Case No, [redacted]

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DEPOSITION OF RICHARD E. SCHLANGER, M.D.

- - -

February 25, 1998
1:10 o'clock p.m.
Surgical Associates
of Columbus
1492 East Broad Street
Columbus, Ohio

- - -

CAROL A. KIRK

REGISTERED MERIT REPORTER

- - -

KIM E. SNYDER
REGISTERED PROFESSIONAL REPORTER
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APPEARANCES:

By Ms. Ann Garson, **Attorney at** Law
Donna Taylor- Kolis**Co., LPA**
1015 Euclid **Avenue**
Cleveland, OH 44115
(216) 861-4300,

on behalf of the **Plaintiffs.**

By Mr. **Jospeh E.** Herbert, **Attorney** at **Law**
Roetzel & **Andress**
75 East **Market Street**
Akron, **OH** 44308
(330) 376-2700,

on behalf of the Defendants.

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FEBRUARY 25, 1998

WEDNESDAY AFTERNOON SESSION

1:10 P.M.

- - -

STIPULATIONS

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It is stipulated by and between counsel for the respective parties that the deposition of RICHARD E. SCHLANGER, M.D., a Witness herein, called by the Defendants under the applicable Rules of Civil Procedure, may be taken at this time by the notary by agreement of counsel; that said deposition may be reduced to writing in stenotypy by the notary, whose notes thereafter may be transcribed out of the presence of the witness; and that the proof of the official character and qualification Of the notary is waived.

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RICHARD E. SCHEANGER, M.D.

being by me first duly sworn, as hereinafter certified, testifies and says as follows:

CROSS-EXAMINATION

BY MR. **HERBERT:**

Q. Could you state your name for the record.

A. Richard Edward Schlanger, S-c-h-l-a-n-g-e-r, M.D., Ph.D, FACS.

Q. Your professional address is 1492 East Broad Street, Columbus, Ohio?

A. That's correct.

Q. And that's where we're at right now?

A. Yes.

Q. Okay, Social Security number is what?

A, 062-44-9592.

Q. I don't have your CV handy. What is your date of birth?

A, 2/12/50.

Q. You just handed me a copy of your curriculum vitae. You've got an extra copy handy there?

A. Yes, I do.

Q. Is that current and up to date?

A. Yes, this is pretty much up to date. I'd have to look at it really, really closely. The one that you have is the right one. The one that I have, there was a typo on the address of my office by my former secretary listed as 1942 instead of 1492, but that would be the only difference.

Q. You said there might be a few changes. What would that have to do with?

A. Just some of the societies I've kind of stepped away from.

Q. Which ones are those?

A. Columbus Surgical Society, Medical Forum, Medical Review Club. That's about it.

Q. And why is it that you, quote, unquote, stepped away from those?

A. Basically it was a money -- that's not a good point. I think it was just I was throwing money into these things, and they were absolutely not essential for any career move.

Q. If I understand you, like paying dues and things like that?

A. And not --

Q. Let me not talk over you. Paying dues and that sort of thing, and it didn't give you back anything in terms of additional education or career

opportunities?

A. Correct.

Q. The reason I'm here today is obviously you've been identified as the Plaintiffs' expert in this case. I'm going to ask you some questions today about your opinions in this case, your review of the case and a little bit about your background and training.

You understand, first of all, that I'm going to be relying on the answers that you give? Do you understand that?

A. Yes.

Q. And those answers are being taken down, and we'll use those answers as we prepare for the trial of this case; do you understand that?

A. Yes.

Q. So everybody understands each other, if I ask you something and you don't understand it, don't answer it; agreed?

A. Yes.

Q. If you need me to speak up or rephrase it, I'll do that; do you understand?

A, Yes.

Q. Do you feel that you've adequately prepared yourself to give your opinions regarding

this case today?

A. Yes.

Q. Do you understand the difference between possibilities and probabilities?

A. Yes, I think I do.

Q. Give me your understanding of the difference.

A. Possible is basically anything that can happen; but when we talk about probable and probability, there is a chance of at least 51 percent or greater.

Q. More likely than not?

A. Exactly.

Q. What is your understanding or definition, if you have one, of the standard of care?

A. The one that I've used over the years has been what is reasonable and prudent for a physician fully licensed or trained to do in his care of a patient based on community or national standards.

Q. So basically what is reasonable for that physician to do under the particular circumstances of that case?

A. That's correct.

Q. Do you have a definition or do you use the concept of medical judgment?

A. I use the concept of medical judgment.

MS. **GARSON:** I'm going to object simply for the basis of getting at any kind of legal definitions; but with that, go ahead, Doctor.

Q. Explain what that means to you, that term.

A. Based on training, based on literature and based on the prevailing trends, it is a way that a physician, surgeon or internist arrives at a treatment plan.

Q. Would it be fair to say that medical. judgment is something that physicians use on a daily basis?

A. Yes.

Q. Practicing physicians, that is?

A. Yes.

Q. Let me ask you for a couple of case specific medical definitions so we have, I guess, a general terminology. Give me an understanding of what the biliary tree is.

A. The biliary tree is the drainage system that drains bile from the liver, constitutes both a right and left side that combine forming the common bile duct, has a small offshoot called the cystic duct which feeds and eventually drains into the

common bile duct, has an inter-pancreatic duct, and at the sphincter of Oddi will dump into the duodenum.

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(Deposition Exhibit A marked.)

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Q. Dr. Schlanger, I'm handing you what I've had the court reporter mark as Exhibit A, and it is unfortunately my rather limited attempt to demonstrate the anatomy that we're talking about in a pencil drawing.

Does that fairly and accurately represent the anatomy in question as opposed to specifically this patient?

A. Without dealing with the inter-hepatic portion, it deals with what looks to be the portahepitis and the inter-pancreatic portion, yes.

If I could just answer this one page real quickly, I'll be right with you.

Q. Please do.

(Pause in proceedings.)

Q. So when we talk about the biliary tree, the area of the surgery in this particular case would have been removal of the gallbladder and clipping or ligation of the cystic duct --

A. That's correct.

Q. -- is that true? Could you just indicate -- I'll give you the pen that works here.

A. Okay.

Q. Indicate where that duct in general would be put.

A. Well, if we're doing the laparoscopic procedure, the best description is to clip it as close to the neck of the gallbladder. So you want to clip it up in here (indicating) and not get down towards the common duct where most of the injuries would occur.

Q. And if you clip it up further towards the gallbladder, that's going to leave you with a little bit of length on the cystic duct stump; is that true?

A. Yes.

Q. I guess we can probably agree that any injury to the biliary tree is probably not fair to characterize it as being trivial; is that --

A. No, that% very correct.

Q. Although I guess in the scheme of things, some injuries to the biliary tree are more significant than others; is that true?

A. Yes.

Q. I guess for this case, or at least for purposes of my questions, can we agree to define a minor biliary leak as being the leak that comes from the cystic duct stump or perhaps from the gallbladder bed?

A. If you want to categorize that, that's fine.

Q. Would you not agree with that kind of a definition, or what definition would you follow?

A. A bile leak is a bile leak.

Q. Right.

A. These are anatomic variances, and you need to define which one they are. Major bile leak, we don't even talk about that, that we get into ductal disruption. So if we're talking about a bile leak at this point, I would go along with us calling a bile leak, exactly that, either a cystic duct leak or ducts of Luschka, which are in the gallbladder bed.

Q. When you talk about the ducts of Luschka, you're talking about ducts that arise directly from the liver and connect directly tu the gallbladder itself?

A. That's correct.

Q. And sometimes these ducts can be

extremely small?

A. Yes.

Q. Is it fair to say they can be even microscopic?

A. For the most part, if they leak, they're not. They're usually visible and a fairly -- they're a depictable size. They are small; but if they were microscopic, they wouldn't be leaking.

