

**Medical Malpractice Laparoscopic Gallbladder Removal (Cholecystectomy)**

**Hommel v Bradford King, MD and Surgical Associates of Fredericksburg**

**\$1,875,000 Verdict – City of Fredericksburg**

**Plaintiff's Attorneys:**

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(For educational purposes only – past results do not guarantee future outcomes)

1. Opening Statement of the Plaintiff (Benjamin Glass)
2. Cross Examination of Defense Expert Stephen Hill, MD
3. Cross Examination of Defense Expert Christopher Steffes, MD
4. Closing Argument (Benjamin Glass)
5. Newspaper account of the case

## VERDICTS & SETTLEMENTS

# Nurse failed to tell surgeon that patient called with post-op complaints

### \$1.85 million Verdict

A 62-year-old female had blood work done to evaluate an inflamed tick bite. Testing showed elevated liver function results. Further investigation led to a discovery of a large gallstone. Surgery was recommended and was performed in September 2012 in Fredericksburg.

At surgery the surgeon took an intraoperative cholangiogram, preplanned to make sure she had no other gallstones in the common duct. The surgeon saved one image from the intraoperative cholangiogram and it was, according to plaintiff's experts, abnormal. Plaintiff's case against the surgeon was that in light of the cholangiogram he should not have proceeded with cutting what he believed to be the cystic duct because the cholangiogram "predicted" that he was about to create a major biliary injury.

The surgeon and his experts testified that the cholangiogram image he took did not tell the entire story because it was but a "moment in time." The surgeon testified that what he saw on the screen before taking the picture showed a normal cholangiogram. At surgery, the surgeon inadvertently removed a large segment of the common hepatic duct and the right and left hepatic ducts, leaving bile to drain into the patient's abdomen. Neither the surgeon nor the pathologist noticed the extra biliary tree parts post-operatively.

The patient went home that day and traveled to her second home in North Carolina, with the surgeon's permission.

There were then a series of phone calls back to the surgeon's office. On the afternoon of surgery the patient's husband called and spoke to a nurse. He told the nurse that his wife is in a great deal of pain. He requested a change of medication from the Percocet to Vicodin. The nurse told him this was normal post-op pain and that Vicodin wasn't going to help. The surgeon never heard about this call.

On the fifth post-operative day, the patient called again, this time complaining that the Percocet wasn't covering the pain, she could not eat anything and she had left shoulder pain. She spoke with a different nurse who told her this is all normal. That nurse did not tell the surgeon either. Instead, she ordered the Percocet stopped and, using the surgeon's DEA number, called in a new prescription for Vicodin to the pharmacy. The pain continued for another nine days but because the patient was under the im-



ABRENIO

pression that the nurse had spoken to the surgeon, and that the surgeon said this was "normal," she did not call back to the office.

Two weeks after surgery, the patient started spitting up bile and now felt even worse. It was later determined that she had four liters of bile, causing bile peritonitis and all sorts of adhesions in her abdomen.

She called the surgeon's office and spoke to the same nurse she has spoken to on day five. The nurse told her to go to the emergency room and "bring your records with you when you come for your follow up visit with the surgeon next week." Again, she didn't tell the surgeon of the call even though at trial she testified that this "sounded a little weird to her."

The patient was evaluated at Wake Med in NC, emergently transferred to a hospital where, after initial testing, a surgeon who did not have much experience in repairing major biliary injuries like this, took her to surgery, creating a massive vertical scar.

While in surgery that surgeon began sending photos to a liver transplant surgeon, who told him to place drains, close, and transfer the patient to his service. That initial surgery was about 6 hours because there were by now massive adhesions and it took a long time to locate what remained of the right and left hepatic ducts. The common bile duct was found with a surgical clip on it (as one might expect after the misidentification).

While she was in the hospital for her first surgery, the surgeon who did the gallbladder surgery called and left several messages on the patient's cell phone, telling her how sorry he was and how he had to apologize because no one in his office told him about her calls.

Several months later she had a definitive repair in a 12 hour surgery by the transplant surgeon (David Gerber, MD), who created a much smaller horizontal incision. Gerber had to go inside the liver to locate what remained of the right and left hepatic ducts. He also had to deal with both the massive adhesions from the bile peritonitis AND the adhesions from the first exploratory surgery. Evidence at trial was that had Dr. Gerber seen her first, she would have



GLASS

avoided the massive vertical incision and scarring.

A year later she had a huge abdominal mesh implanted because of the hernia caused by the combination of the large vertical (caused by the surgeon who had little experience doing this type of a repair) and smaller horizontal incisions which basically crisscrossed. That also was about an 8 hour operation.

She went about 2 ½ years before stricturing down her repaired anastomosis between what remained of her right and left hepatic ducts and her duodenum. That was an 8 day admission for implantation of stents. Shortly thereafter she had a procedure to remove the stents. She also testified that her hernia was now recurring and she was likely headed to yet another surgery.

The surgeon was sued for the original gallbladder surgery. The nurse was not named individually because at the time the lawsuit was filed it was unclear whether the patient's messages of continued pain had actually been passed on to the surgeon. Plaintiff pleaded a claim against the corporation contending that either the messages had or had not been passed to the surgeon but that either way, the corporation was liable.

Past medical bills were \$340,000. There was testimony at trial, some of which came from the defense experts, was that the damages caused by the nurse's failure to pass the messages would have been greatly reduced. The two week delay caused the need for the multiple abdominal surgeries, the later abdominal wall repair, a massive vertical scar and, arguably even the stenting procedure. (One of the defense experts testified that most of the damage to the common bile duct was caused by the effects of the bile during the two week delay.)

The plaintiff's case was finished by 10:30 the second day of trial. The court adjourned the afternoon of the second day of trial because of scheduling issues with two defense experts. The jury received the case (and three pizzas, courtesy of the Court) at 12:40 p.m. on the third day of trial and returned its verdict in favor of the surgeon but against the practice group (for the negligence of the nurse) at 3:00 p.m. (See also the story, VLW, Jan. 25, 2016).

[16-T-006]

**Type of action:** Medical Malpractice

**Injuries alleged:** Gallbladder Surgery and Follow Up

**Name of case:** Christine Hommel v. Surgical Associates of Fredericksburg

**Name of judge:** Gordon F. Willis

**Date resolved:** Jan. 6, 2016

**Verdict or settlement:** Verdict

**Amount:** \$1.85 million

**Attorneys for plaintiff:** Benjamin W. Glass III and James Abrenio, Fairfax

**Attorneys for defendant:** Robert Donnelly and Robyn Ayres, Richmond

**Plaintiff's experts:** Glenn Sanders MD, General Surgery, Maryland; Michael Leitman MD, General Surgery, New York; David Gerber MD, hepatobiliary surgeon repaired the injury, North Carolina; Sherri Smith LPN, nursing standard of care, Midlothian

**Defense Experts:** Stephen Hill MD, General Surgery, Roanoke; Christopher Steffes MD, General Surgery, Detroit

**Insurance carrier:** The Doctor's Company

**In the Matter Of:**

CHRISTINE HOMMEL v. SURGICAL ASSOC. OF FREDERICKSBURG

**TRANSCRIPT**

*January 04, 2016*

**HALASZ**  

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**Reporting & Video**

1 VIRGINIA:  
2 IN THE CIRCUIT COURT OF THE CITY OF FREDERICKSBURG  
\*\*\*\*\*  
3 CHRISTINE HOMMEL,  
4 Plaintiff,  
5 v. Case Number  
6 SURGICAL ASSOCIATES OF FREDERICKSBURG, et al.,  
7 Defendants.  
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9 EXCERPTED TRANSCRIPT OF PROCEEDINGS  
10 BEFORE THE HONORABLE GORDON WILLIS  
11 January 4-6, 2016  
12 Fredericksburg, Virginia  
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19 Richmond, Virginia 23218-1644  
20 (804) 708-0025  
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24  
25 REPORTED BY: GWENDA E. APPELEGATE, RPR, CRR

<p style="text-align: right;">Page 2</p> <p>1 APPEARANCES OF COUNSEL: 2 BEN GLASS LAW 3 3915 Old Lee Highway, Suite 22-B 4 Fairfax, VA 22030 5 By: BEN GLASS, ESQ., 6 Counsel for the Plaintiff 7 8 GOODMAN, ALLEN &amp; DONNELLY 9 4501 Highwoods Parkway, Suite 210 10 Glen Allen, VA 23060 11 By: ROBERT F. DONNELLY, ESQ., 12 -- and -- 13 ROBYN AYRES, ESQ., 14 Counsel for the Defendants 15 16 17 18 19 20 21 22 23 24 25</p>	<p style="text-align: right;">Page 4</p> <p>1 the liver. And the gallbladder really has one 2 function, is it stores bile. So the liver produces 3 it at a constant level. And the gallbladder 4 collects bile. And then when you eat and the body 5 says you need bile, gallbladder sends bile down 6 into the digestive tract. 7 So for purposes of this case then, the anatomy 8 that's important is, these are -- this is a 9 drawing. It's a medical drawing. One of the 10 experts will be using this to help explain the 11 case. Gallbladder here, liver sort of up here 12 overlaps the gallbladder. This green duct, it's 13 called a duct, goes up and down. I like to refer 14 to it as the north/south highway. This duct is 15 running from the liver down into the duodenum, the 16 intestines, your bowels. All right. And so the 17 purpose of this green duct is simply to take bile 18 that's produced by the liver, send it down if need 19 be, straight down into the intestines. But it also 20 goes back and forth along this duct to the 21 gallbladder to be stored. It's very cool. 22 So this duct is an east/west duct, is really a 23 two-way traveling system. This duct is called the 24 cystic duct. This duct is called the bile duct. 25 But below where it intersects with the cystic duct,</p>
<p style="text-align: right;">Page 3</p> <p>1 (January 4, 2016, jury in) 2 3 OPENING STATEMENT 4 MR. GLASS: The events of this case take place 5 just over about three years ago, so we're talking 6 September of 2012. Ms. Hommel is referred to 7 Dr. King, a surgeon, to have her gallbladder 8 removed. A little interesting, she had had a tick 9 bite on her breast. They did some blood work. The 10 blood work showed some abnormalities in something 11 called liver function tests. She had a sonogram 12 that showed she had a gallstone in her gallbladder. 13 Appropriate recommendation is made to have the 14 gallbladder removed. 15 A little bit of anatomy just so we can all be 16 oriented. The important parts of the anatomy for 17 this case are we have our liver. The liver is 18 involved in sort of managing, starting to manage 19 the digestive system, when we eat food. One of -- 20 the liver does a lot of cool things, but one of the 21 things it does that's important for this case is, 22 it produces bile. Bile is used to help digest the 23 food that we eat. 24 Very cool about the gallbladder, it's a 25 pear-shaped organ that sort of sits tucked up under</p>	<p style="text-align: right;">Page 5</p> <p>1 it's called the common bile duct. And above where 2 it intersects, it's called the common hepatic duct. 3 Then it actually branches into a right and left 4 hepatic duct. So that's your basic anatomy that 5 we'll need to understand in this case. 6 So when a surgeon does a gallbladder removal 7 surgery, by and large these days he or she does it 8 laparoscopically. So they stick some scopes in. 9 You have a couple of really tiny incisions, and the 10 goal is to do really three things. Number one is 11 you cut this cystic artery. Now, before you cut 12 anything, you identify it, you are clear that this 13 is what you are intending to cut, and you put clips 14 on either side of where you're going to cut so that 15 when you cut it, the bile and the blood doesn't go 16 everywhere. 17 So in this surgery you cut the cystic artery. 18 You then cut the cystic duct. And again, before 19 you cut the duct, you identify it, you make sure it 20 is the cystic duct. You put a clip on one side 21 near the gallbladder. You put a clip on the other 22 side of where you're going to go. You actually put 23 two clips. The closer you are to this main 24 north/south highway, you put two clips on this, all 25 right, and then you cut.</p>

