against hired me. So he was a plaintiff's attorney, and I worked for him.

So over the years, I have testified and reviewed cases for plaintiffs' attorneys, defense attorneys, hospitals in New York that are self-insured. That is, they don't have an insurance

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company. And I have worked for many insurance companies in New York. And I'm now the in-house surgical reviewer for a major insurance company in New York called PRI, which is called Physicians Reciprocal Insurer. I go to the insurance company, meet with them, and give them my opinion as to whether anything's wrong, and they also send me cases. They have branches around New York State and send me cases to review on a regular basis.

MS. REINKER: Move to strike.

MR. DAPORE: Objection. Move to strike all references to insurance.

Q. Doctor, in the last three or four years, can you give us an estimate as to the percentage of -- of cases, the breakdown of cases, between those you have reviewed on behalf of the medical provider and those on behalf of the patient?

A. I would say at present it's about 60 percent for the hospitals or for defense and 40 percent for patients.

Q. And, Doctor, to your knowledge, is this the first time that you have ever acted as an expert or reviewed a case on -- on behalf of my office?

A. That is correct. This -- this is the

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only time.

Q. Doctor, before we address the quality of care that Mr. Vayl received and how that played a part in his death, I want to ask you about some terms and concepts that will be used, I'm sure, throughout your testimony here today as well as throughout the trial. And what I'm going to ask you to do is explain these terms and concepts, and I want you to feel free to utilize any exhibits that you have at hand or feel free to diagram things that you have, if you so desire, at the board behind you.

And in case I forget to ask you, Doctor, throughout the balance of this deposition, I am seeking your opinion within a reasonable degree of medical probability. Okay?

A. Okay.

Q. Do you understand that?

A. Yes.

Q. Okay.

MS. REINKER: Objection. May we have a continuing objection to any references to the decedent's death?

MR. BECKER: Yes.

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MR. GROEDEL: Join in that objection.

Q. Let's talk a little bit, Doctor, about what is the biliary system. And after you, in essence, describe that, then I'd like you, Doctor, to kind of depict for the ladies and gentlemen of the jury the anatomy and the function of the biliary system.

A. I think I'd like to go draw that. It would make it easier --

Q. Okay.

A. -- if that's okay.

Okay. This is the liver, and the liver produces bile. And bile is a -- is a thick, brownish substance which is used to digest fats. It basically is what's called -- it emulsifies fats. It allows us to digest. And what happens is the liver produces the bile, and it goes -- it -- it gets excreted into the ducts. And there are two major ducts.

I'll label this. This is the right hepatic duct, and this is the left hepatic duct. They flow down into what's called the common hepatic duct, and then it flows into what's called the common bile duct. Now, what happens is is a

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sphincter, or something that closes off here -- it's called a sphincter of Oddi -- it closes off and becomes tight, and the bile then backs up into the gallbladder. This is the gallbladder, and this is the cystic duct. So that when we eat a fatty meal, this sphincter closes off, the gallbladder fills up; and then as we eat, the gallbladder then contracts or squeezes down and forces the bile down this path into the intestine, and we're able to emulsify fat. As a matter of fact, that's what makes our stool brown. If we didn't have bile, our stool would be white. So that's how you know that bile is being produced. So that's the anatomy, and this is how the tract works. Now, in disease states --

Q. Well, let me just stop you for a second.

A. Yes.

Q. How does the bile get up to the gallbladder?

A. When this sphincter closes off, bile keeps being produced. So it backs right up and goes right into the gallbladder.

Q. So the gallbladder is kind of like a reservoir?

A. The gallbladder is essentially a sac.

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It's about the size of a pear or so, and it's in this shape. And it's a sac, which is a reservoir for bile.

Q. Okay. Go ahead.

A. Right now I haven't even; but if I ate something right now, my gallbladder would contract, squeeze the bile down, and come down in here.

Q. Okay.

A. Now, what happens is that we form -- or many people form gallstones, and they're in the gallbladder. Now, gallstones come in various sizes. When we contract our gallbladder, if a gallstone becomes stuck right here at the junction of the gallbladder and the cystic duct and it can't get through because it's too big, the gallbladder continues to try to push the stone through. It contracts and contracts.

It's the same concept as when you have to move your bowels. You feel these cramps. But when you have to move your bowels, you do move your bowels and you feel better. But with a gallbladder, the gallbladder keeps contracting and the stone doesn't pass, that's the pain that you get right up here in your right upper quadrant because that's

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where the gallbladder is.
Now, so that explains what happens. That's why you get pain with stones in your gallbladder. And then because the gallbladder has this bile, the bile becomes contaminated, infected, because it's just sitting there. The body does not work well if things stay in one place and can't drain. And you get inflammation of the gallbladder, and that's called cholecystitis. It's a Greek word, "chole" meaning gallbladder, and "cystitis" means inflammation of the gallbladder. So you get an infection in the gallbladder. So that's what happens in gallbladder disease.
Now, the other thing that we're going to discuss today is if a problem develops in these ducts, you can get what's called a stricture, and a stricture is merely a narrowing of the duct. Let me just redraw the anatomy over here.
If the duct gets narrowed -- let's say that the duct is narrowed and closed off. That's called a stricture, or a narrowing of the duct. When that happens and bile cannot pass as well through this opening, bile will build up under pressure, because, now, instead of having a big

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opening where you can go through, you have a tiny opening. And, therefore, there's a high pressure here.
The bile will back up into the liver and it becomes infected, and that's called cholangitis, or inflammation of the duct. And it's called ascending cholangitis because it ascends up into our liver up in here. And ascending cholangitis is a very serious condition and can become potentially lethal if not treated because it will destroy the liver.
Q. Okay.
A. So that a stricture, a narrowing of the duct, can lead to ascending cholangitis, which can then cause destruction of the liver.
Q. Let's talk a little bit about the vascular supply in this region, Doctor. And feel free to use that illustration that I think is attached to that board.
A. Yes. Okay.
Q. And --
A. Let me talk about -- in general about vascular supplies. There are two types of vessels that function in our body. There are arteries,

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which bring blood that is oxygenated to tissues, and then there are veins, which bring blood back to the heart.
THE WITNESS: Can you see this?
THE VIDEOTECHNICIAN: Yeah.
A. This is a drawing that was provided that was done by Dr. Netter, who's a famous artist, who as a matter of fact worked at Mount Sinai Hospital.
Q. While I'm checking the view on that, Doctor, is that diagram by Dr. Netter -- is that anatomically accurate?
A. Oh, yes. He's considered one of the best anatomical drawers in the world.
Again, here is the anatomy that I drew, and obviously, Dr. Netter's a lot better artist than I.
Q. Hold on one second, Doctor.
All right. Doctor, what I'd like you to do is move that closer to the table.
A. (Witness complies with request.)
Q. Go ahead, Doctor.
A. Okay. So that here is the gallbladder. Here's the cystic duct, as I described. This is the common bile duct. This is the common hepatic duct.

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And these are the two -- the right and left hepatic ducts going up to the liver. And this -- this brown area depicts the liver.
Now, the gallbladder receives its blood supply -- and that's what keeps the gallbladder alive -- by an artery which is called the cystic artery, which you can see right here, which comes off of the right hepatic artery. So the blood comes upwards from the common hepatic artery, which is here. The common hepatic artery divides into two. It gives off a right hepatic artery and a left hepatic artery. Those arteries supply the liver with its nutrition. That's where the liver gets its arterial blood with oxygen. The right hepatic artery gives off a cystic artery. Now, that cystic artery keeps the gallbladder alive.
So that when you perform surgery to remove the gallbladder, because that's the treatment for cholecystitis, you have to remove the gallbladder. You just don't take out the stones. What you do is you tie off, which is called ligate -- it's just a fancy word for that -- the cystic duct, and you tie the cystic artery. Then you can remove the gallbladder, and you're left with a

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situation where you have the common bile duct and the common hepatic duct and the right hepatic duct, but the cystic artery has been tied and the gallbladder is removed. That is the proper technique for removing a gallbladder.
Q. You used the term cholelithiasis?
A. I didn't, but cholelithiasis means stones in the gallbladder.
Q. Okay. I thought you did. All right.
And you've explained cholecystitis already, which was the inflammation of the gallbladder.
And have you completed your description of the vascular supply in that area, Doctor?
A. The only other thing I want to discuss is under here is this blue structure. This is called the portal vein. Now, what the portal vein does is that when we eat food, we digest that food, but it gets absorbed into the veins. But if it got directly into our -- went to our brain directly, it would be very toxic.
So what happens is all the food that we digest in our intestines, which are down in here and not shown in the diagram, comes back to the liver

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through the portal vein. So it's a very large vein. It could be the size of my finger like this. It's a huge vein. And that vein goes to the liver, and the blood in the liver gets detoxified so that all the poisons are taken out of the liver -- out of the body. That's why the liver is so important and you can't live without a liver.
Then after it gets detoxified, it goes back to the heart and then gets sent around the body. So the important structure is the portal vein, which is way behind, but it's a very big structure back there. So the liver receives its arterial supply, in other words, its nutrition, from the arteries. And then it receives all these toxic substances from the intestines through the portal vein. That's the anatomy, yes.
Q. You talked about removal of the gallbladder. What is the medical term for removal of the gallbladder?
A. Cholecystectomy --
Q. Okay.
A. -- meaning -- "ectomy" means to remove. So removal of the gallbladder.
Q. Are there various means to remove the

