		* IN THE
	Plaintiff	* CIRCUIT COURT
	vs.	* FOR
		* BALTIMORE CITY,
	Defendant	* MARYLAND
		* CASE NO:
		* 24-C-09-001467-MM

* * * * * * * *

Reported by:
Richard D. Baker, Jr.

APPEARANCES:

FOR THE PLAINTIFF:

Rodney M. Gaston, Esquire
Miller & Zois, LLC
Empire Towers, Suite 1001
7310 Ritchie Highway
Glen Burnie, Maryland 21061
Telephone: 410-533-6000
Fax: 410-760-8922

INDEX PAGE

WITNESS:

EXAMINATION:

EXHIBITS: (Retained by counsel.)

(Exhibits 1 through 4 premarked.)

Whereupon;

was called for examination, having been duly sworn to tell the truth, the whole truth and nothing but the truth, testified as follows:

EXAMINATION BY MR. GASTON:

Q Good morning, Doctor. My name is Rodney Gaston and I represent in the action that's currently pending in the Circuit Court for Baltimore City. We are here today so that I can ask you some questions regarding the operation you that performed on on February 3rd, 2006.

A February 2nd, not 3rd.

Q February 2nd. Thank you, Doctor. Unless I state otherwise, every question that I'm going to be asking you will pertain to that operation. Have you ever had your deposition taken before?

A Yes, I did.

Q Okay. I'm going to explain to you some

of the guidelines for the deposition so that we can get through this hopefully quickly.

The court reporter is here to take down my questions and your answers. I'll ask that you wait until after I finish asking the question before you answer and I will give you the same courtesy, that way we don't interrupt each other because the court reporter cannot take down two persons talking at the same time. If I ever ask you a question that you do not fully and completely understand, please stop me and tell me that you do not understand the question and I will try to rephrase the question so that you do understand it. If at any time during the deposition you need to take a break please let me know, we'll stop the deposition and we'll resume after we have a break.

Doctor, do you have any trouble reading or writing the English language?

A I do, basically it's accent.

Q I didn't understand exactly what you said.

A I do have trouble with pronunciation.

Q I'm talking about reading or writing the English language. Let's talk about that first. Do you have any trouble reading or writing English?

A No.

Q Do you have any trouble speaking the English language?

A Somewhat.

Q Is that what you just said, you have trouble with pronunciation?

A That's correct.

Q Okay. Do you have any trouble understanding the words that I'm saying today here?

A So far it's okay.

Q Okay. Again, if at any time you don't understand what I'm asking you, please stop me and let me know. Otherwise, for the purpose of the deposition, we will understand and agree that you understand the questions that I ask you and that your answers will be responsive to those questions. Are you able to follow those guidelines today for

the deposition?

A We did before.

Q Are you abile to do that today?

A Yes.

Q Thank you, Doctor. Doctor, you do know that when you were sworn in to testify, your testimony today is the same as if you were in a court of law before a judge or a jury and that you're required to testify truthfully?

A I do.

Q During the times that you've provided deposition testimony in other cases, have you always testified completely truthfully in those other depositions?

MR. BAXTER: Objection. You may answer.

A As much as I could.

Q Well, can you explain? Have you ever testified falsely at any other deposition?

MR. BAXTER: Objection. You may answer.

A I know I don't.

Q I didn't understand that. Does that

mean you've never testified falsely at any other deposition?

MR. BAXTER: Objection. You may answer one more time.

A I did do my best answer my question.

Q Okay. During the times that provided previous deposition testimony, would it be a true statement that you've had a chance to review your testimony after it has been transcribed?

A Yes, roughly, not word by word.

Q At any time when you reviewed any prior deposition testimony did you realize that you testified incorrectly or falsely?

MR. BAXTER: Objection. You may answer.

A Maybe, but I always tell the truth.

Q Okay. In the times when you've realized that you may have testified incorrectly or falsely, can you tell me when that occurred?

MR. BAXTER: Objection. You may answer.

A I don't have an idea.

Q You don't remember?

A No.
Q Okay. Is there anything that would help you to remember when you testified incorrectly or falsely at a prior deposition?
A Why should I know?
Q I don't understand what you just said.
A You asked me where I did not answer the truth, why should I know. Why should I know that?
Q I still--
MR. BAXTER: Why should I know that.
Q Why should I know that, okay. Let's go back. I'll start again.
I'm aware that you've testified in two prior depositions, one deposition occurred on January 15th, 2008 and the other deposition occurred on January 7th, 2009. In both of those depositions you were represented by counsel and I believe you've already testified that you have reviewed the transcriptions of those two depositions. Is that correct?
A That's correct but as I say, I did not

word by word. In general I accept, I signed the paper.
Q Okay. Is there a reason why you didn't go by word for word to make sure that what you testified was truthful when you reviewed the deposition testimony?
A As I say, in general the content is truth.
Q Do you recall reading those depositions and recall where any information was inaccurate or untruthful in both of those depositions?
MR. BAXTER: Objection. You may answer.
A The truth.
Q I'm sorry?
A In general in the content of the deposition is truth and I cannot guarantee one hundred percent it's the truth.
Q Why not?
MR. BAXTER: Objection. You may answer.
A As I say again, you point out I don't know what the true or not truth. You can ask me.

Q But Doctor, if you're sworn in today to tell the truth, is there a reason why you can't testify truthfully today?
MR. BAXTER: Objection. Wait a minute. Where are we going with this? If you want to ask and impeach him in prior deposition testimony I encourage you to do that, but the general inquiries about truthfulness and reasons for why things can't be remembered I don't think are probative and verge on something that is not permitted in a deposition. So I'm going to encourage that if you have a point to get to it and as soon as possible. You may answer the question if you recall it.
A I agree my counsel said. He pointed out what the problem, I answer for you again.
Q Doctor, is there any reason why you can't testify truthfully today?
MR. BAXTER: Objection. You may answer.
A No, I will tell all the possibility, all of the truth is truth. I will do my best.
Q Okay. Now, Doctor, I show you what's

been marked as Exhibit Number 2 and ask if you could take a look at that document and ask if your signature appears on that document? And for the record, these are your answers to the plaintiff's interrogatories.
(Pause for document review.)
A I accept.
Q And, Doctor, for the questions that I'm going to ask you about, your Answers to Interrogatorie,s, your attorney can assist with you some of the answers. Some of this is simply housekeeping with respect to the discovery that has been initiated so far in the case. Some of the answers indicated that you couldn't answer because discovery has not been concluded and because discovery is going to be concluded in about two weeks I will have to ask you some of those questions and again your attorney can assist you with you the answers. I need to know if you intend to offer yourself any expert opinions in this case, and that would be answer to interrogatory number 2

where it says you reserve the right to offer expert testimony. I need to know if you're going to offer any expert testimony number one, and if you are, what that expert testimony is.

MR. BAXTER: will not be proffered as a standard of care expert at trial in the sense that independent experts who are reviewing the case are. He will, however, in all likelihood explain what he did in surgery in question and his other treatment of and why he did it and why he thought it was the correct thing to do. But he will not be a, quote, standard of care expert witness in the traditional sense.

(Cell phone interruption.)

Q Okay. based upon your lawyer's proffer that you will not be called as an expert on the standard of care, is it also my understanding from your lawyer that your lawyer will not be asking you a direct question on direct examination whether or not you believe that you breached the standard of care; is that accurate?

MR. BAXTER: In those words, yes. But again subject to the qualification that he is going to explain what he did and why he did it and why he thought it was the correct thing to do and of course if he gets cross-examined on other issues then all bets are off. But as to terms of my direct examination question on that specific language, no, that won't be asked.

