IN THE SUPERIOR COURT OF THE STATE OF DELAWARE

IN AND FOR KENT COUNTY

SHARON JOHNSON, Administrator of the Estate of THEODORE JOHNSON, Deceased, CHEZELLA THELMA JOHNSON HANKINS, JACQUETTA EVELYN JOHNSON HANKINS, Plaintiffs, v. THOMAS P. BARNETT, M.D., and SURGICAL ASSOCIATES, P.A. Defendants.	ID No. 08C-10-044 Testimony of Dr. Steven Becker, M.D. February 22, 2011

* * * * *

BEFORE: THE HONORABLE ROBERT B. YOUNG, JUDGE

* * * * *

APPEARANCES:

GILBERT F. SHELSBY, JR., ESQUIRE
and ROBERT J. LEONI, ESQUIRE
Shelsby & Leoni
on behalf of the Plaintiffs.

DENNIS D. FERRI, ESQUIRE
Morris James, LLP
on behalf of the Defendants

COURT REPORTER: Andrea M. Saatman, RPR

INDEX TO WITNESSES

DR. STEVEN I BECKER, M.D.

INDEX TO EXHIBITS

PLAINTIFF'S EXHIBITS	ADMITTED
1	6
2	58
3	60

ANDREA M. SAATMAN
Official Court Reporter

(This matter commences at 1:45 p.m.)

THE COURT: Okay.

Mr. Shelsby.

MR. SHELSBY: Thank you, Your Honor. At this time, we would call Dr. Becker as the Plaintiffs' next witness.

* * *

(DR. STEVEN BECKER, having been called as a witness before the Court and Jury, is duly sworn, examined

and testifies as follows:)

* * *

DIRECT EXAMINATION

BY MR. SHELSBY:

Q. Good afternoon, Doctor.

A. Good afternoon.

Q. Would you tell the members of the jury what your medical specialty is?

A. I do general and vascular surgery, and in general surgery, most of my cases are laparoscopic.

Q. All right. We heard from Dr. Barnett about his education, his training and his experience and background. Is that similar to yours?

A. In certain parts, yes. Laparoscopically, we started

about the same time. I started in 1989 doing laparoscopic -- training laparoscopically and did the first laparoscopic cholecystectomy in 1990.

Q. Okay.

A. I then helped develop instruments for a company called Davis & Geck. I developed some graspers that are still used today.

Q. Are you talking about instruments that are used in laparoscopic surgery?

A. Correct. I was a consultant. They asked me to consult when I started doing laparoscopic surgery, and we designed some instruments and also a needle that my name is on the patent. But I did some work with them, but I have been

doing laparoscopic cases since 1990.
Q. And included in the laparoscopic cases that you have done, have they included gallbladder surgeries?
A. That was the first type of laparoscopic cases that were done, laparoscopic gallbladder, then laparoscopic common bile duct, then hernia, then appendectomy, then others, Nissen fundoplication.
Q. Are you still doing laparoscopic gallbladder procedures currently?
A. Yes.

ANDREA M. SAATMAN
Official Court Reporter

Q. All right. And let me talk a little bit about your education. Can you tell us where you went to medical school? Take us through your training up until the time you went into private practice.
A. I did my medical school at the University of Brussels in Belgium. I finished there. I did a clinical clerkship in, it was Long Island Jewish and it was also Queens General. It was a combination. It fulfilled my requirement at Belgium for an internship.
I then did a straight medical internship at Mount Sinai's affiliate in Queens, New York. And then, I did two years at Long Island Jewish Surgery and finished my last three years at St. Vincent's in New York City. I did my chief residency at St. Vincent's, which was my fifth year. I then went to work with a group who was supposedly mainly doing vascular surgery. I didn't complete that. I then went into private practice in 1981, '82. I have been in private practice since that time.

Q. Okay. And the private practice that you are in, would you describe that as general surgery private practice?
A. I do -- 80 percent is general surgery. I do vascular surgery too, but 80 percent is general surgery. And since 1990 and after, most of the cases that I do are

laparoscopic.
Q. All right. Are you board certified?
A. Board certified in 1984. I'm certified till 2016.
Q. And you're board certified in what medical specialty?
A. General surgery.
Q. Okay. Doctor, I have a copy of your curriculum vitae which sets forth your education, your training, some additional information regarding your certifications; is that correct?
A. Yes.

MR. SHELSBY: Your Honor, I'd like to offer this as Plaintiff's Exhibit No. 1.

MR. FERRI: No objection, Your Honor.

THE COURT: All right. Without objection, that can be admitted.

THE CLERK: It is so marked as Plaintiff's Exhibit No. 1, Your Honor.

THE COURT: Thank you.

(Plaintiff's Exhibit No. 1 is received in evidence.)

BY MR. SHELSBY:
Q. Doctor, have you been called upon in the past to review

medical negligence cases at the request of lawyers?

A. I have for the past almost 26, 27 years.
Q. All right. And have you been qualified in jurisdictions to be an expert in the area of general surgery?
A. Yes.
Q. Have you been qualified by courts as an expert in the area of general surgery as it relates to gallbladder surgery?
A. Yes.
Q. All right. You charge for your time in reviewing medical malpractice cases?
A. I do.
Q. And you've charged for your time in being here today; is that correct?
A. That's correct.
Q. Now, your office is located where?
A. Well, I have two, but my main location is in Fair Lawn, New Jersey. I have a smaller satellite office in New York in Queens in Forest Hills.
Q. And you're taking a day off from your general surgery practice, from your practice, to be here today?
A. I am.
Q. What do you charge to appear in court here today?

A. $6,000 a day plus expenses for court testimony.
Q. Okay. Now, at my request, you reviewed a number of the medical records in this case; is that correct?
A. Yes.
Q. Those medical records are fairly voluminous?
A. There's multiple binders, yes.
Q. They include the records from Kent General Hospital?
A. They do.
Q. Records from the University of Maryland and the follow-up care from Mr. Johnson after he was discharged from Kent General Hospital?
A. That's correct.
Q. All right. And you had other records as well relating to his medical background and medical history; is that correct?
A. I did.
Q. All right. You have also had an opportunity to review depositions in this case?
A. I have.
Q. And you, in addition to reviewing the medical records and the depositions, also gave a deposition in this case yourself, correct?
A. I did.

Q. All right. You understand, Doctor, that in order to express an opinion before a jury, you have to do so within a reasonable degree of medical probability. Do you understand what the standard is?

A. I do.
Q. All right. I'm going to ask you some questions today about your opinions, and I'm going to ask that all those opinions be expressed within a reasonable degree of medical probability. You let me know if you cannot do so within that standard. Is that fair enough?
A. Fair.
Q. All right. Based on your experience, your background, your review of the medical records, the depositions in this case, did you formulate an opinion as to whether Dr. Barnett breached the applicable standard of care in his treatment of Mr. Johnson?
A. I did.
Q. All right. And what was your opinion?
A. Well, there are two opinions, two different areas. First, that the anatomy of Mr. Johnson wasn't adequately defined prior to cutting any duct structure, and as a result, the right and left common hepatic ducts were severed in the process, creating a bile leak.

And the second opinion is that in the face of Mr. Johnson's lack of progression and particularly at the point in time when he had an elevated white count and elevated bilirubin, elevated liver functions and other factors, there was no exploration, creating a delay.
There was also a delay in recognizing the injury, as it wasn't recognized at surgery. So the delay isn't recognized in surgery, and then faced with the fact of his condition and significant findings that would suggest an

injury, there was no evaluation or treatment for an extended period of time creating a delay.

Q. I want to separate those two opinions. The first one you said related to his cutting of ducts and the way in which he performed the operative procedure, and I want to focus in on that.

A. Yes.

Q. In the circumstance where you're going to do a gallbladder surgery, what does the standard of care require with regard to identifying anatomy before one starts to cut any tissue or ducts that are in the area?

A. Well, let's take a step back. All gallbladder that we do is either chronic or acute. In other words, they have disease that also leads to adhesions, that always leads to

tissues sticking together. It depends on how long they have had it or how acute the gallbladder is.

The first thing you have to do is you have to identify your structures. The only structures in this operation that should be cut are the cystic duct and the cystic artery, and the gallbladder should be removed from the liver bed. That's the surgery.

The problem you have is you have other structures in the area that are very important. You have the common bile and the common hepatic ducts. If you go high enough, then you have the right and left hepatic ducts, and if you go to the left side, you have even more structures such as the hepatic artery, the portal system,

all which must be preserved. Injury to those structures are devastating, so you have to identify your anatomy. You have to confirm your anatomy before you clip or cut. And once you do that, you've met the standard.

Q. Okay. And how is it -- when you go in to do a gallbladder surgery, how is it that you identify the anatomy before you start to cut? How do you do that?

A. Well, once you enter the abdomen, of course, you look around and you enter with a scope, a telescope that sees inside the body. You lift up the liver, you identify the

gallbladder, you grab it. Very often, there are adhesions, tissue that's stuck to it. You first have to take those off. Those are taken off either bluntly or with scissors and cut. It depends on how thick they are and how much difficulty they give you.

At that point, you have to track down and identify the cystic and gallbladder junction, and then you have to follow the cystic duct down till it meets another structure. The other structure it meets is the common bile duct. Once you identify that junction, all you have to do is encircle the cystic duct and clip it, and the next step once that's done is to identify the cystic artery which passes higher up and encircle it and cut it.

And so, we look for three structures that form a triangle, and we mentioned earlier today the name of that triangle is the triangle of Calot. Originally, it was described with the three sides being the cystic duct, the common bile duct and the liver. Over the years, that's

changed as a teaching method. The cystic artery travels very close to the liver, so if you identify the common bile duct, the cystic duct and the cystic artery, that forms a triangle, and two of those structures have to be identified and then transected to remove the gallbladder.

Q. Okay. You just described that, but I want to see if I can draw a diagram or have you draw a diagram so that we can understand what structure it is that you're trying to identify.

MR. SHELSBY: Your Honor, may I have the witness step down?

THE COURT: Sure. While he's doing that, could I see counsel for a second?

MR. SHELSBY: Sure.

(A brief scheduling discussion is held.)

BY MR. SHELSBY:

Q. All right. Then you've just drawn a diagram. Can you show us on the diagram what the structures are that you've depicted and what their significance is?

A. Yes. Well, first, the liver, which is the structure which creates the bile. From the liver, the bile goes down through the left hepatic duct and the right hepatic duct, and this is the right. These two ducts form what is called the common hepatic duct. Right hepatic. Left hepatic. This is called the common hepatic duct. The gallbladder sits under the right lobe of the liver, and there's a little pocket called a fascia.

23 The cystic duct comes out of the gallbladder,

travels to join the common hepatic duct forming what is called below is the common bile duct. So basically, it changes its name because the cystic duct joins it and it joins lower on as it goes down into the small intestine called the duodenum. And that's the small intestine.

Q. Okay.

A. So you have the duct system, the gallbladder forming with the cystic duct. The red structure is the cystic artery which travels to the gallbladder very close to the liver, and this forms the triangle they were talking about between the common bile duct, the cystic duct and the artery, which is called Calot's triangle, the triangle of Calot.

Q. All right.

A. That's where your structures that you have to pay attention to are all located.

Q. All right. And when you are identifying the structures in that area, why is that important to a surgeon that he or she knows where the structures are when they are in this triangle?

A. For several reasons. First of all, all these areas are either adhesed or inflamed when you do the surgery. What you don't want to injure is the common bile duct, the common

hepatic duct or the right and left hepatic ducts. They are very small. Reconstruction of these ducts is very difficult and has a lot of complications afterwards.

You don't want to injure the common bile duct if you don't have to, but you want to identify it in case you have to work by it because very often, you're dealing with adhesions. Tissue gets stuck and you are very often working by it, so you want to identify where it is so you can see it. You don't have to dissect it free. You just have to know where it is. And if you're working by it, you have to know it's there.

Q. Okay. Lets' go to another page and do a diagram. Just show us when you're trying to take the gallbladder out, explain to us just sort of what anatomy you're looking for and how you would take the gallbladder out so that you do so without causing any injury to a structure that you're not intending to.