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gallbladder, Doctor?
A. Yes. There are -- there are several ways to do it. One of the ways that's most common today is it's done through a laparoscope, meaning that -- a so-called belly button operation. You make a -- a little incision here at your belly button and a couple of other incisions, and you put a camera inside and look. And you have a TV screen which you look at, and you work with long instruments and you remove it. That's one way.
The older way was called an open cholecystectomy where you make an incision in the abdomen and take the gallbladder out. Sometimes when you're doing it with the TV camera laparoscopically, it's too difficult, and then you convert to an open method, which, in fact, is what happened in the case we're going to discuss today.
Q. Okay. What is a bile duct injury?
A. Well, if the duct becomes injured and traumatized in some way, then that's called a bile duct injury, an injury to the duct.
Q. Is that an acceptable risk of a cholecystectomy?
A. In a -- in removing the gallbladder, it

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is not acceptable to injure the common bile duct.
Q. Okay. What is an arterial avulsion?
A. Avulsion. That means that an artery has been pulled off or essentially torn off of an area.
So, for instance, if we would use, let's say -- I'll draw it down here. It will be easier to see. If you have an artery here -- and let's say this is the main artery and this is the smaller artery. If this artery gets pulled off of there or essentially torn off, you have an avulsion or a tearing off, and then it would look like this. You'd have a hole here. That would be an avulsion or a tearing off of the artery.
Q. What are the basic rules in surgery, Doctor, relative to managing a vascular bleed secondary to an avulsion?
A. Well, if you have -- let me go back to this diagram. If you have an avulsion, let's say, of the cystic artery where it's been pulled off of the right hepatic artery, that is potentially a very serious condition because all of the structures are very close to each other. So that the basic principle is if you have an avulsion, you're going to get bleeding. You do what's called a Pringle

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maneuver, and this was described probably a hundred years ago by Pringle. You just place your fingers on the hepatic artery right here. It's very simple to do as I'm doing right here. And let's say this pen was the hepatic artery. You just place your finger on there and put pressure on.
So the basic principle is that when you get bleeding, you put pressure on with your finger and that stops the bleeding. Once you've stopped the bleeding, you put a suction device in and clear the suction out and find the exact point where there's bleeding. And once you find that exact point where there's bleeding, you repair it either by putting a stitch in and repairing that opening, or if there's a little piece of the artery that's still left that's sticking off -- let's say it looks like -- like this. There's a little piece. Once you see this exact point, you tie that off with a stitch and control that.
But the basic principle is you never clamp something that you can't see in this -- especially in this area, because these structures are so close that if you try, let's say, to clamp the hepatic artery, it's very easy to inadvertently

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clamp the common bile duct because it's right next to it. It's within a quarter or even a sixteenth of an inch. So it's so close.
So first rule is if there's bleeding, you do a Pringle maneuver. Second thing is if there's bleeding, never put a clamp in where you can't see in a pool of blood. You've got to clear it away. You've got to control the bleeding, get rid of the blood, and then repair what you have. You never place a clamp where you can't see where that entire clamp is going and what you're clamping.
Q. What is a T-tube?
A. Well, a T-tube -- I brought a T-tube. A T-tube is a tube which is in the shape of a T, and that is a tube which we use as surgeons. And it's used to place in the common bile duct.
The nurses give you the tube in this shape and this size, and what you do is you cut it like this so that you shorten it for the length that you need. And often, you will cut it down here too to open it so you make it more pliable like this. And the T-tube is placed in the common bile duct like this and brought out to the outside. And a T-tube is used in a situation where you have an

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injury to a common bile duct. Then the reason that you use this T-tube is because when you have an injury to a duct -- I think I'll go to the next page.
Now, let's assume that the gallbladder's out now because -- and let's say there's an injury to the duct right over here. If you have an injury to the duct and you just close the injury by putting stitches in, which we call interrupted stitches, meaning you put a stitch in and then you tie it with three knots, then you put another stitch in and you close that opening, there's a very high risk that that suture that you place, it will leak and bile will leak out, because, remember what I said before, this sphincter often closes off. Even though you've removed the gallbladder, the sphincter still closes off, which raises the pressure in the duct, and this area can blow out.
So what you do to avoid a blowout of that line is you place the T-tube. The T-tube is placed in the duct, brought out to the outside. You put a bag on -- the patient just wears a little bag on the side where the bile drains, and this acts as a vent or an escape valve. So that when pressure builds up

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in the bile duct, instead of it blowing out the hole, it comes out the T-tube and flows right out here. So it comes to the outside, and that avoids a leak in the duct.
The other thing that a T-tube is used for is, in a case where you have an injury to the duct and you've sutured it and put in these interrupted sutures, the duct may develop a stricture, or a narrowing. And the rule is the smaller the duct, the more likely it is to develop a stricture, because if you have a duct, let's say, that's this big in diameter and you have a hole, when you put the stitches in, it may narrow it down to this big. It'll -- it will always be a little smaller because you've -- have a piece.
Q. Okay.
A. But if you have a duct, let's say, that's this big in diameter and you put a stitch in, you're going to narrow the duct down even more, and narrowing the duct can lead to a stricture.
Now, let's say that you had a stricture that developed up here. If you have a T-tube in, you can evaluate that area by doing what's called a cholangiogram. You will inject dye in through this

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opening, the dye will fill up this ductal system, and you'll be able to evaluate if a stricture has developed or if it's getting worse. So that -- so now a stricture's used, one, to protect against a leak, or a fistula, which means drainage to the outside, and it also works to evaluate a stricture if you have it.

The other thing is that if you develop infection in the duct, it is much easier to diagnose it when you have a T-tube in because the bile that you're draining will be infected. And you just examine the bile, and you'll see there's bacteria in the bile. So you'll be able to make a diagnosis very quickly that there's infection or cholangitis in the duct.

And remember what I said before, that pressure in the duct going up into the liver is what destroys the liver. You'll avoid the pressure going up into the liver if you have this T-tube because you have an escape valve, and you'll always have a normal pressure in the duct because you've got this escape valve coming in. So the T-tube is a life-saving and a protective mechanism.

So it gives you the advantage of avoiding

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a fistula or drainage, it gives you the advantage that you can follow it with x-rays to see how it's doing, and it avoids infection in the liver, and you make a diagnosis sooner. And you can leave a T-tube in as long as you like and evaluate the patient.

Q. Okay. Doctor, if you would give that T-tube to the reporter and maybe we can go off the record just for a moment so that can be marked.

- - - - -

Thereupon, Plaintiff's Exhibit No. 1 is marked for purposes of identification.

- - - - -

Q. Doctor, we now have marked the T-tube as Exhibit 1. Did you finish your explanation, Doctor?

A. Yes.

Q. Okay. You mentioned something about the smaller the duct is that is injured, the greater the likelihood of a stricture?

A. Yes.

Q. Would you explain that a little bit more for us, please.

A. Sure.

If we had two ducts -- let's say we had

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one that was this big and then we had one that was that big -- let's look at it in cross section, okay. Now, if there's a hole in this duct right here -- let's say it corresponds to that. When I put a stitch in -- let me put it in a different color -- to repair that hole -- I put a stitch in -- it will narrow that duct down. So now the duct will only be, let's say, this big. But it's still a big duct.

But if you have a tiny duct or a -- even what we call a normal size duct, which, by the way, that picture that we showed that Dr. Netter drew, that's about life size. So if you have one about that size, when you put the stitch in, by the very fact that you have to put stitches in, you'll end up with a duct that's small. And that duct -- the two sides of the duct may stick together and be narrow, and that could cause the stricture because the -- the stricture is a narrowing. It would be almost impossible to have a stricture in a duct this size, but in a small duct, you get strictures.

Q. Okay. And you earlier explained stricture, and maybe if we can flip back --

A. Right.

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Q. -- to the other illustration, Doctor.

A. I think I have a picture here where -- I said this was a stricture, but I have a picture here, another drawing that Dr. Netter did. This one isn't reproduced so well, but here is Dr. Netter's drawing of a stricture of the common duct.

In other words, here's the duct. Here's the stricture or the narrowing. You see this little channel. There's just a tiny channel that goes through now for the duct, and here's all this inflammation that's up in the liver and infected the liver.

Q. Okay.

A. So that's what he's showing, or here again, he shows this. Well, as a matter of fact, here's the duct, and you see how it's narrowed as a stricture. And again, he's showing -- he's showing this as a clamp. This is called a Kelly clamp. Instead of it being placed on the cystic duct, they grabbed the common duct. And that caused this narrowing and this narrowing, which led to the cholangitis.

Q. Doctor, speaking about strictures in general, what is -- what is the most common cause

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for a stricture?

A. Injury to the common duct due to an error of the surgeon during the performance of a cholecystectomy.

Q. Okay. Are there other potential causes for strictures but less likely?

A. Yes, there are, but they're very unusual.

Q. Okay. In addition to the -- the stitching as causing a narrowing of the duct, what else causes a narrowing of the duct after an injury occurs?

A. Well, the other thing, which is even more important than the stitching, is what's called a crush injury. When a clamp, as Dr. Netter drew here -- when a clamp is inadvertently placed on the common hepatic duct, these clamps are very destructive. They're crushing clamps. And it destroys the inner wall of the duct, and that destruction of the duct causes a stricture to form. It's the mere trauma of the destruction.

