COMMON PLEAS COURT

LORAIN COUNTY

STATE OF OHIO

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Glen T. Diamond, et al., :

Plaintiffs, :

vs. : Case No. 96CV117098

William B. Saxbe, M.D., :

et al., :

Defendants. :

- - -

: Friday

: August 7, 1998

: 1:10 p.m.

: At the offices *of*

: Dr. Schlanger

: 1492 E. Broad St.

: Columbus, OH

- - -

Deposition of RICHARD E. SCHLANGER, M.D.

- - -

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APPEARANCES:

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On behalf of the Plaintiffs.

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On behalf of the Defendants,

ALSO PRESENT:
Dr. Saxbe
Dr. Summers

- - -

Friday Afternoon Session

August 7, 1998, 1:10 p.m.

- - -

STIPULATIONS

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 for cross-examination under the applicable Rules of Civil Procedure, may be taken at this time in stenotype by the notary, by agreement of counsel, that said deposition may thereafter be transcribed out of the presence of the witness; that proof of the official character and qualificaticns of the notary is waived; and that the examination, reading, and signature of the said Richard E. Schlanger, M.D. to the transcript of his deposition are waived by counsel and the witness; said deposition to have the same force and effect as though signed by the said Richard E. Schlanger, M.D.

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RICHARD E. SCHLANGER, M.D.

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

CROSS-EXAMINATION

BY MR. HERBERT:

Q. Would you state your name for the record?

A. Richard Edward Schlanqer, S-C-H-L-A-N-G-E-R, M.D., PhD, FACS.

Q. Dr. Schlanger, I'm Joe Herbert. We've met before a couple months ago, correct?

A. That's correct.

Q. Once again, I'm going to be asking you some questions today. If I ask you anything you don't hear or you don't understand, please don't answer it.

If you tell me you didn't hear it, didn't understand it, I will be happy to repeat it, say it a different way, or speak up, whatever you need, understand?

A. Understood.

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Thereupon, Exhibit A was introduced and identified.

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BY MR. HERBERT:

Q. I guess some introductory remarks. I'm down here today basically to ask you specifically questions relating to a supplemental report, we'll call it, that you issued that's dated April 28, 1998.

And I'm handing you a copy of that report which I've marked as Exhibit A. Is that what that is?

A. Yes, it is.

Q. So you know, I am not here today to replow old ground. Actually this deposition is being paid for by the plaintiff. I'm sure they would be very upset if I did go over all the stuff I already talked about. I'll try to be as direct as I can.

First of all, I take it you prepared Exhibit A at the request of plaintiff's counsel?

A. Yes.

Q. And this is the only draft of a supplemental report? There is no additional drafts?

A. I should hope not.

Q. Does that mean no?

A. It means all I know is this is the only thing I wrote.

Q. Do you have any -- is that your entire file?

A. Actually it's hers. I have a file.

Q. Which I've seen already.

A. Right. I think this is the only thing that's

in it.

Q. Since the time of the last deposition, have you reviewed or looked at any additional materials regarding this case?

A. The only thing that I have seen which was the response I believe from your expert to this supplemental report.

Q. When did you see that?

A. Yesterday.

Q. Did you have a discussion or conversation with plaintiff's counsel about that, we'll call it, responding report?

A. I called her, told her i got it. I read it. Thank you.

Q. Did you offer any comments or opinions regarding the responding report?

A. I told her I didn't agree with it.

Q. Okay.

A. That's about it.

Q. Did you offer a basis as to why you didn't agree with it?

A. Not really. I think I just said I didn't agree with it. It is not in my typical practice plan.

Q. I think that provides us with a pretty good segue into the report itself. When you talk about

your typical practice plan, to be more precise about it, when we're talking about this specific issue, is it your typical practice plan to get an ultrasound or a CT scan prior to the removal of a drain such a5 the Jackson-Pratt drain used in this case?

A. For the purposes of this situation, yes.

Q. So if I understand your response, there would be some situations when you would not necessarily get an imaging study of some type before pulling a Jackson-Pratt drain or similar drain; is that true?

A. That's correct.

Q. Tell me about those situations,

A. When I put a drain in to prevent a fluid accumulation, such as after a mastectomy, or if I've done a low anterior resection and I know I'm going to get a little bit of *ooze*, i put a drain in to make sure I'm not getting a fluid collection. Therefore when that stops draining, it has done its job. It's 3ut.

But when I'm putting a drain in a fluid collection that has been established before I pull the drain out, I get a subsequent x-ray to make sure all the collection has been completely collapsed, that there are no secondary areas that have not been drained. When those criteria have been met, then the

drain could be pulled quite safely.

Q. You use the word x-ray, did you mean to say ultrasound or CT scan?

A. Those are modalities of what we call x-ray department or radiology.

Q. If I fully understand you, it would have also been appropriate to get an x-ray in this particular case?

A. An x-ray I use that as a generic term talking about the department of radiology, imaging study either CT or ultrasound.