A. And this is very schematic. When you first go in there, as I mentioned, the gallbladder is sitting under the liver, so you actually have to lift it up. We have graspers like pliers that grasp the structure. We pull it whichever direction we want, up and lateral, to try to expose this area.

Another grasper is taken over here and it also is held out. So we try to create as much of a straight line as we can. We then start our dissection along the anterior surface to identify which is the cystic duct. We

follow the cystic duct down until we reach another structure called the common bile duct.

Q. Okay.

A. We're looking for two structure. We are looking for A and we're looking for B, and we want to know where these two structures come in contact with one another. Once we see these two structures, we know that this is cystic and we know this is common. If we have any question, we have two options. We can put a catheter in and take a picture or if we're really confused, we can open, okay?

But you have to know where these two structures are because if you injure this one, you have a devastating complication. You don't want to do that. And, again, there are different types of complications. You can put a hole in it and repair it. That's not that bad. But transection, usually, you can't put the two ends back together. Sometimes you can, sometimes you can't depending on the size, but transection creates problems.

You go down, you understand where your

junction is, and at some point, you place what are called clips. You can put two, you can put three. It really doesn't matter. You then transect the duct. In this case, it's the cystic duct.

Once you've done that -- and, again, you have to look for the next structure, which is the artery. The cystic artery comes out most of the time behind the common bile duct and goes to the gallbladder very often in two branches. You have to identify the cystic artery and you

have to put clips on it and cut it. You can put two clips. It doesn't matter how many clips you put on it. You have to clip it and cut it between, and that frees up the cystic duct, the cystic artery.

Once those are freed up, the gallbladder can be removed. And then it's removed from the liver bed with instruments. There are different types of instruments that can be used. Cautery, which is an electric device, can be used. There are devices that work on vibration, Harmonic scalpels. There's ligature devices which are also electric-type currents. It doesn't matter how. You have to remove the gallbladder from the liver bed. That's your next step. And then you remove the gallbladder from the abdomen.

Q. You were present in the courtroom when Dr. Barnett was

giving testimony?

A. Yes.

Q. And he testified that he does not, as part of doing the gallbladder procedure, identify the common bile duct. Do you have any opinion as to whether that is a breach in the standard of care?

A. Yes. And if you remember what he said, "When we did it open." There's no difference between open and closed in this procedure. Laparoscopic only is how you go in after it. You use puncture wounds instead of a big incision, which is an advantage.

Same surgery. You have to know the same structures. If you want to know and you want to be safe,

you have to know where the three structures are, one, two and three. And that's classical teaching. It's not taught laparoscopically different than open. Open or laparoscopically, you take out the same thing. You have the same complications. There's no difference in complications.
Q. Is it, then, your opinion that it's a breach in the standard of care to not identify the cystic duct before you cut a duct in an effort to remove the gallbladder?
A. The cystic and common bile duct.
Q. The common bile duct. I'm sorry.

A. Both have to be identified.
Q. Okay.
A. Again, not dissected out. The words "skeletonized" was used and "dissecting out." Not dissecting out. When you see your junction -- and you can see it pretty clearly. A small tube goes into a big tube -- you don't have to dissect the big tube. You just have to, at that point, encircle your small tube, put your clips, and that's your cystic duct.
Q. Okay. Let's talk about what Dr. Barnett did when he did this procedure. And I'm going to ask you if you can explain to the members of the jury what structures that he stapled and he cut when he actually did the gallbladder procedure.
A. Okay. Let me take a step back. The reason we know a lot of this is because in the hospital, subsequent tests were done. They were called cholangiograms; they were called ERCPs, which is a cholangiogram done to the duodenum.

Pictures were done, and from the pictures --
Q. Why don't you use another page.
A. Okay. From the pictures and -- well, from the pictures, from the fact that he was operated on in April and from the autopsy, we have an idea of basically what happened

or where things happened.
Q. Let me stop you there. When you say the pictures, we're talking about the ERCPs. Those with the dye studies that were done?
A. There's ERCP's. There's percutaneous cholangiograms. There was an operation and there was an autopsy.
Q. Right. The operation was an operation done at the University of Maryland?
A. Correct.
Q. Then there was the autopsy?
A. Right.
Q. They describe what's in the anatomy as well. So looking at all three of those factors, you're able to go back and reconstruct where the injures were?
A. Right. From where they say things were cut and what they found.
Q. Okay. Would you explain to the members of the jury what the medical records show with regard to where the injures were sustained?
A. Okay. This is the right hepatic duct. We know from the percutaneous transhepatic that a catheter was put in here, that this duct structure was cut and was leaking bile

into the abdomen.

Q. Okay. Can you tell us where the liver is in relation to that?

A. The liver is up here.

Q. Okay.

A. I'm trying to make just the areas that we're working in.

Q. Right.

A. They put a catheter in. They went through the skin. They put a catheter in mainly to drain dye -- mainly to drain bile, but when they injected dye, they noticed that this duct was open and was draining into the abdomen. So it was a bile leak.

Q. Okay.

A. Okay? They also noted that on the other side, which is the left hepatic duct, there was a clip. Again, they found that when they operated on April 9th, they found a clip and they found an open duct. On the ERCPs that were done and the percutaneous, they read that the common hepatic duct, the duct over here, the common hepatic duct, had a clip across and was transected.

And the radiologist said it was transected mid to distal common hepatic duct. So that would be somewhere -- it was before the bifurcation. They also said

that the transection -- I'm just trying to show a "Y" here. I'm not doing a good job. They also said transection of these two ducts was above the bifurcation. So in other words, the bifurcation would be somewhere here. These were transected across.

So you have the right and left hepatic ducts that were free, one with a clip on it. They also made mention of an accessory duct that connected the two. That's just an anatomical thing. You have accessory ducts.

Q. Okay.

A. It has no function. I mean, it has minor function, but it's not a major duct.

Q. Okay. I want to make sure we orient us to where the surgery was done and where the cuts were. Let's start over here on the left hepatic duct. This was cut?

A. Yes.

Q. All right.

A. Right hepatic.

Q. Right hepatic?

A. Right hepatic was cut.

Q. Can you just put a red --

A. Let's do this.

Q. Okay. And that was cut and open?

A. That was cut and bile was freely draining out.

Q. All right. Now, on the left hepatic duct, there were clips?

A. There was a clip, yes.

Q. And what does the clip do to that hepatic duct?
A. It stops the bile from going down. And it was also noted that the duct was dilated, bigger than normal.
Q. And what would cause it to get dilated? Does dilate mean it got bigger?
A. Got bigger because as the bile comes out, it comes out with a pressure and it's pushing against the clips and backing up. And so, this blows up like a little balloon, makes it bigger.
Q. Okay. Now, down here are the common hepatic duct and the common bile duct?
A. Right.
Q. Which is down in this area. There were clips found on the top of that?
A. Yes. The common hepatic duct is transected. It was cut.
Q. All right. And it also had clips on it?
A. It had a clip on it, yes.
Q. All right. Now, in terms of where the gallbladder

surgery should have been done, can you describe for us where the cuts should have occurred in relation to where they actually found structures cut?
A. I'll do that. Let me just add one other point. On the autopsy, we know the distance from the ampular to where it was cut was seven centimeters, the pathologist.
Q. Okay.
A. What you need to do is what I described before. The cystic duct is what you need to cut which is over here. You

need to cut the cystic duct, identify it, cut it, transect it, and the cystic artery needs to be transected. So you're working to the right of the common bile duct.

Q. Okay. So in terms of what the standard of care would have required in the removal of the gallbladder, it was to have staples and cuts at this location?

A. Cystic duct and cystic artery are the only two structures you want to cut.

Q. Okay. Do you have an opinion within a reasonable degree of medical probability as to whether it was a breach in the standard of care in this operation to have transected the right hepatic duct?

A. Yes.

Q. And what is your opinion?

A. Yes.

Q. All right.

A. It's a breach.

Q. And do you have any opinion within a reasonable degree of medical probability as to whether it was a breach in the standard of care in this operation to have clipped and cut the left hepatic duct?

A. I do.

Q. And what is your opinion?

A. Same opinion. It fell below the standard of care.

Q. And do you have an opinion within a reasonable degree of medical probability as to whether it was a breach in the standard of care to have cut the common hepatic duct and to

have clipped the common hepatic duct in this operation?
A. I do.
Q. And what is your opinion?
A. That it fell below the standard of care.
Q. All right. Now, do you have an opinion as to how many -- I want to say -- let me use the word "cuts," but how many cuts were involved in removing the gallbladder in this surgery? Do you have an opinion on that?
A. From everything I see, I would say three cuts. You have to cut one duct, two ducts and three ducts.

Q. Okay. And in terms of the operation itself in terms of the number of ducts you need to cut, if you do it in conformance with the standard of care, it requires how many?
A. Well, one duct, but the different one than these.
Q. Right.
A. The issue is these ducts. You don't need to cut these ducts to remove your gallbladder.
Q. All right. In fact, the only cut that you need to make is right here?
MR. FERRI: Objection. Leading, Your Honor.
MR. SHELSBY: I'll rephrase it.
BY MR. SHELSBY:
Q. Tell us what the one cut is or the one structure you need to cut in order to do this operation in conformance with the standard of care?
A. One ductal structure is the cystic duct. The two structures, you need the cystic artery and the cystic duct. They are two different structures. But the only ductal

structure you have to cut is the cystic.
Q. Okay. I meant to ask you this earlier. You've drawn a diagram of the cystic duct. How long is that cystic duct usually in most individuals?
A. The cystic duct varies in size. It's usually between

one and two sonometers, but it can be longer. It can be shorter. In this case, the pathologist tells us in the path report that he sees a cystic duct that's 1.1 sonometers long. So it's not the shortest cystic duct; it's not the longest cystic duct.
Q. Somewhere in the middle?
A. Correct.
Q. You used the word sonometer, but for 1.2 sonometers, that's a centimeter; correct?
A. 1.1 centimeters.
Q. 1.1 centimeters.
A. Mm-hmm.
Q. Which is about a third of an inch?
A. No. That would be about a half inch.
Q. A half inch?
A. 2.2 is an inch.
Q. Okay.
A. So about a half an inch.
Q. So when you're doing the surgery and you've got the gallbladder and you've got a duct that's here, you're trying to identify the structures that are in that area, do you have to do a lot of dissection or moving things around in

order to get to the triangle to identify the structures?

A. Depends on how much inflammation you have. It depends on how long the cystic duct is. Sometimes, yes. Sometimes there's a lot of dissection that has to be done. Sometimes there isn't a lot of dissection that has to be done.

Again, you're not trying to dissect out your common. You're only trying to track your cystic down. And most of the time, you don't encircle it. You're not getting rid of all the adhesions until you see where your connection is. So you go anterior to it until you can see where your junction is. And then, at that point, you pick to the right of the junction, you encircle it, clip it, and then you work backwards. In other words, you want to work the cystic duct to your right.

Q. Okay. Thank you, Doctor. If a doctor has a question in their mind about the structures that they are encountering maybe because of the operative field or the extent of the disease, is there any way in which they can assure themselves that they are looking at a structure that they think is the cystic duct?

A. Well, you have two ways of doing that. One, you can take a picture which is called a cholangiogram. You put a catheter into the cystic duct and take a picture. Or sometimes, you actually put a catheter into the common bile

duct or a little needle into the common bile duct and inject dye and take a picture.

Or you have the option of opening up if your anatomy is that distorted. When you open up, you have a bigger field to work in and you track the cystic duct to its junction, and that's how you're sure which is where.

Q. Did you have an opinion to a reasonable degree of medical probability if Dr. Barnett had done what you just described in terms of identifying those structures whether he would have caused the multiple injures that were found subsequent to his surgery?

A. I do.

Q. What's your opinion?

A. If he had identified the two structures either with cholangiogram or open, he wouldn't have injured the structures.

Q. Okay. Let's talk about the second opinion that you raised with regard to the following up of the patient and Mr. Johnson's symptoms and your opinion with regard to him making a diagnosis of the leak. Let's start with explain to us once a duct is cut like the hepatic duct or the kind of injures that were suffered as a result of the surgery, what happens to a patient, what's going on in their body, and

what kinds of things occur as a result of that?

A. Well, there's two types of injures. There is an obstructive injury where the clip actually obstructs the duct and no bile can get out of the ductal structures.