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1 Then the gallbladder essentially is peeled  
2 down off of the liver, sort of held to the liver  
3 and held in place by this sort of tissue, which is  
4 called tissue, call it omentum. You'll hear fancy  
5 words. But the surgeon then peels it down. It has  
6 been cut at the cystic duct, the cystic artery, and  
7 now it comes out really cool through one of those  
8 little incisions, boom.

9 Normal gallbladder surgery recovery time three  
10 to five days, you're feeling really, really good  
11 for the vast majority of people. In this case, our  
12 evidence will be through the witnesses that we  
13 present, that Dr. King did not cut through the  
14 cystic artery -- excuse me. He did not cut through  
15 the cystic duct to get the gallbladder out. He  
16 mistakenly cut through this common bile duct, once  
17 below the area where the cystic duct runs into it,  
18 and way, way up here where the common hepatic duct  
19 divides and goes into the liver.

20 So when the gallbladder came out, there was  
21 this segment, you'll call it a segment of the  
22 common hepatic duct, was completely missing.  
23 That's not the way it's supposed to be, because at  
24 the end of the surgery when you do it properly, you  
25 still have this common hepatic duct, the right and

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1 left hepatic ducts all the way down to the  
2 duodenum. You still have that highway perfect.  
3 It's only the exit ramp on the little road that  
4 runs off it that's supposed to be cut, clipped, and  
5 boom. It's really cool. You can live without a  
6 gallbladder. You can live basically a normal life  
7 without a gallbladder. It's interesting, a lot of  
8 animals don't even have gallbladders.

9 Now, in this case, in doing the surgery,  
10 Dr. King took an x-ray during the surgery. This is  
11 a critical, critical piece of the case. So let's  
12 talk about this. It's an x-ray. The fancy name is  
13 a cholangiogram. Since it was taken during the  
14 operation, it was called an intraoperative  
15 cholangiogram. Now, because Ms. Hommel had a  
16 gallstone, knew that before the surgery, Dr. King  
17 preplanned, before the surgery started, he planned  
18 to do this intraoperative x-ray during the surgery  
19 to look to see, to make sure that there weren't any  
20 other gallstones anywhere else along this biliary  
21 tract.

22 So what this picture shows or this x-ray shows  
23 is the common bile duct running down into the  
24 duodenum, but it doesn't show the east/west highway  
25 which is the cystic duct, and it doesn't show the

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1 common hepatic duct which is that part, remember,  
2 that goes up above the intersection; all right? So  
3 this is an abnormal cholangiogram.

4 What it should show is this entire -- you'll  
5 hear the phrase the biliary tree. It looks like a  
6 tree. What happens to get the x-ray is you inject  
7 some dye in. It takes about 15 or 20 seconds to  
8 do. You snap a picture, which is how we get this  
9 picture showing where the dye is, and it should  
10 show this biliary tract lit up; all right? It  
11 shouldn't be stopping here, because when it stops  
12 here, it means, the experts will tell you, that  
13 something is wrong, that you have in this case  
14 likely accidentally clipped not the cystic duct that  
15 runs to the side, but you have clipped the common  
16 hepatic duct and you are getting ready to divide,  
17 to cut that common hepatic duct.

18 So the experts will tell you on our side that  
19 this intraoperative x-ray is a huge stop sign. It  
20 should say to the physician halt the surgery until  
21 you figure out why we don't see the common hepatic  
22 duct and the branches, the right and left hepatic  
23 ducts. There could be reasons why. Sometimes  
24 gravity plays a part, patient needs to be  
25 repositioned. Sometimes the catheter that you used

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1 to insert the dye needs to be repositioned a little  
2 bit. But it's incumbent upon the physician to  
3 figure it out before he goes, because if he doesn't  
4 figure it out, he's in danger of doing exactly what  
5 happened in this case, which is cutting out a  
6 segment and leaving open -- cutting out a segment  
7 of her biliary tract so that now bile is coming out  
8 of the liver and just going into her abdomen,  
9 you'll see for about two weeks or so, and needing a  
10 big-time repair, which we'll talk about here in a  
11 minute.

12 So this x-ray taken during the surgery is a  
13 critical piece of the evidence. And the evidence  
14 will be the standard of care requires that when you  
15 take an x-ray like this, a cholangiogram, you've  
16 got to look at it and you've got to look at the  
17 whole thing. And even though you were looking for  
18 stones down here, the southern part of the x-ray,  
19 when you don't see the rest of the biliary tract,  
20 that's a big, big warning sign that says stop.  
21 What you do is you stop and you figure out, in this  
22 case you figure out that you've got a clip on the  
23 common hepatic duct, and you take the clip off and  
24 everything will be just fine, she never loses a  
25 segment of her common hepatic duct.

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1 Now, immediately after the surgery, Dr. King  
2 dictates his operate note about six, seven eight  
3 minutes afterward. You'll hear, if you're not  
4 already familiar, doctors dictate a note that says  
5 what we do in the surgery, what we did. The  
6 important part for this discussion is that Dr. King  
7 dictates about this cholangiogram. Now, remember,  
8 this is an abnormal cholangiogram. It does not  
9 show the northern part of the ductal system. But  
10 he dictates that the cholangiogram was obtained in  
11 standard fashion, demonstrating, showing normal  
12 intra and extrahepatic bile ducts. You'll hear  
13 those are the more fancy medical words for the  
14 common hepatic duct and the right and left hepatic  
15 duct.  
16 So this operative report tells us that  
17 Dr. King knew that it was important, once you do  
18 the x-ray, to see a full biliary tree. For  
19 whatever reason, he misinterprets this. He either  
20 wasn't paying attention, didn't remember, or what.  
21 But this x-ray, everyone will agree, does not show  
22 normal intra and extrahepatic bile ducts at all. I  
23 don't think there will be any dispute about that.  
24 And he proceeds with the surgery. And the surgery  
25 causes a devastating injury, as you'll hear, to

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1 Ms. Hommel.  
2 Now, that's the negligence part of the case.  
3 So our case is that Dr. King needed to carefully  
4 identify the cystic duct before he cut it. That's  
5 a standard principle of surgery; know what you're  
6 cutting before you cut it, and that he failed to do  
7 that. And he had the greatest tool ever invented,  
8 this x-ray that showed him he was about ready to  
9 get what he got in the surgery.  
10 Now, this is outpatient surgery. You come  
11 into the surgery center, you go home after a couple  
12 hours probably in recovery. And the evidence will  
13 be that later that afternoon Ms. Hommel's husband,  
14 she or her husband, I forget which, called into the  
15 office and said this isn't feeling right, I'm in a  
16 lot of pain, could I have a different pain  
17 medication. She had been discharged on Percocet.  
18 She had had some good experience with Vicodin in  
19 the past. And this call is taken by a staff person  
20 in Dr. King's office who labels the call -- they  
21 have this system that you'll see of obviously  
22 you're keeping medical records and you're keeping  
23 another sort of electronic medical record of calls  
24 that are coming in, a system where the call comes  
25 in, patient, I need a refill or I'm having pain,

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1 when is my next appointment. That person sort of  
2 triages the deal, finds the answer and tells the  
3 patient.  
4 In this case, on the afternoon of the surgery  
5 Ms. Hommel or her husband is calling, this doesn't  
6 feel right. The call is labeled by Dr. King's  
7 staff, by the Surgical Associates of Fredericksburg  
8 staff, as a high priority call. But nobody tells  
9 Dr. King that Ms. Hommel has called. Instead, they  
10 tell her, Hey, this is probably normal, you just  
11 had surgery, you're asking for Vicodin but if  
12 Percocet isn't helping, then Vicodin won't help  
13 either, so just take some Ibuprofen in between the  
14 Percocet and just keep on going, let us know, let  
15 us know if -- how you do.  
16 All right. So Ms. Hommel, she doesn't know  
17 because she never had her gallbladder taken out.  
18 She trusted the doctor. She doesn't get better  
19 over those next one, two, three, four, five days.  
20 And on day five she calls again to the office. And  
21 what I'm reading from you'll have in evidence later  
22 when this case is done. And she complains to the  
23 nurse, and it's a nurse whose name at the time was  
24 Nichole Brooks, and now her name is Nichole Brooks  
25 Graham. And she says this: My Percocet has not