Q. Well, what is it about the trauma? Is there scar tissue that develops?

A. Oh, yes. It would be the same -- it

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would be the same concept as -- I mean, I have a cut on my hand now. This cut, scar tissue's forming now to heal it. It's not going to narrow my finger obviously, but if this were a duct, the scarring inside the duct would get thicker and thicker and would then narrow the duct.

Q. Did -- did you explain the concept of fistula yet, Doctor?

A. I talked a little about it, but I need to explain a little bit more about it.

Q. Okay.

A. A -- a fistula is an abnormal condition due to leakage of some substance, in this case, bile, to the outside of the body. So that if, let's say, in a case we have an injury to a duct and you don't place a T-tube and it leaks, which is very common, the bile that's inside here will leak. And when it leaks out, it will leak out to the outside. It will come through the incision, and you'll have bile that's draining to the outside. And bile is caustic substance. It's caustic to the skin. It's often foul smelling. It's thick. It gets over your clothes, and it irritates the skin. So a fistula is an abnormal connection between the bile duct and the

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outside of the body.
Q. Let's talk a little bit about something called a biliary stent. What is that, Doctor?
A. Well, a biliary stent is a -- is a substance -- it could even be the same substance that a bile duct -- that the T-tube is made of. I just cut off a piece of it. And what that is is that some people will place these inside the duct. The way that they do that -- let's see if there's a picture.
You will place a scope, which you can look through, a long narrow scope -- looks like a garden hose -- down through the stomach into the intestine here, and you then place this into the common bile duct, which allows the duct to stay open. The reason that stents are used is that if you could place this in here, then it would be in this position and the sphincter of Oddi wouldn't close. So it would leave the duct open. And by leaving the duct open, you can decrease the pressure. And it's used sometimes to treat someone who has a fistula, because, remember, if you have lower pressure in the duct, it -- a fistula might close. But if you have high pressure in, it will

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never close. And, therefore, people use stents to try to do that.
But you use a stent when you don't -- when you haven't left a T-tube. If there's no T-tube in for some reason, then you could use a stent. But if you have a T-tube in, you don't have to use a stent.
Q. Doctor, what is the foreseeable consequences of a bile duct injury where a stricture develops, and if no -- surgery is not timely done, what generally happens?
MS. REINKER: Objection.
A. Well, if you have a bile duct injury, it is likely -- it is more likely than not that the patient will develop a stricture. The stricture will then go on, if not treated, to infection in the duct, which is called cholangitis. The cholangitis will then affect the liver, the liver will fail, and the patient will die.
Q. Okay.
All right, Doctor. I want -- now, it's time to turn to Mr. Roman Vayl. And at any time during the balance of this deposition, I want you to feel free to look at the chart, which I have at

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hand, before responding if necessary.
Again, in case I forget to ask you, I'm seeking your opinion within a reasonable degree of medical probability.
Doctor, is it true that I contacted you a few years ago relative to this case?
A. Yes.
Q. Okay. Do you recall what the assignment was that you received from me?
A. You asked me to read through the records and give you an opinion whether anyone deviated from accepted medical practice or not.
Q. All right, Doctor. Is it true that I sent you the following materials to review, including Mr. Vayl's complete chart at Mount Sinai, the depositions of Drs. Aszodi, Ponsky, Tenenhaus, Jackson, Dr. David Bouwman's report, a deposition of Dr. Neissen, the x-rays, the cholangiograms, office records of Dr. Petroff, Dr. Aszodi's office records, Dr. Ponsky's office records, Dr. Baron's records at Mount Sinai Russian Clinic, the Meridia Hillcrest Hospital emergency room record for October 26, '91, Mount Sinai Hospital records of October 29, 1991, Meridia Hillcrest Hospital records of December 9,

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1991, Mount Sinai Hospital records, again, of January of '92, Meridia Hillcrest Hospital records of April and June, and the Cleveland Clinic records, as well as the autopsy and death certificate of Mr. Vayl?
Did you receive all those materials, sir?
A. Yes, I did.
Q. And to your knowledge, Doctor, is that the kind of information that is reasonably relied upon by experts such as yourself in giving an opinion whether or not medical negligence took place and whether that was a competent cause and unnecessary injury to the patient and his ultimate death?
A. Yes.
MS. REINKER: Objection.
Q. Doctor, as a result of your review of these records, I wonder if you could tell the ladies and gentlemen of the jury in your mind what are the salient facts of this case, in essence, what happened to Mr. Vayl.
A. Okay. Well, what happened to Mr. Vayl is he had a -- he had inflammation in his gallbladder, called cholecystitis, with stones. And he was

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operated on by Dr. Aszodi and the resident physician who did the surgery with Dr. Aszodi. They originally started the surgery as a laparoscopic procedure and saw that it was difficult, so they converted to an open procedure and made an incision.
When they did the surgery, they had a great deal of bleeding at the area of the cystic artery where it comes off of the common -- the right hepatic artery. They placed a clamp in the area and -- first, they determined several things: number one, that there was a tear in the common hepatic duct at this point, which they repaired with interrupted sutures. They placed several sutures and closed that.
They also determined that there was bleeding of the right hepatic artery, and they ligated that, meaning they tied off the right hepatic artery, and, therefore, cut off the blood supply to the right lobe of the liver. They then had the gallbladder out, and they closed the patient.
In the recovery room, it was noted that the patient was bleeding, and they took the patient

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back to the operating room for a second time. And at the time of the second surgery, they said there was some oozing, meaning a small amount of blood was coming out of this right hepatic artery, and there was a pinhole where there was bleeding from the portal vein. They ligated this area again in the hepatic artery, and they put a stitch in the portal vein and stopped the bleeding. They then -- patient got out of the operating room and went home. And subsequently, the patient developed many problems.
The major problem was that the patient had cholangitis, or inflammation of the common bile duct. The patient was then sent to another surgeon, Dr. Ponsky, and Dr. Ponsky attempted to place stents in the common bile duct to try to relieve the problem. They had determined that the patient had developed a stricture, and Dr. Ponsky tried to treat this by using a stent. This was unsuccessful.
And the patient eventually went to another surgeon, a Dr. Eisenstat, at Hillcrest Hospital. And Dr. Eisenstat did an operation which is -- has a big name. It's called a choledochojejunostomy, which is just a fancy word for saying that he took the common bile duct, or the

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common hepatic duct as it's called, which is the "choledocho" part, and he hooked this up to another piece of intestine. He brought a piece of intestine up and hooked that up. This is a difficult operation. He did it and, therefore, could bypass the stricture.

So the stricture was here. Let's put it -- show it here. The stricture's here. He did the surgery here by bringing this piece here to a loop of intestine or jejunum.

After that surgery, the patient didn't do well. The problem was that by the time Dr. Eisenstat got the patient, the patient was already developing problems with the liver, and it was too late to save this patient. He tried to by doing this choledochojejunostomy. That developed a leak. In other words, where the two pieces were sewn together, that -- it leaked. That happens because this is a difficult operation. Developed a leak. He had to go to the Cleveland Clinic. He had developed a hematoma, which means he developed bleeding around the area.

And eventually, the patient had a miserable death from liver failure. He had

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developed numerous problems. He'd had fever. He had chills. He had bile draining out on his skin. He had bile draining onto his clothes. He was sick many times. He'd had multiple operations. And unfortunately, as the autopsy confirmed, he died from this infection that developed in the duct, which then infected the liver.

And the final pathology report on the gallbladder which was removed was -- it showed that he had mild cholecystitis, meaning it wasn't very inflamed. It was just a mild case of cholecystitis. But unfortunately, he died.

Q. Okay. Doctor, let's talk specifically now about the quality of care and whether or not there were any deviations from the standard of care by Dr. Aszodi and/or the residents who assisted Dr. Aszodi.

Can we begin, first of all, with the cystic artery injury. Do you have an opinion, Doctor, whether the cystic artery injury that occurred in the first surgery was a deviation from the standard of care?

A. I have an opinion that it was not. It may have been poor technique, but I'll give

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Dr. Aszodi and the resident the benefit of the doubt. I wouldn't say that that is a deviation from accepted medical practice.

Q. Okay.

A. After I read Dr. Aszodi's deposition, I could see where that might have happened without it being negligent. So I would say no, I don't think that's a deviation from accepted medical practice.

Q. All right. Let's approach this matter chronologically, Doctor, and tell us where specifically you do see a deviation from the appropriate standard of care by Dr. Aszodi and the residents who assisted him.

A. Well, the first deviation -- and it's in the operative report itself, that is, the first operation. He says that a clamp was placed over the right hepatic pedicle base to the cystic vessel. This controlled the bleeding, and this was oversewn with a 2-0 silk suture.

Well, when you have bleeding, the proper treatment is not to place a clamp across it. That is clearly a deviation from accepted medical practice. The proper treatment is you perform a Pringle maneuver and control that bleeding. The

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failure to do the Pringle maneuver at that time was a deviation from accepted medical practice, and placing the clamp across the hepatic pedicle, means in this area, is a deviation from accepted medical practice because it is so dangerous to do that because of the risk of inadvertently clamping the common hepatic duct, which was done in this case.

Q. Would you point that out on the diagram.

A. Right.

If you place a clamp here in this area, you are so close to the common hepatic duct. In a bleeding situation, you never do that.

The basic rule is don't clamp unless you can see exactly what you're doing. Don't clamp in the face of bleeding. Don't clamp in the -- unless you've done the Pringle maneuver. And don't clamp across this pedicle. It's a deviation from accepted medical practice.