That's called obstructive jaundice where the bile backs up into the liver and the patient's bilirubin elevates. He may become jaundice, yellow. That's one type of injury.

The second type of injury is where the duct is not closed and it leaks into the abdomen. Bile is abrasive. It's a caustic material. It goes into the abdomen and causes an inflammation. It's called bile peritonitis, inflammation of the abdominal cavity by bile. That usually causes pain. It effects the bowel function so it doesn't function that well. You may have ileuses, you may have nausea, you may have vomiting, but it causes symptomatology in the abdomen. You may have some tenderness. Eventually, you may have some distension.

But bile in itself, when it goes into the abdomen over a period of time, gets infected because it inflames the intestines and there are bacteria in the intestines. It's called translocation. With inflammation, bacteria can move back and forth. So bile usually gets infected over a period of time, so you don't want to leave

it in the abdomen.

Q. And the fact that bile is left in somebody's abdomen for an extended time period, what can happen to them?

A. They become septic. It's an infection, an inflammation that affects their whole body. It's a systemic infection that affects their whole system. So they can become -- at some point, have fevers. They can have elevated white count. They can go on to develop shock, which is a decreased profusion. That's, I mean, basically a

peritonitis. Just like a perforated appendix would cause a peritonitis. If untreated, if the infection continues, eventually you abscesses, which takes a while, and the patient becomes very, very sick.

Q. Is that what happened in Mr. Johnson's case?

A. Pretty much so.

Q. All right. Let's talk about the postoperative, sort of the course of Mr. Johnson. But before I ask that, when most folks have their gallbladder taken out laparoscopically, what's the expectation with regard to when they will go home and what kind of clinical course they'll have?

A. Well, there's two types of gallbladders. There's acute cholecystitis which is inflammation of the gallbladder, acute inflammation of the gallbladder. This is not this

case. Those people can stay several days. They usually come in very, very sick.

They have an elevated white count. They may have fever. They may have nausea and vomiting. They definitely have pain which usually lasts more than 12 hours. They may even have an obstructed cystic duct, in other words, a stone that is trying to get out and it's obstructing the duct. They have a dilated gallbladder, a thick-walled gallbladder, and a lot of inflammation and adhesions. These people are usually very sick. That usually stays one to two days post-op.

Elective cholecystectomies, some go home the same day, some stay overnight, and some people have to stay

a couple of days. It depends on how they do postoperatively. Some people have no problem at all and they go home very quickly.
Q. In Mr. Johnson's case, did he have an acute cholecystitis or did he have a chronic cholecystitis?
A. He had a chronic cholecystitis. He had no acute changes in his gallbladder which was -- that was diagnosed on sonogram and on the pathology. He had a stone in the gallbladder. He had a .3 sonometer wall which is not acute, and he had no edematous changes they were seen. So it's a

chronic -- the pathologist describes it as chronic change.
Q. I was going to show that to you. This is the pathology report of the gallbladder which was done after it was removed and it indicates that it was chronic?
A. It's chronic cholecystectomy.
Q. Okay. And the pathologist makes the distinction between something that's acute and chronic?
A. Yes. They use certain criteria, but yes, they distinguish acute and chronic.
Q. Okay. Now, Doctor, postoperatively in Mr. Johnson's case, did he start to exhibit any signs and symptoms that would cause a reasonably competent general surgeon to be concerned about his clinical course?
A. Yes. First of all, this turned out within the first 24/48 hours. He still was having pain. He had confusion. His white count was elevated. And he wasn't progressing like you would normally expect a patient with this type of condition and a laparoscopic cholecystectomy to perform at.

In other words, you would expect him to be better than he was.

And so he wasn't progressing adequately immediately post-op. The first and second day, he had the pain, he had the confusion, and as I said, he had an

elevated white count. It eventually got to a point where approximately four days postoperatively, he had a lot of other things as well. He had an elevated white count.

He had bilirubin that I mentioned to you that you could see if there's a problem, it's elevated. In other words, it's an enzyme that comes from the liver. In other words, we worked on the liver. We worked on the bile system. The two enzymes we look for are bilirubin and alkaline phosphatase. That's an enzyme that's found in the bile ducts. So if there's any bile duct injury or problems with the bile duct, the alkaline phosphatase will elevate.

You also have liver enzymes which are slightly elevated. He wasn't eating. His liver enzymes were elevated, as I mentioned, and he was developing tenderness at that point in time. There was something going on. In other words, this is not a course that should be expected from this type of operation and from this type of patient. At that particular point in time, some type of study should be done to see if you have bile duct injury or leak.

Q. Okay. Let me make sure that I understand all of the things that you told us, the signs and symptoms. You said

four days postoperatively, so that would be on December

17th?

A. On the 17th, correct.

Q. In my opening statement, I said to the members of the jury that one of the signs and symptoms of an injury to the bile duct system is abdominal pain. Did he have that on the 17th?

A. Yes.

Q. All right.

A. He's had it post-op continuously.

Q. All right. And is poor appetite a sign of an injury to that system?

A. It can be, yes.

Q. And did he have that and exhibit that as well?

A. Yes.

Q. All right. Now, I mentioned a distended belly. Is this a sign or symptom that's associated with an injury to the common bile duct or the bile duct system?

A. It can go along with that. It can go along with an irritation of the abdomen, yes.

Q. All right. And I also mentioned abnormal liver studies. Would that be the bilirubin?

A. Bilirubin, alkaline phosphatase, and there are other enzymes that are affected by the liver, the AST/ALTs.

Q. All right.
A. Those are liver enzymes. Those are all enzymes that when you work in that area, you have to look it.
Q. Now, preoperatively, there was a workup and there had been workups done of Mr. Johnson. Preoperatively, before the surgery on December 13, had he ever exhibited any elevation in his bilirubin?
A. No. His bilirubin was actually taken right after surgery. It was taken on the 14th and it was .5 which is well within the normal range. So one day post-op, his bilirubin was not elevated. Four days later, it's four times the amount. It's elevated.
Q. Now, it's gone up four times. Explain to us why it is that the bilirubin level is normal one day postoperatively and as four days go by, that bilirubin level goes up. Explain to us why that happens.
A. Elevated bilirubins postsurgery, particularly this type of surgery, are due either to obstructions, which is either an injury to the duct like a transection or like a clip placed across it or a retained stone in the system. Those are obstructive processes. Bile leaks, however, the bilirubin goes up but much slower and doesn't go up to the extent that you would see with an obstruction. So

basically, the bile is going into the abdomen and it's being reabsorbed and that's not a normal process, so your bilirubin in your blood and your urine will be higher.
Q. Okay. And the other sign or symptom that you mentioned

that you would be looking for that may be indicating an injury to the bile duct or the bile duct system would be an elevated white blood count. Explain to us what the significance is of that finding.

A. Elevated white blood count is an indication of inflammation and infection, so it means that there is an infectious-type process going on which if you had no complications, you would not expect in a postoperative gallbladder.

And if the white count is up, you have to investigate where it's coming from. And since you have been in the abdomen and I think you know that one of the possibilities is a problem with the bile duct system, that's one of the areas you have to investigate. So white count alone doesn't tell you it's a bile duct leak. It just tells you you have an infection or inflammatory process going on.

Q. All right. But in a case like this where we're talking about on the 17th, which is four days postoperatively -- first of all, four days postoperatively for this procedure,

what would be your expectation as to what his condition would be if there had not been an injury to the common bile duct?

A. He should be home.

Q. Okay. So four days postoperatively, he's still in the hospital. He's got abdominal pain, poor appetite, abnormal liver studies, elevated white blood count. All those things are present on the 17th of December. What would the standard of care require of a reasonably competent general

surgeon in that circumstance?
A. You have to run several tests. First, a test to see if you have a bile leak. It could be something called a HIDA scan. That's a study where a contrast is injected. It's a radioactive contrast. And it goes through the liver, through the duct system, and it's supposed to go into the small intestine. If it goes outside the duct system, it's a leak. So that checks for leak.

The second thing is a CT scan. CT scan tells you do you have fluid in the abdomen that's abnormal called ascites? Are the ducts in the liver dilated? A sign of obstruction. Those are the two basic tests initially you need to do.

Q. And do you have an opinion within a reasonable degree

of medical probability on what day the standard of care requires those tests to be done on Mr. Johnson?
A. They should have been ordered by the 17th.
Q. If those tests had been ordered on the 17th of December for Mr. Johnson, do you have any opinion as to what they would have showed?
A. I do.
Q. Four days postoperatively?
A. I do.
Q. What's your opinion, Doctor?
A. They would have shown a leak from the bile duct, and they would have shown a fluid collection in the abdomen.
Q. If the diagnosis of the leak and the injuries to the

bile duct had been made on December 17th, do you have an opinion as to what effect that would have had on the sequence of events that occurred thereafter?
A. Well, the whole process of draining that bile would have happened earlier. He would not have been sick. He wouldn't have gone on for almost nine days getting worse. He wouldn't have become septic. He wouldn't have gone into shock, and the process would have been treated earlier.
Q. Okay. And you answered my next question which was: The diagnosis of the leak did not occur for another nine

days, correct?
A. That's correct.
Q. All right. Now, the 17th was not the only day that there were signs and symptoms which were -- well, I don't want to lead you. Let me ask it this way: Let's go to the 18th. If we go to the 18th of December --
A. Let me just make one correction. The HIDA scan was done, from what I have here, on the 25th, so it would be eight days.
Q. Eight days. Okay. So the HIDA scan was done eight days later than it should have been?
A. Yes, more or less.
Q. All right. And the CT scan was done on the 24th?
A. Yes.
Q. Okay. And that would have been seven days later than it should have been?
A. Correct.
Q. All right.

MR. SHELSBY: The Court's indulgence for just a moment.

BY MR. SHELSBY:

Q. Let me show you a note which is from the 17th and actually, it says "abdomen STD," which I would proffer to

you -- assume that that means soft, tender and distended. Do you have an opinion as to what would be the significance of the fact that the abdomen is showing up at that point in time to be distended?

A. A distension usually means some dilation of bowel, whether that's an ileus of some type, you need an x-ray to really tell you.

Q. Okay. Let's go to the 18th and let's talk about how he was doing on the 18th. The note on the 18th which I have, the nursing note says, "the patient is moaning in discomfort. He's asked if he's having pain. He said yes. He grimaces when they palpate the abdomen. He's confused and unable to use the pain scale."

What significance does that have to you about what was going on with him at that point in time?

A. There's some type of interabdominal process happening.

Q. And if Dr. Barnett was aware of what was going on with the patient, aware of the medical records on the 18th, do you have an opinion as to what he should have done?

A. You need an evaluation. He needed a CT scan, a HIDA scan. That's the minimum. There are other tests that you can do too. There's MRCPs that can be done instead of the

CT scan, but he needed an evaluation of what was going on in

the abdomen and to evaluate for a possible leak or obstruction.

Q. Okay. Let's just look at the next note on the 18th when he's being evaluated. It says that he "has generalized discomfort. He moans even when his head or his arms are moved and his abdomen is firm."

What's the significance of that description of what's going on with him at that time with regard to his pain level and what's going on with his abdomen? What's the significance of that, Doctor?

A. He, again, has an interabdominal process going on producing pain.

Q. And what would the standard of care have required of a physician who was aware of those findings and those observations by medical personnel about Mr. Johnson?

A. He would need an evaluation, the same answer I gave before. Some type of study, CT scan, HIDA scan.

Q. Now, we're not going to go through each one of the days. On the 19th, the 20th and the 21st, did he continue to have similar kinds of complaints that are described here on the 17th and the 18th?

A. He had similar types of complaints and his blood count started going up.

Q. Okay. And that was his white blood cell count?
A. Correct.
Q. All right. And what does it tell you when, as the days are going by, the white blood cell count is going up?
A. It means you have an infection process that's continuing to be there.
Q. Okay. And does that mean the infection's getting worse?
A. Yes.
Q. Okay. Now, there was some discussion in the medical records about actually sending Mr. Johnson home on December 18th. Do you have an opinion as to whether it would have been appropriate to send him home at that point in time?
A. Well, there were notes there. It wouldn't have been appropriate. He was having problems. He wasn't able -- he wasn't a dischargeable candidate, and they didn't discharge him. The only issue is if they didn't discharge him and they were expecting to is why didn't they evaluate him?
Q. Yes. I wanted to ask you that. If you're thinking about discharging somebody and you're making plans to discharge them and then you change your mind, what goes through a surgeon's mind as to why they would change their mind about discharging?