MR. GASTON: Okay.

Q Again with respect to question number 2, we were provided in discovery a certificate of merit and then expert reports I believe on two expert witnesses, Are there any other experts that you intend to call in this case?

MR. BAXTER: He doesn't know. That is a lawyer matter and we designated experts pursuant to the scheduling order and intend to comply with the scheduling order and expect all the parties to do so. I would presume expert designation deadlines are over.

MR. GASTON: They are. And I need to know whether or not any of your experts are going to provide any testimony as to the reasonableness or not of the follow-up care that received after your operation.

MR. BAXTER: We can talk about that, that's not a question for him, he doesn't know the answer to that but I will give you the answer to that.

MR. GASTON: And also it has to do with the bills as well.

MR. BAXTER: I will give you the answer to that.

MR. GASTON: Very good, thank you.

BY MR. GASTON:

Q Number 6, do you claim, and again maybe your lawyer can assist us, whether or not the plaintiff acted in a manner that caused or contributed to her occurrence?

MR. BAXTER: No, as of today we don't have any information obtained in discovery that

would cause us to raise a defense. If something crazy comes up before discovery is closed or even after that you will be the first to know, but as of today no.

Q Thank you. Doctor, again with number 7 it asks whether you contend any party or person not a party to the action acted in a manner to cause or contribute to the occurrence, which would be the operation on February 2nd, 2006, please identify that person and provide us with the facts. Your answer when you executed the Answers to Interrogatories was no such contention at that time. Is that your position today?

MR. BAXTER: It is.

Q Okay. Again number 8, you contend that the plaintiff's injuries and disabilities were a result of prior or subsequent injuries. This specifically addresses the injury to either the common hepatic duct or the common bile duct that was reflected in report and the treatment that had after that. Are you

claiming that any of that treatment was a result of a prior or subsequent accident or injury?

MR. BAXTER: Prior or subsequent accident or injury, no.

MR. GASTON: Thank you.

Q Number 9, and perhaps counsel can talk afterwards, but we ask whether or not you have any pictures --

MR. BAXTER: He doesn't know the answer to that and I don't know the answer to all that in terms of exhibits at trial yet, but we can talk about it.

MR. GASTON: The reason I asked the question is because if I didn't get an answer when the doctor executed the interrogatories and if I don't ask him now to identify that by and through counsel, which is fine with me, then I don't have an opportunity later.

MR. BAXTER: I disagree. Go off the record a minute.

(Discussion held off the record.)

BY MR. GASTON:

Q Doctor, answer to interrogatory number 12 asks whether or not you were employed by any company, partnership, professional association or other entity and was acting within the scope of that employment when you operated on on February 2nd, 2006. Your answer is no. Is that accurate?

A No.

MR. BAXTER: It is inaccurate or is it accurate?

A No, it's accurate, yes.

Q Thank you, Doctor. Answer number 23, this has to do with the follow-up medical care and treatment that received after the February 2nd, 2006 operation. We have provided to your counsel all of medical records and bills associated with the care she received following the February 2nd, 2006 and we need the answer to question number 23 is, whether you admit that the medical care that she received following

the February 2nd, 2006 operation which was identified in the plaintiff's Answers to Interrogatories, was reasonable, necessary and causally related to this case and to the operation of February 2nd, 2006?

MR. BAXTER: I don't know that he has looked at all of those records so I don't know that he can answer it, but if you can answer it you should and if you can't you shouldn't.

A I agree with you.

MR. BAXTER: But what you have to do is say whether you can answer or not. If you say I don't know then the answer is I don't know. If you say I do know, then you have to answer in detail.

A I don't know.

Q Doctor, have you had a chance to review medical records?

A I did.

Q Okay. And I believe immediately after your operation on February 2nd, 2006 you did request to assist with the treatment

of I

A I just visit him, visit her. I did not write the orders.

Q Would it be fair to say that you're familiar with the treatment she received immediately following your operation?

A I did.

Q And do you believe that that treatment was reasonable and necessary?

A Yes.

Q Do you also believe that the treatment received at the hospital in New Jersey a few months later for her jaundice was reasonable and necessary and related to your operation?

MR. BAXTER: Hang on a second. Reasonable and necessary is one question and related is a separate. If you don't mind if you could break those out.

A I don't--

MR. BAXTER: Hold on, he's going to break them out.

Q Do you believe that the treatment that she received at the hospital in New Jersey for her jaundice was reasonable and necessary in light of her condition?
A Received the treatment, yes.
Q Okay. Do you believe that the condition that she presented with was a result of what happened during the, your operation on February 2nd, 2006?
A I don't believe.
Q Why don't you believe that that treatment was causally related to the obstructive jaundice that she developed immediately after the February 2nd, 2006 operation?
A Because it did take so many medication, particularly that depression medicine can cause the jaundice.
Q Medication that she was taking for depression in your opinion caused the jaundice that resulted in her inpatient stay in the hospital in New Jersey, am I understanding your answer

correctly?
A That's correct.
Q Tell me what depression medication she was taking and how did that cause her jaundice?
A It's Prozac.
Q Prozac. How much was she taking?
A I don't know exactly the dosage.
Q Okay. And what dosage of Prozac would a person take that would cause jaundice?
A Well, it depends, a patient's sensitivity, individual differences.
Q But in this case you claimed that the dosage she was taking caused her jaundice which resulted in her hospitalization. I'm asking you what dosage was she taking that caused the jaundice?
MR. BAXTER: He already answered that, don't answer it again. He said he doesn't know. He's not the first person to come up with this theory, it's in the medical records.
MR. GASTON: Well, the reason I'm

exploring it is because to date no expert that you've identified, Doctor, has rendered this opinion.
MR. BAXTER: Wait a minute. No expert has been deposed, Mr. Gaston. He didn't create this theory, another treating physician stated it in the record so it's not like it's something that's completely far-fetched.
Q Are you going to provide any testimony at trial that the Prozac that was taking caused the jaundice which resulted in her inpatient stay at the hospital in New Jersey?
A As I know, after she discontinued taking Prozac the jaundice subside, improved.
Q That didn't really answer my question. My question was do you intend to testify in this case on the witness stand that in your opinion the Prozac that she was taking caused her jaundice that resulted in her inpatient stay at the hospital in New Jersey?
A I'm not a drug expertee. I don't think

I have a position to, expertee for that. But retrospectively I read the medical record, after they stopped medication the jaundice, it subside.
Q I think I understand your answer to be that you don't have enough expertise to render that opinion; is that accurate?
A Accurate.
Q Thank you, Doctor. Now, do you admit that the treatment she received, the follow-up treatment she received by assie which resulted in the placement of the tubes to drain the bile at Franklin Square Hospital, as reflected in her Answers to Interrogatories, was reasonable treatment and necessary?
A That's true.
Q And do you believe that that was a direct result of the operation that occurred on February 2nd, 2006?
A That's true.
Q Doctor, when you performed the laparoscopic cholecystectomy on on

February 2nd, 2006, when you looked inside of her body with the laparoscope did you find that she presented with normal anatomy?

A Yes.

Q Okay. And I have two charts here that I want to show you that I brought with me that are identified as Exhibit Number 3, which is entitled anatomy of the biliary system or biliary system, however you want to pronounce it, and anatomy of the hepatic and pancreatic ducts which is Exhibit Number 4. And do you agree that these exhibits generally depict the, correctly depict the anatomy of the human body as it's illustrated in these exhibits?