If you have some bleeding -- the patient's not going to die from a little bleeding here. You can always control that. An ounce of blood that you lose isn't going to matter, but the risk of injuring this common bile duct or this common hepatic duct is a potential lethal

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complication, and many patients have died from this. And that was a deviation from accepted medical practice.

Then what he said he did is he oversewed this with 2-0 silk suture. In other words, he took a curved needle and put this 2-0 silk, which is a large silk, and put it in there. That is not the way to do that. That's a deviation from accepted medical practice.

Q. Why?

A. Because you can't see what you're doing when you put in bites with 2-0 silk and oversee it. You can grab something with the stitch and you can't see it, and you can injure the common bile duct or the common hepatic duct. The proper technique is to control the bleeding, see the exact spot where it's coming. So what you do is you hold it or you have your assistant hold it. You suction everything out, you get it dry, and then you let it go. And let's say there was a -- a spot from here. You can see that part pulsating, you can see the blood loss, and you control it. And then you just place a very small clamp right on here and tie off the bleeding site.

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Q. What type of clamp at that point?

A. Well, what you do is you place a small clamp. And then when you determine that there is bleeding from the hepatic artery, you place what's called a vascular clamp. There are many types of vascular clamps, but the basic principle is vascular clamps are gentle clamps. So that if I placed a vascular clamp on this tube right now, it would gently close it and not crush the inside of it. A Kelly clamp or a clamp that is used in general surgery would crush it.

So what you do is you place a vascular clamp on the hepatic artery -- let me just draw that -- and control the bleeding. But what they did -- they had an hepatic artery that was bleeding. What -- what they did is they ligated or tied off the hepatic artery. So, remember, this is going up to the liver. They just tied this off and tied this end off. So they were left with an artery that was tied here, and the other side was tied like that.

The proper technique to do is when you have an injury to the hepatic artery -- which we see all the time in gunshot wounds and stab wounds. They happen unfortunately a lot in New York. We see

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lots of injuries like that. If the artery is torn, what you do is you place a vascular clamp on here, which is a gentle clamp which stops the bleeding, and a gentle clamp over here, and then you do -- you stitch this artery together with some very fine stitches, take the clamps off, and the blood flows back.

So to ligate the hepatic artery in this case was a deviation from accepted medical practice. They should -- there was no attempt made to try to repair this artery. This artery, in my opinion, could have been repaired and should have been repaired. And had it been repaired, it would have worked and the artery would have been intact.

Q. Okay. Any other deviations from the standard of care?

A. Well, the -- the other deviation is that when they had this injury to the common bile duct, they didn't place a T-tube in. They merely closed the duct. And this was not a tiny pinhole in the duct. This was a significant tear in the duct. And the reason I know that is because if it was a pinhole in the duct, they could have used one stitch to close it. But he says in his -- in his operative

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report he used sutures, plural, meaning he used more than one suture to close this tear. Whenever you have a tear in a duct, you must place a T-tube. The failure to place a T-tube was a deviation from accepted medical practice.

Now, the other deviation is they made a hole in the portal vein also. This was -- luckily, it was only a pinhole, so it didn't kill the patient. But that's a deviation from accepted medical practice. You shouldn't be anywhere near the portal vein when you're doing this surgery. The portal vein is way back. So that if you place a clamp blindly, as they did in this case, in my opinion, not only did they injure the hepatic artery, they injured the common hepatic duct and they got the portal vein right behind it. That's because they didn't use the Pringle maneuver, they didn't control the bleeding, and they did this procedure in a pool of blood and therefore caused that. So that was another deviation from accepted medical practice.

Q. Doctor, in your years of practice in doing open cholecystectomies, have you ever had a common hepatic duct injury?

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A. No. And neither has my partner, and he was doing it for 20 more years than I.

Q. Doctor, in your over 20 years of practice, have you ever had a portal vein injury in an open cholecystectomy?

A. No.

Q. Doctor, you indicated earlier that a stricture developed in -- in Mr. Vayl's duct ultimately.

A. Yes.

Q. Okay. Do you have an opinion within a reasonable degree of medical probability as to what the most likely cause of that stricture development was?

A. Yes.

Q. Would you --

A. The most likely cause was a crush injury from this clamp that was placed, which then led to the stricture.

Q. Speaking about the portal vein injury, Doctor, when do you feel that occurred?

A. It occurred during the first operation. That's what necessitated the second operation. The first -- when they got in on the second operation,

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they said that there was oozing from the hepatic artery, in other words, from here. Well, that wasn't what was causing the major bleeding, because if you have -- if the artery was really bleeding, the artery spurts. It's an artery. It's under a great deal of pressure. So you would have -- that would have been the cause of it. It was the portal vein bleeding. The portal vein is such a large vein that even a pinhole opening in it will cause a lot of blood loss. And that's what necessitated the second operation.

Q. Doctor, you -- you outlined a number of deviations by the -- by the physicians involved at this surgery. Is it clear to you as to which physician did the items that you've delineated?

A. Well, it's difficult to say in all cases. Dr. Aszodi said in his deposition that he placed the clamp. So in my opinion, he deviated from accepted medical practice by placing that clamp. The resident should have told him not to place the clamp, in my opinion. But Dr. Aszodi was in charge, so he made the decision.

As far as the -- who injured the portal vein and made a hole in that, I don't know. And I

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don't know who made the decision. I assume it was Dr. Aszodi made the decision to -- to ligate the hepatic artery, but the resident should have known better also.

Q. And what about the placement of a T-tube? Should a resident know better on that issue?

A. Oh, absolutely. I mean, that's a basic surgical principle that the resident should have known.

Q. All right, Doctor. What I'd like you to do now is take the deviations of standard of care that you've already delineated and tell us what the direct and proximate result was of those specific deviations.

MS. REINKER: Objection.

Q. What flowed from that?

MS. REINKER: Objection.

MR. GROEDEL: Objection.

A. Well, the hole in the portal vein, that caused the second operation. So had the patient not had a hole in the portal vein, he wouldn't have had a -- wouldn't have had the second operation at that time.

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The injury to the common hepatic duct led to the stricture, which then the patient developed cholangitis, then developed infection in his liver. If the common hepatic duct had not been injured, the patient would have gone home from the hospital in five or six days and would have done well and be alive today. But because the common hepatic duct was injured, the patient had to undergo the procedures by Dr. Ponsky, which were painful and took time. He had to undergo the surgery by Dr. Eisenstat. He had to develop all the complications that developed, the chills and the fever. And then he had to have other operations at the Cleveland Clinic, the infection in his liver, and his death. So that -- that's very clear.

And also, if the -- when they injured the duct, had they placed a T-tube, it's my opinion that they would have diagnosed the fistula sooner, the patient would not have developed the cholangitis and would not have died. And if they had repaired the hepatic artery, it's my opinion that that would have worked. But because they didn't repair the hepatic artery, they deprived the right side of the liver of its arterial supply. Therefore, that put the

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patient in a weakened state. It made him more likely to develop an infection in his liver because the liver wasn't able to fight the infection as well because there wasn't good blood supply.
It's the same concept with this cut on my finger. This is going to heal in a few days. But if somebody cut off my radial artery, my finger's going to fall off. This is going to get infected, and I'm going to lose my finger.
Well, the same thing affected the liver. The liver was not getting a good blood supply; and, therefore, that -- that liver was at a greater risk to become infected, which it did, and the patient ultimately died. So in summary, had the surgery been done properly, the patient would have -- it was a routine gallbladder that could have been taken care of and the patient home in five or six days.
MS. REINKER: Move to strike.
MR. GROEDEL: Join. Join in that.
Q. Doctor, I'm going to ask you to assume that there may be some experts on behalf of the -- the defendants that may give some specific testimony or opinions here, and I'm going to take this opportunity to ask you to respond to that.

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Before I do, and I guess I forgot to stay this earlier, this matter is set for trial on November 6. Are you going to be available for trial the week of November 6?
A. No, I'm not.
Q. Okay. Doctor, I'm going to ask you to respond to a few things that some of the defense experts have testified to.
First of all, there -- there's a suggestion by them that -- that there may have never been a ductal injury, that -- that simply the duct fell apart at the time that the operative field was -- became apparent after they opened the patient up.
Do you agree or disagree with that, Doctor?
MS. REINKER: Objection.
A. I -- I certainly disagree. It doesn't make any sense. I mean, that didn't happen. There was a ductal injury. There's no doubt in my mind of that.
Q. And, Doctor, there's a suggestion by one of the defense experts that the portal vein injury likely occurred at the second surgery. Do you agree

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or disagree?
A. I disagree.
Q. And the basis, Doctor?
A. Well, they were -- they were nowhere near the -- the portal vein at the second operation. And he said -- if it did occur, he would have said in his operative report, in my opinion. If -- if, during the second operation, he injured the portal vein, he would have dictated something to the effect of, while doing such and such, I made a hole in the portal vein and I put a stitch in and repaired it. He just said a hole was found in the portal vein. I mean, that's -- that's -- happened at the first operation. And also, where did all the blood come from? Why did they go back in and operate after the first operation? It didn't come from the hepatic artery. It came from the portal vein.
Q. And what was the need to take him back to the second surgery?
A. Massive bleeding. That -- that's why they took him back. There was a lot of blood draining, and they noticed this on the -- in the recovery room. The nurses called the doctors and told them the patient's bleeding, and they took him