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1 been providing adequate pain control. I have left  
2 shoulder pain. I have nausea. I have only been  
3 able to eat a couple of bites before feeling full.  
4 I can drink some. Ice makes it feel better. But  
5 I'm reporting this now. What should I do, because  
6 Dr. King had told her look, three to five days  
7 you're going to be, you're going to be up and  
8 about. And Ms. Hommel is concerned because not  
9 only is she not up and about, but she's not getting  
10 better at all.  
11 Now, this call is managed by Nurse Brooks, and  
12 it is listed as a medium priority. But again,  
13 nobody tells Dr. King. There's no system in the  
14 office, no good system for letting Dr. King know  
15 how his patient is doing postoperatively. And  
16 later you'll hear Dr. King calls, now much later  
17 when Ms. Hommel is in North Carolina, he calls her  
18 and says I have to confess, they never told me.  
19 They never told me.  
20 So that's day five after the surgery. Goes  
21 another nine days, she has traveled down because at  
22 that time, they had a place up here in  
23 Fredericksburg. Her husband worked in the area,  
24 they had a place down in North Carolina. She had  
25 asked Dr. King when the surgery was done, can I go

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1 down to North Carolina. He basically says yeah, if  
2 you feel good, you can go down to North Carolina.  
3 She had traveled down there.  
4 But nine days after the day-five call, she is  
5 calling again, speaks to the same nurse she spoke  
6 to on day five, Nichole Brooks, and says, "I've  
7 been having really bad acid reflux since yesterday,  
8 I can't eat or drink anything, it's starting to  
9 turn blackish. I have a hard spot on my right  
10 upper quadrant. I can eat very little, I'm really,  
11 really sick." And the same nurse says, Well, go to  
12 the emergency department. Okay. Appropriate  
13 advice. But again, she doesn't even tell the  
14 doctor again, didn't tell him that this patient is  
15 not doing well at all following this surgery.  
16 Well, she does get into the hands of some  
17 great surgeons down in North Carolina. And she'll  
18 tell you the story. But she presents to the  
19 emergency department. She is sick as a dog. They  
20 start to evaluate her. They find out her belly,  
21 her abdomen is full of fluids. Dr. Jeffrey Abrams  
22 takes her to a first major surgery. Now, remember,  
23 this operation with Dr. King had been minimal  
24 incision surgery with little dots really where you  
25 put the cameras in and the tools in to do it.

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1 Dr. Abrams cut her really from here down to  
2 here, about 82 or 85 stitches to explore her. They  
3 drained out two -- they drained out four liters,  
4 four liters, like two two-liter coke bottles of  
5 bile that was festering in her belly and her  
6 abdomen. Dr. Abrams discovered exactly what I said  
7 earlier, which is that when he finally got in there  
8 to look, they did a series of tests and some other  
9 x-rays. You'll hear about ERCPs and stuff,  
10 discovered that indeed this section of the common  
11 hepatic duct was gone right up and to the liver,  
12 and bile had been draining now for a couple of  
13 weeks into her belly.  
14 So Dr. Abrams takes her to surgery. The best  
15 he can do at that time is to not do really anything  
16 in terms of a repair because the belly is so  
17 aggravated and so angry because of the bile. So  
18 she leaves that hospital with a huge incision, with  
19 all sorts of drains, with bags coming out. And she  
20 sees, she meets Dr. David Gerber during that first  
21 hospitalization. He's a hepatobiliary surgeon. He  
22 did a magical job ultimately in repairing her.  
23 And what happened was several months after  
24 Dr. Abrams' surgery, when her belly has quieted  
25 down and she's had these drains now for several

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1 months, Dr. Gerber, who will be here to testify, is  
2 able to do the repair, basically by bringing her  
3 intestines up just under the liver, finding these  
4 what remain the remnants of the right and left  
5 hepatic duct and attaching them to her intestine so  
6 that, as the liver produces bile, now it's not  
7 going into her belly, it's not going down a drain,  
8 it's getting back to the way it's supposed to work.  
9 The problem with that is that ain't the way  
10 God made her, and these bile ducts over time  
11 stricture and scar. I'll get to that in just a  
12 minute. So original surgery is in September 2012.  
13 Dr. Abrams' surgery is about two weeks after that.  
14 And then in November right before Thanksgiving,  
15 November of 2012 is Dr. Gerber's big-time repair.  
16 Because she had multiple surgeries, she developed a  
17 huge abdominal hernia. And so in June of 2013, she  
18 went back to the hospital and they put a piece of  
19 mesh in her belly that's about the size of this  
20 paper, wrapping it inside her belly to keep it  
21 intact.  
22 I think everyone probably knows what a hernia  
23 is. But it's basically a weakening of the, of the  
24 abdominal wall in most cases. And so now she has a  
25 mesh barrier to help keep her abdominal wall

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1 intact. Just this last summer, in July -- she had  
2 done, by and large for the nature of the injury,  
3 she had done pretty well. This last summer,  
4 however, her bile ducts did stricture. When they  
5 start to stricture and scar down and prevent bile  
6 from leaving the liver, you get really, really  
7 sick. And so she got really sick. She went to the  
8 hospital. They said, Oh, my gosh, this is probably  
9 strictures; spent nine days in the hospital there  
10 getting stents placed and then several weeks later  
11 getting the stents removed. The hope is, the hope  
12 is that this will not stricture down again. But  
13 nobody can guarantee that.  
14 Today Chris Hommel will tell you she's fairly  
15 limited in terms of, like, I'm not going to travel  
16 anywhere because I cannot predict when or if I may  
17 stricture down again and need major  
18 hospitalization. And a lot of her life has now  
19 been really compacted and limited because of this.  
20 At the end of the case, I'm going to ask you to  
21 find Dr. King breached the standard of care.  
22 That's the legal phrase for it. He committed  
23 medical malpractice by failing to correctly  
24 identify the cystic duct before he cut not the  
25 cystic duct but the common, the common bile duct by



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1 failing to use the greatest tool on earth  
2 intraoperatively to tell him that he was about  
3 ready to cause this injury.  
4 I'm going to ask you to find that the practice  
5 is guilty of negligence, violated the standard of  
6 care in failing on that day-five visit to get  
7 Ms. Hommel to a doctor earlier, by not -- by the  
8 nurse not giving Dr. King the message, Oh, your  
9 patient is having so much pain, she needs a new  
10 narcotic medication. By the way, what the nurse  
11 did without asking any doctor was called in a new  
12 prescription for a new narcotic medication. And so  
13 for several more weeks Mrs. Hommel had pain and  
14 accumulating bile because of that negligence.  
15 At the end of the case, I'm going to ask you  
16 to find that he violated the standard of care and  
17 that she's entitled to very, very substantial  
18 monetary damages because of what her life will  
19 likely be like going forward.  
20 Thank you, Your Honor.  
21  
22 \* \* \* \* \*  
23  
24  
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1 (January 6, 2016, jury in)  
2  
3 STEPHEN HILL, M.D.  
4 first duly sworn, testified as follows:  
5 C R O S S  
6 E X A M I N A T I O N  
7 BY MR. GLASS:  
8 Q Good morning, Dr. Hill.  
9 A Hello.  
10 Q Yesterday we heard -- well, you do not dispute  
11 that at the end of this surgery the gallbladder was out  
12 and a section of the common hepatic duct was removed  
13 with the gallbladder; correct?  
14 A No, that's not correct. As I said, the  
15 pathology shows there's a gallbladder and a cystic duct.  
16 There's nothing to describe that the hepatic duct has  
17 been removed.  
18 Q Isn't it true that in the surgery as he is  
19 taking out the gallbladder, Dr. King cuts across the  
20 right and left hepatic duct with a Bovie?  
21 A That, again, that remains to be seen. I don't  
22 know what occurred at that point. All I can say is that  
23 the gallbladder was removed, the cystic duct was  
24 removed, and then he removed some other areas there.  
25 But the pathology specimen shows just a cystic duct.

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1 Now, there was damage, obviously. That's why  
2 we're here. But nothing was removed that was diagnosed  
3 or described on the pathology report.  
4 Q Right. And that Bovie is that -- I think it  
5 was termed an energy instrument, is that --  
6 A It's an instrument that we use in surgery all  
7 the time basically to coagulate bleeders or to cut  
8 across something. Again, it's used frequently.  
9 Particularly, in an inflamed gallbladder, you want to  
10 stop any little bleeding, it's used for that. And  
11 that's used both in open as well as closed gallbladders.  
12 Q So what a Bovie does is it can cut across  
13 tissue but it also coagulates or seals bleeders, right,  
14 if you cut across something that would either bleed or  
15 leak fluid?  
16 A Correct, depending upon the amount of energy  
17 you set it.  
18 Q Sure.  
19 A Yes, it will coagulate and seal.  
20 Q All right. You agree with me, I think, that a  
21 physician violates the standard of care if they have not  
22 done their best to visualize everything that they can;  
23 correct?  
24 A A physician should visualize everything he can  
25 see in order to proceed with the surgery.