A. Well, we change our mind because the patient isn't able to go home, but the question is is why isn't he able to go home? What am I missing? You know, this is a patient, as I said, who should be home two days later. He's not home two

days later. And we've worked in the abdomen and if there's a problem, the money's in the abdomen, so that's the place I'd start the evaluation. But you got to explain why he's not ready to go home.

Q. Did Dr. Barnett do any re-evaluation by ordering CT scans or HIDA scans to evaluate his abdomen at that point in time?

A. No.

Q. Okay. And was that a breach in the standard of care?

A. Yes. It was a delay, lack of evaluation.

Q. I'm going to move along. Let's talk about the 22nd. There's a note that he has severe pain in his RUP, that's upper right quadrant. Now, the pain is in his abdomen and it's described and you have talked about that. Now, we're getting descriptions of pain that is now going up into the right upper quadrant. What's the significance to you of that?

A. Well, you've worked there. That's where you did your surgery. Your gallbladder is in the right upper quadrant,

so that's where you did your surgery. That would lead you to believe that something happened, you know, from the surgery.

Q. Okay. Did there come a time on the 22nd when he started having problems breathing?

A. Yes. A lot of things happened on the 22nd. He was short of breath, his white count was repeated and was 14,000, his abdomen was distended and tender, and there was also a note, I believe, in one of the notes that he hadn't

had a bowel movement in approximately ten days. So he was not progressing, and developing more symptoms.

Q. Okay. What's the significance of the fact that he hadn't had a bowel movement in that time period?

A. Well, that's a function -- in other words, if your bowels were functioning normally, by that period of time, you should have a bowel movement. It means that it's highly suspicious of perhaps an obstruction, perhaps an ileus but that the bowels aren't functioning properly.

Q. Okay. There came a time when he started to vomit a dark brown emesis. Do you recall that in the medical records?

A. That would be on the 23rd.

Q. Right.

A. Yes. A lot of things happened on the 23rd, but he vomited on the 23rd.

Q. And he was vomiting dark brown emesis. Do you know what the significance or do you have an opinion as to what the significance is of that?

A. Well, there are several. It could be an ulcer. It could be a bleed. It could be an obstruction as well. Those are the two things you'd look for, what we call coffee ground vomitous indicating that there's some issue going on inside the -- this would be the stomach or small intestine.

Q. Okay. Let me share with you another note on the 23rd which there was an assessment in AP. That's assessment of plan? Or is that physical? I'm sorry. What's "AP" mean?

A. I'm not sure.
Q. You're not sure?
A. I can't see the note.
Q. Oh, I'm sorry. Let me show you the note first. I want to refer you to finding No. 3.
A. Yeah, assessment of plan.
Q. Okay. And what is the No. 3 listed on that?
A. Abdomen distension.
Q. Okay. Let me put that back up. This is No. 3 which would be abdominal distension. All right. Now, on December

23rd, how many days had it been since the operation performed by Dr. Barnett?
A. This would be about ten days.
Q. All right. Now, for ten days, he's had pain?
A. Yes.
Q. He's had poor appetite?
A. Yes.
Q. His abdomen is becoming distended?
A. Yes.
Q. He's got abnormal liver studies?
A. Yes.
Q. Elevated white blood count?
A. Yes.
Q. He's having problems breathing?
A. Yes.
Q. He hasn't had a bowel movement?
A. Correct.
Q. He's vomiting brown emesis?

A. Correct.
Q. Right. Do you have an opinion as to whether that is a patient who seems like they are getting better?
A. Well, he's not getting better but also his blood pressure is going down. He has episodes where his blood

pressure is like 97 over 60. His heart rate is over 100 at certain points in time. His oxygen saturation is low. So this is a sick patient who's getting sicker. And at this point, nobody really knows why.
Q. Okay. At that point in time, had anybody done a test? A HIDA scan? A CT scan? Any test to evaluate his abdomen to see if there was anything going on?
A. I think on the 23rd, there was a sonogram.
Q. That was the first one?
A. That was the first one, and that showed that there was some fluid in the abdomen.
Q. Okay. And then, they did a CT scan the next day?
A. I believe the 24th.
Q. And then, they did the ERCP on the 25th?
A. That's correct.
Q. All right. Now, on the 23rd, you talked about his condition. You mentioned that his blood pressure was starting to drop. What's the significance of the fact that his blood pressure's starting to drop?
A. Several things. First of all, it looks like he's becoming septic. His volume is low. His intervascular volume is low. And his situation with his saturation --

saturation is the ability to oxygenate your tissue -- is

decreased, so you're worried about a septic type of process at that point in time.

Q. And you mentioned that his heart rate was going up. It's a condition called tachycardia?

A. Yes. He had periods throughout this whole event with tachycardias, but his heart rate at certain points was over 100 which means the heart has to pump harder to get more volume out or fluid out or oxygen to the tissues. So that's the significance of that.

Q. All right. Prior to him having the ERCP -- or the ERCP and the HIDA scan, are they the same thing? Do they check the -- no?

A. No. The HIDA scan is a radioactive dye. They inject it. It's concentrated in the liver and as it's excreted, actually, dots are counted to form a picture, and it goes from the liver to the duct system and it's supposed to go through the duct system into the intestines. What happens is if it doesn't go into the intestine and it goes outside, they can see a leak. It only tells us if there's a leak or that the duct system's intact. That's the main thing it shows.

Q. Okay. Now, on the 25th, the HIDA scan was done by a gastroenterologist, his name is Dr. Delbay[phonetic]?

A. ERCP.
Q. I mean the ERCP. I'm sorry. And prior to the time that he did the ERCP, he wrote a note with regard to what his diagnosis was on the 25th. Let me show you the note first.
A. Yes.
Q. Okay. Let me put that up. Before we even did the test, the ERCP, what was his diagnosis?
A. Well, he knew from the HIDA scan there's bile leak. And then, he basically says we're dealing with sepsis and he wants to wait until he gets cleared to do the ERCP. He needs a medical clearance to do the ERCP.
Q. Okay. The ERCP, it's an operative procedure, correct?
A. It involves anesthesia.
Q. Right. Now, when anesthesia does a procedure on a patient, do they evaluate them to see what their condition is?
A. Yes.
Q. All right.
A. They use a scale which is an ASA scale which goes from 1 to 5 and with the significance if it's an emergency room, they use an "E."
Q. Okay. If somebody is an ASA-5, tell us what that means

about their medical condition?
A. Pretty much the category says that they are moribund, and they are probably not expected to live within the next 24 hours.

Q. And what was Mr. Johnson's ASA rating on December 25th, 2006?

A. He was rated as an ASA-5-E which means, you know, 5 being the lowest category, the most, you know, potential life-threatening, and "E" means emergency, so this was done as an emergency.

Q. All right. Now, they did an ASA rating of him prior to the time they took his gallbladder out, did they not, Doctor?

A. They did.

Q. And what was his ASA rating prior to the time they took out his gallbladder?

A. He was an ASA-3 which means he had severe medical problems, but he was stable enough to undergo the surgery.

Q. Okay. And do you have an opinion within a reasonable degree of medical probability what caused Mr. Johnson, who was an ASA-3 on December 13th, to become an ASA-5 on December 25?

MR. FERRI: Objection, Your Honor. May we

approach?

(The following sidebar discussion commences:)

MR. FERRI: When I took this physician Becker's deposition, this was not an opinion that was rendered. In fact, many of the opinions that he's rendered, I've let a lot of them go, but we're just going on and on, and I'm going to object at this point. I don't believe that Mr. Shelsby can show the Court in any way or in my deposition or any expert deposition that this was an opinion

that was disclosed.

MR. SHELSBY: You could go back and look at the deposition, but it's my last question on -- it's evidence of his deterioration of his condition. He's commented on it. I can rephrase it.

THE COURT: He's never rendered an opinion before?

MR. SHELSBY: I'll rephrase it. I'll just rephrase it.

THE COURT: How are you going to rephrase it to make it okay?

MR. SHELSBY: How about this: Do you have an opinion as to what caused his condition to change between December 13th and December 25th?

MR. FERRI: I don't think he's given that opinion.

THE COURT: I mean, I don't know. I haven't read the deposition.

MR. SHELSBY: I can go back and look. I mean...

MR. FERRI: Well, if you've already got it in.

MR. SHELSBY: I'm asking the question because, clearly, it's just tying up that there was a deterioration in his condition.

THE COURT: That's fine, but if he's never been asked about what caused it...

MR. SHELSBY: Oh, he gave that opinion. I mean, I have that designation that the delay in the diagnosis, that caused his condition to deteriorate and he developed sepsis.

MR. FERRI: If he asks it in that way, I'm okay.

THE COURT: Okay.

(The sidebar discussion concludes.)

BY MR. SHELSBY:

Q. Doctor, do you have an opinion as to the cause of the

change in Mr. Johnson's condition between December 13th and December 25th?

A. Yes. Because of the injury in the ductal system, he had a persistent bile leak which progressively continued, and he eventually became septic and his condition deteriorated.

Q. Okay. On the 26th, he was placed on a ventilator?

A. He was.

Q. Okay. And what was his condition at that point in time?

A. At that point, he was in septic shock. His blood pressure was low. He was on medications to keep his blood pressure up called pressors and he was being ready to be transferred. He also had a drainage procedure done, I believe it was at the bedside, to drain the bile that was accumulating in his abdomen. He also had a 30,000 white count at the time.

Q. Okay. And the normal white blood cell count would be

what?
A. Ten or below.
Q. Now, he was subsequently flown to the shock trauma unit at the University of Maryland?
A. He was.

Q. All right. And he was treated there; is that correct?
A. That's correct.
Q. All right. Now, subsequent to his transfer to the University of Maryland, he was treated. And if you can just sort of take us through the general way of what treatment he had thereafter?
A. Well, first, they had to stabilize him. He was a man in septic shock, so they had to stabilize his fluids, they had to control his blood pressure, they had to support him with a ventilator, his respirations. At some point on the 29th, they did a procedure to drain the bile that was accumulating in his abdomen through his liver called a percutaneous transhepatic cholangiogram and drainage so they could drain the bile that was accumulating.

And he also had the stent that was put in in Kent just before he left on the 26th. They put a larger one in at some point to drain the bile. So their first goal was to contain the bile leak to what we call a controlled fistula and to support Mr. Johnson through this process, through the septic shock and to get him better.
Q. Okay. Did there come a time when they had to do a surgery to try to correct the injures that occurred as a

result of Dr. Barnett's surgery?

A. Yes. In April, they went ahead and they did a reconstruction of the bile ducts. In other words, they put the left and right hepatic duct into a tube of small intestine, and it's constructed. It's called a Roux-en-Y. Very simply, they created a tube that would go up to the liver bed, and they did a hepatico-jejunostomy, which is basically put the ducts into the small intestine so the bile would drain into the intestines like they should.

Q. Now, this procedure you talked about, the Roux-en-Y, is that a procedure that you have done?

A. I've done Roux-en-Y, sure.

Q. Okay. Now, the Roux-en-Y procedure that was done, does that correct all the problems with the abdomen or does it correct some of them or does it correct -- tell me to the extent it corrects any of the problems.

A. Well, it corrects the bile leak. In other words, it gives the bile a more normal path to go through. That usually solves the problem as far as your bile leak and your reconstruction. The rest is how sick the patient is and complications they have afterwards. It requires that they have a tube in the liver through the anastomosis of the ducts for an extended period of time. So that catheter has to be changed periodically and there are complications from

that.

And then, the general health of the patient determines how well he does, how well he fights his infection. After someone is in septic shock, malnourished like this patient was and is a diabetic, his healing time is extended dramatically.

Q. Now, you've reviewed the record. Mr. Johnson required hospitalizations, multiple hospitalizations. He was in a nursing home. He was treated at Milford. He was in and out of the hospital or the nursing home or convalescent homes from the time he was transferred to the shock trauma unit?

A. Yes, he was.

Q. All right. And do you have an opinion within a reasonable degree of medical probability if Dr. Barnett had complied with the standard of care whether that treatment would have been necessary?