Q. But not necessarily x-ray?

A. Flat plate x-ray would not show anything.

Q. That was my point. Thanks.

A. It would not show anything.

Q. Now you mention that you differentiate this )articular case because there was an established fluid :ollection; is that true?

A. That's correct.

Q. And when you talk about an established fluid ollection, what do you mean?

A. Basically it's an area in the abdomen that ormally does not have fluid that will now be filled ith some sort of material, i.e. blood, serum, scites, bile, depending on the location.

These are normally not extravascular fluid collections. Normally if I have a person that's undergone a gallbladder, there should be no fluid, but if I have already diagnosed a collection biloma or free bile peritonitis and the fluid should be there; therefore, that's an established collection.

Q. When was the last time that you had such a situation where you had an established fluid collection and prior to removing the drain obtained an imaging study?

A. Tuesday.

Q. Give me a sense during 1998 how many times you have been in that situation where you have obtained an imaging study?

A. Probably about two a week.

Q. When you remove a drain, when you pull it out, do you look at it?

A. Do I look at the drain?

Q. Um-hmm.

A. Most of the time, yes, before I throw it out, yes.

Q. Why do you do that?

A. It's right in front of me. I'm making sure it's not clotted, that there isn't any extra fluid or gas, something that's collapsed in it that's making it

not drain.

There could be some kind of other sorted material such as a plasma plug. I just want to make sure it was functioning normally. I also make sure I have the full length.

Q. Sure. So when you have an established, as we've been discussing it here for purposes of this deposition, an established fluid collection, you routinely obtain imaging studies before that drain is even removed?

A. That's correct.

Q. That is without regard to whether or not the patient has any clinical symptoms or not?

A. If the drain has stopped draining, irrespective if they're doing great or not doing great, I want to make sure I've get everything out before I pull that drain.

I routinely get an x-ray, excuse me, routinely get an ultrasound or CAT scan.

Q. We've established that's what you mean. That's fine.

Just so it's clear, even if the patient says I feel great, I have no symptoms, ne problems, your exam finds no indication that there is a problem, simply because there was this, quote, established

fluid collection, you would automatically get an imaging study?

A. Yes.

Q. Let's say, again, for purposes of our discussion here today that an imaging study is obtained in this particular case at the time that you think it should have been in the office before the drain is removed, right?

A. Correct.

Q. If I understand you, what you're saying then is this patient would basically have Seen treated as he was in Florida only without the delay, in other words, you put the patient in the hospital?

A. Correct.

Q. Work him up and potentially he goes through the same steps that they went through down in Florida?

A. Correct.

Q. So the issue there in your mind is time; is that fair?

A. Can we go over that one more time.

Q. Yeah. And think about it because I really want to understand it.

A. Right.

Q. When I read your report and when I listen to what you're saying, my impression is that you're

saying you get an imaging study in the office, He would have seen that there was a remaining fluid collection which would have told him that we need to do something for this patient.

Fair enough?

A. Fair enough.

Q. And is it fair to say that it's likely, although we don't know with certainty, that that patient would have at that point basically been treated in a similar fashion to the way he was treated when he got down to Florida; although, you know, he lost some time and during that time he had some discomfort, essentially he would have still followed through more likely than not with the same kind of treatment?

A. I don't know if I can say that exactly because I don't see in the initial treatment that type of follow through,

I'm hesitant to say, yes, he would have had an ERCP. He would have had further drainage. I don't know if I can say chat 100 percent from the initial treatment the way I was listening not listening but reading the history. I know what happened in Florida.

Q. Right.

A. I'm reticent to agree 100 percent those next

steps would definitely have happened.

Q. Let me try and make it easier for you.

A. Okay.

Q. I understand your concern. I understand that frankly it's impossible for any of us to be 100 percent certain.

A. Right.

Q. Whether or not, I'm not asking you to make a prediction as to what you think Dr. Saxbe would or would not have done.

Is it fair to say that you feel there is an element of speculation there that you're uncomfortable with to try to guess what his next moves would have been?

A. That's basically what I'm saying.

Q. But assuming for the sake of my question that any doctor, any hypothetical doctor, does this imaging study that you recommend, it would have been a reasonable course of action to follow through the same sort of treatment and work-up that was done down in Florida?

A. Yes.

Q. And so in tnat situation what we're talking about is a loss of time as opposed to --

A. I guess it does boil down to time.

Q. Take a minute and think about it because, again, I just want to be sure.

A. Thinking about it, based on those things, it is a time element.

Q. Do you have any specific literature citations to discuss supporting the idea that a, quote, established fluid collection, as we've described it here today, would require an imaging study prior to a drain being pulled?

A. I haven't looked.

Q. Okay.

A. I know when I work in conjunction with my radiologists and I could probably find radiologic literature to support that. We've been doing it as common practice for as long as I can remember. With these type of situations we have not just pulled. We've always taken a look.

Q. So that's based on your experience here at this particular hospital?

A. Actually it's been the way we've done things at probably five or six of the hospitals here. Every one that I have come in contact with as far as surgeons pretty much when we've gotten a patient who had a fluid collection when we drain it has always been before we pull the drain let's go ahead and get

an ultrasound or CAT scan.

