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KIM E. SNYDER
REGISTERED PROFESSIONAL REPORTER
2264 CLAIRBORNE DRIVE
POWELL, OHIO 43065
(614) 888-7812

1 **APPEARANCES:**

2 **By Ms. Ann Garson, Attorney at Law**
3 **Donna Taylor- Kolis Co., LPA**
4 **1015 Euclid Avenue**
 Cleveland, OH 44115
 (216) 861-4300,

5 **on behalf of the Plaintiffs.**

6 **By Mr. Joseph E. Herbert, Attorney at Law**
7 **Roetzel & Andress**
8 **75 East Market Street**
 Akron, OH 44308
 (330) 376-2700,

9 **on behalf of the Defendants.**

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1 FEBRUARY 25, 1998

2 WEDNESDAY AFTERNOON SESSION

3 1:10 P.M.

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5 STIPULATIONS

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

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P R O C E E D I N G S

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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?

1 a. Yes, this is pretty much up to date. I'd
2 have to look at it really, really closely. The one
3 that you have is the right one. The one that I
4 have, there was a typo on the address of my office
5 by my former secretary listed as 1942 instead of
6 1492, but that would be the only difference.

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

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

11 Q. Which ones are those?

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

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

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

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

22 A. And not --

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

1 opportunities?

2 A. Correct.

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

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

12 A. Yes.

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

16 A. Yes.

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

20 A. Yes.

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

23 A, Yes.

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

1 this case today?

2 A. Yes.

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

5 A. Yes, **I think I do.**

6 Q. Give **me** your understanding of the
7 difference.

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

12 Q. More likely than not?

13 A. Exactly.

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

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

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

23 A. That's correct.

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

1 A. I use the concept of medical judgment.

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

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

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

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

14 A. Yes.

15 Q. Practicing physicians, that is?

16 A. Yes.

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

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

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

4 - - -

5 (Deposition Exhibit A marked.)

6 - - -

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

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

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

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

20 Q. Please do.

21 (Pause in proceedings.)

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

1 A. That's correct.

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

4 A. Okay.

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

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

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

17 A. Yes.

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

21 A. No, that's very correct.

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

25 A. Yes.

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

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

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

10 A. A bile leak is a bile leak.

11 Q. Right.

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

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

24 A. That's correct.

25 Q. And sometimes these ducts can be

1 extremely small?

2 A. Yes.

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

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

9 Q. They would have very small leaks?

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

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

16 A. Most of the time, correct.

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

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

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

1 A. That's a fair statement.

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

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

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

12 A. Some, yes.

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

18 A. No.

19 Q. Are you aware that has occurred?

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

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

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

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

7 A. In a first trial, yes.

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

11 A. Yes.

12 Q. How many times?

13 A. Somewhere between 100 and 150.

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

18 A. No.

19 Q. No?

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

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

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

3 A. Not always.

4 Q. Is it frequently seen?

5 A. No.

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

8 A. Less than 5 percent.

9 (Pause in proceedings.)

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

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

15 Q. How about 1995?

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

18 Q. How about 1993?

19 A. Maybe 3 to 4.

20 Q. How about 1990?

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

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

1 A. Yes.

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

7 A. Yes.

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

11 A. That's correct.

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

14 A. Yes.

15 Q. Do you perform ERCP yourself?

16 A. No, I do not.

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

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

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

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

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

9 A. Pancreatitis.

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

12 A. Yes, it can.

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

16 A. Yes, it can.

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

19 A. Yes.

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

23 A. That's true.

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

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

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

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

10 A. Yes.

11 Q. To make that investment of time?

12 A. Yes.

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

16 A. Yes.

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

20 A. No.

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

23 A. No.

24 Q. -- and have followed it with drainage?

25 A. No.

1 Q. Why not?

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

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

16 A. I can't pull anything out right at this
17 second, but I know the standard of care in this
18 community -- and we have been doing lap choles since
19 1989 -- has been any patient that has any question
20 of a blip in bilirubin gets a hepatobiliary scan;
21 and if that's inconclusive, they do a ERCP, no
22 questions asked.