Q. They would have very small leaks?

A. Most of the time if we're doing a Laparoscopic or open chole and you've applied electric current to the liver, they would have already been electrocoagulated and covered with coagulum and you'd never see them,

Q. Key words there, "most of the time"?

A. Most of the time, correct.

Q. The liver produces anywhere from 1,500 CCs to 2,000 CCs of bile a day on average; is that true?

A. It's about 1,500 or slightly less, but that's a good estimate,

Q. There may be occasions within the range of normal where it can be as much as 2,000 CCs; but in general, it's going to be around 1,500; is that fair?

A. That's a fair statement.

Q. In the case of leaks that arise from the ducts of Luschka or cystic duct stump leaks, historically it has been shown that these ducts can heal themselves; is that true?

A. For the most part, no. Historically, there are cases where they have spontaneously closed, but the vast majority have been surgically repaired, including the Luschka ducts.

Q. Again, key words there, "most of them." Some of them do heal themselves; is that true?

A. Some, yes.

Q. In the past, have you in your experience seen gallbladder leaks that have arisen from laparoscopic cholecystectomy which were treated either with drainage or without drainage and no ERCP? Have you seen that?

A. No.

Q. Are you aware that has occurred?

A. Not in either my practice or in this area.

Q. Are you aware that some physicians in the past advocated that such gallbladder leaks can be effectively treated or managed with appropriate drainage?

A. Not unless a diagnosis has been made that it is an isolated leak.

Q. Assuming that there was a diagnosis made that it was an isolated leak, under those circumstances in general, it then can be appropriate to manage that with drainage?

A. In a first trial, yes.

Q. Have you treated gallbladder leaks arising from laparoscopic cholecystectomy in your practice?

A. Yes.

Q. How many times?

A. Somewhere between 100 and 150.

Q. Whether it's done via open or laparoscopically, any gallbladder surgery, cholecystectomy, results in usually some bile spillage?

A. No.

Q. No?

A. No. A good biliary tract surgeon doesn't spill bile. There's no reason to, unless there is an inadvertent entering of the gallbladder during the procedure, and that should be avoided.

Q. Maybe I used the wrong term. Is it fair to say that in most gallbladder surgeries, either

open or via laparoscope, there will be some fluid remaining in the area of the surgery?

A. Not always.

Q. Is it frequently seen?

A. No.

Q. Give me an idea of how frequently you would expect to see that?

A. Less than 5 percent.

(Pause in proceedings.)

Q. What is the -- I guess for lack of a better term -- leak rate, bile leak rate, for lap tholes?

A. Right now it should be about less than 1 percent.

Q. How about 1995?

A. Oh, 1995 was fairly recent. still less than 1 percent.

Q. How about 1993?

A. Maybe 3 to 4.

Q. How about 1990?

A. There we were seeing almost the same leak rate as we did with the common ducts, about 7 percent.

Q. Would you agree with me that medicine is an evolutionary process?

A. Yes.

Q. In other words, as new procedures come along, there may be a period of time where complication rates are higher because the techniques have not yet evolved, the instrumentation has not yet evolved? Is that fair to say?

A. Yes.

Q. And then over time as those procedures become tried and true, complication rates can go down?

A. That's correct.

Q. And those procedures become more and more generally accepted within the medical field?

A. Yes.

Q. Do you perform ERCP yourself?

A. No, I do not.

Q. Can you give me an idea of what the potential risk and complications of ERCP are in a case such as this?

A. Basically the only major complication that I would see in a case of this is inadvertent cannulization of the pancreatic duct with a possibility of transient chemical pancreatitis. Perforation is probably not a risk, nor is cholangitis a risk.

Q. Have you in your experience -- maybe not in a patient of yours, but somebody else in the group -- had a patient who was in a situation like this, underwent ERCP and developed a complication as a result of the ERCP?

A. We've had one or two, yes,

Q. Give me an indication of what those complications were.

A. Pancreatitis.

Q. Can ERCP lead to the development of a bile peritonitis?

A. Yes, it can.

Q. And pancreatitis itself when it is not just a mere chemical pancreatitis can be quite serious as a complication; isn't that true?

A. Yes, it can.

Q. It can be a life-threatening complication; isn't that true?

A. Yes.

Q. Would you agree with me that ERCP is not a procedure to be performed by an occasional operator?

A. That's true.

Q. You would agree that ERCP requires special dexterity, substantial investment in time in

order to learn the procedure, and I guess a constant practice in order to maintain skill in that procedure?

A. I can't answer that since I'm not a gastroenterologist.

Q. If you were to refer your patients to a gastroenterologist for that type of procedure, is that what you would want that gastroenterologist to have done?

A. Yes.

Q. To make that investment of time?

A. Yes.

Q. So then you would agree with me that ERCP is a procedure that's best accomplished by a subspecialist?

A. Yes.

Q. If ERCP is not readily available by a skilled operator, can it be reasonable to manage a situation like this without ERCP --

A. No.

Q. -- if you've made a diagnosis of a minor bile leak --

A. No.

Q. -- and have followed it with drainage?

A. No.

Q. Why not?

A. All the literature that's been written, all the precepts from the Society of Laparoscopic Surgeons, SAGES and everyone, that we have decided through the Ohio State University and the University of South Florida in Tampa, you cannot presume that you have a minor bile leak until you've documented such with an ERCP, a transhepatic choleangiography or hepatobiliary scan. Assuming that you have a minor bile leak and treating it with open drainage is substandard.

Q. How long has that standard been in existence? In other words, can you point me to any literature or documentation that indicates ERCP is required in a situation such as this?

A. I can't pull anything out right at this second, but I know the standard of care in this community -- and we have been doing lap choles since 1989 -- has been any patient that has any question of a blip in bilirubin gets a hepatobiliary scan; and if that's inconclusive, they do a ERCP, no questions asked.

Q. When you talk about hepatobiliary scan, you're talking CT scan or HIDA scan?

A. It's HIDA scan, not CT scan.

Q. I'm sorry. HIDA scan?

A. That's correct.

Q. And depending upon the results of the HIDA scan, you may not go forward or you may go forward with an ERCP?

A. That's correct.

Q. What are you looking for on the HIDA scan?

A. Leak.

Q. If you do not find the leak, do you, nevertheless, continue with the ERCP?

A. If the HIDA biliary scan is perfectly normal and there's no other explanation for the blip in the bilirubin, chances are we will proceed with an ERCP; but if it is normal and the bilirubin is coming down and no fluids collection on ultrasound, there's no reason to go any further.

Q. So the second part of that equation that we just talked about has to do with the play of clinical factors?

A. That's correct.

Q. So even with a HIDA scan, clinical factors play an important role in the decision of whether or not you would say this patient needs an ERCP?

A. That's correct.

Q. I guess to kind of cut to the chase here, you wrote a report in this case, and we'll mark that and get to that in more detail; but in my review of your report, it seems to me that you identify the deviation from the standard of care as being the following -- and correct me if I get this wrong -- that on 9/22 when Dr. Saxbe decided to go ahead and place drains in this patient for the bile leak, he should have gotten an ERGP at that point?

A. Prior to surgery, correct.

Q. In terms of the indications for this surgery, no problems with that in terms of the indication for the cholecystectomy itself?

A. The original operation is fine. I have no problem with the diagnosis and what seems to be a routine cholecystectomy done laparoscopically.

Q. Just so it's clear, no problems with like the pre-op workup, the technique used in the surgery or the postop care from that first discharge?

A. Probably not, yes. No, there were no problems, okay?

Q. All right. And informed consent is not an issue?

A. Informed consent has never been an issue.

Q. So it would be fair to say, then, that the deviation from the standard of care that you've identified here arises on 9/22, the date when he placed tubes surgically and did not get an ERCP?

A. Actually it's the fact that, number one, he entertains and makes the diagnosis of a biliary leak based on the sonogram, does not go ahead and identify such biliary leak, and then subjects the patient to a general anesthesia just to place drains and not address the problem.