Q. When you talk about five or six different hospitals, tell me what hospitals you're talking about and over what period of times?

A. Well, it has been for the last ten years. If we go past 15, we are including Ohio State University Hospitals. Mount Carmel East Medical Center, Mount Carmel Medical Center, Park, it was then St. Anthony's, Grant and occasionally Riverside because I do attend the resident training programs in morbidity mortality, and these kind of questions will come up.

It is being told to the residents when we do have these situations especially since laparoscopic cholecystectomy has been around since 1990 especially in Columbus it has not been unusual for us to take the tertiary referral of the patient with bile leaks. They are usually CAT scan guided drain removal.

Before the drain is removed, there is an imaging study to make sure we've taken care of the problem.

Q. What do you mean when you say tertiary referral?

A. Basically the patients that have had their initial surgery elsewhere, gotten sick and transferred for their permanent care so to speak.

Q. Of the hospitals you named over the last, let's just say, ten years, which ones do you spend most of your time during surgery in?

A. Here and Mount Carmel East.

Q. Give me a sense of the breakdown.

A. It is about 70, 30. 70 here, 30 there.

Q. The rest negligible?

A. The rest negligible. An occasional insurance case that has to go elsewhere.

Q. So it is clear, you don't have any specific literature citations to discuss today, right?

A. That's correct.

Q. And you think as you sit here, you may be able to find something in the radiologic literature?

A. I'm sure there is something. Again, a lot of what I do is based on conference, collaboration with other surgeons and other doctors and what we feel is just good, sound practice.

Q. Give me a sense of outside of the Columbus area where else in Ohio you've done surgery.

A. I've been up in Delaware at Grady Memorial, but basically these were -- my practice is Columbus based.

Q. When were you up in Delaware?

A. 1991, 1992 setting up their laparoscopic

program.

Q. What hospital was that?

A. Grady Memorial.

Q. Do you still have privileges there?

A. No, I gave them up.

Q. Have you ever been to Lorain County to testify?

A. Which is Lorain County?

MS. TAYLOR-KOLIS: West of Cleveland. Elyria.

THE WITNESS: No. I'm from New York initially. When you start talking counties, once I'm outside Manhattan, I'm lost.

Q. Since the last time I deposed you, have you reviewed any other cases for Donna Taylor-Kolis or her Law firm?

A. No.

Q. Since I last deposed you, have you reviewed any additional cases on behalf of medical malpractice plaintiffs?

A. I think I've seen two cases.

Q. From where?

A. They are in my office. I'd have to take a Look.

Q. Are they Ohio cases?

A. No. I think one is from West Virginia. Another one was from Rhode Island. How I got them, I have no idea.

Q. Do you know the lawyer's name?

A. I'd have to look.

Q. That's okay. Those are both on behalf of plaintiffs potentially?

A. One's plaintiff, one's defense.

MR. HERBERT: Let me take just a quick three or five-minute break.

(Off the record.)

BY MR. HERBERT:

Q. Again, in this hypothetical world, if you see this patient in the office and you get your ultrasound, your CAT scan and there is no fluid collection at that point in time, it is perfectly okay to pull the drain?

A. Yes.

Q. So the assumption in your mind is there would have been a fluid collection visible on whatever imaging study was done or you say should have been one at that time, correct?

A. Yes.

Q. And you are taking that position because of the amount of fluid that was present when the patient

was seen in Florida?

A. Correct.

Q. In conjunction with the fact that you believe this was a continuous yet slow leak, true?

A. Correct.

Q. In your mind, this was not an intermittent leak, correct?

A. Correct.

Q. If you should feel the need to review any literature sources or citations and you come upon things that you feel are supportive of your position in this case and you would like to comment upon those things or discuss them in even a general way at the time of trial, I would ask you that you provide in letter form a list of those citations to plaintiff's counsel so that she can take the appropriate steps under the rules to let us know. Would you do that?

A. Absolutely.

MR. HERBERT: Again, you've got the right to read this after it's written up or you can waive the right.

THE WITNESS: I'll waive it.

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Thereupon, the deposition was concluded at 1:36 p.m.

CERTIFICATE

STATE OF OHIO )
) SS:
COUNTY OF DELAWARE )

I, Kim E. Snyder, an RPR and 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 by me first duly sworn to testify to the truth, the whole truth, and nothing but the truth in the cause aforesaid; that the deposition then given by him was by me reduced to stenotype in the presence of said witness, afterward transcribed by computer; that the foregoing is a true and correct transcript of the deposition so given by him; that the deposition was taken at the time and place in the caption specified and completed without adjournment; and that I am in no way related to or employed by any attorney or party hereto, or financially interested in the outcome of said action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Powell, Ohio, on this 8th day of August, 1998.

Kim E. Snyder

KIM E. SNYDER, NOTARY PUBLIC
IN AND FOR THE STATE CF OHIO

My commission expires
January 12, 2000

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