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

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

1 Q. I'm sorry. HIDA scan?

2 A. That's correct.

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

6 A. That's correct.

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

9 A. Leak.

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

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

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

21 A. That's correct.

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

I A. That's correct.

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

11 A. Prior to surgery, correct.

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

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

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

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

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

25 A. Informed consent has never been an issue.

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

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

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

13 A. Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

25 A. That's correct.

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

3 A. No such thing as an intermittent leak,

4 Q. Why do you say that?

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

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

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

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

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

2 Q. Is that **possible**?

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

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

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

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

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

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

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

7 A. Demerol.

8 Q. Okay. Anything else?

9 A. Not really. Passage of a stone.

10 Q. Anything else?

11 A. Not really.

12 Q. Can alcohol cause that?

13 A. I haven't heard of that,

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

16 A. Not yet.

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

19 A. No.

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

24 A. That's correct.

25 Q. Has anything been removed or discarded

1 from that file?

2 A. Not that I know of.

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

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

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

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

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

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

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

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

25 Q. Not a problem. Would you agree with me

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

4 A. I would agree with that statement.

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

8 A. Yes.

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

12 A. Correct.

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

17 A. That's happened very infrequently.

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

22 A. It's possible.

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

1 A. Yes.

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

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

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

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

20 Q. Understood.

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

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

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

5 A, It depends,

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

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

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

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

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

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

18 Q. I know.

19 A* -- is the fact that you can never assume
20 the size of the leak until you've actually diagnosed
21 it, because there are common duct leaks that are
22 small. knicks, small areas of necrosis that will act
23 very much like a cystic duct **leak**. There may be an
24 evolution of the cystic duct that's leaking in this
25

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

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

8 A. That's true.

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

12 A. That's true.

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

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

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

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

1 make it irritated.

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

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

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

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

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

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

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

1 out that there was bile there that was not drained?

2 A. I can't.

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

4 A, That's true.

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

10 A. It's pretty much what I would expect from
11 a typical cystic duct leak. We still have two clips
12 on the duct, It's not a full blow-out, You just
13 have enough where bile is coming out of a totally
14 non-occluded cystic duct, so it's dripping, and that
15 drip -- even though you've said you've got 1,500 to
16 2,000 CCs coming out of the main duct into the
17 duodenum, there is an offshoot of maybe 10, 15 CCs a
18 day.

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

23 A. That's correct.

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

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

3 A. No.

4 Q. Why not?

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

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

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

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

24 Q. Do you know a Dr. Jeffrey Ponsky?

25 A. Yes, I know Jeff Ponsky very well.

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

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

8 Q. Right.

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

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

18 A. About 30 percent.

19 Q. What makes up the remaining 70 percent?

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

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

25 A. About 120 to 150.

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

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

8 Q. You started lap choles in probably 1989?

9 A. 1990.

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

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

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

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

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

25 A, Yes.

1 Q. It says in press,

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

5 Q. You have somewhere a copy of that in a
6 **file** perhaps?

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

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

11 A. I will.

12 Q. Thank you.

13 A. No problem.

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

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

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

24 A. Correct.

25 Q. Have you ever been a defendant in a

1 lawsuit that involved a complication from a lap
2 chole?

3 A. Yes.

4 MS. GARSON: Objection. Go ahead.

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

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

12 Q. Go ahead.

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

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

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

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

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

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

12 A. Absolutely.

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

15 A. Sure.

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

18 A. New York.

19 Q. Is that license still current?

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

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

24 A, No.

25 Q. Where do you have privileges besides

1 Park?

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

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

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

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

12 A. No.

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

15 A. No.

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

18 A. No.

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

21 A. That's correct.

22 Q. Are you eligible in any other
23 certifications?

24 A. **No.**

25 Q. Have you attempted any other

1 certifications?