Page 21

1 Q And you agree with me, I think, that a surgeon  
2 doing a gallbladder surgery should use all of the  
3 information available to him to make sure the patient  
4 has a safe operation; correct?  
5 A Correct.  
6 Q And I think that you just testified that at  
7 some point during the surgery, in order to comply with  
8 the standard of care, Dr. King needs to see the ducts as  
9 he described them in the operative note; correct?  
10 A He needs to see -- in the operation, he needs  
11 to see the cystic duct. In the cholangiogram he ought  
12 to see the common ducts and the hepatic ducts.  
13 Q Including the hepatic duct up into the right  
14 and left hepatic duct?  
15 A Only on the cholangiogram. You never dissect  
16 up in that area.  
17 Q I wasn't, I wasn't splitting it into seeing.  
18 I'll go with you. He needs to see it on the  
19 cholangiogram in order to comply with the standard of  
20 care in proceeding with the surgery, correct?  
21 A He needs to see that. He does not need a  
22 static picture of it. He doesn't need to save it for  
23 posterity. He should see it.  
24 Q We'll get there. I understand your position.  
25 And if a physician doesn't see the common

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1 hepatic duct, the right and left hepatic duct in doing  
2 this surgery, he violates the standard of care in going  
3 forward and creating an injury like this; correct?  
4 A Correct.  
5 Q You looked at the -- let me do this.  
6 MR. GLASS: If Your Honor, please.  
7 BY MR. GLASS:  
8 Q In doing the surgery and looking through your  
9 scope, if you're looking at a common duct and a cystic  
10 duct, they look pretty much identical to the eye;  
11 correct?  
12 A No, not at all.  
13 Q Okay. So what should a physician see that's  
14 different between a common duct and a cystic duct?  
15 A Normally I and most people don't even expose  
16 the common duct because of dangers. You look at  
17 basically the gallbladder/cystic duct junction. And  
18 again, when you look in this area, you see under a pile  
19 of fat, et cetera, off to the side, you see where there  
20 is a common duct. But you never expose it unless there  
21 is an indication to expose it because it leads to some  
22 dangers of bleeding. There are major blood vessels  
23 around there, the portal vein and hepatic artery. So  
24 you really want to stay away from that area because you  
25 could bleed massively and quickly in that area.

Page 23

1 So you want to basically dissect at the  
2 juncture -- junction of the gallbladder to the cystic  
3 duct. And that gives you, in some people a centimeter,  
4 and some people a millimeter distance to carefully  
5 divide the cystic duct.  
6 Q Are you done? My question was what's the  
7 difference when you do see them. I asked you whether  
8 they are identical. You said they weren't. I asked you  
9 what's the difference. You haven't answered that  
10 question. Could you answer my question?  
11 A The answer to that question is they go --  
12 anatomically they are different. The cystic duct comes  
13 off at an angle. The common duct goes up. The common  
14 duct is often larger and the common duct is off to the  
15 side. Does that answer your question?  
16 Q That's good enough.  
17 Now, you believe that at the time that the  
18 cholangiogram was -- the static image that we've seen,  
19 that there was no clip across the common hepatic duct;  
20 correct?  
21 A Correct.  
22 Q Do you know today whether Dr. King used a  
23 temporary clip to hold that catheter in place?  
24 A It would appear that way from the note that he  
25 used a temporary. Often people -- as I told you

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1 previously, there are different ways to hold the  
2 catheter in place. Some people use a clamp. Some  
3 people use a clip. Some people tie it in place.  
4 Sometimes these little catheters have little bulbs on  
5 them so once you get them in, they'll stay there, the  
6 purpose being that when you inject, you don't want it  
7 popping out again and filling the whole operative field  
8 with the dye, which then obviously gives you a poor  
9 picture.  
10 Q Do you agree when I came to Roanoke and took  
11 your deposition, you didn't know the answer to that  
12 question?  
13 A Again, I'm going by what I -- no. I remember  
14 you asked me that question and I told you there were  
15 different areas, different ways in which the cystic duct  
16 would be tangled and how it would be held in place.  
17 MR. GLASS: Can you do me a favor, Mr. Omar?  
18 Put up that colored cholangiogram picture real  
19 quick for me, please.  
20 BY MR. GLASS:  
21 Q I think you said as we're looking at an image  
22 of a cholangiogram, this is an x-ray; correct? Right?  
23 A Correct.  
24 Q It's like an x-ray. And so what this dye,  
25 when you put the dye in, it becomes the darker parts of

Page 25

1 the x-ray; correct?  
2 A Well, actually, it becomes the lighter parts.  
3 Again, it's hard.  
4 Q That's what --  
5 A I mean, again, it doesn't become green, it  
6 doesn't become yellow, and it doesn't become red.  
7 Q Of course.  
8 A It depends on how it's viewed. As I said,  
9 oftentimes you see the picture as you see up in the  
10 upper corner there, you see that. Or you can see on the  
11 actual x-ray film, sometimes it's white. It varies.  
12 Q You talked about that big black area at the  
13 bottom of the duodenum --  
14 A Yes.  
15 Q -- being dye.  
16 A Correct.  
17 Q Right? And it is dye, correct?  
18 A Correct.  
19 Q Actually, I have the cholangiogram here. Step  
20 down. Could you come here for a second?  
21 A Certainly.  
22 Q Now, do you agree with me that we don't see  
23 the cystic duct at all on this cholangiogram?  
24 A Correct. It's rare that you'll see the cystic  
25 duct because of the fact that you have the catheter in

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1 the cystic duct to get to the common duct.  
2 Q Doctor, do you agree with me that you don't  
3 see the cystic duct on this cholangiogram?  
4 A Correct.  
5 Q And you read Dr. King's deposition?  
6 A Yes.  
7 Q Carefully?  
8 A Several months ago.  
9 Q Sure. Well, didn't you read it preparing for  
10 this?  
11 A I skimmed it, did not memorize it. Sorry.  
12 Q Gotcha. And do you remember Dr. King, on his  
13 deposition, talking about where he saw on this  
14 cholangiogram, on this static image, dye refluxing into  
15 the common hepatic duct? Do you remember that  
16 discussion?  
17 A Correct.  
18 Q And that -- did you -- did they ever send you  
19 the video that I took of Dr. King during that  
20 deposition?  
21 A No.  
22 Q Do you know that Dr. King, would it surprise  
23 you to know that he is talking about this section in  
24 here as being what he viewed on the static image as  
25 reflux into the common hepatic duct?

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1 A I'm not quite sure what you're asking.  
2 Q When I asked Dr. King the question in his  
3 deposition, show me on the static image where you saw  
4 dye refluxing into the common hepatic duct, right,  
5 common hepatic duct is that part above the cystic  
6 duct --  
7 A Correct.  
8 Q -- correct? That he pointed to this darkened  
9 area, do you remember that in the deposition?  
10 A No. I didn't remember.  
11 Q All right. Did they ever send you, in  
12 reviewing the case, the exhibit that Dr. King marked  
13 on --  
14 A Yes.  
15 Q -- in that deposition?  
16 A Yes.  
17 Q And in the exhibit, he marked with that arrow  
18 where the tip of the catheter was?  
19 A Correct.  
20 Q You remember that part?  
21 A Correct.  
22 Q Last part. Look at this. Clip, correct?  
23 A Uh-huh.  
24 Q Clips, correct?  
25 A (Indicating in the affirmative).

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1 Q Clip, correct?  
2 A Correct.  
3 Q Clip, correct?  
4 A It looks like there's a clip there.  
5 Q Looks like there's a clip there. Could we get  
6 a marker? Would you mark on this that last clip,  
7 please?  
8 A I'm not sure. I see some dye here. This  
9 could have been the cystic duct. That might be a clip  
10 there.  
11 Q It's right where the catheter -- I'm sorry.  
12 Tell me if I'm in your way, please.  
13 It's where the catheter is coming into, enters  
14 the cystic duct; correct?  
15 A Correct.  
16 Q The ductotomy is in the cystic duct. A  
17 ductotomy is the hole where the catheter goes in --  
18 A Correct.  
19 Q -- correct? Clip there, right?  
20 A Right over, over here it looks like.  
21 Q Correct?  
22 A It looks like.  
23 Q And tip of catheter over here?  
24 A Right.  
25 Q And you agree that the tip of the catheter is

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1 there?  
2 A Absolutely.  
3 MR. GLASS: All right. Let me check my notes  
4 and I may be able to be done.  
5 THE COURT: All right. Doctor, you can have a  
6 seat on the witness stand.  
7 BY MR. GLASS:  
8 Q You are not of the professional opinion that  
9 Mrs. Hommel's cystic duct was fused to the common bile  
10 duct.  
11 A Are you asking or telling?  
12 Q I am asking a question.  
13 A I think --  
14 Q Let me rephrase it.  
15 A Okay.  
16 Q Dr. Hill, are you of the opinion here today  
17 that in this case, Mrs. Hommel's cystic duct was fused  
18 to either the common hepatic duct or the common bile  
19 duct?  
20 A Well, I mean, it's connected to that. And  
21 when you get an inflammatory response as she had from  
22 the cystic duct stone impacted, what you will get is  
23 you'll get an inflammatory response that will bring and  
24 stick everything together. So -- and again, it's fused,  
25 God made it that way, the cystic duct to the common

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1 hepatic duct. It's connected.  
2 **Q It's connected.**  
3 A That's the way it's supposed to be.  
4 **Q Right.**  
5 A What I'm saying is when you have inflammation,  
6 what happens oftentimes is everything gets pulled  
7 together. So whether it's fused or whether it's stuck  
8 together due to the large amount of inflammation and  
9 infection there, I don't know how you can differentiate  
10 that.  
11 **Q And that's one of the variations of anatomy**  
12 **that you-all, you surgeons know about when you're going**  
13 **in to do a surgery like Mrs. Hommel had; correct?**  
14 A That is one of numerous abnormalities or  
15 aberrant anatomy that occurs in every individual. And  
16 that's why this is a difficult surgery. That's why  
17 these kinds of things occur because no one is the same.  
18 Everybody has a different anatomy which is markedly,  
19 markedly changed with inflammation, infection, et  
20 cetera.  
21 And so that's -- and again, was it fused, was  
22 it brought together by inflammation, I don't know how  
23 you differentiate. All I know is that having been  
24 experienced, in those times that you have this, there is  
25 a large amount of inflammation that will alter the