Q. Most ERCPs, are they done under a local sedation?

A. Yes.

Q. I guess I'm having -- I guess I want to understand the issue of the general anesthesia. I mean, that, per se, is not below the standard of care to place drains under a general?

A. Well, the problem is if I have this patient and I have said, well, gee, I've got a bile leak, and I'm going to put this guy to sleep and put the drains in, that to me makes absolutely no sense and is poor judgment.

If I'm going to take the time to put the patient to sleep that has a bile leak, a reasonable general surgeon who is an expert in biliary tract

surgery, which I consider most surgeons that do biliary tract surgery, i.e., lap cholecystectomies, the operation of choice would have been to have had a pre-op anatomical idea that I have a cystic duct leak, operate on the patient, drain the bile completely, go down, find my stump, and put two silk ligatures on it, put a drain in, thank you very much, problem solved.

Instead what I've done is kind of a half procedure, I've placed the patient under anesthesia and put a drain, and the drains were put where I think they should go and not really accurately placed as far as I could read it from the op note. They were placed in a collection.

So I think we have a wasted operation, which I find to be substandard,

Q. Did the operation that was performed drain the bile?

A. It drained a collection; but since the patient was not fully explored, we don't know if there were other areas.

Q. I guess what I'm asking you is: Based upon your review of these records, can you say that it was unsuccessful? Can you point to a bile collection that was not drained?

A. Well, obviously he developed a bile collection of 1,000 CCs in October which isn't that far away. So I'm suspecting that the drain initially took care of a collection but loculated off because it wasn't draining anything further, and there is no way physiologically to say that this stopped draining. It was continuing to drain bile into the abdomen in another area.

Q. I want to make sure I understand you here. The bile that was drained in Florida, the thousand CCs in October, do you believe that bile leaked and was present in the abdomen at the time of the 9/22 drainage placement?

A. Not the whole amount, but you have a continued drainage; and when you put a suction drain in, you're opposing tissue, and whatever collection he took care of didn't truly take care of the leak. So we have an ongoing leak and now a new lead partition area that is not amenable to the original drain, and that's why it wasn't draining any further, and that's what allowed a new collection to occur.

Q. I guess I'm trying to understand. You've indicated that this was an ongoing leak, true?

A. That's correct.

Q. Why is this an ongoing leak as opposed to an intermittent leak?

A. No such thing as an intermittent leak,

Q. Why do you say that?

A. Because that would have required this to close. The only way that this could have closed and reopened is if there was a distal obstruction, and there's no evidence that he ever had stones in the distal common duct, nor was there any indication of sphincter spasm.

If the main channel is drained appropriately, the only way that could stay open is there's a consistent leak, and it doesn't have -- we're not talking about a full spigot, wide open. It's just dripping, and over time the drip will fill a basin which is the right upper quadrant.

Q. You said there was no evidence of sphincter spasm. How did you rule that out?

A. There's no evidence of severe right upper quadrant discomfort, a renewed attack of biliary colic. There is no evidence that you have of this guy saying, hey, it hurts just like my old gallbladder. I mean, the guy has pain, but it's different. So I don't think we have spasm or distal obstruction which would have blown out a healed or

scarred over cystic duct. It just doesn't happen.

Q. Is that possible?

A. I haven't heard it. If you don't take care of the duct, it continues to leak. If it closes once, they don't reopen.

Q. Physiologically if you have a situation where the sphincter of Oddi for one reason or another spasms and for a period of time restricts flow of bile out into the duodenum, the pressure within the biliary tree can increase and potentially cause leakage of bile through the area of the ligated cystic stump? Is that a potential?

A. That's a potential, but the vast majority is going to back up and cause dilatation interhepatically and the patient should be significantly jaundice.

Q. Would that also be a factor of how often that spasm occurred? In other words, if it was very intermittent, it may not be present long enough to cause significant jaundice clinically?

A. No, but there would be significant other symptoms. I mean, this would be recurrent pain of a nature of either pancreatitis and/or the patient having intermittent biliary colic and coming back to the doctor very, very frequently saying, I thought

you took my gallbladder out. I don't have that kind of history.

Q. In terms of things in your knowledge that can affect this sphincter of Oddi and cause this spasm, can you think of any things that might cause that?

A. Demerol.

Q. Okay. Anything else?

A. Not really. Passage of a stone.

Q. Anything else?

A. Not really.

Q. Can alcohol cause that?

A. I haven't heard of that,

Q. Have you done any literature research in this case?

A. Not yet.

Q. Have you been provided any literature research in this case?

A. No.

Q. Before the deposition started, I looked at a set of materials on your desk there,.and you indicated that was the, quote,.unquote, file you have for this case?

A. That's correct.

Q. Has anything been removed or discarded

from that file?

A. Not that I know of.

Q. There's a letter there that indicates that you had received the deposition of Dr. Saxbe and the deposition of Mr. Diamond.

A. I have Mr. Diamond's. I don't know where the heck I put Dr. Saxbe's.

Q. Because that's what I was going to ask. Do you remember reading Dr. Saxbe's deposition?

A. I think I did, but I'd have to go back and relook at it, because I did not see it this time around.

Q. When I reviewed those two depositions, it did not seem to me that there was a great deal of disparity factually in terms of the patient's complaints. Is there anything in your mind that stands out that there was a discrepancy?

A. I'd have to reread them before I could answer that appropriately.

Q. Fair enough. Did you make any notes regarding your review of this case?

A. Other than an occasional underlining, no, and I don't remember what I underlined to be quite honest.

Q. Not a problem. Would you agree with me

that a bad result or an unsuccessful outcome does not necessarily mean that the health care provider deviated from standard of care?

A. I would agree with that statement.

Q. In fact, in your own practice you've had unfortunately situations occur where you've had an outcome that was less than what was hoped for?

A. Yes.

Q. And that was not because anything you did was below the standard of care: it just happens, right?

A. Correct.

Q. Have you seen in your practice situations where two competent, well-trained physicians have looked at the same situation and decided to take different treatment routes?

A. That's happened very infrequently.

Q. But the situation can occur where two physicians are presented with the same clinical parameters and they may choose different routes of treatment?

A. It's possible.

Q. Will you agree with me that in areas of medicine, there may be different schools of thought on how to treat a particular problem?

A. Yes.

Q. And would you agree with me that assuming that you're in one school of thought and another physician is in another school of thought, that maybe a minority school but is nevertheless recognized to be a reasonable school, the fact that that other physician follows his school of thought does not necessarily mean that he was below the standard of care just because he's in a different school than you in general?

A. I'd really have to take a look of what school he's in.

Q. I'm not talking about the flat earth society. Assuming the school of thought is a minority although recognized to be reasonable.

A. That would be the key, recognized to be reasonable. There are a lot of minority schools of thought that are not reasonable, even though we're divergent from our standard of treatment.

Q. Understood.

A. And it would have to be a very reasonable alternative.

Q. Understood. Suffice it to say, there are situations in medicine where there are differences of opinion among physicians; nevertheless, in

general, the mere fact that there's a difference of opinion as to treatment doesn't necessarily mean that one physician is wrong and the other one is right; it depends?

A. It depends,

Q. You would agree with me that, in fact, there was not an injury to the common duct in this

A. You didn't know that until the ERCP was done in Florida.

Q. But in point of fact, it was not injured, right?

A. Once it was diagnosed, that's correct.

Q. I guess the fact that it was diagnosed later doesn't change the fact that it wasn't injured?

A. No, but the point that I'd like to make --

Q. I know.

A* -- is the fact that you can never assume the size of the leak until you've actually diagnosed it, because there are common duct leaks that are small. knicks, small areas of necrosis that will act very much like a cystic duct leak. There may be an evolution of the cystic duct that's leaking in this

same manner: and until someone has diagnosed it with image, you can't assume that you have a minor ductal problem.