A. I do.

Q. What's your opinion?

A. That if he didn't have the injuries he had at surgery, then he wouldn't have suffered all the consequences afterwards.

Q. Okay. And as a consequence of the need for that treatment, he incurred medical expenses related to that

treatment; is that correct?

A. Yes, he did.

Q. Okay.

MR. SHELSBY: Your Honor, I'd like to mark as

Plaintiff's Exhibit No. 2 the medical bill exhibit.

MR. FERRI: May I see it?

MR. SHELSBY: Sure.

MR. FERRI: There's no objection, Your Honor.

THE COURT: Without objection?

MR. FERRI: Without objection, Your Honor.

THE COURT: Without objection, that can be admitted.

MR. FERRI: As to amount.

THE COURT: I'm not exactly sure what that means.

MR. FERRI: That's all it's being put in for. We're not agreeing to causation.

THE COURT: Oh, right. Sure.

THE CLERK: So marked as Plaintiff's Exhibit No. 2, Your Honor.

THE COURT: Thank you.

(Plaintiff's Exhibit No. 2 is received in evidence.)

MR. SHELSBY: Your Honor, may I just have a moment?

THE COURT: Take your time.

BY MR. SHELSBY:

Q. One last inquiry. And I did forget to ask you about this before. There was a bilirubin result that was done during the hospitalization at Kent General by Dr. Barnett. Do you have an opinion as to whether after he received an abnormal bilirubin count whether he should have repeated or

done the test again?
A. Well, there were several bilirubins taken. The first one was on the 17th. You could repeat it. There's nothing wrong with repeating it, but the idea is that it's an abnormal bilirubin and you have worked in the bile system so you have to evaluate the abnormal bilirubin. Repeating it would be only one issue. If you repeat it and it's the same, you have to investigate the process, what is going on.
Q. Okay.
MR. SHELSBY: Your Honor, I'd like to mark as Plaintiff's No. 3 the diagram that was drawn by the witness and move its admission.
MR. FERRI: No objection, Your Honor.
THE COURT: Without objection, that can be

admitted.
THE CLERK: The diagram is so marked as Plaintiff's Exhibit No. 3, Your Honor.
THE COURT: Thank you.
(Plaintiff's Exhibit No. 3 is received in evidence.)
MR. FERRI: Your Honor, I have two requests.
THE COURT: I'm sorry. Does that end your questioning?
MR. SHELSBY: Yes, Your Honor. I apologize.
THE COURT: Yes, sure.
MR. FERRI: I have two requests. One, may we have a brief break? Number two, may I look at the doctor's

chart during this period so as not to waste any time.

THE COURT: Sure.

MR. FERRI: Thank you.

THE COURT: We'll take a 15-minute recess.

(The jury exits the courtroom at 3:05 p.m.)

(A brief recess is taken.)

THE COURT: All set?

MR. FERRI: Yes, Your Honor. We're ready.

THE COURT: All right.

(The jury enters the courtroom at 3:20 p.m.)

THE COURT: Mr. Ferri.

MR. FERRI: Thank you, Your Honor.

* * *

CROSS-EXAMINATION

BY MR. FERRI:

Q. Good afternoon, Dr. Becker.

A. Good afternoon.

Q. You went to Brooklyn College undergraduate school; is that correct?

A. That's correct.

Q. And then you went to the University of Brussels?

A. That's correct.

Q. In Belgium?

A. That's correct.

Q. Had you applied for entrance into any medical schools in the United States?

A. Yes.

Q. And were you denied admission?

A. Yes.
Q. And how many schools denied you admission?
A. I think there were around 20.
Q. You said that you have been doing laparoscopic surgery since sometime around 1990; is that correct?

A. I started working with a GYN in 1989 to learn the techniques of laparoscopic surgery. I took my courses in 1990 to do a gallbladder and my first gallbladder was done in 1990.
Q. Okay. Now, as far as being someone who testifies in medical malpractice cases like you're doing here today, how long have you been involved in doing that?
A. I have probably done it for about 26, 27 years.
Q. So you weren't too far out of medical school before you were involved in expert testimony; is that correct?
A. I think you mean training.
Q. Training.
A. Yes. I started -- I think my first case I saw was probably 1984 or '85. That was one case, and I probably didn't see another case for maybe months or years.
Q. Okay. Now, my information shows that you have reviewed cases, medical malpractice cases, for attorneys from approximately 20 given states; is that correct?
A. I think the number is 26.
Q. 26?
A. 26 or 27. I don't think 30 yet, but...
Q. Okay. And have you testified at trial in all of those

states?

A. I don't believe I testified in trial in all of those states.
Q. Most of them?
A. I don't know about most of them. I think as far as deposition goes, I think those states I've had depositions in -- most of those states that have depositions. Some do not -- but I'm sure I have not been to all those states testifying in trial.
Q. Okay. Based on your recollection, in what states have you testified at trial?
A. I've testified, of course, in New Jersey, New York, Massachusetts, Connecticut, Pennsylvania, Georgia, Florida, Illinois, Ohio, Michigan. I did a case in Nebraska.
Q. Texas or Vermont?
A. I've never been to Texas. I don't remember a case in Vermont. I remember I had a case from Vermont but I don't think I ever testified in Vermont.
Q. Iowa? Missouri? Rhode Island?
A. Never been to Iowa. I've reviewed cases from Missouri, but I've never testified in Missouri. I gave a deposition in Missouri, a couple actually, but I've never been -- I was only to Missouri once and that was well before I was a physician.

Q. Okay. Now, you said that you charge $6,000 for your time to come in to testify, and that's based upon what? A day's missing of work?
A. It's actually less than a day's missing at work. If I do an operation, I make more than $6,000. It's based on an average charge that other experts charge for their time in my specialty.
Q. Okay. What's the furthest away that you've ever testified?
A. Probably Nebraska was the furthest place I've ever testified.
Q. Okay. Now, if you testified in Nebraska, what would you charge?
A. I was in Nebraska for one day. I came there the night before. I left the same night. $6,000.
Q. Now, you have testified in approximately a hundred trials; is that right?
A. I think I've been in court approximately 110 times in 27 years, 26 years.
Q. Okay. And every single time that you've testified, you've testified on behalf of the plaintiff; is that correct?
A. That's correct.

Q. I wanted to ask you some questions about the records that you have reviewed. You said that you reviewed some depositions. Would you tell me what depositions you reviewed?

A. I don't have all the names in front of me, but I reviewed the Plaintiff's, I think, daughters' deposition, Dr. Barnett's deposition. I reviewed your experts' depositions. There were two other experts in this case that I reviewed as well. So I've reviewed, I'd say, about six depositions in total.

Q. Okay. Did you read Dr. Gryska's deposition?

A. Yes.

Q. Okay. Did you disagree with any part of Dr. Gryska's deposition?

MR. SHELSBY: Objection, Your Honor. May we approach?

THE COURT: All right.

(The following sidebar discussion commences:

MR. SHELSBY: His question is whether he disagrees with any of the portions of the deposition of one of my other experts. It's not a proper question.

THE COURT: Gryska is your expert?

MR. SHELSBY: He's my expert, yes.

THE COURT: Is he testifying?

MR. SHELSBY: He may or may not.

THE COURT: Okay.

MR. SHELSBY: Typically, it's using an out-of-state deposition. It's not a proper way of utilizing the testimony.

THE COURT: I guess you can ask him --

Go ahead.

MR. FERRI: Well, I don't think it's

improper. I don't think there's any prohibition against asking him this. He said he reviewed the deposition. I presume that it's fair game, anything that he reviewed.

THE COURT: I mean, clearly, he could say do you agree with this, do you agree with this, do you agree with this, without identifying it as Gryska's, but that's not the point at the moment.

MR. FERRI: No. The point is as far as I knew, Dr. Gryska is being called and he's reviewed the deposition, and Dr. Gryska recognizes bile leak injuries as recognized complications, which this witness doesn't.

MR. SHELSBY: But what it does, Your Honor, is it's using another deposition to then basically insert that testimony in without the witness being called.

THE COURT: Of course, that's the issue. He doesn't know whether he's going to be called and if he is called, and he's gone, what's he supposed to do about that?

MR. SHELSBY: Well, it's still -- if he's called, then he can cross-examine Dr. Gryska on what his opinions are.

THE COURT: Yes, but he won't have had this guy. So, I mean, maybe you had better commit to whether he's going to be called or not.

MR. SHELSBY: Well, if I commit to him being called, then he's not going to be cross-examined on this?

THE COURT: Well, if you commit to his being called, then he can cross-examine him.

MR. SHELSBY: Okay.

THE COURT: Because he's certainly entitled to set up a discrepancy between two of your witnesses, but this guy won't be available to come back if Gryska's called.

MR. SHELSBY: Well...

THE COURT: Do you want to take five minutes?

MR. SHELSBY: Yes. Can I just -- actually, give me two minutes.

THE COURT: I'll send the jury out.

(The sidebar discuss concludes.)

THE COURT: We'll take a five-minute recess.

(The jury exits the courtroom at 3:35 p.m.)

MR. SHELSBY: Your Honor, just to clarify the case so we can make it clear.

THE COURT: Sure.

MR. SHELSBY: Dr. Gryska is scheduled on Thursday. I want to make sure there's not going to be any issue with regard to his testimony. He gave testimony at the time of his deposition that there's not going to be any issue raised with regard to his testimony or the extent of it or the scope of his testimony or Dr. Schoenberger who's coming in tomorrow.

THE COURT: I'm not sure what you're saying but, of course, if he tries to testify to something he hasn't said before...

MR. SHELSBY: Oh, yeah. No, no. There's no issue on that.

THE COURT: Then I'm not sure I understand

what you're saying.

MR. SHELSBY: Well, I don't know if there's any objection to whether his testimony is cumulative or whether that's any objection to any issue with regard to Dr. Gryska. If there's an issue with Dr. Gryska's testimony

that would impact on whether I would call him, you know, I'd like to know that today.

MR. FERRI: I don't have an issue with -- as far as cumulative, no. I don't know what else I can answer to, but I'm not going to --

THE COURT: I don't either. Clearly, the only thing I can think of off the top of my head is if he attempts to testify to something that he hasn't opined about before, there will be an objection and it probably will be sustained.

MR. SHELSBY: Yes. I wanted to make sure, Your Honor, that there was no cumulative issue because I have three experts that are coming to give testimony, Dr. Schoenberger, Dr. Gryska...

THE COURT: Okay.

MR. FERRI: Now, there will be an issue with -- I'll put everything out -- with Dr. Schoenberger. He's a critical care specialist. I will challenge his right to give opinion testimony with regard to a surgeon. Now, he can give other testimony with regard to cause of death, which you've already ruled, and with regard to perhaps causation but not standard of care because he's critical

care. Dr. Barnett is a general surgeon.

THE COURT: Right. That doesn't -- that's not part of what you're saying, is it?

MR. SHELSBY: No, but he's already given that opinion and they have a critical care expert who opines on the standard of care of a surgeon as well. But that should have been the subject of a motion in limine, Your Honor, if there was an objection because he was designated and he was deposed on that issue. And now, I'm hearing that there's going to be an argument tomorrow as to whether he can give testimony on the standard of care.

MR. FERRI: As to a surgeon. I don't think there's any problem with that.

THE COURT: What kind of a specialist is he?

MR. FERRI: Critical care pulmonary.

THE COURT: All right. And you have a critical care pulmonary?

MR. FERRI: I do.

THE COURT: Who's going to testify as to what the standard of care is?

MR. FERRI: Well, I don't know. I have to go back and look. They say he's going to testify to standard of care.

THE COURT: I'm talking about your guy.