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1 anatomy. So whether this is fused from birth as a  
2 congenital defect versus severe inflammation sucking it  
3 all in together is impossible to tell.  
4 **Q And because it is one of those many varieties**  
5 **or variations, that leads back to what we just talked**  
6 **about in the beginning, which is why it's important and**  
7 **mandated under the standard of care for a physician to**  
8 **use all of the tools available to try to figure that out**  
9 **before he cuts through that common hepatic duct?**  
10 A Absolutely.  
11 MR. GLASS: Thank you.  
12 \* \* \* \* \*  
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1  
2 CHRISTOPHER STEFFES, M.D  
3 first duly sworn, testified as follows:  
4 C R O S S  
5 E X A M I N A T I O N  
6 BY MR. GLASS:  
7 **Q So let's talk about the injury again which is**  
8 **part of the case first, that part of your testimony**  
9 **first.**  
10 You agree with me that this is, this injury  
11 that Ms. Hommel sustained is a type of devastating  
12 injury that's described in your literature, the  
13 literature of surgeons who do laparoscopic gallbladder  
14 removal; correct?  
15 A It's a major injury. I don't use the word  
16 devastating.  
17 **Q It is something that will change her life**  
18 **forever, won't it, having lost that segment of her**  
19 **biliary tract?**  
20 A It changed her life in the sense that she has  
21 a scar and subsequent surgery. It -- as far as the  
22 physiology of the digestive system, the bile now still  
23 has a way of getting into the small bowel, mixing with  
24 the food and aiding digestion.  
25 **Q You said that she's undergone this one**

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1 **stenting procedure, right?**  
2 A Yes.  
3 **Q And she, over the course of her life, will be**  
4 **at least subject to the possibility of additional**  
5 **stenting procedures; correct?**  
6 A It is possible. But at this point, looking at  
7 the outcome of the last one, it's not, it's not a  
8 guarantee.  
9 **Q Nothing's a guarantee, is it?**  
10 A I don't think it's probable, but --  
11 **Q Nothing's a guarantee?**  
12 A It's possible.  
13 **Q All right. And leading up to the last**  
14 **stenting procedure which is -- which was in, excuse me,**  
15 **July of 2015, what happens is the patient, this patient**  
16 **gets symptoms, she gets sicker, she presents to the**  
17 **hospital, they have to figure out her anatomy, right,**  
18 **and she spends eight days there having this procedure**  
19 **done; correct?**  
20 A I'm not aware of the details of that.  
21 **Q You didn't review the records that closely?**  
22 A Well, I saw some of those in the, in the  
23 summary, but I don't know if that is a --  
24 **Q You remember --**  
25 A I didn't see all the ER visits or anything.

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1 Q You have no reason to disagree with me there  
2 was an eight-day admission to have this stent in?  
3 A Oh, at that admission, yeah.  
4 Q Right.  
5 A There is the one admission that was eight  
6 days, and they actually did quite an impressive job  
7 of --  
8 Q She's fortunate, isn't she, that she lives  
9 near a place where they've got great surgeons; right?  
10 A I don't know that I can comment on that.  
11 There are a lot of great surgeons around --  
12 Q Do you know Dr. Gerber? Do you know  
13 Dr. Gerber?  
14 A I don't.  
15 Q Are you aware of him? Okay.  
16 Now, I think you also said that had Dr. King  
17 been told by his nurse that indeed this lady had called  
18 on day five still needing coverage of narcotic pain  
19 medication, that she could have had one less surgery; is  
20 that right?  
21 A Yes.  
22 Q And the less surgery is what? She would have  
23 skipped Dr. Abrams' surgery?  
24 A That's my conclusion, yes.  
25 Q Right. And so there's no doubt in your mind

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1 that had Dr. King been told by his nurse on day five  
2 post-op, that Dr. King would have done everything he  
3 could to get her to the very best surgeon in this area  
4 or in Northern Virginia; correct?  
5 A I think that's what would have occurred, yes.  
6 Q All right. And so she would have, she would  
7 have avoided -- do you agree that she would have avoided  
8 the long scar that Dr. Abrams put in, the long incision,  
9 82 staples?  
10 A She would have avoided one of those incisions.  
11 Some surgeons do the midline incision. Some do the  
12 transverse incision.  
13 Q Right.  
14 A But yes, she would have avoided one of those  
15 incisions most likely.  
16 Q And during that nine days between day five  
17 post-op and nine days after that when she finally makes  
18 her way to a walk-in emergency department down in North  
19 Carolina, her belly is filling up with bile; right?  
20 A Yes.  
21 Q And as they get her there and they figure out  
22 what's going on, they take out four liters, four liters  
23 of bile; right?  
24 A Yes.  
25 Q Right, two coke bottle, two-liter coke bottle

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1 size bile has filled up in her belly, causing bile  
2 peritonitis; correct?  
3 A Yes.  
4 Q That would have been avoided had that nurse  
5 told Dr. King, Hey, this lady is calling me, she still  
6 has problems five days post-op; right?  
7 A Well, it's, it's very -- I wouldn't say it's  
8 abnormal. Some patients can put that much bile and not  
9 have a lot of symptoms until weeks later and present  
10 with low blood pressure. There are some patients where  
11 one little drop of bile leads them to terrible pain that  
12 leads them to the emergency room.  
13 Q Some patients. We're not talking about some.  
14 I didn't mean to interrupt you. Are you finished?  
15 A Yes.  
16 Q Talking about this patient, this doctor, no  
17 doubt in your mind that had that nurse told Dr. King on  
18 day five that this lady has called, that he is getting  
19 her to the very best surgeon he can get ahold of;  
20 correct?  
21 A Yeah.  
22 Q Because he wants his patient to have the very,  
23 very best care she can have as quickly as she can get  
24 it; correct?  
25 A Yes.

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1 Q Now, going forward, you agree with me that she  
2 will need to be monitored medically likely for the rest  
3 of her life; correct?  
4 A Well, I think her liver enzymes will need to  
5 be monitored, yes, blood draws every so often.  
6 Q Right. Because it's the liver enzymes and  
7 those other lab studies we look at that can tell us even  
8 before the patient endures a symptom or a pain that  
9 indeed she may be stricturing again, correct?  
10 A Well, yes, especially since there are the  
11 confusing factors, the fatty changes in the liver that  
12 can also cause abnormalities. So blood draws on a  
13 routine basis I think will be necessary.  
14 Q Right. So her life is made more complex going  
15 forward for the rest of her life because of the injury  
16 she sustained in this surgery, correct?  
17 A Well, most of us have routine blood draws when  
18 we see our primary care physicians.  
19 Q Really?  
20 A Yes.  
21 Q How many -- how often do you see a primary  
22 care physician for routine blood draws?  
23 A Well, I --  
24 MR. DONNELLY: Objection, relevance, Your  
25 Honor.

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1 MR. GLASS: I'll withdraw that question.  
2 BY MR. GLASS:  
3 Q Okay. Now, I take it that we don't have  
4 disagreement on what the standard of care required  
5 vis-a-vis this cholangiogram. And in that, I mean in  
6 order for Dr. King to move forward with the exam, he  
7 would have needed to visualize the common hepatic duct,  
8 the right and left hepatic ducts; correct? We don't  
9 disagree about that, do we?  
10 A Oh, no. Are you saying that you have to see  
11 a -- that Dr. King would have to see a normal  
12 cholangiogram before --  
13 Q Yes.  
14 A -- proceeding with the operation?  
15 Q Exactly what I'm saying, yes, sir.  
16 A Well, some believed that back in 1992. But  
17 since that -- in the subsequent 20-some years, surgery  
18 in this country has moved away from using a  
19 cholangiogram to guide gallbladder removal.  
20 Q Didn't ask that question. Didn't ask that  
21 question. That's a slightly different question, right?  
22 Do you agree, do you agree with me that in  
23 order to move forward with this surgery, Dr. King needed  
24 to see what he dictated on the operative note, normal  
25 intra and extrahepatic ducts?

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1 A No. I disagree.  
2 Q All right. So he can -- so putting it in a  
3 different way, if you're giving your board exam to a  
4 young surgeon and you're showing him the static image of  
5 this cholangiogram in this case and you ask that surgeon  
6 can you proceed with this surgery and he said yes, you  
7 would pass him or flunk him?  
8 A I wouldn't ask that question because there are  
9 other cues that I would want him to give me as far as  
10 the cues for proceeding with the operation, identifying  
11 the anatomy visually.  
12 Q Is this cholangiogram in this case a normal  
13 cholangiogram or an abnormal cholangiogram?  
14 A For the static version that I've seen --  
15 Q Yes, sir.  
16 A -- that looks at the distal bile duct, is a  
17 normal cholangiogram.  
18 Q And it's not a normal cholangiogram for  
19 showing the proximal bile duct, is it?  
20 A Well, if you were looking for a stricture and  
21 an abnormality in the proximal bile duct and judging  
22 that on a static cholangiogram, no, that wouldn't be  
23 adequate. You'd want to see that. But that wasn't the  
24 purpose of the cholangiogram.  
25 Q I know it wasn't the purpose of the

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1 cholangiogram. But this cholangiogram, this static  
2 cholangiogram clearly shows that there is no dye flowing  
3 to the common hepatic duct, the right and left hepatic  
4 ducts; correct? No disagreement with that, right?  
5 A Correct. On that static image there is  
6 nothing in the common hepatic duct, which is the duct  
7 above the cystic duct and the right and left ducts.  
8 Q And part of your opinion in this case relies  
9 upon, relies upon Dr. King's testimony that he saw  
10 something different and dictated something different in  
11 the operative note; correct?  
12 A Yes. The fact that, when I was asked that, if  
13 the cholangiogram should have -- could have shown that,  
14 I said yes because that's what Dr. King dictated in his  
15 note.  
16 Q That's part of what you rely upon to say he  
17 complied with the standard of care in this case, his  
18 testimony that he saw something different than what we  
19 see in the static image; right?  
20 A Could you ask that again?  
21 Q Part of the basis, the factual basis for your  
22 opinion testimony here today that Dr. King complied with  
23 the standard of care is that he saw something different,  
24 he saw the common hepatic duct, he saw the right and  
25 left hepatic duct; correct?