Q. And let me just ask you just straightforward factual questions to make sure we're on the same page. It is a fact that the common duct was not injured in this case: is that true?

A. That's true.

Q. It is a fact that the radiologist in Florida felt that the leak was coming from the cystic duct stump; is that true?

A. That's true.

Q. Do you believe that, or do you have an opinion as to whether or not that's probably true, that the leak was coming from the cystic duct stump?

A. The leak was coming from the cystic duct stump.

Q. Do you have an opinion or an explanation to a probability as to why this patient apparently did not have significant symptoms during the time of the lap chole until basically the day he presented again about a week. later?

A. Bile sterile. You can have a bile collection and be asymptomatic until it either becomes infected or some other phenomenon happens to

make it irritated.

Q. And then from the 29th until. sometime around the 4th or so of October, is it your understanding that he did not have symptoms?

A. From what I read, I don't believe he had many specific symptoms, if any.

Q. Do you have an explanation as to why he would have some symptoms before then, be treated in the hospital, apparently improve clinically for a number of times and then worsen?

A. I can't really explain that, other than the fact that he had his bile, and it may have just been a phenomenon of the volume.

Q. Do you know how much bile was present in the abdomen at the time that the abdomen was drained by Dr. Saxbe on 9/22?

A. Sounds like 400 CCs in the one area, but you don't have a completion echo to let me know that he's drained everything. We just know there's a drain, 400 CCs are out; and over the next few days, we get down to about an ounce, and then the drain is discontinued.

Q. So would it be fair to say that you know there was at least 400 CCs of fluid, but you can't say if there was more bile there? You can't rule

out that there was bile there that was not drained?

A. I can't.

Q. It may have been; it may not have been?

A, That's true.

Q. Assuming there was only 400 CCs of fluid there at the time it was drained on 9/22, what does that tell you about the nature of the leak if it had occurred at the time of the surgery which took place on the 11th of September?

A. It's pretty much what I would expect from a typical cystic duct leak. We still have two clips on the duct, It's not a full blow-out, You just have enough where bile is coming out of a totally non-occluded cystic duct, so it's dripping, and that drip -- even though you've said you've got 1,500 to 2,000 CCs coming out of the main duct into the duodenum, there is an offshoot of maybe 10, 15 CCs a day.

Q. Cystic duct stump is sort of, I guess, off the beaten path? I mean, in other words, it's not in the direct line of the bile coming down the common duct?

A. That's correct.

Q. In order for there to be a significant leak from that cystic duct stump, would you need

some sort of back pressure in order to fill in a retrograde fashion?

A. No.

Q. Why not?

A. Because the normal physiology is that the gallbladder will fill from the common duct, so there is a flow mechanism normally going that way that's a non-valved system except for two valves near the gallbladder itself;

These valves sometimes are disrupted and they don't have any resistance to flow; and since this has now been clipped, there is no bile bag now to fill, it will just pour into the abdomen. It's not a pressurized system that has to have back flow.

Q. And that's a function of the sphincter of Oddi; in other words, the sphincter of Oddi is what creates the back flow?

A. Well, actually it's just a normal physiologic phenomenon. You have bile flowing all day long, and the common duct -- basically its periodic secretions by enzymes or other phenomenon will cause a greater expulsion and contraction, but there will be constant flow into the cystic duct.

Q. Do you know a Dr. Jeffrey Ponsky?

A. Yes, I know Jeff Ponsky very well.

Q. Do you recognize him to be a reasonably skilled and intelligent authority in the field of laparoscopic cholecystectomy and the use of **ERCP** to diagnose bile leaks?

A. I recognize him as an excellent physician that has -- where is he now; at the Cleveland Clinic?

Q. Right.

A. He's very well read. The thing we note him most for is the Ponsky G tube, but I know he's a decent surgeon and fairly well recognized in the field, but I can't tell you what he's done laparoscopically. I have not read much about him.

Q. Fair enough, Give me a sense in your practice right now what percentage of your practice is the performance of laparoscopic cholecystectomies?

A. About 30 percent.

Q. What makes up the remaining 70 percent?

A. Either cancer or non-cardiac thoracic, and then there's a small portion that's just a variety of general surgery.

Q. Last year -- I may have asked you this -- how many lap **choles** did you do roughly?

A. About 120 to 150.

Q. Was it been fairly standard since you've been doing them?

A. Actually when we first started, we were doing them every day almost, about 40 percent laparoscopic; and of that 40, 35 percent are lap choles, so I can't tell you, but it's been steady since,

Q. You started lap choles in probably 1989?

A. 1990.

Q. Have'you ever written or published on the subject of laparoscopic cholecystectomy complications?

A. I don't know if complications. I did a whole bunch of other things. Let's see. We did one that hasn't been published. They sent it back, they didn't want it, and that was on bile duct injuries during laparoscopic cholecystectomy, and I'd have to go through my files to find it.

Q. Let me see if I can find that on your CV then.

A. It's the second -- I think it's the second to last page.

Q. I've got No. 22, "Bile Duct Injuries During Laparoscopic Cholecystectomies."

A, Yes.

Q. It says in press,

A. We've sent it, it comes back, sent it, comes back. We're probably not going to do anything with it.

Q. You have somewhere a copy of that in a fife perhaps?

A. I'll have to find it. They're probably at home or in the attic,

Q. Go ahead and send it to the Plaintiffs' attorney, and I'll make the request of them.

A. I will.

Q. Thank you.

A. No problem.

Q. I notice on your CV there's a number of publications that are listed as being in press.

A. Right. We've submitted them. We're still waiting to get answers. Some have been sent for publication. Others have been presented at grand rounds, asked to be presented, but this is everything that we have as a list of stuff that we have accumulated and sent in for peer review.

Q. And then they decide, their peer review decides, whether or not it's worthy to be published?

A. Correct.

Q. Have you ever been a defendant in a

lawsuit that involved a complication from a lap chole?

A. Yes.

MS. GARSON: Objection. Go ahead.

Q. Tell me about that particular case in terms of what the alleged deviation from the standard of care was.

MS. GARSON: So that I don't have to continue to interrupt, I will show a continuing objection to this line of questioning.

Q. Go ahead.

A. A young girl had a lap chole. We converted to open, removed the gallbladder, She developed a bile leak a week later. We did an ERCP. It should be noted that the patient had a cholangiogram in her first operation which was read as perfectly normal, She had a reoperation by my partner for the bile leak. He had found two small canaliculi in the gallbladder which he thought were Luschka, ducts of Lusehka. Did a repeat cholangiogram. It was read as normal,

The patient stopped draining; started draining again about a month later, never saw us again, went to Ohio State. After three years and repeated ERCPs, they finally found that she had a

small segmental right hepatic that was going directly into the gallbladder that was not seen. It was coagulated over and they felt that that was substandard. They had Dr. Mousa from Florida being the expert. It was a Wolske & Blue case, and it was settled.

Q. I guess the obvious question is I take it you disagreed with Dr. Mousa?

A. Oh, yeah, so did Chris Ellison at The University who was our expert.

Q. Did you feel second-guessed by Dr. Msusa?

A. Absolutely.

Q. I'm just going to ask you some miscellaneous-type background questions.

A. Sure.

Q. I'm going to cross the Ts and dot the Is. You're licensed in Ohio. Any other states?

A. New York.

Q. Is that license still current?

A. It's what we call in hibernation, so to speak. I can reactivate it at any time.

Q. Have you ever been denied a license in any state?

A, No.

Q. Where do you have privileges besides

Park?

A. Mt. Carmel Medical System, Ohio Health System, and those hospitals include Grant, Riverside, St. Ann's, Mt. Carmel East, Mt. Carmel West and here.