2 A. No.

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

5 A. Yes.

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

9 A. Probably since either '88 or '89.

10 Q. Why did you start doing it?

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

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

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

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

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

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

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

12 A. No, it has not.

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

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

16 Q. For her?

17 A, For her,

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

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

21 Q. You have one right now?

22 A. Correct.

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

25 A. Yes.

1 Q. Did those also involve laparoscopic
2 procedures?

3 A. One did.

4 Q. Was it a lap **chole**?

5 A. Yes.

6 Q. What was the alleged negligence in that
7 case?

8 MS. GARSON: Objection. If you can
9 recall.

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

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

15 A. Perforated colon during colonoscopy.

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

19 A. Yes.

20 Q. Did you give testimony in those cases?

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

23 Q. Aside from this one?

24 A. Aside from **this** one.

25 Q. Okay.

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

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

5 A. No.

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

8 A. No.

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

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

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

17 A. Right.

18 Q. -- on the trial video?

19 A. No, no. Trial personal appearance is
20 3,500; and if we do a video depo, it's 15.

21 Q. It's 15?

22 A. Hundred.

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

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

1 amount.

2 Q. Do you keep any kind of listing?

3 A. I don't.

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

6 A. Probably close to.

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

9 A. No.

10 Q. Do you belong to any referral services?

11 A. No, definitely not.

12 Q. Do you know anyone involved in this case?

13 A. No, I don't,

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

16 A. No.

17 Q. What is post cholecystectomy syndrome?

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

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

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

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

7 A. Right.

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

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

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

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

18 Q. Maybe we better get a copy.

19 - - -

20 (Deposition Exhibit B marked.)

21 - - -

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

24 A. Yes.

25 Q. And that is a three-page piece of

1 correspondence addressed to Donna Taylor-Kolis,
2 true?

3 A. Yes.

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

8 A. That's true.

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

11 A. Yes.

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

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

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

5 Q. The fact that it is of sudden onset and
6 not accompanied by fever, **nausea** or vomiting, **any**
7 particular significance in your mind attached to
8 that?

9 A. Not really.

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

13 A. No.

14 Q. Any significance on that?

15 A. Not really.

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

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

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

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

8 A. No.

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

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

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

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

1 Q. But in general, without those factors --

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

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

8 A. Um-hmm.

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

15 A. That's correct.

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

21 A. It's in the records, yes.

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

23 A. Yeah,

24 Q. -- is you remember that?

25 A. Right.

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

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

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

11 A. No.

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

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

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

23 A. That's correct.

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

1 A. Correct.

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

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

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

14 A. Correct.

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

18 A. Correct.

19 Q. And bile accumulated in a different
20 place?

21 A. That's right.

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

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

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

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

13 **A.** That's correct.

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

17 **A.** That's correct.

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

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

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

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

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

15 Q. Right.

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

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

23 A. A cystic duct leak is a recognized
24 complication.

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

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

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

7 Q. Right.

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

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

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

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

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

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

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

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

15 A. The 20th.

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

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

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

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

3 A. Fair. That's one.

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

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

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

16 A. No problem.

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

23 A. I understand that.

24 Q. Fair?

25 A. The use of general anesthesia to place

1 the drain is probably not substandard.

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

6 A. Correct.

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

9 A. In a week? No.

10 Q. Why not?

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

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

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

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

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

13 A. No.

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

17 A. True.

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

21 A. I don't think so.

22 Q. You say I don't think so?

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

25 Q. Right.

1 A* -- that we talked about.

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

8 A. Yes.

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

12 A. Correct.

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

20 A. Absolutely.

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

23 (Pause in proceedings.)

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

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

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

12 A. No.

13 Q. Have you ever had that kind of
14 responsibility?

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

18 Q. Did they drop their surgical program?

19 A. Yes, they did.

20 Q. That's what I thought.

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

23 A. No, thank goodness.

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

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

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

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

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

24 Q. You talked about Dr. Reddick.

25 A. Reddick.

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

4 A. I think so.

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

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

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

11 A. No.

12 Q. What animal training did you do?

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

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

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

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

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

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

12 A. Yes.

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

18 A. Yes.

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

1 A. Fair.

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

5 THE WITNESS: I'd like to.

6 MR. HERBERT: No other questions.

7 - - -

8 Thereupon, the testimony of February 25,
9 1998, was concluded at 2:40 p.m.

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1 STATE OF OHIO:

SS:

2 COUNTY OF FRANKLIN:

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

9 _____
10 RICHARD E. SCHLANGER, M.D.