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back to the operating room.
Q. Doctor, there may be some testimony from one of the defense experts that the stricture that ultimately formed was -- was merely due to inflammation and devascularization from dissecting the surgery.
Do you agree or disagree with that?
A. I disagree.
Q. What is your basis for that, sir?
A. My -- my basis is that they traumatized the duct during the surgery. That makes up 99 percent of all strictures. This -- there's no evidence that there was devascularization of the duct itself, and devascularization would be such a rare cause of a stricture that I don't think that that's the likely cause.
Q. And what does devascularization mean?
A. Well, that you've cut off the blood supply to the common bile duct. Well, if you -- but if you've cut off the blood supply, why did it just stricture at one spot? Why didn't the whole duct just stricture down? I mean, it's too coincidental that at the -- at -- if you look at the anatomy, here's where the injury occurred to the right

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hepatic artery. And where is that? It's right next to the junction of the left and right hepatic ducts, which is where the stricture was. So it's due to a -- it's due to the trauma that I described from the clamp at the time of the surgery.
Q. Finally, Doctor, do you have an opinion within a reasonable degree of medical probability whether Mr. Vayl's horrendous pain and suffering, as you've described, and his death in July of '92 was avoidable, preventable, and unnecessary?
MS. REINKER: Objection.
A. Yes, I have an opinion.
MR. GROEDEL: Objection.
Q. What is that opinion?
A. That it was. Had this been -- it was avoidable and preventable. And had the surgery been done properly, the patient would have been spared all this tremendous pain and suffering and would -- would not have died.
MR. BECKER: No further questions.
Off the record.
(A discussion is held off the record.)
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CROSS-EXAMINATION
BY MS. REINKER:
Q. Dr. Bassin, my name is Susan Reinker. We met a little earlier. As you know, I represent Dr. Aszodi in this lawsuit, and I have a few questions for you today.
A. Okay.
Q. Okay. I think there are a couple of points we can agree on.
First of all, you would agree that a physician can exercise appropriate care and still get a bad result or an unanticipated result?
A. Yes.
Q. And sometimes there are complications during surgery?
A. Yes.
Q. And bleeding can be one of those complications?
A. Yes.
Q. And that's why you hold the opinion in this case that the initial tear of the cystic artery was not below standards because a bleeding complication can happen during surgery?
A. Yes.

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Q. Now, once that bleeding complication occurred, the physicians had to deal with it?
A. Yes.
Q. Okay. And that -- by the way, have you ever had a cystic artery tear during the course of one of your procedures?
A. No.
Q. You've had other vessels tear or be disruptive, I presume?
A. Oh, yes. Many.
Q. And when that happens, it's no longer a routine case, correct?
A. It's different than normal, but we as surgeons are trained to deal with that. And I have had cystic artery bleeding. I've never had an avulsion, but I've had the cystic artery bleed and I've used the Pringle maneuver to -- to control that. So that's not that uncommon.
Q. It's not that uncommon, but -- but it's not the completely routine, average cholecystectomy that you would do?
A. Oh, no.
Q. Okay. And in order to deal with the bleeding problem, the surgeon has to do some

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additional dissecting or cutting. That means you have to move some tissues out of the way so you could get to the bleeding vessel and treat it, right?
A. Sometimes. Sometimes you don't have to move anything away. In this case, you may not have had to move anything away. If you did a Pringle maneuver and there was an avulsion, since you were tying at that area, you could have seen it.
Q. Doctor, in some cases, the surgeon does have to do some additional dissection to get to the bleeding vessel, correct?
A. Sometimes.
Q. And that's a judgment call that the surgeon has to make at the time?
A. Yes.
Q. In this case, you agree that the procedure, the whole surgery, was a very difficult dissection?
A. Yes.
Q. And that was because -- initially because of the inflammation, the inflammatory tissue from the cholecystitis?
A. Yes.

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Q. Now, I gather your testimony is -- is that when the bleeding occurred -- I think you even said this -- that Dr. Aszodi blindly put a clamp on in a pool of blood. Is that your --
A. He either blindly put it on in a pool of blood or he put it as he described, across this hepatic pedicle. He didn't control the bleeding. He used the clamp to control the bleeding. So there had to have been blood there, yes.
Q. Did you -- you made the statement he put a clamp on in a pool of blood.
A. Yes.
Q. Now, that would be a pretty incredible thing for a skilled surgeon to do, wouldn't it?
A. Incredible, meaning it shouldn't have been done. I have seen other surgeons who have done that and injured the common bile duct. This is not the first time I've ever seen a common bile duct injured in this fashion.
Q. And I'm talking about putting a clamp on in a pool of blood. That is something a well trained surgeon would not do; isn't that correct?
A. Yes. And if he did, it would be a deviation from accepted medical practice.

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Q. That's something that is such a basic violation of the principles of surgery, you would not expect a first-year resident to do something like that, would you?
A. I would not.
Q. Now, we know in this case where the clamp was placed, correct?
A. Yes.
Q. From the operative note?
A. Yes.
Q. And I think you've quoted that sentence in the operative note. It says very clearly that a clamp was put on -- excuse me one moment here. The clamp was placed over the right hepatic pedicle base to the cystic vessel. That's what the operative note says, correct?
A. Right.
Q. If a surgeon can find a little stump of the vessel, a little stump of the cystic artery, which you've drawn on the diagram there, and put a clamp on it, that's -- that's the first step a surgeon could take to control bleeding, correct?
A. If you see a stump, you could place a fine clamp on that stump and then ligate that, yes.

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Q. That would be appropriate?
A. Yes.
Q. And if that's what happened -- if that's what happened in this case, that would be appropriate management of the bleeding vessel, correct?
A. But that's not what happened. Dr. Aszodi drew a picture at his deposition and showed that it wasn't on the cystic artery stump.
Q. Doctor, I'm asking you at the moment to assume if that's what happened in this case, that would be appropriate management of the bleeding cystic artery base, correct?
A. You're asking me to assume something I don't believe; but if I assume what you're saying is true, then yes, that would be appropriate. But I don't believe that happened in this case.
Q. You have no idea what clamps were being used during this part of the surgery, do you?
A. That is correct. I don't know which clamps.
Q. You don't know if they were big clamps or fine clamps or vascular clamps or nonvascular clamps? You don't know what they were?

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A. In my opinion, they were not vascular clamps. You do not have vascular clamps on the operative field when you do a cholecystectomy. And had he used a vascular clamp, he would have dictated it in his report and he would have said in his deposition, I assume.
Q. Doctor, if a vascular clamp was used in that -- this case, that would be appropriate? You described that earlier, correct? To clamp the bleeding vessel?
A. If a vascular clamp was placed and you could see where the tips of that vascular clamp were placed and you placed it properly, then that would be appropriate.
Q. Have you seen any evidence as to where or how the clamp was placed in this case? I mean, have you seen any photographs or x-rays or pictures or anything that show a clamp in place?
A. Yes. I saw Dr. Aszodi's drawing that he made at his deposition, and based on his drawing, he placed that clamp improperly.
Q. Doctor, Dr. Aszodi will explain his diagram, okay. I'm asking you: Based on the facts of this case, on the x-rays that you've seen, have

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you seen anything that showed the position of a clamp during the surgery?
A. No. You never see that.
Q. Now, you've agreed, I think earlier, that all of these structures are very close together. I'm talking about the cystic artery, the hepatic artery, the cystic duct. The portal vein even is right behind them. They're all in close proximity to each other, correct?
A. The portal vein is much further away, but the other structures are very close together. The portal vein is -- is behind. You'd have to really dig down to find that.
Q. How much further behind is it? It's within half an inch, right?
A. Oh, yes. Yes. But it's -- but we're talking about -- you know, in this case, we're talking about less than half -- a half inch is a long way in this particular operation.
Q. Correct. So all these vessels, they were lying right on top of each other almost, correct?
A. Oh, yes. They're supposed to.
Q. When a gallstone is stuck in the cystic duct, that also will make the surgery a little more

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difficult, correct?
A. Yeah. But that's very common. That's -- that -- when -- this is -- this --
Q. Doctor, my --
A. This --
Q. -- my question is: Does that add to the difficulty of the surgery?
MR. BECKER: Please let him answer his -- please let him finish his answer.
Q. Let me rephrase my question.
Does the presence of a gallstone in the cystic duct add to the difficulty of the surgery in removing the gallbladder?
A. Sometimes it does and sometimes it makes it a lot easier.
Q. In this case, we know there was inflammatory tissue, correct?
A. There was some. The pathology report says mild.
Q. There was inflammatory tissue, Doctor, correct?
A. Yes.
Q. There was a bleeding episode, correct?
A. Yes.

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Q. There was the presence of a gallstone stuck in the cystic duct, correct?
A. Yes.
Q. This was not a routine cholecystectomy, was it?
A. It was a routine difficult cholecystectomy but one that all general surgeons have faced hundreds of times. This is a common thing that happens here. His gallbladder was not any more difficult than ones that we do all the time.
Q. So -- so you're saying this was not a difficult cholecystectomy?
A. It was a difficult cholecystectomy but one that could have been handled by a competent general surgeon.
Q. You made a statement earlier that a clamp was placed on the common bile duct. Is that what you said?
A. Or the common hepatic. I believe that the -- when the -- when -- when he clamped to control the bleeding, he also grabbed the common hepatic duct, which is where the stricture and the leak developed.