Q. Are all those admitting privileges, or are some of those courtesy?

A. I have admitting privileges at all of them, even though I may be courtesy at two.

Q. Ever had privileges suspended, denied, curtailed in any way?

A. No.

Q. Ever voluntarily given up a license in any state?

A. No.

Q. Ever investigated by the State Medical Board of any state?

A. No.

Q. You're board certified in general surgery: is that true?

A. That's correct.

Q. Are you eligible in any other certifications?

A. No.

Q. Have you attempted any other

certifications?

A. No.

Q. Did you pass the boards on your first attempt?

A. Yes.

Q. Let's talk a little bit about your expert review work. How long have you been reviewing medical/legal matters?

A. Probably since either '88 or '89.

Q. Why did you start doing it?

A. My two partners, Drs. Cooperman and Schwarzell do a lot of malpractice work and asked me to review a certain amount of cases that they felt I was better qualified to look at than they were, and that's what started things.

Q. How is their practice different than yours? They're general surgeons, right?

A. They are, but basically I was the first one to do the laparoscopic. I was also the director of trauma here. I also did chest work, and my expertise ran a little bit more of these areas: and when they would get a case, they would ask me to take a look at it from those standpoints.

Q. Since you've been doing expert review work, give me a sense of the breakdown plaintiff

versus defendant. What percentage are for defense cases, what percentage are for plaintiffs' cases?

A. 75 to 80 percent are defense. I did a lot of work for the now defunct Jacobson, Maynard, Tuschman and then Kalur and now without Kalur and now without anybody, and then the remainder would be plaintiff work.

Q. Has that percentage altered in the areas -- in other words, when you first began, was it more for defense, and has it changed to be more plaintiff?

A. No, it has not.

Q. Have you reviewed any other cases for Donna Taylor-Kolis or her law firm?

A. I've done a total of three cases,

Q. For her?

A, For her,

Q. And give me a sense of the timing of those three cases,

A. 'It's been over about three years.

Q. You have one right now?

A. Correct.

Q. And then there were two other cases that were a year ago and two years ago?

A. Yes.

Q. Did those also involve laparoscopic procedures?

A. One did.

Q. Was it a lap chole?

A. Yes.

Q. What was the alleged negligence in that case?

MS. GARSON: Objection. If you can recall.

A. Basically it's a case from out of state in which the surgeon was being proctored and basically cut everything.

Q. And the third case was about what in general?

A. Perforated colon during colonoscopy.

Q. Let me just ask about the other two. The other two cases, did you find deviation from the standard of care?

A. Yes.

Q. Did you give testimony in those cases?

A. I've given testimony in one. The other one --

Q. Aside from this one?

A. Aside from this one.

Q. Okay.

A. And the other, basically it was just a review, and it's still on-going.

Q. Have you been advised that she has any additional cases for you to look at in the future?

A. No.

Q. Have you told her I don't want any more cases from you?.

A. No.

Q. What do you charge for a review of the records?

A. $250 an hour for general review, and then I believe we get into the depositions are 500, and I believe trial is 3,500 a day out of town, and video depositions are $1,500.

Q. So that's $500 an hour for deposition time, $3,500 for a whole day --

A. Right.

Q. -- on the trial video?

A. No, no. Trial personal appearance is 3,500; and if we do a video depo, it's 15.

Q. It's 15?

A. Hundred.

Q. Do you know how much time you spent thus far on this case?

A. Many hours. I can't give you the exact

amount.

Q. Do you keep any kind of listing?

A. I don't.

Q. You don't even have a wild guess as to how much? Well, is it more than ten?

A. Probably close to.

Q. Have you discussed this case with any other health care providers?

A. No.

Q. Do you belong to any referral services?

A. No, definitely not.

Q. Do you know anyone involved in this case?

A. No, I don't,

Q. You've never met or talked to the Plaintiff, Mr. Diamond?

A. No.

Q. What is post cholecystectomy syndrome?

A. Post cholecystectomy syndrome is kind of a mixed term. Years and years and years ago everyone thought that if you left a long cystic duct remnant, that there may be a stone left in it, and that's where it was coming from.

The thinking of maybe the last eight to ten years has been you've probably missed the diagnosis of peptic ulcer or gastritis, reflex

esophagitis or something else in the area, that the chances for this being part of a cystic duct sludge syndrome was non-existent.

Q. I didn't see a lot of correspondence in your file materials when I looked at them. There was the cover letter for the depositions?

A. Right.

Q. Did you receive any correspondence that came with the records when the case initially came to you?

A. No. I usually don't ask for anything other than just send the records after I've talked to any attorney over the phone,

Q. Can you get a copy of your report in front of you?

A. You'll probably have to give it to me. I don't have mine.

Q. Maybe we better get a copy.

- - -

(Deposition Exhibit B marked.)

- - -

Q. Doctor, I marked a copy of your report as Exhibit B. You've got a copy of it in front of you?

A. Yes.

Q. And that is a three-page piece of

correspondence addressed to Donna Taylor-Kolis, true?

A. Yes.

Q. As I interpret your report, it looks like the first two pages are essentially a summary of the facts of the case as you understand them to be based upon your review; is that true?

A. That's true.

Q. And then on page 3, it appears that you set forth your opinions regarding this case?

A. Yes.

Q. Let me ask you a couple of things about your report. Starting on page number 1, towards the bottom of the page, you were recounting some of the history here, You say, "The patient is readmitted on September 18th with a 16,000 white count and the sudden onset of severe generalized abdominal pain not accompanied by fever, nausea or vomiting." What is the significance of that in your mind clinically?

A. Clinically, really the fact that he's got a white count that's what I consider a leukocytosis of abnormal and he has a symptom that brought him to the emergency room, which was the onset of abdominal pain after a lap chole. What it is, that's why we need to work him up.

I don't know what would cause that, but my gut feeling after doing so many is I better make sure there isn't something going on with the biliary tree.

Q. The fact that it is of sudden onset and nut accompanied by fever, nausea or vomiting, any particular significance in your mind attached to that?

A. Not really.

Q. The next sentence says, "According to the admission note, his liver functions were apparently normal." Do you disagree with that?

A. No.

Q. Any significance on that?

A. Not really.

Q. And then it says on September 19th, the patient had an ultrasound performed -- I've got that out of order, but essentially which showed a small amount of ascites noted around the anterior aspect of the liver near the dome of the diaphragm, no significant anomalies seen in the liver, common bile duct does not appear enlarged. Just taking that amount of that sentence, what significance is that?

A. There's fluid, there's not an obstructed common duct, and this would make me believe that

since there's no dilated duct, I either have a leak which is responsible for the fluid -- and there may even be an injury to the duct and that's why we don't have a dilated common duct, but the fluid makes me very suspicious of a problem.

Q. By the way, did you actually review any films or any radiologic studies of any type?

A. No.

Q. The fact that the bile duct, the common bile duct, does not appear enlarged, is that reassuring in the sense that it indicates that there probably is not a stone obstructing the common bile duct?

A. No, If you look at a number of films in which the cystic duct is blown out, you're decompressing the common duct through the cystic duct stump, so you will not get an idea of whether you're obstructed or not. The patients that have had a stone impacted in the common duct after a cholecystectomy, usually that will be the etiology of a blow out of the stump.

Q. Can you see a stone within the common duct if it's these using a sonogram?

A. In the distal area, chances are with this overlying bowel gas, no.

Q. But in general, without those factors --

A. It's difficult, but you may be able to see a defect, but chances are you'll see just the dilated duct.

Q. Dropping down, still on page 2 now, about the middle of the page, we're recounting more the history, his JP, Jackson-Pratt drain, right --

A. Um-hmm.

Q. -- is producing less than an ounce per day and the fluid is clear serum and the collector and drain are removed, and then you go on to say unfortunately this was not the end of the problem. If it had been the end of the problem, there wouldn't be a case here, right?

A. That's correct.

Q. The patient is admitted on October 5th to Gainsville. You mentioned that he had 1,000 CCs of fluid drained down in Florida, and I didn't see that in your report. Is that something that you remember from your review of the records?