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

18 _____
19 NOTARY PUBLIC-STATE OF OHIO

20 My commission expires: _____
21
22
23
24
25

1 CERTIFICATE

2 STATE OF OHIO :
3 COUNTY OF FRANKLIN : SS:

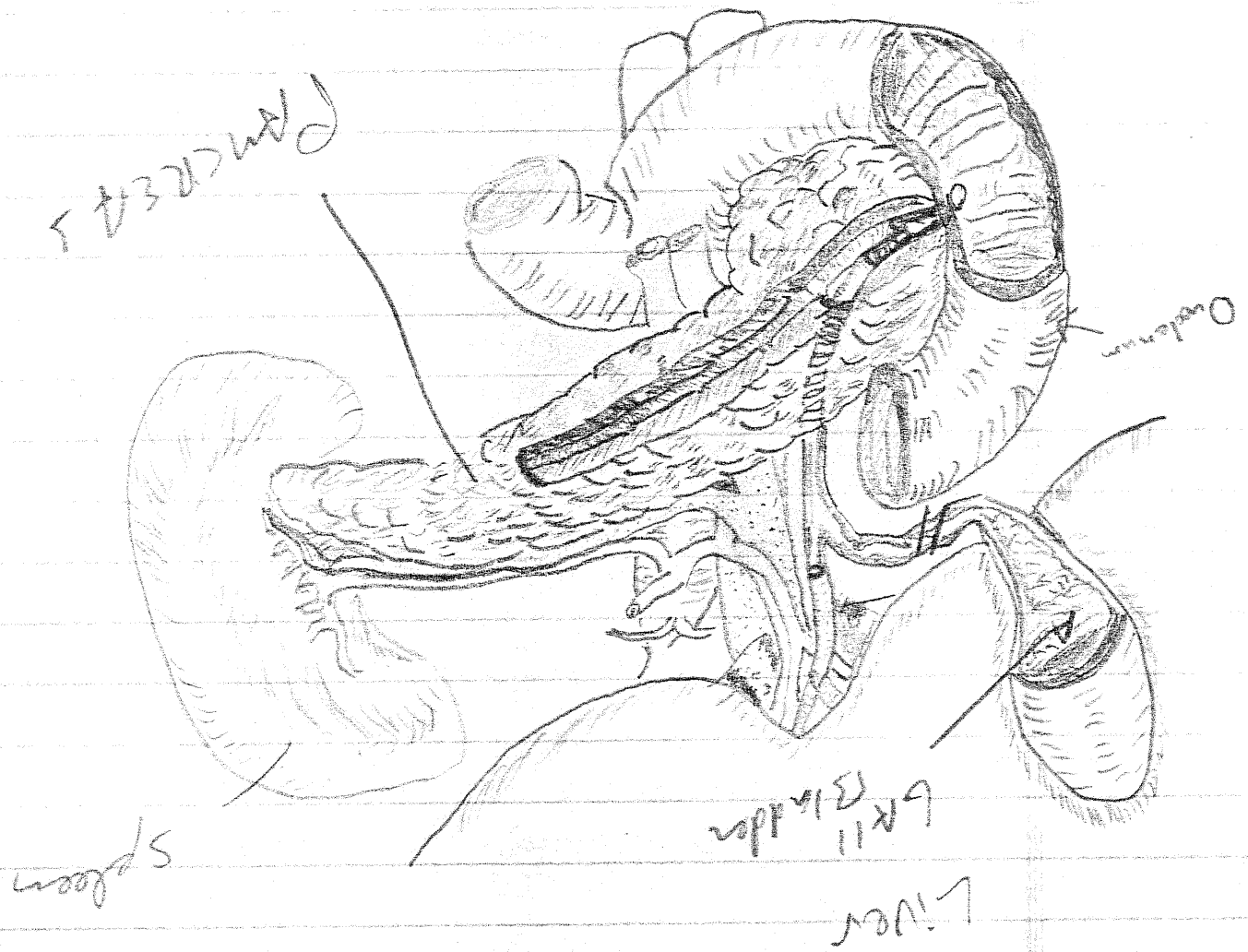
4 I, Carol A. Kirk, RMR, a notary public in
5 and for the State of Ohio, duly commissioned and
6 qualified, do hereby certify that the within-named
7 RICHARD E. SCHLANGER, M.D., was first duly sworn to
8 testify to the truth, the whole truth, and nothing
9 but the truth in the cause aforesaid; that the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