MR. BAXTER: Are those deposition Exhibits 3 and 4 or is that from another proceeding?

MR. GASTON: Deposition Exhibits 3 and 4 for this.

MR. BAXTER: And you'll keep custody?

MR. GASTON: Yes.

A That's correct.

Q Thank you, Doctor. Doctor, during the course of this case we will have expert testimony from various doctors regarding the standard of care. I'm asking you as the defendant in the case, are you familiar with the standard of care, medical care that was applicable to you as a surgeon when you performed the laparoscopic cholecystectomy on on February 2nd, 2006?

A There's no standard procedure for cholecystectomy.

Q Okay. That sort of didn't answer my question. Let me see if I can rephrase it again.

As a surgeon performing-- and I'm going to refer to this as a gallbladder surgery, Doctor, so that I understand a little bit easier and maybe members of the jury can understand it. Is there a standard of care, which means the manner in which the operation is to be performed, that is applicable to you as a surgeon, a skilled surgeon, when performing this type of operation in the state

of Maryland, is there a recognized standard of care?

A Standard of care of gallbladder?

Q Surgery, yes, Doctor.

A Yeah. What about it? Clearly --

Q Do you agree that there is a standard of care that was applicable to you when you performed the gallbladder surgery on on February 2nd, 2006?

MR. BAXTER: Do you understand what standard of care means?

THE WITNESS: Not really.

MR. BAXTER: Maybe he can explain it.

Q Let me explain to you what my definition, how I understand the standard of care is. The standard of care is that care and treatment that a surgeon similarly skilled is required to exercise when performing a similar operation in the same or similar communities. Which means it's a manner in which the operation is performed.

Do you believe that there are certain standards that surgeons like yourself are required to follow in performing gallbladder operations in the state of Maryland?

A There is no written order or --

MR. BAXTER: Can I help or do you not want me to?

MR. GASTON: I would be glad if you could assist.

MR. BAXTER: What I think he's getting at is is there a generally accepted correct and safe way to do cholecystectomies. And I don't mean written in a book, I just mean known from surgeon to surgeon is there generally a proper way to do a cholecystectomy that most surgeons try to follow? Is that generally known?

A Yeah, there is a certain rule, yes.

Q Thank you, Doctor. And, Doctor, do you agree that this standard of care would apply to a surgeon with your similar skills performing a similar operation, that it's the same whether the

operation is performed in Baltimore County, Baltimore City, Washington, D.C., New York, New Jersey, that it would be the same standard of care?

A As long as the patient doing well, that's the standard of care, that's important thing. No matter which way you do, as long as it make the patient better.

Q Is there any -- let me ask it another way. If you were performing this operation, let's assume you were licensed in every state in the United States, would you perform the operation any differently if it occurred in any other state?

A Almost the same manner, same fashion do the surgery, yes.

Q Thank you. And there's no lower standard of care that you would employ in any other different state for the same operation, is there?

A No.

Q Okay. Now, Doctor, can you describe to me in your own words what you believe is the appropriate and safe manner in which a surgeon such

as yourself should perform a gallbladder surgery, the removal of a gallbladder? If you can go down step by step if you can and hit the major points for me regarding the operation.

A First of all, preoperatively -- do you want detail, what I do regularly?

MR. BAXTER: I think that's what he's looking for. I mean you can ask him. I can't guide you on that.

A Your question is all vast.

MR. BAXTER: Why don't you start with a general description and then he will ask more questions.

A First of all you evaluate the patient if it's suitable for surgery or not.

Q All right. If you determine -- I'm going to try to speed this up a little bit. If you determine the patient is suitable for surgery what would be your next step?

A Put patient to sleep and prep and depend on the patient, the condition, if the patient had a

previous surgery, then you approach it different. Here the thing it is so different way to enter the problem of individual different patient.

Q Let's talk specifically about ' Okay? I want you to describe what you believe to be the safe manner in which to perform a gallbladder surgery on

MR. BAXTER: Can we break for one second?

(Brief recess.)

Q In case which approach did you elect, Doctor?

A she has existing multiple medical problems. MI, coronary heart disease, have a five vessel bypass, has diabetes, has hyperlipidemia, has a pernicious anemia, have a peripheral vascular insufficiency. So I called cardiology to evaluate her heart is good or bad for surgery and is a clearance by Dr., cardiologist. So next day she underwent general anesthesia. We prepped her, make a pneumoperitoneum, put a trocar

inside and under the direct vision put the two other trocar in the right upper quadrant, 10 millimeter trocar in the xiphoid site process.

Q The procedure that you're describing, I understand that to be a laparoscopic procedure; is that correct, Doctor?

A That's correct.

Q Is there also a procedure that is called a open procedure by which a gallbladder can be removed by making an incision on the outside of the person's skin and simply dissecting all of the way down, using retractors to open the incision and to remove the gallbladder in that fashion?

A That's correct.

Q Did you consider an open procedure for before you elected to use the laparoscopic procedure?

A We always considered the best interest for the patient, the less trauma is the best for the patient. That is the way we do. Always, all of the cases going to have a gallbladder removed,

we always talk to the patient. This possibility the laparoscopy might not able to do it, we have to do the open. Besides that, we reemphasize all of the surgery carry a risk, particularly her, she have existing multiple medical problems. She had a very high surgical risk of complication and I mentioned to her particularly on the gallbladder surgery, which is a very delicate surgery, and we could not, we could not injure it.

MR. BAXTER: We could not injure it?

THE WITNESS: Correct.

Q I got all of the way up to the point about the high risk and complications but I didn't understand the last phrase that you mentioned.

A I emphasize to her the gallbladder surgery is a delicate surgery, such could cause bleeding, infection, injure the bile duct, injure the liver, injure the organ, intestine, colon or heart and lung problems.

Q Let me stop you there for a second. You said that this surgery was a high risk surgery for

her and a high risk for complications. Okay. What specifically about her medical condition -- sorry. What was the higher risk for her performing the surgery in light of her medical condition?

A Risk, she had existing multiple medical problems as I mentioned about. They can cause cardiac arrhythmia and even can cause arrest, another MI. That's a risk.

Q You're talking about cardiac risks. I'm talking about were there any, was she at a higher risk for any other injury to her organs, to arteries or ducts because of her current existing medical condition?

A She has a very bad gallbladder.

Q All right. How does the bad gallbladder make it an increased risk for her to have injury to the liver, gallbladder, cystic duct, cystic artery or other bile ducts in the body?

A My experience told me when the people over 60 in her life at least have several gallbladder attack and that will cause a lot of

adhesion and adhesion, it is there, can cause more complications.

Q All right. Now, let's talk about the adhesions in this case. Is there anything, are you claiming the adhesions in this case caused the complication that resulted in either the hepatic duct or the common bile duct being clipped and clamped?

A No, not this case.

Q I really want to talk about the problems that she had that would cause an increased risk to her internal organs. We already talked about the heart. I want to talk about the organs that are close to where the operative field is, I want to talk about the liver, the gallbladder, hepatic duct, cystic duct, common bile duct. Did her medical condition increase her risk for injury to any of those bodily organs?

A Well, anesthesia can cause a complication for the heart. Operation in itself, it's a stress, can cause complication and risk too,

yeah.

Q Hang on a second, I didn't understand what you said. We're leaving the heart out of this, the heart is a separate part, you already explained increased risk to the heart. I'm talking about did you believe when you went in to perform this gallbladder operation, that her medical condition caused an increased risk to injury to her liver, gallbladder, any of the arteries in the area of the gallbladder or any of the ducts in the area of the gallbladder?