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1 A No. My opinion that he performed the  
2 operation within the standard of care is based on his  
3 identification of what he thought was the cystic duct.  
4 Upon visual examination, he saw it on the screen, he saw  
5 it on the laparoscope, he got a 360 identification of  
6 it. And that is my opinion that -- or that's the basis  
7 of my opinion that he removed the gallbladder within the  
8 standard of care.  
9 Q Okay. Because he purportedly identified and  
10 circled 360 degrees around the end of the gallbladder to  
11 find the cystic duct, correct?  
12 A That technique, yes, he did that technique.  
13 Q That technique. Which -- and that technique  
14 is not described in the operative note, correct?  
15 A No. I don't see that in the operative note he  
16 described that.  
17 Q Okay. Now, we saw the pictures here, and we  
18 won't go through the pictures again. But I believe that  
19 you testified that it is -- and the issue of the joining  
20 of the cystic duct with the common hepatic duct, or  
21 common bile duct were you telling me?  
22 A Right where they join is the -- it changes  
23 names.  
24 Q I understand that.  
25 A Right where the cystic duct comes in, it

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1 changes names.  
2 Q We all get that. You're talking about the --  
3 I heard you talk about sort of the fibrous joining, the  
4 stickiness --  
5 A Yes.  
6 Q -- of placing the two together.  
7 A Yes.  
8 Q Is it your testimony in this case that that  
9 stickiness that places the cystic duct along the common  
10 bile duct is at the level of -- in other words, it's  
11 sticky above and beyond its junction? Does that make  
12 sense?  
13 A No.  
14 Q Let me put --  
15 MR. GLASS: Could you put that picture up,  
16 sir? I think it's Mrs. Hommel's anatomy. Thank  
17 you, Omar.  
18 BY MR. GLASS:  
19 Q Can you see this all right from there?  
20 A Sure.  
21 Q It's not the best way to see it. But you and  
22 Mr. Donnelly have described, I guess, this is  
23 stickiness, right, joining the cystic duct with the,  
24 answers my question, common hepatic duct?  
25 A Yes.

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1 Q That's what -- this is what you are thinking,  
2 what you believe happened; right?  
3 A Correct. Now we're talking about the same  
4 thing.  
5 Q And I apologize because I should have gotten  
6 that better the first time.  
7 But I think you said it's very common that  
8 they are joined, correct?  
9 A It is.  
10 Q So you would disagree with the surgeon --  
11 A It is.  
12 Q -- who would say no, that's really unusual to  
13 find this joining; correct?  
14 A Well, most of the time you don't really -- in  
15 doing the vast majority of your gallbladders that come  
16 out routinely, we don't appreciate that it does join a  
17 wall there sometimes. And when there's more  
18 inflammation in that area, that just shortens the  
19 effective amount of cystic duct that we have to identify  
20 it.  
21 Q But it's common, right?  
22 A Oh, it is.  
23 Q It's not a big surprise to a surgeon,  
24 shouldn't be a big surprise to a surgeon; right?  
25 A No.

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1 Q In fact, I think your testimony was it's sort  
2 of predicted by the two-centimeter gallstone; right?  
3 A No. Not -- I think they're two different  
4 issues. I think there's the anatomical variation with  
5 the stickiness here, and then that whole area is  
6 inflamed with that two-centimeter gallstone because of  
7 the inflammation that goes through the wall.  
8 Q Okay. So let's be clear, make sure you and I  
9 are on the same page. So the stickiness thing, that's  
10 common; right?  
11 A It is, yes.  
12 Q The two-centimeter gallstone was predictive  
13 because we saw that in the preoperative sonogram, right?  
14 A Uh-huh.  
15 Q Correct?  
16 A Yes.  
17 Q You have to say yes.  
18 So that should have been no big surprise to  
19 Dr. King, correct, that he encounters a two-centimeter  
20 gallstone, because that was in the report he had before  
21 the surgery; right?  
22 A Right. Right. Let me just -- that stickiness  
23 here --  
24 MR. GLASS: I don't have a question pending,  
25 Your Honor.

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1 THE WITNESS: Okay.  
2 BY MR. GLASS:  
3 Q Can I get you just to stand down and talk  
4 about the cholangiogram, my version of it real quick?  
5 THE COURT: Stand down.  
6 BY MR. GLASS:  
7 Q Won't take but a few minutes.  
8 A Could I get a cup of water, too?  
9 Q Sure.  
10 THE COURT: Yes. The bailiff will get you a  
11 cup of water. We've got some over here.  
12 THE WITNESS: I was jealous that you had your  
13 drink.  
14 BY MR. GLASS:  
15 Q I'm sorry. Are you good?  
16 Okay. Again, let's see where we have  
17 agreement. Let's see where we have disagreement. Do  
18 you agree that the cystic duct isn't shown on this?  
19 A I think this right here is a little bit of the  
20 cystic duct, that little bit of dye in there.  
21 Q Can I put a circle around that dot?  
22 A Sure.  
23 Q And so again, anatomy-wise, above -- and this  
24 is the common bile duct, right?  
25 A This is the common bile duct.

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1 Q Right. And you said it changes names at the  
2 cystic duct, where the cystic duct enters?  
3 A Correct.  
4 Q Correct. So above that it's the common  
5 hepatic duct, --  
6 A Correct.  
7 Q -- right? And the tip of the catheter is here  
8 where this arrow is pointing. Would you be in agreement  
9 with that?  
10 A I agree with that, yes.  
11 Q Right. And so the catheter is actually in the  
12 common bile duct, right?  
13 A Yes, it is.  
14 Q You really want it in the cystic duct,  
15 correct?  
16 A No, not necessarily.  
17 Q Don't you really want to see, when you put the  
18 catheter in, you want to see dye in the common hepatic  
19 duct and the cystic duct, and actually, I think the --  
20 excuse me. Let me start over because I said that wrong.  
21 You want to see the cystic duct, the common  
22 bile duct at least, so you can see this junction,  
23 correct, when you're doing a cholangiogram?  
24 A If you are doing a cholangiogram to identify  
25 the anatomy, then you would want to see that. Dr. King

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1 was doing this to look at this part of the duct, to see  
2 that it's nice and smooth like it was here.  
3 Q Because he's looking for stones, strictures,  
4 tumors; correct?  
5 A Yes.  
6 Q Which could occur anywhere on this path,  
7 correct?  
8 A It could. But the stones usually flow this  
9 way because they're forced down to this. And the most  
10 common thing that happens is a stone that's impacted  
11 down here.  
12 Q Sure. But stones, strictures and cancer can  
13 occur anywhere along this biliary tract, and a physician  
14 can't ignore that; right? Can't ignore the inordinate  
15 part of the cholangiogram.  
16 A Well, the -- if it's in one of these areas  
17 here which are probably down here a little bit farther,  
18 but if there's a right or left duct, you wouldn't see  
19 the elevation because bile drains across here. It's  
20 kind of like a marsh that everything is in here. When  
21 it gets down to the common area here, that's where you  
22 see elevations in the --  
23 Q But if you're doing an x-ray to look for one  
24 of these three things, stone, stricture, which is  
25 narrowing, or cancer, you're supposed to look at the

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1 whole x-ray that you get; right?  
2 A Well, he dictated that he saw that --  
3 Q Right.  
4 A -- before. And the static image shows us  
5 what's down here.  
6 Q I understand. All right. Clip, right?  
7 That's a question. That's a clip?  
8 A Yes, that is a clip.  
9 Q Clips? Clips? Those are questions.  
10 A Yes, that is a clip.  
11 Q Clip?  
12 A Yes.  
13 Q Clip where that green arrow is?  
14 A Yes.  
15 MR. GLASS: Okay. That's all the questions I  
16 have. Thank you.  
17 THE COURT: Thank you, Doctor. You may have a  
18 seat.  
19  
20 \* \* \* \* \*  
21  
22  
23  
24  
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1  
2 CLOSING STATEMENT  
3 MR. GLASS: May it please the Court, ladies  
4 and gentlemen of the jury, I so much think after  
5 these relatively short trials that each one of you  
6 could get up and do the argument that I'm going to  
7 give and the argument that Mr. Donnelly is going to  
8 give. So I want to start by thanking you. You've  
9 come off the holiday and you get summoned to be  
10 here and you've put three days and this afternoon,  
11 however long it takes to deliberate, and that's  
12 inconvenient. On behalf of Ms. Hommel, I want to  
13 thank you for the inconvenience and the disruption  
14 that it has caused to your life.  
15 So let me talk to you for a few minutes about  
16 the case and our position in the case. If this was  
17 a car accident case, you would be deciding things  
18 like maybe was the light red or green. And the  
19 judge gives you instructions which are the law of  
20 the case. So whether the light is red or green is  
21 a decision you make after hearing the testimony.  
22 The law you have to follow whether you like it,  
23 don't like it, whatever. That's the difference  
24 between instructions and evidence in the case.  
25 The instructions and the verdict forms talk