MR. FERRI: My guy?
THE COURT: Yes.
MR. FERRI: Yes. They say he's going to testify to standard of care.
THE COURT: No. You say that your guy is going to testify as to standard of care?
MR. FERRI: I don't think he is.
THE COURT: Well, okay then.
MR. FERRI: I mean, I don't know. I mean...
MR. SHELSBY: I took his deposition and he gave opinions on the standard of care, but if he's not offered on that, then that's fine. But Dr. Schoenberger who's coming tomorrow is critical care and did offer standard of care opinions. He was deposed on those opinions; he was identified specifically on those opinions; and you know, I'm hearing today for the first time there's going to be an objection to his giving testimony.
MR. FERRI: On the standard of care.
THE COURT: And that was never raised before.
MR. FERRI: I didn't -- I actually didn't recognize it until I was preparing the other night and saw that he had given some opinions on the standard of care of surgeons. The way it was phrased in the designation was

"healthcare providers including pulmonary critical care people and surgeons." And when I saw "surgeons," I mean, I don't think...
I don't know. Maybe I have, but I don't

think I've waived any right to challenge that. I mean, I don't think it will take a very long time. I think Dr. Schoenberger will probably admit that he doesn't have the competence to testify to standard of care for a surgeon.

THE COURT: Well, if he admits to that, then I guess that ends it, but what if he doesn't?

MR. FERRI: Well, I think we could have -- I would request just a short voir dire to find out whether or not he has the qualifications to do it.

THE COURT: He can testify as to the standard of care in his field...

Go ahead, Mr. Shelsby.

MR. SHELSBY: Your Honor, his deposition is extensive discussions about the standard of care. He was identified specifically -- and I can show this to the Court -- as a physician who treats patients, he can evaluate an individual to determine whether their clinical problems are the result of some disease. He treats critically ill patients. He has had experience treating individuals who

have had bile duct injuries, abdomen injures, et cetera. And so, he's qualified.

Under the Balen case, you don't have to be of the same medical specialty. You just have to be familiar with the treatment of patients of the same and similar condition and he clearly has that experience and background.

But, again, Your Honor, I go back to I'm hearing that today as the first time. And just sort of putting this in context, you know, I was precluded from

putting into evidence the death certificate based on the fact that I presented that ten months ago and I made my argument and the Court's made its ruling on that.

And now, after a pretrial, I'm hearing for the first time and the Court's hearing for the first time that my expert, who's coming in tomorrow, that there's going to be an objection. And, frankly, Your Honor, it should have been raised at some point in time where I could have briefed it or dealt with the issue. It's unfair at this juncture.

When we go to a pretrial, the purpose is to say what issue is out there. You've ruled on Dr. Schoenberger's giving opinions. You've ruled on Dr. Abdel-Misih giving opinions. You've written opinions on all

those. So to now say, I've got an issue, that he can't give an opinion on the standard of care, at this point in time, I would submit to the Court that first of all, I think he's qualified, number one; and number two, I would submit that's waived. It certainly would be extremely unfair at this juncture to now inject that.

THE COURT: It seems pretty tough at this juncture.

MR. FERRI: Yes. I mean, I realize that I would have a tough burden on voir dire to exclude him the same way that, I mean, as far as Dr. Seneff is concerned.

THE COURT: Who's he?

MR. FERRI: My expert. I mean, if he's

testified to standard of care -- and quite honestly, I haven't looked at his deposition carefully because he's not coming till Monday yet -- or lately, let me put it that way. I mean, they are either both qualified or neither is qualified because they are both pulmonary critical care, but my preference would be to ask the Court for a brief inquiry.

And recognizing that the Court won't have -- I mean, they have Dr. Gryska and they have Dr. Becker here and Dr. Schoenberger will be a third to testify on the standard of care. I mean, at that point, I think it may be

cumulative. When I was saying no cumulative, I was thinking two. Now it's three, so...

MR. SHELSBY: But those are issues, Your Honor, that should have been raised before the pretrial. I mean, Dr. Schoenberger's coming tomorrow. I have Dr. Gryska scheduled to fly in on Thursday. All those arrangements have been made, and if my experts are going to get precluded, I should know before I get to the second day of trial, Your Honor.

MR. FERRI: Well, Dr. Gryska's not going to be precluded and Dr. Schoenberger is not going to be precluded on cause of death and life expectancy and many of the opinions. It's just on the narrow area of standard of care of the surgeon. So I don't think it's all that detrimental to the plaintiff, and I apologize to the Court. We did brief a lot of issues, and I mean, one can escape you.

THE COURT: I'm not concerned with its having

escaped before. It's the fairness to the plaintiff that I'm concerned about.

MR. FERRI: Well, if they are worried about standard of care, they have two, Dr. Becker and Dr. Gryska. And they may have three or they may not have three.

THE COURT: What does he add to Becker and Gryska?

MR. SHELSBY: Dr. Schoenberger?

THE COURT: Yes, on the standard of care.

MR. SHELSBY: Well, he actually has some testimony that relates to the later days in terms of diagnosis. He takes it up to about the 23rd that there was a failure to diagnose. Dr. Schoenberger also has opinions with regard to his clinical course. He's not going to talk about the operation. There's no issue on that.

And Dr. Seneff, when I took his deposition, who is Dennis's expert, opined on the standard of care as well saying, Look, here's what's going on with this guy. You would not be expecting a common bile duct injury.

THE COURT: Yes. I think that that area postsurgery is a different story. I suppose whatever the circumstances, you can ask for a voir dire and we can have a relatively restricted one, but on what I'm hearing now, I think that's fair game one way or the other.

MR. FERRI: I understand.

THE COURT: Okay. Given that, are we set?

MR. SHELSBY: Yes, Your Honor.

MR. FERRI: I don't know. Are we calling

Gryska or not calling Gryska?

MR. SHELSBY: Well, I'm assuming that I'm going to let him examine him as if I am going to call him, and I can still decide not to.

MR. FERRI: Okay. I didn't know where I was on the question.

THE COURT: Okay. Fair enough.

(The jury enters the courtroom at 3:45 p.m.)

THE COURT: Mr. Ferri.

MR. FERRI: Thank you, Your Honor.

BY MR. FERRI:

Q. Dr. Becker, just to kind of rephrase or bring us up to current, you did read Dr. Gryska's deposition, correct?

A. Yes, I did.

Q. And you know that Dr. Gryska is one of the plaintiffs' experts, correct?

A. Correct.

Q. All right. And Dr. Gryska testified, did he not, in his deposition that it would not be negligence to cut the common bile duct?

MR. SHELSBY: Objection, Your Honor. That's not the proper form in which to ask that question.

THE COURT: Well, all right. If it's not in

the deposition, then...

MR. FERRI: Well, it is, Your Honor.

THE COURT: But if it's in the deposition, there's nothing wrong with that.

BY MR. FERRI:

Q. Dr. Becker, do you recognize that as being in the deposition?

A. Well, I don't think it's exactly that way. I mean, I can answer it because the subject was breached in the deposition.

MR. FERRI: Just a moment, Dr. Becker.

I apologize, Your Honor. I'm not coming up with Dr. Gryska.

I'm sorry. I have it here.

MR. SHELSBY: I was going to withdraw the objection.

BY MR. FERRI:

Q. Do you agree, Dr. Becker, that he testified that injury to the common bile duct is a recognized complication of gallbladder surgery?

A. Yes, I agree with that.

Q. Okay. Do you agree that he said that he did not find fault with Dr. Barnett for injuring the common bile duct?

A. No. That part, I don't agree.

Q. Okay. Let me -- there's a copy of Dr. Gryska's deposition.

A. Sure.

Q. Would you turn to Page 19, please?
A. Sure.
Q. And would you go to Line 10 on Page 19?
A. Okay.
Q. Doesn't he say, "I do not find fault in Dr. Barnett's injury to the common bile duct per se. We all wish we could avoid it. We have tools at our disposal to avoid it; and yet, sometimes -- and our literature is exploring this phenomenon, the surgical science literature -- understanding what we are looking at, things that aren't labeled in there, so we can sometimes believe we are seeing something, cut it anyway and find out it's the wrong structure. The act of cutting the common bile duct is not by itself negligence."
Did he not say that?
A. He did say that.
Q. Okay. You disagree with that?
A. My opinion, and I think it's pretty clear, that you have to identify your structures before you cut them. I believe in his deposition he also said that, you know, in

not all instances cutting the bile duct -- and I think I said it -- is not in all instances is malpractice. There are times that you are near the structure, and you have to work there and you can injure it, yes; but you have to identify the structure, you have to know what you're dealing with, and you have to repair it when it's done.
Q. Okay. Now, you were here when Dr. Barnett testified about how he did the surgery and his approach to the surgery; is that correct?

A. Yes.
Q. Okay. And he testified that the way he was trained was that you didn't have to identify the common bile duct, but you had to get that critical view, which he drew in there. And you saw him draw that in?
A. I saw him mention the term "critical view," but he mentions the triangle.
Q. This is the critical view --
A. No.
Q. -- that he mentioned?
A. He mentioned it, but I don't know what that means. I know what the triangle of Calot means. I know the structures that have to be identified in that triangle. I don't know what critical view means. And my testimony is

you have to identify your duct structures or you'll injure one of them and probably the wrong one.
Q. Okay. So do you disagree with what Dr. Barnett said about how he approaches and identifies the structures?
A. Well, he doesn't identify the structures. He says, "I see a critical view, but I don't have to identify the common bile duct," so it's not identified. And in this case, it was severely injured not once but as many as three times.
So my testimony is Calot's triangle is cystic duct, common duct and either you want to take the original which is the liver or you want to take the hepatic artery is the more common triangle. Those structures have to be identified, you have to know where they are, and you have to

know where the cystic duct enters the common bile duct or whichever duct it enters. And that's what you have to do, and that's your triangle, and that's what you have to watch for.

Q. And that's your opinion?

A. That is.

Q. Correct?

A. Correct.

Q. And that's not Dr. Barnett's opinion, correct?

A. He said what he said.

Q. Right. Okay. So if you're taking issue with Dr. Barnett, you are also saying, am I correct, that if that's the way he was trained, he was trained improperly?

A. The answer is yes.

Q. So his mentors who trained him are doing it wrong as well?

A. I don't know what they are doing.

Q. Assuming they are doing it -- I want you to just assume. I just want you to assume they are doing it the way Dr. Barnett said that he was trained. They are doing it incorrectly?

A. They are doing it incorrectly, and then, the bile duct injures that are occurring are related to their teaching.

Q. Okay. And if we assume that Dr. Barnett did 2,500 gallbladder surgeries the way he was taught and this is the only injury to the common bile duct that he's ever had, you still think it's below the standard to use that approach?

A. Without identifying the structures, yes.

Q. Okay. Now, I took your deposition in this case, did I not?
A. Yes, you did.
Q. All right. Doctor, you have a file with you. There are some records, correct?

A. That's right.
Q. Or part of a file?
A. I don't have all the records in front of me, no. I just have some selected ones, yes.
Q. And why did you select those particular records?
A. Because, particularly, I thought we were going to be discussing part of them, so I thought they were to be most appropriate, but we have all the records here, so we can discuss any records you like.
Q. Right. Do you remember when I took your deposition -- and just let me get the date. I took your deposition back November the 13th of 2009. Does that sound about right to you?
A. Yes, more or less.
Q. All right. Now, when I took your deposition, did you at any time offer that opinion that there were three cuts made?
A. I was not asked. I was asked about the injury and, again, I don't have my deposition to my memory, but I don't know if you asked about how many cuts were made. I think you asked about the injury.
Q. Okay. Let me hand you your deposition?

A. Sure.

Q. And I would ask you to turn to page -- I apologize, Doctor. Let me come back to that, if I can. I may not be able to.
A. Sure.
Q. Okay. As part of the records that you reviewed, did you review the hospitalization of Mr. Johnson in October from October 13 to November the 16 and then from November the 16 when he was transferred to the Milford rehabilitation center until December the 6th when he was released?
A. Are we talking about when he had his amputation and he went to the rehab facility? I had some partial records. That wasn't my main area of review, but I had seen some records to that.
Q. Did you see the entire record from those two admissions?
A. No. I'm sure I didn't see the entire record.
Q. So you've never seen them?
A. Correct.
Q. Okay. Do you have any records there in front of you that come from either of those admissions?
A. No.
Q. Okay. Can you tell us why he was in the hospital in October?