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

22 In witness whereof, I have hereunto set
23 my hand and affixed my seal of office at Columbus,
24 Ohio, on this 5th day of March, 1998.

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

My commission **expires:** March 14, 2002



Cheng-Hong Wang

Surgical Associates of Columbus

MARC COOPERMAN, M.D.
JOHN R. SCHWARZELL, M.D.
RICHARD E. SCHLANGER, M.D. PhD

1492 EAST BROAD STREET
COLUMBUS, OHIO 43205
(614) 253-0060
FAX: (614) 253-4322

September 5, 1996

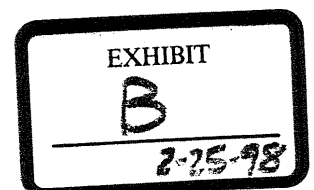
Donna Taylor-Colis, Co., L.P.A.
Attorney at Law
1015 Euclid Avenue, Third Floor
Cleveland, OH 44115

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 the colon. The patient had an ultrasound performed on September 19 which showed a small amount of ascites is noted



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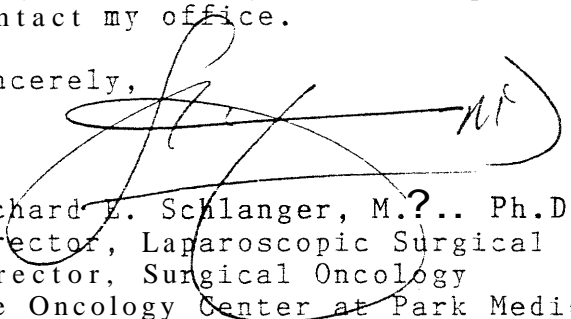
around the anterior aspect of the liver near the dome of the diaphragm, no significant anomalies seen in the liver, common bile duct does not appear enlarged and dilated colon of small bowel loops consistent with an ileus. The patient progressively had the pain was no better, white count remained elevated, 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 his 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.

Page 3
RE: Glen Diamond

The patient underwent a laparoscopic cholecystectomy and came back several days later with a bile 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

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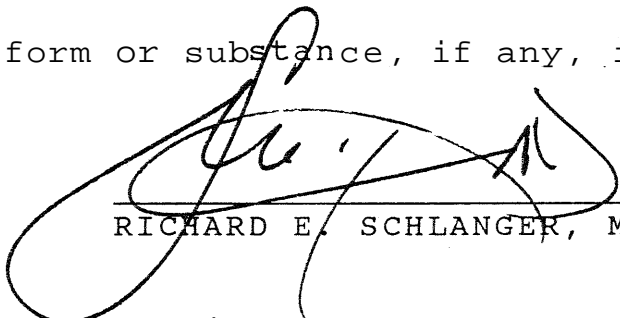
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1 STATE OF OHIO:

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2 COUNTY OF FRANKLIN:

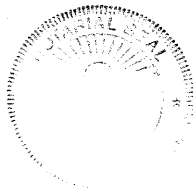
3 I, RICHARD E. SCHLANGER, M.D., do hereby
 4 certify that I have read the foregoing transcript of
 5 my deposition given on February 25, 1997; that
 6 together with the correction page attached hereto
 7 noting changes in form or substance, if any, it is
 8 true and correct.

9 
 10 RICHARD E. SCHLANGER, M.D.

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

18 
 19 NOTARY PUBLIC-STATE OF OHIO

20 My commission expires: 9-26-98



LINDA L. CASTLE
 NOTARY PUBLIC, STATE OF OHIO
 MY COMMISSION EXPIRES SEPT. 25, 1998