A No, but herself, the age increasing the risk inside operation.

Q Okay, her age.

A Yeah.

Q How did her age increase the risk of injury to the liver, gallbladder, arteries or any of the ducts associated with this gallbladder surgery?

A Because the old people always say I have indigestion, actually it is gallbladder attack,

infection.
Q Well, but I don't understand and you'll have to explain it to me, how did this increase the risk of her organs being at a higher risk for injury just because she's old? We're talking about the risk that occurred during the surgery itself.
MR. BAXTER: He's getting to it. Keep asking.
A Because old people as I say, you don't do this and we do this, old people gallbladder in general much more complicated compared to 20- or 30-year-old patients. The reason behind because older people oh, maybe it's my heart attack, actually it's a gallbladder infection, gallstone attack. And repeatedly repeat of this can cause adhesion and adhesion in itself can prolong the surgery, can cause more complication.
MR. BAXTER: Let me stop for a minute.
(Discussion held off the record.)
Q Doctor, we already eliminated that adhesions have increased any risk of injury in this

case and you already said it had nothing to do with it. What I'm asking you now directly is for the injury that sustained in this case, you can correct me if I'm wrong, I understand that the injury was a placement of a clip either on the hepatic duct or the common bile duct. Is that your understanding of the injury in this case?
A Yes, I did.
Q Now, how, how did her current medical condition increase the risk of that happening in this case, if it did? I need to know one way or the other.
A Okay. She has a big gallstone and repeat and repeat attack. And this stone can stretch and stretch in the cystic duct. And cystic duct become obliterated, which means disappear. So the gallbladder directly contact to the common bile duct. And this common bile duct directly come from the gallbladder. When you do surgery, because it is the only one bile duct connected to the gallbladder so you will presume as routine this is

the cystic duct. This the reason I clipped and divided.
Q And you knew this before you started to operate on ?
A After the injury we look in the cholangiogram, looked in the HIDA scan.
Q Hang on a second, let me go back. You testified because of her age there is an increased risk that the cystic duct is obliterated coming off of the gallbladder and it can be confused with a common bile duct, correct, because of her age?
A Yes.
Q And you knew that before you started the operation?
MR. BAXTER: Knew that generally, not that it specifically existed in her case but knew that generally? Objection to the form. My request is whether you're asking a general question or specific to
Q Did you know that that was a common increased risk in her case before you started the

operation?
A Before the operation, no.
Q Okay. Then I thought you just explained that the increased risk for a person of 80 years of age is that they will present with an obstructed cystic duct.
MR. BAXTER: I think he misunderstood your question, but go ahead.
Q Let me make sure that I understand your answer. We were talking about the increased risks for this type of injury because of age. Okay? Now, the increased risk for this type of injury you indicated is because in older people, such as the cystic duct becomes obliterated and when surgeons go in they confuse and are unable to appreciate the difference between a cystic duct and a common duct because of this obliteration; would that be accurate?
A It's a retrospective after I started this case but not before.
Q Okay. So the risks that we talked about

about the cystic duct being obliterated because of her age, were you aware that that was a possibility that would present with this type of anatomy before the operation?

A No.

Q You weren't aware of that?

A No.

Q Okay. Was it, then it was a surprise to you?

A Yes.

Q Okay. What other risks, higher risks was at for this type of an injury?

A Injury to duodenum causing more bleeding.

Q Okay. I don't want to go too far. I want to talk about the risks for putting the clamp on the wrong duct. We already went over that. Was there anything else about her age that would make her more susceptible to the injuries she had other than what you already explained?

A You mean specific to the bile duct

system?

Q Yes, sir.

A Beside the confused anatomy?

Q Yes, sir.

A Well, as I know the most common it's adhesion to the common bile duct.

Q We already talked that adhesions weren't part of this case. Is there anything else that you can think of that we haven't talked about that's relevant to this case regarding the additional risk for this type of injury?

A You tell me, I don't know.

Q Okay. Now, Doctor, it's been my understanding that you performed approximately 3,000 gallbladder operations?

A That's correct.

Q Of that 3,000 about 2,000 are laparoscopic and 1,000 were open procedures?

A You can say there were.

Q Of the 3,000 gallbladder operations you performed, how many of them have been on people

over the age of 65?

A Actually more than 50 percent in my case.

Q 50 percent. And of those 50 percent, which would be about 1500, how many of those presented with cystic ducts that were somewhat obliterated like the duct you found in body?

A Two or three case.

Q Two or three cases. Was that before you operated on or after?

A Before.

Q Before. In those cases where you found the cystic duct was partially or fully obliterated, were you able to appropriately identify the cystic duct and clamp it without causing injury to the common bile duct?

A Usually the case is anatomy is not very clear, like That kind of a case, after we opened up we dissect, we find out the situation, gallbladder directly to the common bile duct. But

the case you can see the tube directly come out from the gallbladder so it's a little bit different, and the case is after I clip it, later after starting we find out he doesn't have a cystic duct. Actually the duct come from the gallbladder is a common bile duct.

Q Doctor, about five minutes ago you told me that presented with normal anatomy. Do I remember testifying to that?

A Yes, look normal --

Q And --

MR. BAXTER: Let him finish. Let him finish.

MR. GASTON: He said yes.

MR. BAXTER: Wait a minute. Let him finish his answer, sir. Go ahead, Doctor.

A In this case we can clearly identify gallbladder neck, come as a tube, another is a cystic artery. That is a very standard, normal anatomy after we careful dissect and this is the reason I don't have any hesitance, put a clip and

divide it.
Q Doctor, you just testified that the common bile duct was connected directly to the gallbladder, correct?
A Yes.
Q That's not normal anatomy, is it?
A No. See the point is your word is different. I can show you the picture. It's right here, it's your picture.
MR. BAXTER: Just try to answer his question. He will ask you a question, you'll answer and then we will move on. Okay?
THE WITNESS: All right.
Q You're claiming now tha common bile duct was connected directly to the gallbladder, correct?
A Correct.
Q That's not normal human anatomy, is it?
A No.
Q Then why ten minutes ago when I asked you if presented with normal human anatomy

you said yes?
A Maybe my explanation not clear to you. In the routine we dissect this way, dissect it from the neck of the gallbladder and then you will find the tubular structure, all right, and then you will find artery. This is a landmark of the regular surgery. You're able to do so. Then you presume, all of the people do the same thing, unless you cannot find the bile duct, then you have to open. And in this case the pictures show, this is the reason I put a picture in the operation room.
MR. BAXTER: For the record he is referring to photographs from his chart that are here in front of him.
A I believe I give to her, I give to her before.
(Photographs tendered.)
MR. GASTON: Can I have this marked?
(Exhibit 5 marked.)
MR. BAXTER: There are three sets of photos.