A. I believe -- wasn't that the amputation? I don't have that in front of me. I know there was an amputation several weeks before, but I don't have those records.
Q. Can you tell me about any of the problems that he was having during that over-a-month-and-a-half time he was in both of these institutions?
A. Well, you have to be more specific with what problems you're talking about. Are you talking about related to this issue?
Q. No. I'm talking about any problems. Are you aware of any medical problems that he was having during that month and a half?
A. Specifically? No. I know he had multiple medical problems with his diabetes and his cardiac situation and his vascular situation, but no, I didn't do extensive reviews.
Q. And, of course, nothing even before that, right?
A. That's correct. My opinion doesn't relate to that.
Q. Do you work full- or part-time now?
A. I work full-time.
Q. Full-time. And you're in solo practice?
A. I am.
Q. How many days a week do you do surgery?
A. Depends on the week. It depends. I try to do

surgeries on Wednesdays and Fridays. That's not always the case, especially nowadays with the scheduling the way it is. Those are the days I try to do surgery, but if I have an emergency, I do it whenever I can.

Q. Okay. The laparoscopic gallbladder surgeries that you do, 99.9 percent of them are done laparoscopically, correct?
A. Yes.
Q. Okay. And you've only had one open case in the past five years; is that correct?
A. I'm not sure. With the past five years, one or two. I had one last year that I opened. Prior to that, it's been a number of years. If you say five, it's very possible.
Q. Okay. Do you do a cholangiogram routinely with your gallbladder surgeries?
A. Pretty much routinely, which is the way I did it when I did them open. It's not all the cases, and now with MRCPs, I'm a little more selective, but I do do what you would call more routine cholangiography.
Q. Okay. That's not standard of care, is it, Doctor?
A. It's not below standard of care. It's looking for retained common duct stones, and I do find them which means I know there's a stone in the common bile duct. But is it required by everyone to do that? No. No.

Q. But you do do it more than others, correct?
A. Yes. I'm concerned about stones that may be retained in the common bile duct and that's why I do it because many times I can remove them laparoscopically and they don't have to go for an ERCP, but that's my practice.
Q. Okay. But would you agree that the majority of surgeons do not do cholangiograms as routinely as you do?
A. I would probably agree with that. And I'm not saying it's standard of care for everyone to do. I feel

comfortable in doing it.
Q. Okay. Now, over the course of your practice, you've injured a bile duct on three different occasions, am I correct?
A. Yes, I have, all recognized. One was the gallbladder was adherent to the common bile duct and I had to get it off, and I perforated and repaired it. The other two were a specific type of syndrome called Mirizzi. That's when the stone actually eliminates -- the cystic duct is no longer there and it goes directly into the common bile duct. And these were earlier on. We didn't have the tools that we have now nor the stapling devices and I had to actually cut the common duct to get a tube in to repair it.
Q. Okay. Would you agree with this statement, Doctor:

That only one-third of common bile duct injures are detected interoperatively during the surgery and that two-thirds aren't detected until later on at various times?
MR. SHELSBY: Objection. Timblin, Your Honor.
THE WITNESS: The answer is I don't know where you're pulling that.
THE COURT: Wait, wait. There's an objection there.
MR. FERRI: I don't think that's Timblin, Your Honor. Just because it deals with numbers doesn't mean it's Timblin.
THE COURT: Yes. And Timblin, of course, is

not a preclusive decision. It's a balancing decision under 403. I'll let you go on with this.

MR. FERRI: Okay.

THE WITNESS: I think the answer is I don't know where you get your statistics from.

BY MR. FERRI:

Q. That's fair enough. You're not aware.

A. So I'm not aware of the article you're particularly referring to.

Q. Okay. And it's not part of your general knowledge?

A. No.

Q. That's fine. Going back to this diagram here where you testified today that in your opinion, there were three cuts, you agree that that's not something you told me at your deposition?

A. I don't think I was asked that at my deposition. I think we discussed where the injures were, but I don't think you asked how many times they were cut. I don't think I have been asked that. This is the first time.

Q. Well, you knew that that deposition was a discovery deposition and you were going to give me all your opinions?

A. I was going to give you all the opinions I was asked for, yes.

Q. Did you read in the operative report or any report from Maryland where they indicated that there was a low bifurcation --

A. Yes.

Q. -- of the two hepatic ducts?

A. Yes.
Q. And these are the two hepatic ducts here, correct?
A. Correct.
Q. So if there's a low bifurcation, does that mean the cystic duct is closer to that -- goes into the common bile

duct closer to those two hepatic ducts?
A. Yes, it can.
Q. So if there is a problem, one cut could go and cause all this, am I correct?
A. I don't believe so. That's quite a distance. I don't think we have a scissor that reaches that far. It's above the bifurcation and you're going from right hepatic to transection of the left hepatic. I mean, you could probably do it in a couple of cuts, but I don't believe you can make it in one cut. It's quite a distance.
Q. But the testimony that you gave that it was three cuts, that's your opinion, correct?
A. I was asked do I believe -- yes, I believe this was three cuts.
Q. You never saw that in any medical record from Maryland that it was three cuts, did you?
A. No, no. Maryland only described where the clips were or weren't and the right duct that was draining into the abdomen.
Q. Generally speaking -- and I know this isn't your drawing.
A. Right.

Q. This is Mr. Shelsby's drawing, but the common bile

duct, is that usually bigger than the cystic duct?
A. The answer is yes.
Q. And, generally, how far around or the diameter of the cystic duct, generally?
A. Cystic ducts vary. They can be very small; three, four millimeters. It depends on a lot of issues. You can have the syndrome I mentioned to you which is Mirizzi where the cystic duct really no longer exists. The whole gallbladder goes right into the common bile duct. And that can be over a sonometer.
Q. So that this gallbladder is scrunched up right next to the common bile duct?
A. Exactly. What happens is the stone actually pushes the cystic duct so it dilates and the opening is the size of the stone. And it could be a sonometer, sometimes a little bit more. So the diameter of the cystic duct varies, but usually less than five millimeters, but it could be bigger.
Q. Okay. Could it be as thin as two millimeters?
A. Yes.
Q. And how about the common bile duct? What's the size of that, generally, again?
A. Under a sonometer. Over a sonometer, we consider it dilated, so it can be five, six, seven, even eight

millimeters and that would be perfectly normal.
Q. And can that vary with individuals? Can, for example, the common duct be smaller than the cystic duct?
A. I've never seen that. You can have a -- usually, it's proportional. The cystic duct in almost every case is smaller than the common bile duct because there's a convergence of two ducts. But can they all be very small? Yes. And actually, in women, sometimes they are very small, but the average is not very small.
Q. All right. Now, we do know in this case that Dr. Barnett cut a duct that he didn't want to, but I guess my -- well, let me -- yeah, he cut a duct he didn't want to. Would you agree that you don't necessarily have to see bile if there's a cut of the common bile duct immediately before you would close from the operation?
A. Yeah. The answer is you can cut and not see bile in certain cases for a number of reasons, but that's definitely a possibility; but if you recognize the duct that's cut, whether the bile's coming out or not, you know, you have a problem.
Q. I understand. Now, you gave some testimony in this case that in your opinion, there should have been a diagnosis of a bile leak on the 17th, am I correct?

A. That's correct.
Q. All right. Or at least a suspicion?
A. A suspicion and an evaluation.
Q. Okay. And then, if we're assuming that you're correct,

then there would have been an ultrasound or a CT scan? Which?
A. Well...
Q. Either?
A. A CT scan is better.
Q. Right.
A. It's more specific. You know the ultrasound and it is limited and not as accurate as the CT scan, so if you want to go for the money and not do a lot of tests, a CT scan and a HIDA scan would give you the information -- which they did eventually on the 24th and 25th -- would give you all the information you need to know if you had an injury.
Q. Okay. Even under your theory, though, that there should have been a suspicion of a bile leak on the 17th, would you agree that it would still be standard of care to do a ultrasound, CT scan, the next day or the day after?
A. The answer is you can order things as a STAT basis. You can get it quick. But I think if it was done on the 18th, the morning of the 18th, it wouldn't have been a very

big difference because he didn't decompensate till the 25th, basically, 24th and 25th. So you have a week. So you're saying if he's suspected on the 17th, order it on the 17th, and they did it first thing in the morning, you could get both tests done the same day.
Q. Okay. Now, let's assume you're correct and let's assume that they did a CT scan and it showed what you testified that you think it would have shown. He still would not have been repaired -- the common bile duct or

whatever was injured would not be repaired for a number of weeks or months, am I correct?

A. I agree, but we're not doing this for the repair. The repair in most places is delayed. What you're doing it for is to drain that bile out of the abdomen so he doesn't become sicker, and that requires two procedures to do; but the repair is not going to happen immediately, especially with his medical problems. He's not going to have it done immediately.

Q. Right. And what they are going to try to do is drain it, make sure he gets in the best condition he can to undergo surgery like that and then do it, and it probably would have taken place about the same time it was done in this case, wouldn't you agree?

A. I wouldn't argue that if he had problems afterwards -- very often what they do is they wait until the duct dilates because if the duct dilates, it's easy to work on. These ducts are three millimeters in size. Doing that in that stenosis is very difficult and keeping it open. So if it was controlled and was stable, they could have waited several months, sure.

Q. Okay. Now, you said that a Roux-en-Y is the name of the operation, correct? The name of the surgery that they performed?

A. Right. A Roux-en-Y hepatico-jejunostomy.

Q. And you said that you have performed that?

A. Yes.

Q. How long ago?
A. Oh, it's been many years. And it wasn't for this; it was for cancer. It's a while ago.
Q. Would you perform one today?
A. I don't see why not. My training at St. Vincent's, we did liver resection. Could I do it? Sure.
Q. When is the last time you did any biliary reconstruction?
A. Oh, it's been a number of years. I did a Whipple 12 years ago. I think that would be -- that's even more

complicated.
Q. And even though you haven't been doing them for a while, you would feel comfortable doing one now?
A. Sure, why not.
Q. We talked about some time -- a couple of times you were asked some questions about Mr. Johnson being readied for discharge and so forth.
A. Mm-hmm.
Q. Does it happen in your practice that you get pressure from insurance companies to get people out of the hospital?
MR. SHELSBY: Objection, Your Honor. Relevance.
THE COURT: Yes, I'll sustain that. You can pursue that perhaps some other way. I don't see what his practice has to do with anything.
MR. FERRI: Okay.
BY MR. FERRI:
Q. Do you find that -- okay. I'll pursue it otherwise.

Now, you gave your reasons as to why, in your opinion at least, a suspicion of a problem should have been thought about, and these were some of the symptoms and signs that you talked about, am I correct?

A. And findings, yes.

Q. Yes. Now, you have to look at the patient overall, am I correct, in order to make a diagnosis based on signs and symptoms?

A. I agree.

Q. You have to look at the whole clinical picture?

A. I agree.

Q. It's important to know what -- I'm sorry. Let me ask it this way: It's an advantage to know a person's prior medical conditions by having been his doctor previous to a surgery? Would that be fair to say?

A. I'm not quite sure what you mean. If you want to be more specific -- I mean, you have to know his medical history.

Q. Sure.

A. You have to know his medical problems. That, I agree with.

Q. Okay. Well, for example, let's talk about poor appetite. He had a poor appetite before the surgery, am I correct?

A. Correct.

Q. He had lost 92 pounds?

A. He had. I didn't see the number and I don't remember

the chart, but he lost weight. I know that.

Q. He lost a lot of weight. All right. So he had a poor appetite?

A. Okay.

Q. So that doesn't necessarily tell you that the poor appetite means something that is caused by bile leak, am I correct?

A. That's true. It's just a symptom.

Q. And when we look at some of these things, for example the distended belly, if we look at each day, we see that a lot of times when he was examined, he didn't have a distended belly, correct?

A. That's correct.

Q. And it really depended on who was examining him at the time, correct?

A. Correct.

Q. And you did read all of the medical records for this hospitalization, am I correct?

A. I did.

Q. And you checked and you saw that Dr. Barnett called in a number of consultants, correct?

A. Correct.

Q. He called in infectious disease?

A. Yes.

Q. And pulmonary, yes? And he was continued to be followed by the kidney doctors and the heart doctors and so forth, right?
A. That's correct.
Q. All right. And also his family doctor, the primary care physician, correct?
A. I think he saw him too. I think the others made more notes in their specialties than he did.
Q. Right.
A. Yes.
Q. All right. And the primary care doctor's function is to more or less coordinate the overall care of the patient, correct?
A. Not in this case. In this case, it's the surgeon.
Q. Okay. What's the function of the primary care doctor in this case?
A. In an outpatient, yes, to see the patient's medical problems and refer him to the appropriate -- but in the hospital, this man's been operated on. The best person to know what's going on is the surgeon, and he has to be aware. He's operating on the person.
Q. Sure. And if he's having difficulty or believes he's having difficulty, is it his obligation to call in

consultants?
A. Correct.
Q. Which he did?
A. Correct.