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Q. What evidence do you see for that in the records?
A. I base it on everything that I've read. It doesn't say it specifically, but if you have a hole in the -- if you have a tear -- he said there was a tear in the -- in the common hepatic duct. If there's a tear in the duct, something had to tear it. And it's more likely than not it was the clamp because that's the most common way that a duct is torn or crushed, and it -- also, a clamp was used in this case when there was bleeding. So I've concluded that the clamp caused the tear and caused the crush.
Q. And that's an assumption on your part?
A. Based on a reasonable degree of medical probability.
Q. Do you have any literature to support your contention that the most common cause is -- of injuries or problems with the duct is the placement of the clamp? Is that -- do you find that in the literature anywhere?
A. Oh, sure. It's been written up -- as a matter of fact, that's why Dr. Netter in his diagram put this here.

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Q. Can you cite me any articles that support that.
A. Let me just finish my answer, okay.
If you see here, this is -- this is -- the most common way that a -- that a common bile duct --
Q. Doctor --
A. -- common hepatic duct is injured is with a clamp.
Now, can I cite you any specific articles? I don't know any, but there have been many written about it. And it's a very common phenomenon, and it's taught to every resident and intern.
Q. Doctor, my question is -- again, I think you've stated you cannot cite to me any literature that says the most common cause of injuries is the placement of the clamp, correct?
A. I can't cite -- I have seen literature. I can't cite you chapter and verse of all the journals that I've ever read and -- I can't give you a specific article right now.
Q. You have no idea as to the size of -- of any injury to the -- to the cystic -- the duct, do

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you, the hepatic duct? You don't know how big of an injury it was?
A. Well, I know it was big enough that he couldn't repair it with one suture; so, therefore, it had to be a significant injury to the duct.
Q. Big enough to take two sutures?
A. At least two.
Q. Okay. If there's a small opening in the bile duct, either hepatic or the bile duct, one of the recognized appropriate ways to manage that is to place one or two sutures, correct?
A. I wouldn't say a small -- a small opening you would close with one. Once you need more than one, you've got -- I wouldn't call that a small opening.
Q. Doctor, that's happened to you, hasn't it?
A. Has what happened to me?
Q. You've had a case -- well, let me start. You yourself have had a complication during the course of a gallbladder surgery where a small opening was made in the bile duct, correct?
A. Yes. But that was completely different. That was a case that was a laparoscopic

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cholecystectomy, and there was a tiny -- and I'm talking about not any bigger than a hair -- accessory duct that came off of the common hepatic duct which could not be seen on laparoscopy, which did make a tiny hole in that duct.
Q. That was -- I think you described that tiny hole in your case as the size of a pinhole, correct?
A. Right.
Q. And you repaired it with one suture?
A. Yes.
Q. And you did not place a T-tube, did you?
A. Correct. But that's because --
Q. That --
A. -- it was a pinhole size. It was not a tear. It was a pinhole size opening.
Q. So if, in this case, the opening in the duct was a pinhole size and was repaired with a suture and no T-tube was placed, then, like in your case, that would be appropriate management, correct?
A. No, because in my case, I didn't use a clamp. I didn't use any clamps. So, therefore, I could not have crushed the duct. I was using

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different kinds of instruments. That was a laparoscopic cholecystectomy. That was not a case where I had bleeding and I tried to control the bleeding and I placed a clamp across the hepatic pedicle. It was a completely different situation.
Q. In that case, you did not place the T-tube, correct?
A. That's correct.
Q. Have you looked at the cholangiogram films taken during the surgery in this case?
A. I did not because I was shown all the films and the cholangiogram surgery films were not there.
Q. So you've never seen the -- the x-rays taken during the surgery?
A. No, I have never seen them.
Q. So you have no idea how any of the common bile duct or the hepatic duct appeared during the surgery?
A. On the cholangiogram, that's correct. But I've seen subsequent cholangiograms, so I know the size of the ducts --
Q. I'm talking about --
A. Well, you're -- let me just finish.

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I know the size of the ducts and I saw the stricture, but I did not see the O.R. cholangiogram that was taken.
Q. So you don't know how those ducts looked when Dr. Aszodi checked for their continuity and to make sure the repair was adequate before he closed the patient's abdomen? You've never seen those films?
A. That's correct.
Q. There's nothing that can be done to prevent a stricture in the -- in the duct, correct? Nothing that will prevent it?
A. There are some things that can be done, but many times it doesn't work.
Q. And the placement of a T-tube does not prevent a stricture?
A. No, it does not.
Q. By the way, how do T-tubes -- you showed that little T-tube before. That's about, what, a quarter of an inch round maybe?
A. Yeah, I'd say.
Q. How does that get out, come out?
A. Well, what you do is -- the reason that I cut it here, if you notice, is it makes it bend

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better. So that in a routine case where you place a T-tube -- like when you open the common bile duct to remove a stone, you always place a T-tube -- you just gently pull on the T-tube, and the T-tube collapses like that and comes out of the duct.
Q. So this is done with the patient lying in their hospital bed perhaps?
A. Yes.
Q. And so it leaves a little quarter inch hole in the common duct?
A. Yes.
Q. Aren't you -- in this case, the initial injury was only described as a pinhole size hole by Dr. Aszodi, right?
A. Right.
Q. And you're saying if a -- if a T-tube had been placed, then it would have been safe to just pull the T-tube out and leave a little hole in the duct about a quarter inch around?
A. Yes, because when you place a -- when you place a T-tube in like this, the body forms a fistulous tract around the tube. So when the tube comes out and you pull it out of the duct, the tube comes out, the fistulous tract stays open. But

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since there's no obstruction to flow, this closes.
Q. So how long does it take for that little opening to close?
A. Well, you usually leave a T-tube in about ten days, and the hole will close in two or three or four days usually.
Q. And the patient would just continue to have bile draining to the outside during that period of time you're waiting for the hole to close?
A. But a very small amount because 99 percent of the bile goes through the bigger opening and then the -- the fistula closes.
Q. After the surgeries on October 1, you are not critical of anything else that happened during Mr. Vayl's stay in the hospital, correct, at Mount Sinai?
A. That's correct.
Q. And he went home on October 11?
A. Yes.
Q. And in your opinion, in order to give appropriate care, Dr. Aszodi had a couple of weeks to get him reevaluated? I think you said within two weeks he needed to be reevaluated.
A. Yes.

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Q. And you're aware he was evaluated and an ERCP done on October 29?
A. That's correct.
Q. Just about two weeks and four days later?
A. That's -- that's fine.
Q. So I gather you feel that would be an appropriate interval?
A. Yes.
Q. Doctor, you -- you yourself have never operated on a patient to take care of a -- this kind of a stricture in a common hepatic duct, correct?
A. I have never done it. As a resident, I have assisted surgeons at doing that, but I have never done a stricture. I've done this procedure, the choledochojejunostomy. I've done many of those but not for strictures for other things.
Q. Other doctors don't refer patients to you to have strictures treated, right?
A. Right.
Q. By the way, after Mr. Vayl left Mount Sinai Hospital on October 11, after that time, essentially the -- the vascular injuries -- he had no further bleeding, no additional problems from the vascular injuries, correct?

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A. Correct.
Q. Now, we know he went on to develop the stricture.
A. Yes.
Q. Have you reviewed any of the subsequent medical records in between October, or rather, January of 1992, and the surgery in June?
A. I reviewed all of them.
Q. Okay. By the way, you completed your residency in 1974. You told us that earlier, correct?
A. Yes.
Q. And for the first two years you were out, you worked in an emergency room?
A. Right. I directed Mount Sinai's affiliate hospital, Elmhurst Hospital.
Q. You really didn't start into practice as a general surgeon until 1976?
A. Correct.
Q. And your entire career, you've been in sole practice with one partner for a while who's now retired --
A. Right.
Q. -- right?

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A. I was in partnership with him for 16 years.
Q. You've never held a teaching appointment at a university medical school, anything like that?
A. Oh, yes, I have. I was -- I was an instructor in surgery at Mount Sinai Medical School. I was --
Q. I'm sorry. That was -- that was -- that was back in what, the '70s?
A. Yes. And then I was a -- I was a clinical instructor in surgery at the New York Osteopathic Medical School.
Q. And again, that was back in the '70s?
A. I think so. You have my CV. Yes.
Q. You have not been involved in the ongoing teaching of residents for 12 to 15 years?
A. I teach residents, but I'm not on the faculty of any medical school teaching residents, per se. I'm in the active practice of general surgery.
Q. You have 19 articles that you've published?
A. Yes.
Q. And the last one was 1979?

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A. Correct.
Q. You've never published anything on gallbladder surgery or biliary tract surgery, anything like that?
A. Correct.
Q. Okay. You've never done any research on those subjects?
A. Correct.
Q. You're currently a member of the American College of Occupational Medicine; is that correct?
A. Yes.
Q. You're not a member of the American College of Surgeons?
A. Correct.
Q. You're not a member of the AMA?
A. Correct.
Q. You're not a member of any of the New York State medical societies?
A. That is correct.
Q. You do practice medicine in Manhattan, right?
A. No.
Q. I'm sorry.
A. I practice in Forest Hills, Queens.