THE WITNESS: The one I gave to her and this one is showing a big stone to the neck.
Q Doctor, let's go back. We were talking about the two operations where prior to when you found the cystic duct was obliterated. I asked you whether or not you were able to perform those operations safely without clipping the common bile duct and I don't think I received your answer.
A Yes, I told you before surgery I didn't know. After we find out complication we, my explanation --
MR. BAXTER: He's asking a different question. In the other two cases or so that you encountered the same anatomy, were you able to safely clip the cystic duct? Sorry for interrupting, I think that's what you're asking.
THE WITNESS: Thank you.
A These two other case, because I cannot identify the cystic duct, identify the common bile duct, so we open and we dissect from the gallbladder inside itself, inside the gallbladder,

and trace from the gallbladder and we find out. The same thing this patient, that two patient did not have a cystic duct.
Q So you were able to safely perform gallbladder surgeries in those other two cases without causing any unintended injury to those patients, correct?
A That's correct. Because poor anatomy.
Q And when you have poor anatomy, then that is the reason you convert to an open procedure so you have a better visualization of the operative field?
A Exactly.
Q And when you found poor anatomy in case and you said you saw the cystic duct obliterated, you didn't convert to an open procedure in her case?
MR. BAXTER: Objection. He never said he found poor anatomy in her case. That's your interjection or interposition of those words into the second part of the question. So I object to

the form of the question. You may answer.
A I believe I did clearly told you in this case as the pictures show, I can clearly dissect out the bile duct from the gallbladder. It's not a confused, we can see on the laparoscope.
Q And did you see the cystic duct as well?
A Yes, because normal anatomy is that duct directly come out from the gallbladder must be a cystic duct. 99.9 percent.
Q So you saw the cystic duct clearly, correct?
MR. BAXTER: Talking about case now?
MR. GASTON: Yeah,
Q You saw the cystic duct in case clearly, correct?
A We saw the bile duct directly come out from the gallbladder, presume it's the cystic duct.
Q And was there a cystic duct attached to gallbladder?
A There's no cystic duct in her case. You

can look at the pathology but the pathology presume that bile duct is the cystic duct but actually it's the common bile duct.
Q So in your operative report-- I show you Exhibit Number 1. When did you dictate the operative report?
A A couple of minutes after surgery.
Q Okay. And when did you realize that you had clipped the common bile duct and not the cystic duct?
A Until next day.
Q Not until the next date?
A With the HIDA scan, on June 3rd I ordered the HIDA scan of the obstruction.
Q Now, in order to correctly identify the duct that comes out of the gallbladder, isn't it true that you follow the duct from the point it leaves the gallbladder and you follow the duct until it terminates?
A We don't do that in a standard operation.

Q Why not?
A You just find the bile duct directly come from the gallbladder, because the more you dissect unnecessary you induce more complication.
Q Well, let me ask you this. In a normal operation when you have a cystic duct that you're clamping, how long is the cystic duct before it connects to the common bile duct?
A Cystic duct lengths, the lengths of cystic duct vary patient to patient, is different.
Q Give me an idea.
A Somehow this one nothing, some are one centimeter, some are three, four centimeter.
Q So all you had to do is to follow the duct as it exited the gallbladder for three centimeters, then you would have been able to determine if it then hooked up to the common bile duct, correct?
A Well, I'm sorry to say you are not a surgeon. As I say again, we do the less trauma, less dissection. As long as you do the job, that's

the important part. You do more unnecessary you create more complication and it's good for your lawyer.
Q Doctor, one to three centimeters is how many inches?
A One inch is 2.34 centimeter.
Q So all you had to do before you put that clamp is to look an inch and a half to see whether the duct you were clipping connected to the common bile duct or not. Did you do that or did you not do that before you clipped that duct?
MR. BAXTER: Hold on a second. There's a statement in there that may or may not be true and then there's a question of whether he looked that long.
MR. GASTON: Could we do speaking objections outside the presence of the witness, please?
MR. BAXTER: We can. I'm going to object to the form and let him answer. I'm going to ask that complex questions with multiple

components be limited because we have a language barrier and it's hard enough when there isn't a language barrier. So I will just object to the form here and you can answer the question or you can ask the reporter to repeat the question.

A Actually in this case I did, you can see here, this is, I presume is the common bile duct, all right. This is a cystic duct I divided. This is a big, this one is the common bile duct and this one is artery. Okay?

MR. BAXTER: Referring to Deposition Exhibit Number 5.

Q You referred to the paragraph in the upper right-hand corner of Exhibit Number 5 which contains three photos and one black box. The duct that you identified as the cystic duct is the duct that is obviously cut, correct?

A Yes.

Q The duct you identified as the common bile duct is the larger duct to the right of the cystic duct, probably an inch to the right; is that

correct?

A That's correct.

Q And the smaller duct above the common bile duct, which is about one-third the size of the common bile duct, you referred to as the cystic artery, would that be correct?

A Yeah, there's a pulsating tube or structure.

Q Doctor, you didn't answer my original question. My original question is you testified that in patients the distance of the cystic duct between the gallbladder where it intersects with the common bile duct is one to three centimeters?

MR. BAXTER: No, he didn't.

MR. GASTON: I'm sorry, correct me if I'm wrong.

MR. BAXTER: Zero to four.

A In this case is zero to four.

Q In this case it was zero to four?

MR. BAXTER: Wait a minute. You misstated his prior testimony. His prior testimony

was in this case it was zero, it could be as much as four. Now he's asking you was it zero to four in this case or what was it in this case.

A In this case retrospectively it is a zero cystic duct.

Q The duct that you cut, what was the distance between the gallbladder and the common bile duct?

THE WITNESS: I'm sorry, what did he ask?

MR. BAXTER: You can answer as best you can. I think he is sort of mixing apples and oranges, but if you can answer it, answer it. If you can't, you can't.

A Can you repeat? Can we go to the facts instead of using your --

MR. BAXTER: Wait, don't argue with him. He has a right to -- Doctor, he has a right to ask his questions and we have an obligation to do our best to answer and you're doing great. So let's try to stick to that game plan. Okay? I know it's

difficult for you, but let's stick to that game plan. He has a right to ask questions.

Q Let me go back to just a basic question, Doctor. When you're about to dissect a cystic duct in a gallbladder operation, isn't it true that you should follow the cystic duct from the time it leaves the gallbladder to the time it hooks up to the common bile duct to be sure that you're actually cutting the cystic duct and not the common bile duct?

MR. BAXTER: Objection. It's been asked and answered twice. I'll let him answer one more time. You may answer, sir.

A I would say 99 percent of surgeons, they don't do the way you do.

Q I'm asking what you did.

A No.

MR. BAXTER: Wait, wait, wait, that's not a question. Don't argue with him and he won't argue with you.

MR. GASTON: Very well.

Q Doctor, are you saying it's not the appropriate standard of care for surgeons in similarly situated like you in performing gallbladder surgery, to identify the cystic duct as it comes out of the gallbladder and follow it through to where it attaches to the common bile duct before you clip it, your testimony is that it's not the standard of care?

A I don't believe it is the standard of care.

Q Then how, if you don't follow the cystic duct from the point it comes out of the gallbladder to the time it enters the common bile duct, how do you know if you're cutting the cystic duct and not another duct?

A That is what I told you before. 99.9 percent the duct directly come from the gallbladder must be a cystic duct, period.

Q But in two other cases before you found out that it wasn't, correct?

A No, as I say again, the two other cases

is, anatomy not so like this clear, not so like anatomy is so clear. That two case is everything is not together, gallbladder and the bile duct all mixed together, we cannot dissect it like it is, this is the reason we had to open up and dissect it and find out the gallbladder just mixed with common bile duct.

Q But Doctor --

A Is that clear?

Q Yes, it is. Are you telling me that in 99 percent of your operations, gallbladder operations that you do not follow the cystic duct out of the gallbladder to the point where it intersects the common bile duct to be sure you have the cystic duct, you just clamp it and cut it?

MR. BAXTER: Objection to the form. You may answer.

A Some are very easy to see, cystic duct, common bile duct. Some are, you just cannot see that because of chronic inflammation, dense adhesion and you-- my job is to strictly dissect it

from the gallbladder to find out it's a duct connect with a, directly coming from the gallbladder. At least we always presume this is a cystic duct. I have been practice this 30 some, 3,000 cases, it's only one with this problem.