<p style="text-align: right;">Page 50</p> <p>1 about two defendants, Dr. King and Surgical 2 Associates of Fredericksburg. The second 3 defendant, Surgical Associates of Fredericksburg, 4 is all about the nurse because she was employed by 5 Surgical Associates of Fredericksburg. And so 6 that's the easy one, submit and argue to you. 7 We brought you a nurse expert who said that 8 Nichole Brooks violated the standard of care, even 9 went beyond her license in not advising Dr. King of 10 Ms. Hommel's phone call five days post-op, calling 11 in the new prescription for Vicodin, and that that 12 caused a delay. And they brought you nobody. They 13 brought you no expert witness to dispute that. So 14 I would suggest on the issue of the negligence of 15 Surgical Associates of Fredericksburg via their 16 nurse, that is a closed issue. 17 One of the things that's important to 18 remember, you'll have an instruction here about how 19 you weigh evidence. And we've all watched TV and 20 we know criminal trials. They talk beyond a 21 reasonable doubt. The burden in this case, 22 instructions are that whoever has the burden of 23 proving something to you needs to prove it by 24 what's called a greater preponderance of the 25 evidence. It's the lady with the scales of</p>	<p style="text-align: right;">Page 52</p> <p>1 peritonitis. Dr. Gerber told you that that makes 2 the whole deal much more difficult once Dr. Abrams 3 and he get involved in the case. So I would 4 suggest and argue to you that there's no question, 5 there's evidence in -- there's no contrary evidence 6 in the case that on the issue of whether Surgical 7 Associates of Fredericksburg is responsible to 8 Ms. Hommel for damages, that the answer is yes. 9 Let me talk to you now about Dr. King. 10 There's a very important instruction here, and it's 11 instruction number four. And it talks about, you 12 heard in the -- throughout the trial sometimes 13 witnesses or parties will be questioned about their 14 prior testimony because the lawyers go around, we 15 take depositions, put people under oath, put them 16 on a video screen. You saw the video. We ask them 17 questions so that we can know what everybody is 18 going to say. That's the civil justice system. 19 And the law is, the law is via this 20 instruction number four that if you believe from 21 the evidence that a party, a party is Ms. Hommel, a 22 party is Dr. King, versus a witness like one of the 23 experts or Mr. Hommel, they are witnesses, but when 24 a party -- if you believe from the evidence that a 25 party previously made a statement inconsistent with</p>
<p style="text-align: right;">Page 51</p> <p>1 justice, whichever it tips. So we don't have to 2 prove anything beyond a reasonable doubt in the 3 case. 4 But on that issue was the nurse negligent, 5 there is no contrary evidence. Did the nurse's 6 negligence cause damages; you just heard 7 Dr. Steffes tell you that at the very, very least, 8 there's no doubt in his mind that she would have 9 avoided that whole first surgery, that she would 10 have gotten into the hands of somebody like 11 Dr. Gerber who would have done the whole thing all 12 at once. 13 And you'll see the bills. We have, as you 14 probably heard me say earlier in the trial, we 15 didn't submit all of the literally hundreds of 16 pages of bills in the case. We worked with 17 Dr. King's lawyers. There's a bill summary there. 18 But you can see the bills for that first 19 hospitalization. We also know that from that day 20 five to nine days after day five, to day 14, there 21 is -- Ms. Hommel is getting sicker and sicker and 22 sicker, to the point where four liters, and I 23 mentioned this in the, I think the voir dire and 24 the openings, four liters of bile is filling up in 25 her, in her belly and it's causing bile</p>	<p style="text-align: right;">Page 53</p> <p>1 his or her testimony at the trial, that previous 2 statement may be considered by you as evidence that 3 what the party said previously was true. 4 That's important on this whole issue of what 5 did Dr. King actually see that day, because again, 6 let's move back for a moment. I thought until 7 maybe 15 minutes ago that there was going to be no 8 dispute about what the standard of care required 9 with this cholangiogram. I brought you two 10 experts. And Dr. Hill, the first expert this 11 morning, said the standard of care required that 12 the cholangiogram show flow into the common hepatic 13 duct, right and left hepatic ducts before a surgeon 14 can know that it is safe to move forward. 15 Dr. Steffes wouldn't go with me on that. He said, 16 Oh, no, you can basically ignore the northern part 17 of the cholangiogram because you're only looking 18 for a stone, which as I know you know now really 19 doesn't make sense because stones can be anywhere. 20 But I would suggest to you that on the issue 21 of what does the standard of care require -- and I 22 asked Dr. Hill, I said I don't think you and I 23 disagree on this. The standard of care requires 24 that cholangiogram be good, be good up and down, 25 and Dr. Hill said yes. Their expert witness said</p>

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1 yes. So I would suggest and argue to you that on  
2 the issue of what the standard of care required,  
3 again, the preponderance of the evidence is the  
4 standard of care requires a good cholangiogram you  
5 can see up and down.  
6 So then we get to the issue well, what did  
7 Dr. King see. He tussled with me on Monday morning  
8 with that whole deal about I said you didn't see  
9 the common hepatic duct. And I said didn't we talk  
10 about it in this deposition. He says, Well, no,  
11 all I said in the deposition was that this  
12 cholangiogram was representative, was  
13 representative of what I had seen over that 15 to  
14 20 seconds.  
15 And we showed you the video. And yesterday  
16 when Dr. King was testified -- was testifying, I  
17 said to him, Isn't it true that during the  
18 deposition, that we talked to -- that you told me  
19 that you didn't see anything else that was  
20 significantly different than what is on this static  
21 image. And he said, Yes, that's what I said at my  
22 deposition. All right.  
23 That's what that instruction is for. You can  
24 consider that evidence as true vis-a-vis the  
25 tussling that he did with me on Monday morning

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1 about whether or not this static image was  
2 representative of what was seen on the entire 15 to  
3 20 seconds of the fluoroscopy.  
4 The other thing you think about there, too, is  
5 that there's no reason to take a picture of a  
6 cholangiogram that isn't representative of the 15  
7 to 20 seconds. And so either he saw the whole  
8 thing lit up like he said in his operative, his  
9 operative note, in which case you would make darned  
10 sure if you're a surgeon, that that's the picture  
11 that becomes a part of the medical record, or he  
12 didn't. And I would suggest to you that he,  
13 because he was focused on the southern part of the  
14 cholangiogram, that by rote, he dictated that, that  
15 when I talked to him at his deposition -- now,  
16 think about this. You're being deposed. There's a  
17 video camera on you. There is a court reporter  
18 that is sworn to you -- sworn you to tell the  
19 truth. And I believe he did at the deposition.  
20 And you know the cholangiogram is the essential  
21 part of the case. You know it's the most important  
22 piece of evidence in this case. And I'm asking him  
23 there, Gee, is this cholangiogram what you saw, and  
24 he says in the deposition, Yes, this is  
25 representative of the 15 or 20 seconds.

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1 Well, if you're being sued for malpractice and  
2 what you want the other team to know is that no,  
3 no, I saw other stuff, you say, No, no, I saw, I  
4 saw more, I saw dye flowing into the common hepatic  
5 duct. That's what you say at a deposition. But  
6 there's more.  
7 You've all heard that term, right? It was a  
8 famous guy that sells stuff on infomercials, Ron  
9 Popeil, and he always said that there's more, "But  
10 wait, there's more." You're really familiar with  
11 this cholangiogram by now. But we played the video  
12 this morning, and I asked Dr. Hill about this. And  
13 the fact is that when I talked to Dr. King at his  
14 deposition about show me where, when you're saying  
15 dye flowed into the common hepatic duct in the  
16 northern part, show me what you mean. And he said,  
17 Mr. Glass, it's between here, this arrow which is  
18 the end of the tip of the catheter, and it's this  
19 darkened area here. Okay.  
20 And Dr. King, remember -- and Dr. Steffes I  
21 think just drew this red circle around what they  
22 think is the cystic duct. And that's important  
23 because Dr. King tells you now, when his good  
24 lawyer team argues now that he saw dye into the  
25 common hepatic duct, that's not what he said in his

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1 deposition. He said, I saw dye here, and this is  
2 the cystic duct I think, and so this is the common  
3 bile duct, not the common hepatic duct.  
4 The thing that's very interesting about the  
5 cholangiogram -- and what you'll have as an exhibit  
6 is the original. We've got the original, original  
7 picture that they took at the ambulatory surgical  
8 center. And look real closely. Dr. Hill confirmed  
9 this. Dr. Steffes confirmed this. But clip, clip,  
10 clip, there is a clip. Now we've kind of marked it  
11 over on this exhibit. But you look at the  
12 original. There is a clip right across right where  
13 this dye ends.  
14 The dye ends not because it has flown or  
15 traveled back south because of gravity or anything  
16 else. The dye ends because there is a clip. This  
17 is exactly the cholangiogram as Dr. Sandler told  
18 you the other day that predicts the injury that she  
19 has. And we're going to go over these medical  
20 drawings here in a minute.  
21 But I suggest to you this is exactly what  
22 Dr.-- why Dr. Sandler and Dr. Leitman and indeed  
23 Dr. Hill this morning say that you need to see a  
24 full cholangiogram. There's a clip there. It's  
25 likely, I would argue to you, that catheter clip.

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1 And it's blocking travel. And you need to, you  
2 need to know that because you're going to cut  
3 there. That's where you're going to cut.  
4 Now, there's another thing that's interesting  
5 about this, is that we talk -- Dr. King talked  
6 about this darkened area, and you heard that this  
7 is dye down here. And Dr. Leitman I think told  
8 you, you know, it gets grayer and grayer and grayer  
9 here. There's less dye. This is showing you where  
10 dye is pooled. It's darker. Why is dye pooled?  
11 It's because it's been pushed under pressure with a  
12 catheter. It can't go north because there's a clip  
13 on it. And there's a clip across the common  
14 hepatic duct. And there is no way, there's no way  
15 that could have been dye going north.  
16 That's not what Dr. King said in his  
17 deposition. He said, No, I -- what I saw was from  
18 here to here, I interpreted that as a common  
19 hepatic duct and I thought that I was fine. And he  
20 was wrong. I think that his cholangiogram tells  
21 you that he's wrong. Three of the four experts  
22 told you that he's wrong.  
23 Let's look at these diagrams because, because  
24 you say, All right, well wait, there's more. So  
25 they come in here -- if I can sit down, Your Honor,

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1 just for a second -- and they tell you that there  
2 is this stickiness between the common hepatic duct  
3 and the common bile duct. Okay. They can't even  
4 get on the same page about this, because Dr. Hill  
5 says, Well, it's very, very unusual. And  
6 Dr. Steffes says, No, that's very, very, very  
7 usual. Okay. Well, which is it? Doesn't really  
8 matter.  
9 Let's assume for a moment that they are  
10 correct. Again, now this drawing becomes very,  
11 very consistent with that cholangiogram. You have  
12 a catheter. You have a catheter with its tip down  
13 south of the clip. This is the temporary clip to  
14 hold the catheter. It's pushing dye into here.  
15 And either it does or it doesn't go north, all  
16 right? I asked Dr. King, Hey, we're putting this  
17 clip on to hold down this thin little catheter so  
18 the whole thing doesn't move. And he says, Yeah,  
19 but it's not enough to prevent dye from going up.  
20 Okay. Let's run with that argument here for a  
21 moment.  
22 If it's not enough to prevent dye going up,  
23 then why is there no dye also going up in the  
24 common -- excuse me, in the cystic duct, right?  
25 They're alleging sticking together. There is a