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Q. Okay. That's near New York City?
A. Yes.
(Pause in proceedings.)
Q. Doctor, you mentioned a couple of journals before with which you were involved. That was back in the early '80s, correct?
A. Yes.
Q. You've not been an editor of any journals since 1984?
A. Correct.
Q. By the way, you just -- you were just learning how to do laparoscopic cholecystectomies in 1991, correct?
A. Right.
Q. You've never taught any courses in how to do laparoscopic or open cholecystectomies, have you?
A. No.
Q. You told us earlier about your involvement in medical malpractice lawsuits.
A. Yes.
Q. And you really started getting involved in that kind of work right after your residency, right?
A. Yes.

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Q. From the late 1970s until 1991, you reviewed from 350 to 550 cases a year?
A. No.
Q. No?
A. I reviewed -- I've testified as many times. I reviewed between 50 and 100 cases per year.
Q. Well, let's take a look at your deposition. You have a copy of it there.
A. Well, there are -- there are many errors in my deposition.
Q. Well, let's just read this -- this one.
A. Okay. Go ahead.
MR. BECKER: Excuse me. Can I get the question again, please.
Q. We're looking at page 78 of your deposition, line 5. And I'm just going to read it, and I want you to read along with me, make sure I'm reading it correctly.
A. What line?
Q. Five.
My question to you was: Roughly how many medical malpractice cases have you been retained to review for either side?

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Your answer was: In the '80s and late '70s, I reviewed between 350 and 500 cases per year.
A. No. That's -- no.
Q. Well, Doctor, did I read that correctly?
A. You read it correctly --
Q. Okay.
A. -- but there are many errors in this deposition. For instance, on --
Q. Doctor, did I read that quote correctly?
A. Yes.
Q. Okay.
A. But I want to say that that --
Q. Okay. You'll have a chance later on to clarify anything.
Now, you have looked at --
A. Well, I -- I want to clarify it right now. That is not correct, and that's not what I said. It's a mistake. We did this by phone last week, and there were many errors because the person who was taking down the information was not sitting next to me like this lady. She was in your office. And there are many errors that are made in this. I said -- in one place, I said clearly, and they said

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poorly or vice versa. So there are numerous typographical errors in this deposition.
Q. Did you make any list of those corrections?
A. Yes, I did.
Q. Okay.
A. I have them for you.
Q. Doctor, you would agree that you have reviewed more than a thousand medical malpractice cases over the years?
A. Yes, I would. But not 350 or 400 in a year.
Q. Okay. And you were earning at times in the past between 50,000 and 100,000 dollars a year from your work as a medical malpractice expert, correct?
A. Yes.
Q. How many years was your -- were your earnings from testifying as a medical malpractice expert in that range, 50 to 100 thousand?
A. Probably in the '80s, so I would say about ten years. It's appreciably lower now since my partner retired and I review much fewer cases.
Q. You do work for both sides, for defense

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and for plaintiffs, right?
A. Yes.
Q. All of your defense work is done in New York State?
A. No.
Q. Okay. Have you had any recent cases outside of New York State?
A. Many.
Q. Many? Since when?
A. In the last three or four months.
Q. Okay. Your testifying outside of New York -- well, let me just -- prior to three or four months ago, isn't it fair to say that all of your defense work was done in New York State and all of your plaintiffs' work was done outside of New York State?
A. No. I've testified many times for plaintiffs in New York State.
Q. Okay.
A. And now, I've testified or have reviewed cases in numerous states for the defense.
Q. Okay. How many states have you reviewed cases in for the defense?
A. Florida, Louisiana, New Jersey,

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Pennsylvania, Michigan, a couple others.
Q. And you've done all those reviews in the last three to four months?
A. Maybe six months or so, yes.
Q. You have given depositions for plaintiffs in -- I think I counted 19 states, correct?
A. It may be more.
Q. You have given more than a hundred depositions for -- on behalf of plaintiffs in medical malpractice cases?
A. Correct.
Q. There are four different agencies that lawyers can go to who will give them your name as one -- as an expert to review cases, correct?
A. Yes.
Q. Doctor, by my count, let's assume for the moment that you were earning $100,000 a year on the high end for about ten years at least reviewing medical malpractice cases. You might have earned over a million dollars already from just reviewing medical malpractice cases, correct?
A. Could be. I think it's less than that, but it could be almost a million dollars, yes.
Q. You are aware that Mr. Vayl died in July

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of 1992?
A. Correct.
Q. And he died after surgery performed on him by Dr. Eisenstat at Hillcrest Hospital?
A. Yes.
Q. Do you know when Mr. Vayl last saw Dr. Aszodi?
A. It was way before that. I don't know the exact date.
Q. You're aware that Dr. Aszodi had nothing to do with that final surgery?
A. I'm aware of that, yes.
Q. And, in fact, Dr. Aszodi didn't even know that Mr. Vayl had gone to Dr. Eisenstat for care, correct?
A. Yes, that's correct.
Q. Mr. Vayl actually died from a number of complications of the surgery performed by Dr. Eisenstat, right?
A. Yes.
Q. Did you testify earlier that the reason Mr. Vayl needed the surgery at that time was because he had cholangitis?
A. That was -- no. The main reason was that

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he had the stricture. That was what necessitated the surgery, but he did have cholangitis from the stricture. But the main indication was the stricture.
Q. Doctor, are you aware that at the time Dr. Eisenstat operated on Mr. Vayl, he did some samples, he took some biopsies from the liver?
A. Yes.
Q. And are you aware that the biopsies of the liver showed no evidence of ascending cholangitis?
A. Yes.
Q. You said that by the time Mr. Vayl got to Dr. Eisenstat, it was too late. Did you make that statement earlier?
A. Yes.
Q. At what point in time for this patient was it too late?
A. Well, I'm not certain about that. I -- I don't place stents; and, therefore, I can't say -- I would have to defer that to someone who's more familiar with stent placement and the repair of ducts.
Q. So you have no opinion as to when it was

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too late for this man?
A. I don't have an opinion about when -- exactly when it was too late.
Q. Do you know when he first came under Dr. Eisenstat's care?
A. I don't have the records in front of me, but it was late -- it was later in the course. Certainly after Dr. Aszodi was no longer treating him.
Q. So it's your understanding that he first saw Dr. Eisenstat after Dr. Aszodi stopped treating him?
A. Well, the surgery took place after Dr. Aszodi stopped treating him.
Q. But you don't know how long he'd been under Dr. Eisenstat's care before that surgery?
A. I don't recall.
Q. Now, as a complication of Dr. Eisenstat's surgery, Mr. Vayl developed abscesses, correct?
A. Yes.
Q. He developed a hematoma?
A. Yes.
Q. And a hematoma is a blood clot inside that comes from bleeding?

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A. Yes.
Q. You don't know what was bleeding that caused the hematoma though, correct?
A. No, I do not.
Q. He did develop a bile leak, didn't he, after that surgery?
A. Yes.
Q. Are you aware that Dr. Eisenstat never took Mr. Vayl back to surgery to find out what was causing those problems?
A. Yes, I'm aware of that.
Q. Then the patient developed sepsis?
A. Yes.
Q. He developed kidney failure?
A. Yes.
Q. He developed respiratory failure?
A. Yes.
Q. Are you critical in any way of the care Dr. Eisenstat provided to Mr. Vayl?
A. No.
Q. Another name for the surgery that Mr. -- that Dr. Eisenstat performed was called a Roux-en-Y procedure, correct?
A. Yeah, that's the -- it's -- it's a

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Roux-en-Y choledochojejunostomy. The reason -- it's just made into a Y. That's why they call it that.
Q. And you have done many of those procedures, correct?
A. Yes.
Q. And none of your patients died?
A. None that I know of, no.
MS. REINKER: I have nothing further.
MR. GROEDEL: Go off the record.

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CROSS-EXAMINATION

BY MR. GROEDEL:
Q. Dr. Bassin, my name is Marc Groedel. We met over the phone. I represent Dr. Tenenhaus, Dr. Jackson, and Mount Sinai Medical Center. And I do have a few questions for you.
First of all, do you know at what level the residents were during this operation, at what level in their training? Do you recall that?
A. I don't remember.
Q. Okay. Residents are basically students, are they not?
A. Well, they're -- they're postgraduate students. They're already physicians, and now,

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they're learning -- they are doctors, and now, they are learning the art and skill of surgery.
Q. Under the direction of attending surgeons or -- or experienced surgeons, true?
A. Yes.
Q. They're -- they're there to learn how to do operations that general surgeons do out in private practice or institutions, true?
A. Correct.
Q. And so by assisting general surgeons in operations such as the one at hand, that's basically how they learn --
A. Yes.
Q. -- true?
Okay. And certainly, you would agree that, generally speaking, attending surgeons are more experienced than residents when it comes to surgeries like this, true?
A. Yes.
Q. And you certainly wouldn't hold a resident to the same standard of care that you would hold an experienced attending surgeon to, true?
A. True.
Q. All right. Now, let's go back to -- the

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standard of care for a resident would be much lower than it would be for --
MR. BECKER: Objection.
Q. -- for -- for a surgeon, true?
A. It would be a -- it could be a different standard because he doesn't have the knowledge and experience of a general surgeon.
Q. Of course.
A. But the principles we're talking about here any resident should now.
Q. Okay. You've -- you've testified that the most likely cause of the -- the stricture in this case was the placement of the clamp, true?
A. Yes.
Q. And you've already told us that there's no evidence that any resident placed that clamp, true?
A. Right.
Q. Okay. And that the -- the stricture is what caused the cholangitis, which in your opinion is what eventually led to the ultimate result in this case --
A. Yes.
Q. -- true?