Q So getting back to my original question, in the 99 percent of the operations you performed, do you follow the cystic duct to the common bile duct before you cut it or not?

MR. BAXTER: Okay. Objection. He's answered that three times, I think that's enough. He said he doesn't follow it to the common bile duct. Why are you asking three times?

Q Doctor, in the distance between where the duct in this case came out of gallbladder and if it was the cystic duct where it should have joined the common bile duct would have been between zero and 4 centimeters, correct?

MR. BAXTER: Wait a minute, I don't understand the question. Are you asking what was the distance in this case or what is the range of

distances you see in the human anatomy?

Q I'm assuming the distance in this case is zero because it's the common bile duct and not the cystic duct, correct?

A Yes.

Q Now, in all of the other 99 percent of the cases that you've done, I think you testified that the average distance between the cystic duct as it comes out of the gallbladder to where it hooks into the common bile duct is between 1 and 3 to 4 centimeters; is that accurate?

A In normal, that's correct.

Q And this is something that can be can visualized by the laparoscope, correct?

A That's correct.

Q Okay. Did you get a chance to review the operative report of which, for the operation that he performed on after your operation?

A Yeah, I just roughly go over it.

Q Is it your testimony that did

not have a cystic duct at all?
A Yes.
Q Did any of the pathology reports indicate that nad a cystic duct?
A As I mentioned, when you look at a pathology let's say the second was a cystic duct, actually that's a common bile duct because histologically, cystic duct is the same as common bile duct. Actually more detail, you can see the spiral valve on the cystic duct or you call the Houston valve, like membrane.
Q Did you ever mention to any other doctor that Ms. Rode did not have a cystic duct?
A No.
Q Is there anywhere in your report that mentions did not have a cystic duct?
A Do you mean talk to patient?
MR. BAXTER: No, operative note I think he means, your typed operative report.
MR. GASTON: Which is Exhibit 1.
A I believe --

MR. BAXTER: Look at your note.
A I believe I wrote a picture on the operative note after I reviewed the HIDA scan right here.
MR. BAXTER: He is pointing to page 2 of his operative note with a handwritten note dated 2-6-06 on our copy of the medical record.
MR. GASTON: I don't have that. Could I take a look at that, please?
MR. BAXTER: You certainly can. The hospital gave this to us.
(Document tendered.)
MR. GASTON: If you want to make a copy could we mark this and have a copy made?
MR. BAXTER: Why don't we refer to it now and we'll make a copy and mark it at the end if you remember, all right? Because I don't want to mark my copy.
Q Doctor, what's been handed to me is page 2 of an operative report and there is some handwritten notes at the bottom of the page dated

2-6-06. Can you tell me if that's your handwriting?
A Yeah, that's my signature and my handwriting.
Q I cannot read your handwriting. Can you read word for word what you wrote in that narrative?
A After seeing percutaneous cholangiogram which demonstrate common bile duct was completely transect. It amazed that the presumed cystic duct was showing in the picture actually was a common bile duct. Hence, she did not have a routine cystic duct at all.
Q Doctor, how far, how far outside of the gallbladder along what you now testified is the common bile duct did you place the clip?
A We always apply as close as to the gallbladder we apply the clip.
MR. BAXTER: As close to the gallbladder as what?
THE WITNESS: As possible.

Q Did I have a right hepatic duct and left hepatic duct?
A Well, after I saw the cholangiogram she has, but we did not see on the laparoscopy at that time. Nobody do that.
Q That brings me to the next question.
A To see the right or left hepatic at all.
Q So would it be fair to say you didn't look for the right or left hepatic duct?
A Exactly.
Q And you didn't look for the common hepatic duct either?
A Exactly because in her case so much of this adhesion, the more dissecting the more trouble.
Q I thought we already talked about three times now that adhesions had nothing to do with this operation, correct?
A Who told you?
Q You did.
A No, adhesion can can cause you more --

MR. BAXTER: No, he's asking did she have adhesions, not whether it can generally cause it, did she have adhesions that affected this surgery?

A Oh, yeah, she had adhesions.

Q Then we're going to have to go back because we talked about the risk of adhesions and I asked you did that have anything to do with this operation and you said no.

A Because I overcome the adhesion. We able to dissect out the duct from the gallbladder.

Q You were able to dissect what?

A The cystic duct from the gallbladder.

Q Excuse me. You just said you were able to dissect the cystic duct from the gallbladder, you just said that, right?

A I just told you I able to dissect the duct from the gallbladder which we presumed the cystic duct and now retrospectively this cystic duct was a common bile duct. I have written there and I always give my same statement, you just try

to confuse.

MR. BAXTER: He's really not trying to -- believe me, he's trying to ask some basic questions. It's unhelpful to accuse him of trying to confuse things even if you think he is. So let's just try to wait for his question and if you want to take a break I'm sure at an appropriate point Mr. Gaston might agree with that and we'll stay on. But just try to do question and answer, it's best for you. Okay?

Q Doctor, can you explain to me where you found the adhesions in body and what steps you took to dissect them away from whatever organs or ducts they were attached to in order to effectively remove the gallbladder?

A I believe you read my operative note. First of all, there's omentum attached to, adhesed to the gallbladder so we peel this down and the gallbladder was huge, distended, indurated, we had to decompress, aspiration the content of the gallbladder. So we able to grasp the gallbladder

to expose the so-called counter triangle. And then I dissect around the gallbladder wall to the neck and then from there by sharp and blunt dissection we able to dissect a tubular structure directly come from the neck of the gallbladder. And I have been doing this for thousand case, this must be a cystic duct. Is that clear to you?

Q It is. Getting back to my original question, how did adhesions affect any way that the anatomy was presented during the operation, if at all?

A Adhesion can mix you up, can make all the bile duct, common bile duct confused with gallbladder or the duodenum.

MR. BAXTER: He is asking about in this case, not generally. In this case what a difference, if any, did the adhesions make in the operation, in this case. If it made no difference at the end of the day, tell him. If it did make a difference in this case, tell him.

A This case I able to dissect. I can find

out where is the duct come from, from the gallbladder.

Q That's what I thought. I thought your initial answer was the presence of adhesions had nothing to do with the manner in which the operation was performed; is that accurate?

A Yeah, in this case adhesions, I become experienced and dissect it out, yeah.

Q Let's go back to the chart we have, number 4. Okay. You said you didn't look for the left hepatic duct, correct me if I'm wrong, you didn't look for the right hepatic duct and you didn't look for the common hepatic duct, correct?

A Correct.

Q If you put the clip on the common bile duct, is it attached to the gallbladder, as close as you could to the gallbladder?

A Yes.

Q Then why did that result in obstructive jaundice if there was room along the right hepatic duct and common hepatic duct and common bile duct

for the bile to get down to the intestine?
MR. BAXTER: You just made that statement that there was room for that after the clip was placed and he's already told you in retrospect the duct was found in the common bile duct, so what he has told you is inconsistent with your unsupported statement.
Q Doctor, what I understand you to say is you put the clip as close to the gallbladder as you could on the common bile duct, correct?
A Yes.
Q Now, why did that then block or result in obstructive jaundice?
THE WITNESS: Can I draw a picture?
MR. BAXTER: That's up to Mr. Gaston.
A That's okay. One, this stone right here, and in old people this heavy stone push, push, push, push, okay, this is the reason my retrospect explanation to see how could it happen, all that stone push, push and the cystic duct become this big in here. All right? Direct saw

the gallbladder is directed down here and then when you dissect the tubular structure come from the gallbladder and this we presume is a cystic duct so we put a clip here and a clip here. So when I do the cholangiogram, the blockage is right here.
Q I understand. So the clip that you placed in common bile duct was approximately where on Exhibit Number 4 there's an arrow going from the common bile duct over to the green which is actually the duct in this place, that the approximate place where you put the clip?
MR. BAXTER: Objection. There has been no agreement or even a representation that this exhibit accurately reflects duct system but you can answer the question.
A You can say that way in her case.
Q Is that accurate, Doctor?
A Yes.
Q Okay. Doctor, in your operative report I'm going to ask you to explain this sentence to me.