A. It's in the records, yes.

Q. Okay. That's what I'm asking --

A. Yeah,

Q. -- is you remember that?

A. Right.

Q. Do you have an opinion as to what an ERCP would have shown had it been performed by Dr. Saxbe on the 22nd of September or earlier, sometime during that admission?

A. Most likely, it would have shown a perfectly intact common duct, non-dilated intra-hepatic ducts and small but persistent leak at his cystic duct stump.

Q. The chance remains that it would not have shown that, true?

A. No.

Q. Well, there's no guarantee that it would have shown that leak: is it fair to say that?

A, No, not really. If this guy came in with fluid in his abdomen and that kind of pain, it is more likely than not that there was a leak present at that time, and the ERCP would have been absolutely pathognomonic for the diagnosis and source of the leak.

Q. So I'm clear, basically you're indicating that there would not have been fluid present in his abdomen just from the surgery?

A. That's correct.

Q. That it would have been present from a leaking cystic duct stump or from some other --

A. Correct.

Q. All right, I take it you feel that the reason the SP drain was only draining about an ounce a day of clear fluid is that it was not in the right place?

A. I think what it did is it probably drained a collection but from suction closed itself off from another area of the abdomen, which was the new collection basin for this continued leak.

Q. And I think I understand this. Let me restate it to make sure that I do. The initial. collection of bile was successfully drained more likely than not?

A. Correct.

Q. However, once that area was drained, the drains were closed off by virtue of the fact that the tissue closed down in that area?

A. Correct.

Q. And bile accumulated in a different place?

A. That's right.

Q. Why did the bile all of a sudden accumulate in a different place?

A. You have a patient that's had surgery. There are scarrings. There are adhesions. There

are things that will close off. The first collection of bile that is up on the anterior surface towards the diaphragm, which is a very dependent portion, this is where Dr. Saxbe by his estimate puts the drain, and he doesn't know if that connected to this undersurface or was closed off by adhesions; and, therefore, it was not amenable to further drainage once the Jackson-Pratt established its closed suction.

Q. Is it fair to say that there's a certain degree of speculation involved in that? We don't have any hard data?

A. That's correct.

Q. On page 3 at the top of the page, "The fact that there is fluid underneath the liver in any laparoscopic case must be taken for bile"?

A. That's correct.

Q. Okay. And then you say, "'Therefore, simple drainage of the situation is often inadequate," but begs the question there are occasions when it is adequate?

A, If it has been determined that there is no further leak, let's say this was something that happened over a weak and we do an ERCP or some other investigatory exam that shows, yes, I have fluid,

but I have looked at the common duct, I find there is no evidence of leak, at this time external drainage is probably adequate; but if there is an ongoing leak, all I'm doing is creating now a path of least resistance tu continue that leak; therefore, I need to either extend the biliary drain or close the cystic duct in order for now to divert the bile stream in its natural path down into the duodenum.

Q. A hypothetical situation: Assuming you have a case where it is merely a leak from the cystic duct stump, in that situation, that can on occasion be successfully treated with drainage?

A. If I have established that's what it is.

Q. Right.

A. There are situations in which the first attempt would be closed drainage, but you need to follow this, I have to establish the diagnosis, and ultrasound is not sufficient to diagnose this.

Q. The fact that there was a bile leak is not a deviation from the standard of care in this particular case?

A. A cystic duct leak is a recognized complication.

Q. So in terms of the need for a second or

an additional hospitalization, the discomfort that the patient had as a result of the original complication, that's just unfortunate luck, it's not due to a deviation from the standard of care?

A. The initial reason for the hospitalization I go along with.

Q. Right.

A. But where I'm critical. is what's happened during that hospitalization.

Q. And that's my second question. I want to try to get a sense from you when it is in that second hospitalization that you think the ERCP should have been done.

A. Well, basically when he came in and he has these non-specific symptoms. It's not unusual to watch for 24 hours. Once his symptoms get worse and we have some pertubation in his liver functions, at that time the sonogram shows fluid, that's when the definition of his biliary tree needs to be done in order to maintain continuity of his biliary tract, in other words, make sure there's no injury to the common duct and define where the bile is coming from.

I assume -- and most of us that do laparoscopic surgery -- that fluid seven days after

these procedures is bile until proven otherwise, and that's why there is a necessity to do some imaging, whether hepatobiliary nuclear medicine or ERCP, and most of us would refer an ERCP.

Q. So if I understand you, sometime -- giving him the benefit of doubt, sometime on what, the 20th --

A. Well, the 19th I believe is when he has his first problems; in other words, he's got an ileus, his liver functions are up. That's the frame, 19th through 20th, he needed to have some form of imaging.

Q. I think he got the sonogram on the 19th, so giving him the benefit of the doubt --

A. The 20th.

Q. You would agree with me that even if on the 20th an ERCP had been performed, there would be no guarantee to Mr. Diamond that he would not potentially have to face any complications down the road from the ERCP?

A. The ERCP is not innocuous, I will guarantee that; and is there a risk for a complication, yes.

Q. We talked about deviations on the part of Dr. Saxbe. And, as I understand your criticism, it

is a failure to image particularly by ERCP the biliary tree on basically September 20th, fair?

A. Fair. That's one.

Q. And that's my next question. Is there anything else?

A. Well, taking him to surgery with general anesthetic to drain this area when it would have been my opinion the standard of care to have operated on him since he had made the decision to take him to the operating room, would have been to explore, drain, visualize the leak and take care of it at that time. Failure to do so I believe was substandard.

Q. Let me break that down a little bit and try to get through it quickly.

A. No problem.

Q. When it gets to the aspect of placing drainage, tubes, in and of itself the use of general anesthesia in that particular situation is not below the standard of care, is that fair, particularly if the patient is anxious and doesn't really want to be awake for that?

A. I understand that.

Q. Fair?

A. The use of general anesthesia to place

the drain is probably not substandard.

Q. Your idea is that if you're going to go through the trouble to do that surgery, why not go ahead and explore the area and sew up whatever it is you need to sew up, fair?

A. Correct.

Q. Now, are there certain risks to exploring that area which has been recently operated on?

A. In a week? No.

Q. Why not?

A. Basically it's fresh. There should be very little in the way of adhesions. The bile is a wonderful dissector and you've got two clips on your cystic duct. It should be fairly easy to find. Hemorrhage in this area -- there aren't significant adhesions, it's a laparoscopic procedure, which was done initially, so there is minimal trauma to the area. This is something that is done frequently, done fairly easily with a very small risk. If we were a month down the road, whole different story.

Q. This varies from procedure to procedure, I would imagine. Some lap choles are easier than others?

A. But the lap **chole** itself being difficult is one thing; but when you go back in those areas a

week to ten days later, they're fairly virgin; and if you've had bile leaking which has made a plain between any adhering surfaces -- bile is very slippery. The amount of adhesions is very minimal unless there is a tremendous amount of bile peritonitis. That's different. It becomes very tenacious, but there's no evidence of bile peritonitis. There's no exudative material seen in any of the drainage,

Q. Do you have any problems with the care he received by any of the health care providers involved in this case?

A. No.

Q. So at least one ERCP would have been indicated by virtue of his original complication, true?

A. True.

Q. Do you have any other opinions regarding deviations from the standard of care as it relates to Dr. Saxbe?

A. I don't think so.

Q. You say I don't think so?

A. I just read that, I don't think I have anything more other than those two --

Q. Right.

A* -- that we talked about.

Q. That's fair enough. And the only reason I say this -- and I follow up in depositions the same way with everybody, The most important thing to me, and please understand, is that I get a sense before trial of what your criticisms are, and you understand that?

A. Yes.

Q. And, as I said at the beginning, I'm here to find out those things to help me prepare for trial, you understand?

A. Correct.

Q. If between now and the time of trial you arrive at any additional opinions, if the opinions that you have given me are changed or modified, if you develop new bases for those opinions, will you agree to let the Plaintiffs' attorney know so that she can take the appropriate steps under the rules to alert me so I'm not surprised at trial?