Q. Now, would you agree that -- and I'm not going to go through every single day or every single note, but there are a number of notes, almost every day, that indicate that his abdomen was nontender, soft and nondistended, am I correct?
A. I don't know about every day, but there are notes that are contrary to that, too, that he was distended, tender and firm.
Q. Right.
A. So you have different findings at different times, but persistently, you've had abdominal pain, you've had distention that's been mentioned multiple times and tenderness has been mentioned multiple times.
Q. Okay. But the only documents that were put up for you, Doctor, when you testified were the ones that showed distension and showed tenderness, am I correct?
A. Correct.
Q. None of the others were put up there that showed soft, nontender, nondistended?
A. True.

Q. Okay. His bowel sounds, for the most part, were normal, am I correct?
A. The bowel sounds on several occasions were noted to be present. Normal, I don't know because if you go to the 22nd, without having a bowel movement for ten days, I don't know where you consider those a normal bowel function. But he had positive bowel sounds on multiple notes, true.
Q. Of course, he's not eating very much, is he?
A. That doesn't affect bowel movements. I know it's a

misconception, but you have bowel movements even without eating.

Q. Okay. Fever. He doesn't have fever until the 26th, am I correct?

A. Right. After he was in septic shock, he never manifested a febrile episode.

Q. But no fever before that?

A. That's what I said.

Q. Correct?

A. That's what I said.

Q. His white blood count, we talked about that, and that fluctuated, did it not?

A. True, but he was on antibiotics. He had a very broad-spectrum Zylox, a very broad-spectrum antibiotic. He

was on Zosimine[phonetic]. He was also on Vancomycin at some point in time. So he had broad-spectrum antibiotics. I would expect those to treat an infection. So the white count should go down, true.

Q. Okay. And the white count really didn't go real high until the 24th, am I correct?

A. No. On the 17th at 16,000; repeated at 15,000. That's high. By the time you get to the 24th, you're in the 20,000, and the 25th, you're in the 30,000.

Q. Right.

A. Those, I think, are astronomical.

Q. Okay.

A. Those are not just high. Those are very high.

Q. But here we are on the 19th, it's 11.5, correct?
A. Correct.
Q. And 11.4 on the 25th?
A. Correct. And 14.3 on the 22nd and 16.9 on the 17th.
Q. So it's going down and then up and then down and then up, correct?
A. But not normal.
Q. He has a urinary tract infection, doesn't he?
A. He does.
Q. That's an infection, correct?

A. Correct.
Q. And he has Vancomycin-resistant enterococcus, correct?
A. Correct.
Q. And he had that prior to his surgeries, correct?
A. Correct.
Q. So he kind of always has an infection, doesn't he?
A. Well, he has an underlying low-grade infection, yes.
Q. His blood pressure is generally pretty good until he becomes hypotensive or a little hypotensive on the 23rd, but then it bounces back up and then goes down again, am I correct?
A. Correct. Around the 23rd, his blood pressure started becoming low into the 25th when he goes into shock.
Q. Okay. So, actually, his vital signs were pretty good up until that point in time around the 24th, 25th, correct?
A. Well, I don't know what you mean by pretty good.
Q. For him?
A. Well, let's put it this way: He still had his

infection. He still had is bile leak. He, at this particular point, was stable, hemodynamically stable. And on the 23rd, 24th, 25th and 26th, there were signs that his stability was going, that the infection was going to overtake his stability, and it eventually did on the 25th.

Q. Doctor, you would agree that it's a lot easier to see a problem retrospectively than it is prospectively, correct?
A. Well, I think suspecting a problem and seeing the absolute results are two different things. Retrospectively, we know what happened, but prospectively, when you do something like surgery and you see a problem with elevated white counts and liver enzymes that are abnormal, you have to start suspecting something. And even if you do a test that comes out to be normal, that's fine, but you have to look, and I think that's the issue.

MR. FERRI: May have a moment, Your Honor? I don't have any other questions, Your Honor. Thank you.

Thank you, Doctor.

THE WITNESS: You're welcome.

THE COURT: Mr. Shelsby.

MR. SHELSBY: Your Honor, just briefly.

* * *

REDIRECT EXAMINATION

BY MR. SHELSBY:

Q. Doctor, you review cases on behalf of defendants in medical negligence cases as well?
A. About 15/20 percent are defense cases that I look at.

Q. And this issue about poor appetite that he had before

the surgery, what was one of the reasons why they were going to take his gallbladder out?
A. Well, because he had nausea and vomiting and couldn't eat.
Q. Which was poor appetite?
A. Yeah. Well, basically, yeah.
Q. Okay. Now, when somebody causes an injury as a result of a surgical procedure, a general surgeon who's done, let's say, a gallbladder removal, who's in the best position to make that diagnosis?
A. Well, as I said, he did the surgery. The surgeon. I mean, I don't care what other specialty you have. We, as surgeons, deal with gallbladder removal every day, so we should deal with the complications of gallbladder every day. The assumption that another doctor is better qualified is nonsense. You're a surgeon. We operate.

We do get complications. I'm not saying we don't get complications. But, you know, and it's been said here by many experts, one of the complications in this surgery is a leak. One of the complications is injury to the common bile duct. One of the complications in an obstruction of the duct for whatever reason. Retained stone, clip, whatever. Those are complications.

So when the patient isn't doing well, and you want to go for where the money is, you just operated on the guy. If you do all those tests and they are normal, you look for something else. I'm not saying you don't have to look for something else.

But, like, he brought up the urinary tract infection. You can have a urinary tract infection. This is more serious to me than a urinary tract infection. This is the first thing you should look at. If this comes out to be the urinary tract infection, treat it.

Q. Okay. Urinary tract infections, do they cause somebody's belly to become distended?

A. Actually, they can.

Q. They can?

A. They can, yeah, in severe enough cases. But the point is you were just in this guy's belly operating, so if you had a problem, it would be in his belly. I mean, that's what you'd be looking for.

Q. Now, the final question, Doctor, you were asked about this diagram that you did, and you described in the diagram that there were three places that were cut, the left hepatic duct, the right hepatic duct, and the common hepatic duct. All three of them were cut?

A. That's correct.

Q. All right. And you have given us the opinion, which you gave earlier today, that those were three separate cuts, correct?

A. I agree, yes.
Q. And you were asked whether you were asked that question at the time of your deposition. When your deposition was taken by Mr. Ferri, your deposition was about 37 pages long. Do you have a copy of it?
A. Actually, I do, yes.
Q. Okay. And is it your recollection that was a relatively -- at least in the times you've had a deposition taken -- a relatively short deposition?
A. It was.
Q. Okay. Now, where you got the information about where these three separate cuts were came from the operative report at the University of Maryland when they went in to repair that?

MR. FERRI: Objection, Your Honor. He's leading the witness.

THE COURT: Sustained.

BY MR. SHELSBY:
Q. Let me ask it this way: Where did you get the

information to be able to reconstruct where the three transections occurred?
A. The operative report at the University of Maryland on the 4-9-2007 and also the cholangiogram that was done on 1-5-07 all explaining where the clips were and the operative report explaining what they found at surgery, those two ducts being cut, one clip, one open and a clip across the common -- I think they call it common bile duct. The radiologist says it's common hepatic duct.

Q. Okay. Let me show you a copy of the University of Maryland -- and do you have a copy?
A. I'm sure I have it somewhere. Bear with me a second.
Q. Do you have the operative report?
A. I do.
Q. All right. Right on the top of the University of Maryland, who did this report, this operative report dated April 9, 2009, and the preoperative diagnosis was "severed common hepatic duct," and then they go on to discuss the indications. When a surgeon dictates an operative note and gets to the section where it says "indications," what does that mean?
A. That's his reasons for operating. In other words, why he put all the reasons. His pros for going in for

operating, whatever it is.
Q. Okay. Now, can you just tell me where on that report it shows the injuries that you've described, which is the transections that are on the diagram marked as Plaintiff's Exhibit No. 3?
A. Well, in this part, it basically says, "preoperative percutaneous transhepatic cholangiogram revealed that he had a low bifurcation of the right and left duct and bile duct was injured above the bifurcation." In other words, where those two joined in the "Y," there was an injury above that.
Q. That's where the "Y" should have been?
A. Right.
Q. But it was above there. So it's above there where

you've drawn it?
A. Yes, right.
Q. Okay.
A. So both ducts, that means they are cut individually.
Q. All right. And does it describe each the right duct and the left duct? Does it describe what they found?
A. Yeah. "Therefore, the right and left duct" -- well, there was a small accessory duct we talked about. "From the left hepatic duct branch." But the left duct wasn't draining, and it was dilated. "It appeared that there was a

clip across that duct."
Q. All right. Now, when you did your diagram, you drew a little clip on the left duct?
A. Correct.
Q. All right. And does it talk about what they found when they looked into the right duct?
A. Well, the right duct was leaking.
Q. Okay. And you showed on your diagram where it was cut and where it was leaking. And the reason it was leaking is because?
A. It was cut.
Q. And it didn't have a clip on it?
A. No clip on it.
Q. Now, in addition to these two cuts --
MR. FERRI: Your Honor, we've been through this before. I think it's repetitious.
THE COURT: Well, it's redirect.
MR. SHELSBY: Your Honor, I'm just about

done. This is my last question.

BY MR. SHELSBY:

Q. Does the report indicate further what they found with regard to the common bile duct?

A. Yes. Again, they called it the common bile duct here,

but on top, they called it the common hepatic duct. But here, they called it "the common bile duct was severed."

Q. It was severed?

A. Cut.

Q. All right. And that's what you wrote right here or depicted on the diagram which is the third severed duct?

A. Right.

Q. Okay. So all three of the things that you described that are on this diagram are on that operative report?

A. Yes, and the cholangiogram report.

Q. Okay.

A. Well, parts anyway.

Q. Okay.

MR. SHELSBY: No further questions, Your Honor.

THE COURT: Mr. Ferri.

MR. FERRI: Thank you.

* * *

RECROSS-EXAMINATION

BY MR. FERRI:

Q. Doctor, do you still have your deposition up there?

A. Sure.

Q. I had asked you some questions earlier about you

didn't -- suggesting that you didn't tell me about these cuts that were going to be your opinions. You said that I hadn't asked you, correct?

A. You hadn't asked me about cuts.

Q. Hadn't asked you? Could you turn to Page 32 of your deposition.

A. Sure.

Q. And go to Line 5.

A. Yes.

Q. See where I said, "We've discussed a number of areas where you believe that Dr. Barnett breached standard of care with regard to Mr. Johnson"?

A. Yes.

Q. "Are there any other opinions that you have that we have not discussed because I would like to hear them today?" Answer? Would you read your answer?

A. "I don't believe there are any other issues that we have not discussed."

Q. Thank you, Doctor.

A. You're welcome.

THE COURT: Mr. Shelsby.

MR. SHELSBY: No further questions, Your Honor.

THE COURT: All right. Thank you. May the witness be excused?

MR. SHELSBY: Yes, Your Honor.

MR. FERRI: Yes.

THE COURT: All right. You can step down and be excused, Doctor.

(The witness steps down and is excused.)

ANDREA M. SAATMAN
Official Court Reporter

CERTIFICATE OF REPORTER

I, Andrea M. Saatman, Official Court Reporter of the Superior Court, State of Delaware, do hereby certify

that the foregoing is an accurate transcript of the testimony adduced and proceedings had, as reported by me, in the Superior Court of the State of Delaware in and for Kent County in the case therein stated, as the same remains of record in the office of the Prothonotary of Kent County at Dover, Delaware.

This certification shall be considered null and void if this transcript is disassembled in any manner by any party without authorization of the signatory below.

WITNESS my hand this _____ day of _____, A.D., 2011.

_____
Andrea M. Saatman
Official Court Reporter

ANDREA M. SAATMAN
Official Court Reporter