A In my or his?
Q Yours, Doctor, page 1, the document you have right in your hand.
A Right here?
Q It's the exhibit.
MR. BAXTER: There are different versions of it.
Q I'm going to refer you to Exhibit 1. Down towards the bottom of the page it says after the gallbladder was removed, since I am concerned the cystic duct with the common bile duct and with further investigation I can now find. You did --
MR. BAXTER: Give him a second. This sentence here that starts here.
(Pause for document review.)
A Okay.
Q Is what I just read -- see, I don't have that in front of me, Mr. Baxter.
MR. BAXTER: All right. Go ahed.
Q The words that I just read to you is exactly as it appears on your report. Doctor, when

you read that, can you explain what that means to me?
A Because I always concerned the big cystic duct. If that the case, I encountered several hundred cases like that. I always concerned not only this one. Then I would do further investigation before sending the patient home.
Q The investigation says I can now find it. Does that mean you found the cystic duct or not?
MR. BAXTER: This actually says I can now find, period.
MR. GASTON: Yeah, that's what mine says.
A I cannot find, the cystic duct was obliterated.
Q Can find it or cannot?
A Cannot find it.
Q How was it obliterated?
A As I mentioned to you, and also the

picture show here, you've got a heavy stone and this keep on push down, push down. She might have a cystic duct but the gravity, infection, because you know the normal function is this, every time when there's something, gallbladder contract and gallbladder contracts and push the stone to the distal. Gallbladder tried to squeeze out to the cystic duct to the common bile duct, that's the major cause of the gallstone.

Q And then after you opened the gallbladder itself, in your report, to the neck of the gallbladder was identified, the cystic duct was obliterated and able to pop out of the opening. So it looks like after you cut the gallbladder open you were able to find the cystic duct; is that accurate?

A But that cystic duct is a common bile duct.

Q Doctor, if the cystic duct was a common bile duct, then why did you write in your report after you cut the gallbladder open that you

identified the cystic duct? Why didn't you just call it the common bile duct?

A It's open, there is a tubular structure so we call the open up. I don't know why you try to misleading me.

Q I'm not misleading you. I'll ask you the question again. If you don't understand my question, I will rephrase it.

You wrote in your operative report after you cut, after opening the gallbladder itself, to the neck of the gallbladder was identified, the cystic duct was obliterated and able to pop out of the opening. Now, you know the difference between the cystic duct and a common bile duct, correct?

A Only anatomy.

Q Do you know the difference between a cystic duct and a common bile duct?

A It's anatomy or histologically.

Q It's a yes or no question, Doctor.

MR. BAXTER: It doesn't have to be. He's answering the best he can.

Q When you wrote the cystic duct was obliterated, is that what you meant?

A Yes. But it still an opening. And to a duct. That is what I tried to say.

Q I'm trying to figure out if what you wrote here was correctly, that the cystic duct was obliterated and able to pop out of the opening.

MR. BAXTER: Wait for a question.

Q That means it was there.

A No, that means cystic duct not complete blockage by the stone, that is what I'm trying to say.

Q Well, did the cystic duct pop out of the opening or not?

A Yes. The cystic duct had a neck, we opened it up, that's what I'm trying to say. It's the end of the cystic duct.

Q So were you able to find the cystic duct attached to the artery, I mean attached -- excuse me, my mistake. You were able to find a cystic duct that was attached to the gallbladder?

A Yes.

Q All right.

MR. GASTON: Can we take five minutes?

MR. BAXTER: Yeah, sure.

(Brief recess.)

Q Doctor, in Exhibit number 5, is there any page, any of these photographs you can tell me that show where the stone is that you say worked it's way down through the gallbladder? Number 5.

A Stones are right here.

Q Okay.

A Stone is right here.

Q So the area that you're pointing to --

A Yeah, stone right here.

Q -- if we are going to identify picture in the upper left-hand corner --

A Stone right here.

MR. BAXTER: Wait, one at a time. Let him talk.

Q What is this black instrument that's in the upper left-hand corner of photograph Exhibit 5?

A That's a dissector.
Q Dissector, okay. You're indicating that the stone is to the lower side of the dissector in the gallbladder itself?
A We call the neck of the gallbladder.
Q Neck of the gallbladder.
A Yeah.
Q Okay. And in the picture that is on the upper right-hand corner, can you indicate where in this picture is the stone?
A Right here, right here. Lifted the gallbladder up to take a picture and exposed it right here.
Q So the stone would be, we have the duct that's cut on the left-hand side, the stone would be to the right of that and slightly upward?
A Yeah, just right here, around here, yeah.
Q All right. Thank you, Doctor.
A Okay.
Q Doctor, how many other operations have

you found that a large stone made its way down through the neck of the gallbladder obliterating the cystic duct?
A How many?
Q Yeah.
A Some are completely obliterated, some are just part of the cystic duct obliterated. How many? I would say maybe about less than ten.
Q Less than ten. Okay. Would it be fair to say in case you were able to identify the presence of the stone down towards the neck of the gallbladder before you clamped and cut the duct?
A You can say that.
Q In the other cases where you found the gallbladder stone down towards the neck and obliterated the cystic duct, how were you able to identify the cystic duct from the common bile duct in those cases?
A Most of them we, most of them not able to clearly identify the duct system. All of them

it's open case.
Q So in those cases you converted to open?
A Yeah.
Q In those cases where the stone had came down and obliterated the cystic duct, was it similar to what you found in case?
A Well, not similar. They are the cases I could not identify through laparoscopy like case which so many mass structure, I cannot see who is who, who is the gallbladder or who is the cystic duct, who is the duct system. So they're all kind of case we open up and then after analysis and if they are we are lucky, we open up.
Q What I'm -- so when you -- in the less than ten cases, did these cases occur before case?
A Yeah.
Q So in those cases where you have the stone all of the way down toward the neck that obliterated the cystic duct, you decided to do the open procedure, correct?

A Yeah.
Q Now, in case when you had the stone all of the way down toward the neck of the gallbladder, based upon your prior experience, in those other cases where the cystic duct was obliterated, did it cross your mind that the cystic duct could also have been obliterated in this case?
A It could but unluckily we able to -- well, you cannot say it that way. We see a lot of case like big neck come out of the tube structure like this case. But all of them we can come over without damaging the common bile duct.
Q What I'm asking is when you saw the stone that far down in the gallbladder neck, did it cross your mind that the cystic duct could have been obliterated by the stone?
MR. BAXTER: In case?
MR. GASTON: In case.
A This is the reason I concerned after we remove the gallbladder.
Q No, no. Back up. I'm talking about

before you removed the gallbladder. In other cases you've seen the stone come down and obliterate the cystic duct. In this case the stone came down close to the neck where the cystic duct would be. Did you consider in this case that the cystic duct could also be obliterated because of the stone?

A Yeah, this other case but all other case I can, there is no injury to the common bile duct and I saw this might be as the previous case the same thing, big cystic duct. Okay, but it turned out to be not like the case.