A. Absolutely.

Q. Let me look at my notes. We're basically done.

(Pause in proceedings.)

Q. Give me an idea of the teaching that you do at the current time. What is that, if any?

A. Basically the teaching that I do do, number one is wound care with hyperbaric oxygen to other physicians. I do EMS training. I do family practice training, in other words, taking family practitioners and showing them surgical problems, what they should be referring, what they shouldn't, and occasionally I trouble shoot lap choles and other laparoscopic procedures with other doctors in the area who are having trouble.

Q. Currently are you involved in teaching residents or fellows?

A. No.

Q. Have you ever had that kind of responsibility?

A. Years ago we did. We had the Meharry Medical College from Tennessee up here. We rotated surgical residents through.

Q. Did they drop their surgical program?

A. Yes, they did.

Q. That's what I thought.

Do you have any teaching appointments or academic affiliations with Ohio State University?

A. No, thank goodness.

Q. Are there any authoritative textbooks or journal articles you can point to or point me to to

help me better understand this case and better understand your position in this case?

A. Well, I don't look at medical literature as authoritative. I look at it as guidance, and one of the better texts is Charlie Zucker, Advanced Laparoscopy, and there are some journals, Surgical Clinics of North America have one or two volumes on laparoscopic complications.

Q. When you did your laparoscopic training, and I guess in particular your lap chole training, was there a particular physician or number of physicians whom you went to to learn the procedure? There's a number of names, and I just wondered --

A. Well, I went to Eddie Joe Reddick in Georgia in 1989, and then there were two gentlemen, I think it's Bill Saye, S-a-y-e, he's a gynecologist. These two gentlemen I watched and did some things with, and then came back and did animal labs, went through our investigation review board and started doing the lap choles before anyone in the city; and then after that everyone made their own courses up and did things, and I didn't do that. I basically trouble shot for U.S. Surgical.

Q. You talked about Dr. Reddick.

A. Reddick.

Q. I believe that's the physician that Dr. Saxbe went to. Was that your understanding from reading Saxbe's --

A. I think so.

Q. And the training that you did, you did some animal training, was that doing the procedure on swine, for example?

A. Well, basically that's what he did.

Q Did you do that as well as a part of your training?

A. No.

Q. What animal training did you do?

A. Well, basically what I was doing were dogs and the models that we did -- at this point Eddie Joe didn't have a course. I went down and worked with him, and then came back and actually made a black box for myself, used bovine livers which we'd suspended in a dark box and recreated the laparoscopic atmosphere. We're talking before anybody knew what else ehey were doing. And we got away from the laser, never used the laser, made my own electrocautery units.

So we really pioneered this, and it blew up in 1990 with everybody giving courses on street corners, and I had to go through the investigational

review board here with a complete experimental guide for 25, 30 cases with review and have a gynecologist present for the first 20 to make sure everything was right.

Q. I take it the first laparoscopic procedures that you did were not lap choles?

A. The first ones I did were lap choles, as a matter of fact.

Q. Just to help me understand that, really you learned the procedure in order to do cholecystectomies laparoscopically?

A. Yes.

Q. As I understand it, we've talked about your criticisms. It is also your position that had the treatment been as you suggested it should have been, Mr. Diamond would have been able to avoid his hospitalization in Florida?

A. Yes.

Q. Assuming -- and I don't know this to be true. I'm asking a hypothetical question. Assuming Mr. Diamond developed significant abdominal pain, significant to the degree that he thought that he was going to die and he waited for personal reasons, you know, 12 hours a day or longer to seek medical attention, that would be his responsibility, fair?

A. Fair.

MR. HERBERT: Doctor, you've got the right to read this after it's written up, and feel free to do that. You can make changes.

THE WITNESS: I'd like to.

MR. HERBERT: No other questions.

- - -

Thereupon, the testimony of February 25, 1998, was concluded at 2:40 p.m.

- - -

STATE OF OHIO:

SS:

COUNTY OF FRANKLIN:

I, RICHARD E. SCHLANGER, M.D., do hereby certify that I have read the foregoing transcript of my deposition given on February 25, 1997; that together with the correction page attached hereto noting changes in form or substance, if any, it is true and correct.

_____

RICHARD E. SCHLANGER, M.D.

I do hereby certify that the foregoing transcript of RICHARD E. SCHLANGER, M.D., was submitted for reading and signing; that after it was stated to the undersigned notary public that the deponent read and examined the deposition, the deponent signed the same in my presence on the _____ day of _____, 1998.

_____

NOTARY PUBLIC-STATE OF OHIO

My commission expires: _____

CERTIFICATE

STATE OF OHIO :
SS:
COUNTY OF FRANKLIN :

I, Carol A. Kirk, RMR, a notary public in and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named RICHARD E. SCHLANGER, M.D., was first duly sworn to testify to the truth, the whole truth, and nothing but the truth in the cause aforesaid; that the testimony then given was reduced to stenotypy in the presence of said witness, afterwards transcribed; that the foregoing is a true and correct transcript of the testimony; that this deposition was taken at the time and place in the foregoing caption specified.

I do further certify that I am not a relative, employee or attorney of any of the parties hereto, and further that I am not a relative or employee of any attorney or counsel employed by the parties hereto or financially interested in the action.

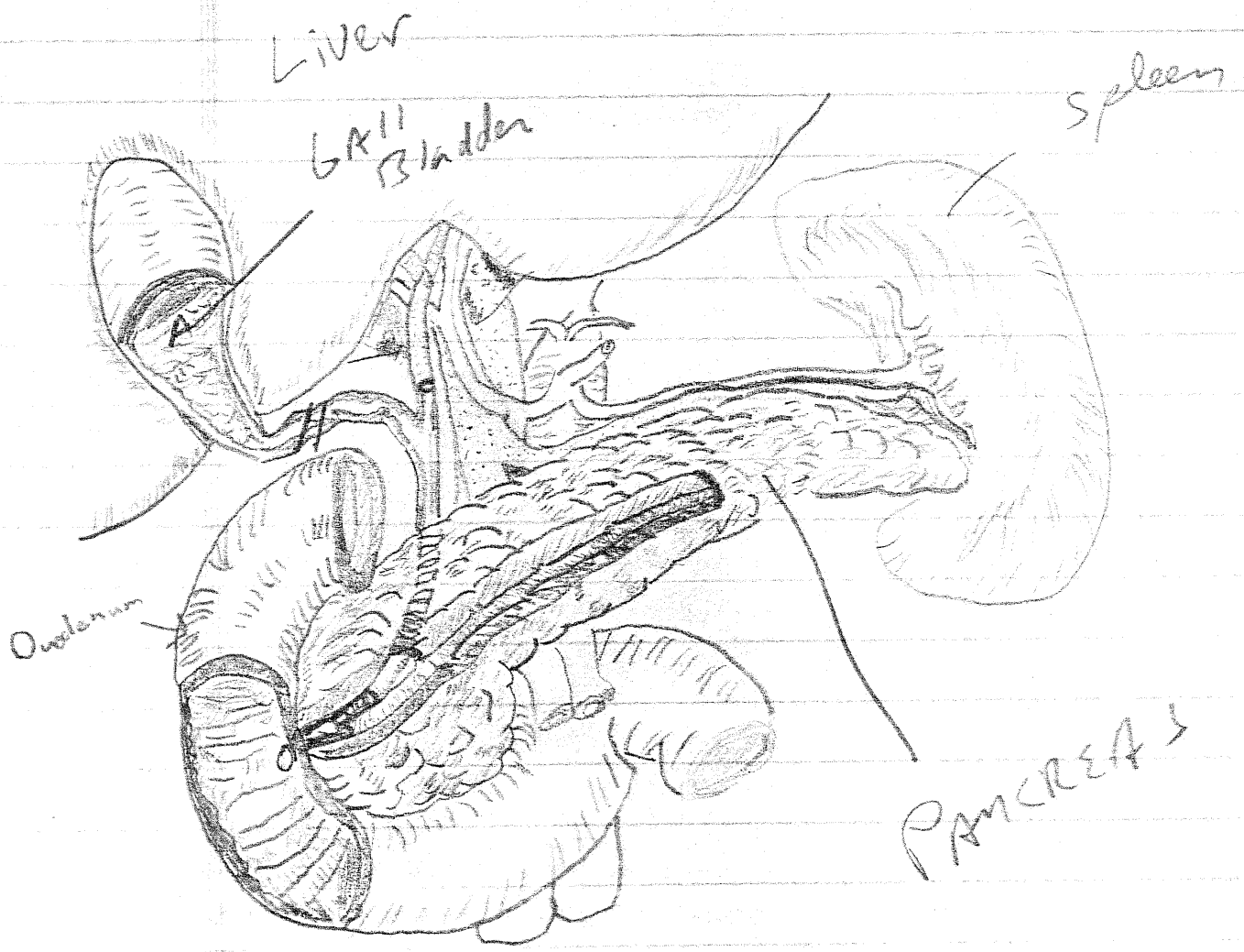
In witness whereof, I have hereunto set my hand and affixed my seal of office at Columbus, Ohio, on this 31st day of March, 1998.