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If that's the case, then there's really no indication that anything that a resident did was a significant factor to the outcome, true?
A. Well, if -- if Dr. Aszodi was the only one who placed the clamp and --
Q. Then I'm right?
A. Well, let me finish.
Q. I'm sorry.
A. -- and the resident didn't tell him not to place the clamp, then the resident should have told him that. But of course, Dr. Aszodi could overrule the resident because he was the attending. There are other possibilities for how the duct was injured.
Q. But those --
A. But --
Q. -- are speculative --
A. But --
Q. -- on your part, right?
A. -- in my opinion, it's more likely than not that it was the clamp that did it. But other possibilities are certainly that -- that 2-0 silk suture that was placed or a retractor that was inadvertently placed could have torn the duct, and

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the resident may have done that. But the most likely cause and based on a reasonable degree of medical probability, it was the clamp that did it.
Q. Okay. And obviously, if the attending surgeon -- the final call as to where a clamp should be placed or if a clamp should be placed rests with the attending surgeon as opposed to the resident?
A. Yes.
Q. All right. And truthfully, you don't really have a -- a full understanding of -- of what exactly the residents did or didn't do in this operation, true?
A. I don't know exactly what everyone did.
Q. Okay. You've read Dr. Neissen's deposition, haven't you?
A. Yes.
Q. You're aware of the fact that he was retained by Mr. Becker also to testify on behalf of the Vayl family?
A. Yes.
Q. And you're aware of the fact that he -- he wasn't critical of any of the residents for the first operation, true?
A. I don't remember, but could be.

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Q. All right.
A. I'm not basing any of my opinions on what Dr. Neissen said.
Q. Well, obviously not. You're the only one in this case that's critical of the residents during that first --
MR. BECKER: Objection.
Q. -- surgery; isn't that true --
A. If I --
Q. -- to your knowledge?
A. If you -- if I assume what you tell me is correct and Dr. Neissen said that, then I am. But I would let Dr. Neissen speak for himself.
Q. Okay. So from bottom line standpoint, if the evidence in this case is that the residents didn't place the clamp, the probabilities are that the residents aren't responsible for the final outcome, true?
A. That's true.
MR. GROEDEL: No further questions. Thank you.
(A discussion is held off the record.)
MR. BECKER: Just state it on the record then, no questions.

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MR. DAPORE: Dr. Bassin, my name is Tony Dapore and I represent Dr. Ponsky. I have no questions.
THE WITNESS: Okay.
MR. BECKER: Off the record.

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REDIRECT EXAMINATION

BY MR. BECKER:
Q. Doctor, I have a few more questions for you on redirect examination. There was some discussion about this initial cholecystectomy being a difficult one, and then there was some talk by you in reference to the pathology.
First of all, what did you mean by this surgery being difficult?
A. Well, there are all degrees of gallbladder removal. Some patients, you get in and it -- and it -- there's no scarring at all and you just make a little incision around, it just pops right out. This was one of those that was more difficult than that in that there was scarring, you had to take it out. But this was a typical gallbladder that you operate on for cholecystitis or inflammation of the gallbladder. There was scarring

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and there was inflammation, but the pathology report showed it was just mild inflammation. So this -- this was a typical gallbladder that general surgeons do all the time.
Q. How reliable, Doctor, is the -- the -- the gross pathology in this case to depict what the scene was like for the surgeons?
A. Very reliable. The pathologist has the gallbladder in his hand and can tell you what it was like.
Q. Doctor, defense counsel has asked you to assume that there was actually a cystic artery stump left. Do you have an opinion whether there was, in fact, a cystic artery stump left after the avulsion?
A. Oh, I -- I have an opinion that there was not. It was avulsed off. They don't talk about in their operative report that they had a stump which they clamped and ligated. They put stitches in, and then they had to ligate the -- the cyst -- the hepatic artery, so there was no stump left.
Q. Doctor, there was some discussion earlier about the fees that you have earned over the years doing medicolegal work. I don't recall whether it was 10 or 20 years of doing this, but what -- what

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percentage of your time, Doctor, is -- is involved in medicolegal work?
A. Less than 10 percent.
Q. And what percentage of your income, Doctor, is involved in medicolegal work?
A. Less than 10 percent.
Q. Doctor, there was a reference to the T-tube and a question asked of you as to, when the T-tube is removed, there -- there might be an opening as great as -- as one quarter of an inch and -- and what happens to that with the suggestion in the question that somehow that might be analogous to a situation where the initial tear occurs. Is it analogous at all, Doctor?
A. No. It's a completely different situation. Maybe I could draw that and just explain it.
Now, if this blue is the -- is the T-tube in the duct -- and it looks like this -- when you have a T-tube in, you always leave it in for ten days. And the reason that you leave it in is because scar tissue forms around the duct, very thick scar tissue forms around the duct, because it's a foreign body, and the body reacts negatively

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to a foreign body.
Q. You said the duct, Doctor. You meant the T-tube?
A. Oh, I'm sorry. Around the T-tube. I'm sorry.
Q. Okay.
A. So, therefore, this scar tissue has formed around here, and it's actually like a tube of scar tissue. So that when you pull this tube out, it comes through this long tube of scar tissue, and then it's -- when the tube comes out, this scar tissue closes down right here and it all closes off. So that's why the opening closes. There's no obstruction to flow coming down, so the bile goes down this way, and this scar tissue which is formed just closes down. Sometimes we'll remove a T-tube, and in three or four hours, there'll be no bile draining. The scar tissue just goes boom and closes.
Q. Now, Doctor, when a surgeon places a T-tube after there's been a significant injury, how long is that T-tube generally kept in?
A. Oh, months.
Q. Why is that, Doctor?

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A. Well, because you need the T-tube in there so that you can evaluate the -- to see if a stricture develops. And then if a structure does develop, you have it in there to drain the area so that you don't get increased pressure.
Q. Speaking of the T-tube, Doctor -- and there were some questions by the hospital counsel on behalf of the residents -- you indicated that the residents had some responsibility relative to recommendation on the T-tube; is that correct?
A. Oh, yes. The resident should have recommended to Dr. Aszodi that he place a T-tube in the common duct because there was a tear in the common duct.
Q. Okay. And -- and what is the direct and proximate result of the failure to place that T-tube?
A. Well --
MS. REINKER: Objection.
A. -- by not placing the T-tube --
MR. GROEDEL: Objection.
A. -- they allowed the infection to continue and they delayed the surgery that Dr. Eisenstat would have performed. And had a T-tube been left in

place, it's my opinion the surgery could have been done earlier, it would have been easier, and the patient would have survived.
Q. Doctor, finally, referring to Dr. Eisenstat's surgery, which occurred in -- I believe in mid 1992, would that surgery have ever been necessary had the appropriate things, as you've earlier outlined, taken place?
A. It would never have been necessary, and because -- if it was done properly, the patient wouldn't need the surgery. And also, if they hadn't injured the hepatic artery during the surgery, that is, tied it off, it's my opinion that Dr. Eisenstat's surgery would have been successful, because by injuring the hepatic artery, the liver had less blood supply, which decreased the healing capacity of the liver and the body itself and the anastomosis.
MR. BECKER: That's all I have.
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RECROSS-EXAMINATION
BY MS. REINKER:
Q. Would you take a look at the operative note, please, Doctor, the -- from the first surgery

on October 1.
A. Yes.
Q. Now, at the very bottom of that note, Doctor --
A. Which page?
Q. The first page. I'm sorry.
-- there's an indication that the reason Dr. Aszodi had to convert from a laparoscopic cholecystectomy to an open cholecystectomy was because of the tremendous amount of inflammatory reaction about the gallbladder. Do you see those words?
A. Yes.
Q. And you are aware that when Dr. -- when the open procedure was done, Dr. Aszodi used what's called a retrograde approach --
A. Yes.
Q. -- which was done because of the inflammatory reaction, correct?
A. That's typical, yes.
Q. You had the pathology report on the gallbladder before your deposition was given last week, right?
A. Yes.

Q. And at your deposition, you testified that you still hold the opinion that this was a very difficult dissection, correct?
A. Yes.
Q. Doctor, did you tell us that the amount of money you've earned from medical malpractice testifying is about 10 percent of your income?
A. I said less than 10 percent.
Q. Okay. So that $1 million might be about 10 percent of your income over the years?
A. It might be, yes.
Q. $10 million might be your income?
A. It might be, over ten or so years.
MS. REINKER: Thank you, sir.
MR. GROEDEL: Off the record.
No questions.
MR. BECKER: No further questions. Thank you, Doctor.
(Signature waived)
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Thereupon, the aforementioned proceedings concluded at 12:30 p.m.
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State of Ohio : CERTIFICATE
County of Franklin :
I, Sharon T. Pontius, a Registered Merit Reporter and Notary Public in and for the State of Ohio, do hereby certify the within-named RICHARD BASSIN, M.D., was by me first duly sworn to testify to the whole truth in the cause aforesaid; testimony then given was by me reduced to stenotypy in the presence of said witness, afterwards transcribed by me; the foregoing is a true and correct transcript of the testimony so given; and this deposition was taken at the time and place as specified on the title page.
I do further certify I am not a relative, employee or attorney of any of the parties hereto, and further I am not a relative or employee of any attorney or counsel employed by the parties hereto, or financially interested in the action.
IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Columbus, Ohio, on November 1, 1995.

Sharon T. Pontius, RMR, Notary Public - State of Ohio. My Commission expires March 13, 1996.

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