Q When you considered in case that the cystic duct could be obliterated by the stone and the position it was in the gallbladder, why did you not agree to go to an open procedure in her case?

A Well, I can very well define the duct is come out from the neck of the gallbladder. I can very well define the tubular structure directly come out from the gallbladder and also my experience told me this must be a cystic duct. I

can count about ten cases like this and I able to avoid lawsuit like this one.

Q You were able to avoid an injury to the patient in the other cases because you converted to a open procedure?

A No, no, no, no, no.

Q I'm sorry?

A We can do the same thing. No, no. Some of --

Q I'm sorry. Were any of the other --

A Hold on.

MR. BAXTER: Wait a minute. Let him finish.

A Yeah, let me explain to you.

MR. BAXTER: Well, let's just try to respond to his question, okay, if you don't mind, but go ahead, Doctor.

A Some case picture swollen tubular structure like the case, swollen cystic duct and I able to just do the same thing as I did on , clip it, divide it and do the study and show

no injury common bile duct. Until this.

Q Doctor, in lieu of converting to an open procedure, because there was a possibility that the cystic duct had been obliterated in this case and you considered that before you clipped the duct, could you have performed a cholangiogram?

MR. BAXTER: Intraoperative?

MR. GASTON: Yeah, intraoperative cholangiogram.

A It's another layman's question. If the duct is there connected directly from the gallbladder, you do the cholangio, do the cholangiogram. If this is a common bile duct as you thought, you might injure the common bile duct. Why you had to do a cholangiogram at that time? You may as well just don't do it, less complications instead of doing a cholangiogram on this one.

Q Are you telling me --

A Unless you cannot clearly identify the tubular structure.

Q You answered the question I think saying that you believe it was too risky to do the interoperative cholangiogram in this case because of potential injury to the duct?

MR. BAXTER: Objection to the form. You may answer.

A Unnecessary cholangiogram.

MR. BAXTER: Unnecessary.

A Unnecessary cholangiogram you just do harm to the patient. There's only about five percent of the laparoscopy cholangiogram being performed, unless you cannot clearly identify the tubular structure.

Q Okay.

A And then you do cholangiogram down, cut through the cystic duct, through the gallbladder, injection of dye get to the gallbladder and then the gallbladder will connect you to the cystic duct, to the common bile duct.

Q But if you used a cholangiogram in this case it would have clearly revealed that the duct

you were about to cut would be the common bile duct?
A If I could not clearly identify the tubular structure come from the gallbladder neck, I will open. I don't do cholangiogram.
Q Okay. The next question is if you realized that the duct you were about to cut would be the common bile duct, how would you remove her gallbladder?
MR. BAXTER: Do you mean if there was no cystic duct?
MR. GASTON: Right.
MR. BAXTER: If you knew that going in, if you know that in the patient how do you take the gallbladder out?
Q Yeah, how do you remove the gallbladder without causing obstructive jaundice to the patient?
A Can you make it clear for me?
Q Sure, Doctor. In this case we all know that you cut the common bile duct and that resulted

in obstructive jaundice, correct?
A Yeah.
Q Now, if you had realized before you clipped the common bile duct that it was the common bile duct, then how would you remove the patient's gallbladder, what steps would you take?
A All right. You said before you removed the gallbladder and you sure this is the common bile duct to the gallbladder?
MR. BAXTER: That's correct.
Q Assume that, assume that for this question.
A Yeah. It's easy. You open the gallbladder, get rid of the stone, suction out and you put the staple on the neck of the gallbladder and you get rid of that and it come out.
Q So by putting the staple on the neck of the gallbladder you then don't obstruct the common bile duct?
A Exactly.
Q And that's an easy procedure?

A Exactly.
Q Have you ever done that procedure on a patient?
A No.
Q But you do know how to do it?
A Exactly.
Q Did you ever explain to ! what happened during the operation?
A Yeah, I did.
Q What did you tell her and when did you tell her?
A The next day I guess, her daughter there too, and I showed them the picture.
Q The picture you're talking about is Exhibit 5?
A Yeah. And I say well, your anatomy is very unique. You do not have, you did not have a cystic duct which I thought it turned out to be the common bile duct and you need a repair secondary.
Q Did you explain to her that you accidentally clipped and cut the common bile duct?

A I didn't say accidentally. I told her your bile duct come from the gallbladder, it's common bile duct, not the routine cystic duct. There's a reason you got complication.
Q Did you explain to her that what I thought you clipped was the cystic duct and it turned out to be the common bile duct?
A Exactly.
Q That's what you told her?
A Yeah.
Q Doctor, during the performance of a gallbladder operation if a surgeon has a choice of performing a portion of the operation in one of two methods, and one method exposes a client to a risk and the other method would completely eliminate that risk, do you believe as a surgeon it would be prudent for the doctor to choose the method that completely eliminates the risk?
MR. BAXTER: Objection to the general nature of the question and failure to address any risks attended to the alternative. You may answer

the question.
A Well, we tried to avoid raising complications with the patient. That is my principle rule for do surgery.
Q So if there was a choice for a procedure that would completely eliminate the risk of injury, then you would choose that method?
MR. BAXTER: Objection.
A Yes.
Q I'm sorry, is that yes?
MR. BAXTER: Objection.
A Yes.
Q Okay. Thank you.
MR. GASTON: That is all I have.
MR. BAXTER: Just for the record, we have here original chart including three sheets -- may I see those for a minute?
MR. GASTON: Sure.
MR. BAXTER: -- of photographs, two of which, one of which is a copy of the other. And there are four pictures on each sheet. On the

first sheet there are three pictures of anatomy and a black picture, on the second sheet there is one picture of the anatomy and three black sheets. The third sheet of photography is a copy of the second sheet. Have we marked all three of these collectively as Exhibit 5?
MR. GASTON: No, I would ask the reporter to mark the second photograph as 6. And the second and third are identical, correct?
MR. BAXTER: Yes.
MR. GASTON: Just the second one as Exhibit 6. And if I could get color copies I would greatly appreciate that. We also need to have the court reporter mark the second page of operative report as Exhibit 7 I believe.
(Exhibits 6 and 7 marked.)
MR. BAXTER: You have a right to review the typing of this testimony to make sure our court reporter has accurately recorded what you said. Because you have an accent, I think it might be helpful for you to read it and then you will be

given a chance to make corrections if you think corrections are in order and I will explain how you do that later. Having been advised of that right, would you like to read the transcript?
THE WITNESS: Yeah. When they finish they are going to send me a copy?
MR. BAXTER: Yes. We will read.
(Deposition concluded at 12:03 p.m.)
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CERTIFICATE OF DEPONENT

I hereby certify that I have read and examined the aforegoing transcript, and the same is a true and accurate record of the testimony given by me.
Any additions or corrections that I feel are necessary, I will attach on a separate piece of paper to the original transcript.

STATE OF MARYLAND, COUNTY OF BALTIMORE:

I, Richard D. Baker, Jr., a Notary Public in and for the State of Maryland, County of Carroll, do hereby certify the within named M.D. personally appeared before me at the time and place herein set out and, after having been duly sworn by me according to law, was interrogated by counsel.

I further certify that the examination was recorded stenographically by me and then transcribed from my stenographic notes to the within typewritten matter in a true and accurate manner. I further certify that the stipulations contained herein were entered into by counsel in my presence. I further certify that I am not of counsel to any of the parties, nor an employee of counsel, nor related to any of the parties, nor in any way interested in the outcome of this action.

AS WITNESS my hand and notarial seal this 4th day of January, 2010, at Eldersburg, Maryland.

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