Carol A. Kirk

Carol A. Kirk, RMR
Notary public, State of Ohio.

My commission expires: March 14, 2002

Gut transplant of Rat Embryo



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September 5, 1996

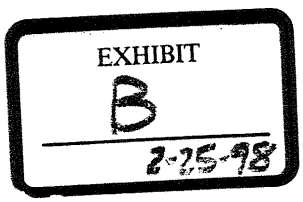
Donna Taylor-Colis, Co., L.P.A.
Attorney at Law
1015 Euclid Avenue, Third Floor
Cleveland, OH *44115*

RE: Glen T. Diamond

Dear Ms. Colis:

I had the opportunity to review the above captioned case, and feel that the summary to my best recollection is as follows.

Mr. Diamond had an ultrasound of his gallbladder on June 13, 1995 which showed a 7mm. stone in the gallbladder. The walls of the gallbladder were normal as was the common bile duct and intra-hepatic radical, It was determined that his pain was consistent with gallbladder disease and it was recommended by his surgeon, W.B. Saxbe, M.D., that he undergo a cholecystectomy. A laparoscopic cholecystectomy was considered and in the progress notes on September 11, 1995 there is a letter from Dr. Saxbe stating that the patient has had the procedure explained and pertinent risks have been appeared to be indicated and have been accepted by the patient. He underwent a laparoscopic cholecystectomy on September 11, 1995 as well as the excision of a ganglion from the right hand and the injection of the left gracilis tendon all under general anesthesia and he was sent home the following day. It should be noted that no laboratory data was obtained post-operatively. The operation itself shows that adhesions and the peritoneum around the cystic artery and cystic duct were taken. down. The cystic duct and cystic artery were doubly clipped and divided. The gallbladder was taken out and there seem to be no undue complications during the case. The patient is re-admitted on September 18 with a 16,000 white count and the sudden onset of severe generalized abdominal pain not accompanied by fever, nausea, or vomiting. According to the admission note his liver functions were apparently normal. The patient underwent several days of bowel clean out due to the acute abdominal series showing in effect significant stool within tne colon. The patient had an ultrasound performed on September 19 which showed a small amount of ascites is noted



around the anterior aspect of the liver near the dome of the diaphragm, no significant anomalies seen in the liver, common bile duct does not appear enlarged and dilated colon of small bowel loops consistent with an ileus. The patient progressively had the pain was no better, white count remained elevated, The patient ileus on September 20 was somewhat worse and had to have an NG placed. His bilirubin on September 21 had risen to 2.4 and the physician, Dr. Saxbe, felt that this was absorption of the peritoneal cavity of the bile leak from his recent laparoscopic cholecystectomy. At that point he had decided to go in and drain the bile leak and the operative note said that he made an incision in the right subcostal area and placed a Jackson-Pratt drain in the bile collection. The patient was discharged. The office note from September 29 says three days after discharge from the hospital, after draining the right peri-hepatic space of bile following his iaparoscopic cholecystectomy, the patient feels well. His JP is producing less than an ounce per day and the fluid is clear serum. The collector and drain are removed. Unfortunately, this was not the end of hi5 problem. The patient on October 5 was admitted in Gainesville Florida to the North Florida Regional Medical Center with abdominal pain. At this point in time his bilirubin was 1.3, alkaline phosphatase was 426. Other liver functions test were slightly remarkable as well as a white count of 13,500. The provisional diagnosis by Diane Walker, M.D. was abdominal pain with probably biliary leak from previous cholecystectomy site. The patient was admitted to Dr. Braver, Over the next few days the patient went through several procedures including on October 6 drainage of bile from the abdominal cavity. This was done under x-ray guidance and the biloma was drained. The catheter by Dr. J.J. Stork, M.D. was placed as close to the cystic duct as possible. Over the next few days the patient had another CAT scan done on October 12, 1995. There was increase fluid around the left lobe of the liver, the caudate lobe and a little bit around the tip of the right lobe, Therefore, the patient underwent an ERCP and was stented. The ERCP showed the contrast filling the cystic duct and filling the biliary tree of the liver, It also shows a long cystic duct remnant with a leak, The patient on October 17 underwent a re-evaluation of his biliary tract using the nasogastric tube that had been placed at the same time as the stent. There is no persistent leak from the cystic duct stump, free flow into the CBD and duodenum which basically means that the patient had complete resolution of his problem. My criticisms of Dr. Saxbe are the following.

The patient underwent a laparoscopic cholecystectomy and came back several days later with a biie leak. The fact that there is fluid underneath the liver in any laparoscopic case must be taken for bile. Therefore, simple drainage of the situation is often inadequate. The problem with this case is if Dr. Saxbe bothered to take the patient for a general anesthesia, the patient should have been fully explored. Therefore, the patient would have been opened, the right upper quadrant observed, the leak would have been identified once the cystic duct was found, The area could have been re-ligated, copiously irrigated, and appropriate drain placed which would have avoided the third and fourth procedures which took place in Florida, that being the CT or radiologically guided drainage of the biloma followed by the stenting by ERCP. Dr. Saxbe fell below the standard of care in not dealing appropriately with the leak, failing to establish the location of the leak. I can not assume that this was a cystic duct leak. This could have been a leak from the main bile duct, the bile duct could have been clipped, an accessory duct could have been in play, one of the hepatic radicals could have also been injured. Therefore, without the road map by ERCP there was no way to adequately treat this patient.

If you have any further questions, please do not hesitate to contact my office.

Sincerely,

Richard E. Schlanger, M.D., Ph.D., F.A.C.S.
Director, Laparoscopic Surgical Services
Director, Surgical Oncology
The Oncology Center at Park Medical Center

RES/slc

STATE OF OHIO:

SS:

COUNTY OF FRANKLIN:

I, RICHARD E. SCHLANGER, M.D., do hereby certify that I have read the foregoing transcript of my deposition given on February 25, 1997; that together with the correction page attached hereto noting changes in form or substance, if any, it is true and correct.

RICHARD E. SCHLANGER, M.D.

I do hereby certify that the foregoing transcript of RICHARD E. **SCHLANGER,** M.D., was submitted for reading and signing; that after it was stated to the undersigned notary public that the deponent read and examined the deposition, the deponent signed the same in my presence on the 11 day of March, 1998.

Linda L Castle

NOTARY PUBLIC-STATE OF OHIO

My commission expires: 9-26-98

LINDA L. CASTLE
NOTARY PUBLIC, STATE OF OHIO
MY COMMISSION EXPIRES SEPT. 26, 1998