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1 clip across here. We're pushing dye here. And how  
2 come we can see, according to Dr. King, dye running  
3 up the common hepatic duct, but we can't also, at  
4 the same time, then figure out that the cystic duct  
5 and the common hepatic duct are running parallel  
6 with each other. You can't have it both ways. Dye  
7 runs up, one, but dye does not run up the other.  
8 Again, this is why they, doctors, experts call the  
9 cholangiogram really the golden tool to use to  
10 understand the anatomy in the case.  
11 Now, we would argue to you that it's much more  
12 likely that if this drawing is accurate, that this  
13 clip is across the common hepatic duct, the common  
14 bile duct as they have drawn it, and that is why  
15 there is no dye running north. And that's exactly  
16 the clip, when you look at the original  
17 cholangiogram, the clip that both Dr. Hill and  
18 Dr. Steffes identified. It's a clip, you'll see  
19 right here. You see it even better on the original  
20 cholangiogram that's in the exhibit. We've marked  
21 it up a little bit, but it goes right across where  
22 they say, where the dye ends and where you are  
23 getting ready to cut.  
24 And the injury occurs because you do now, not  
25 having, not having noticed that you have no flow

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1 north, you cut right across where the common  
2 hepatic duct and the common bile duct are allegedly  
3 sticking together, creating the injury.  
4 Now, Dr. King, to his credit, told you  
5 yesterday, you know, way up top near the liver  
6 where the right and left hepatic duct were left  
7 just tiny little pieces, that I likely cut that  
8 with the Bovie. Dr. Hill wouldn't even, like, be  
9 on the same page with that. And I think when you  
10 hear somebody like Dr. Hill testify that, Oh, he  
11 didn't violate the standard of care but he doesn't  
12 agree with a basic fact of the case, you have to  
13 say to yourself why is Dr. Hill here, what is he  
14 doing, can he be believed on anything when he won't  
15 agree with even one of the basic facts of the case.  
16 Let me show you one other thing, too, that I  
17 found very interesting, and you may. There's this  
18 whole business in this case about, well, normal  
19 anatomy went up here and her anatomy went to the  
20 left. Okay. Again, that's why you do a  
21 cholangiogram, because if indeed he's seeing dye  
22 run up the hepatic duct and right and left hepatic  
23 ducts, if he actually saw it, he would see, Oh,  
24 this isn't normal, I may have a problem here if I'm  
25 not careful. So for them to come in here and say,

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1 well, her anatomy was really altered, it was way  
2 over here to the left and not to the right, and to  
3 not even try to explain to you how he didn't see  
4 that with dye running up that he claims he saw is  
5 just not believable.

6 So I suggest and argue to you that on the  
7 issue of the standard of care of Dr. King, that he  
8 failed to identify the right structures to cut  
9 because for whatever reason, for whatever reason,  
10 he just failed to appreciate what was going on  
11 north of the cystic duct. He was focused in his  
12 head on what was going down below. But contrary to  
13 what Dr. Steffes says, you cannot as a surgeon just  
14 ignore stuff that's on -- it would be like a knee  
15 surgeon taking a knee x-ray and ignoring a tumor  
16 because it doesn't involve, you know, the cartilage  
17 of the knee or something like that. So that's not,  
18 that's not believable.

19 So let me talk to you about what we're asking  
20 for in the case, because jurors say what are you  
21 suing for, what do you want. And there's an  
22 instruction in the case that itemizes under  
23 Virginia law the different categories of damages  
24 that you can award money for if you find we have  
25 proven them with reasonable probability. Again, we

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1 don't have to prove anything to a penny, but we  
2 have to give you a reasonable argument for these  
3 damages. And again, this isn't evidence. There's  
4 an instruction on that. But jurors ask so I tell.

5 We're asking for \$750,000 for Ms. Hommel's  
6 bodily injury. Bodily injury is that devastating  
7 injury to her biliary tract. And, you know, I  
8 couldn't believe Dr. Steffes is like downplaying  
9 that. Sometimes these surgeons who do really,  
10 really complicated stuff and save lives and all I  
11 think kind of downplay it. He downplayed real  
12 life. Real life is that she has lost a major  
13 segment of her biliary tract. And for that injury  
14 we're asking for \$750,000.

15 There's no charts for any of this. There's  
16 no, there's no book that says, well, pain is worth  
17 "X" or pain is worth "Y." But I can tell you that  
18 for all of the pain that she has gone through, and  
19 pain is physical pain, you cut yourself, somebody  
20 hits you, we fall down, you hurt your knee, we're  
21 asking for \$750,000 for pain.

22 Mental anguish is different than pain. Mental  
23 anguish is worry. Mental anguish is dread. Mental  
24 anguish is wondering as you're getting sicker and  
25 sicker and sicker and the nurse is telling you, Oh,

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1 the doctor says this is normal, the doctor says  
2 this couldn't be related to your surgery and you're  
3 wondering what in the world is going on with your  
4 body, that's mental anguish. And every time she  
5 went to the hospital and, you know, she told her  
6 she had all these people around wondering about her  
7 anatomy, spending days and days in hospitals,  
8 that's mental anguish.

9 And mental anguish is wondering as I go  
10 forward in my next almost 20 years, because --  
11 there's an instruction that talks about life  
12 expectancy, and that comes from a standard table  
13 that we use here in Virginia, she has almost 20  
14 years of life expectancy. We hope it's longer,  
15 could be shorter, is wondering every time she gets  
16 pain or starts to burp up something that tastes  
17 like bile, she's going to be -- or gets a lab  
18 result that says, Oh, your liver enzyme tests are  
19 elevated, is this going to be the next big one.

20 The last big one cost her nine days in the  
21 hospital. It's a \$70,000 deal when they go in to  
22 implant these tents. And then you've got to go  
23 back to have the stents removed. That's the  
24 mental, the mental anguish part of the case.  
25 Disfiguration, we're asking for \$500,000.

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1 Fairly easy for me to define it for you. The  
2 disfiguration is all the scar she has, the huge  
3 scar that goes down the front, the scar that goes  
4 down the side. She has scars from all of those  
5 tubes that she gets to come out of the hospital  
6 with, all of which keeps her to dressing and  
7 undressing in the closet, keeps her from not even  
8 having sexual relations with her husband, keeps her  
9 from -- keeps her being embarrassed about what she  
10 looks like. For that we're asking for 500,  
11 \$500,000.

12 We're asking for \$350,000 for inconvenience.  
13 I used the word inconvenience when I thanked you  
14 all for your three days here. Inconvenience is her  
15 life has been controlled by the doctors telling her  
16 she has to show up for appointments, you've got to  
17 be in the hospital, you can't travel -- the doctors  
18 haven't said she can't travel but she doesn't  
19 travel because she, correctly and rightly so I  
20 think, doesn't want to get far from guys like David  
21 Gerber and Jeff Abrams and the other great doctors  
22 that she's had down in North Carolina.

23 And inconvenience is every time for the last  
24 three and-a-half years and for the next 20, when  
25 she would rather have done something but she needs

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1 to be involved with a doctor, that's the  
2 inconvenience that I am arguing to you. Past  
3 medical bills are probably the easiest of all this.  
4 They're a touch under \$340,000. You will see that  
5 in the exhibit summary.  
6 We're asking for a hundred thousand dollars  
7 for future medicals. Let me tell you why that's  
8 reasonable. Because as Dr. Steffes told you today,  
9 he can't guarantee that she won't stricture down  
10 sometime between today and the day that she dies.  
11 And we know that the last one was a \$70,000  
12 admission. She's going to need medical monitoring.  
13 She kind of downplays that. Dr. Gerber told you  
14 she's going to need bile thinners for the rest of  
15 her life. She's going to need to see doctors for  
16 the rest of her life. As so a reasonable  
17 protection, a reasonable protection for future  
18 medical damages, we're asking for a hundred  
19 thousand dollars there.  
20 So we're asking for your verdict of  
21 \$3,540,000. That's what we ask. I know that you  
22 have spent time in the case. You will spend time  
23 today as you eat lunch, I guess, and beyond into  
24 this afternoon. I want to thank you for that time  
25 and attention on behalf of Ms. Hommel and really

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1 her husband. I want to tell you that we know that  
2 you-all will do the right thing in this case.  
3 Thank you.  
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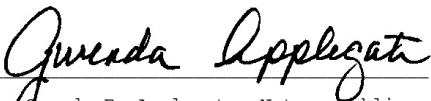
1  
2 FURTHER CLOSING STATEMENT  
3 MR. GLASS: I like trying cases with really,  
4 really, really good lawyers. And my friend Bob is  
5 a really, really good lawyer. And it makes things  
6 interesting. I think it makes things interesting  
7 probably for the Court, too, to have good lawyers  
8 here. And so I use a lot of words and he uses a  
9 lot of words, but I'm going to show you how it's  
10 Dr. King's words that tell this case. And, no,  
11 we're not calling Dr. King a liar.  
12 A couple things. The pathology report thing,  
13 that's like an interesting nonissue. There's no  
14 dispute that Dr. King took out, because he agreed  
15 with us, the gallbladder and everywhere from down  
16 here to up to the right and left hepatic ducts, and  
17 he cut those with a Bovie. There's no dispute that  
18 they all came out. It isn't like it got left  
19 inside the abdomen or anything like that. So it's  
20 an interesting nonissue as to what the pathologist  
21 wrote and why.  
22 On the issue of the temporary catheter clip,  
23 again, not my words, not Mr. Donnelly's words,  
24 Dr. King's words, I asked him -- again, we had to  
25 go back to his deposition to talk about this. But

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1 we talked about it. And I said -- he described,  
2 "You start to squeeze down when I'm doing the  
3 cholangiogram, as I start to squeeze it down, I  
4 don't want to apply it one hundred percent. Of  
5 course you don't want to cut the duct in half with  
6 a clip by applying it one hundred percent." And he  
7 said, "You do it just enough to keep the dye from  
8 refluxing and leaking back out. Of course. You  
9 apply that temporary clip just enough to keep the  
10 dye from refluxing and leaking back out." So this  
11 isn't where he put it in just enough to hold the  
12 catheter but the dye goes up and down. It isn't my  
13 words, Mr. Donnelly's words, but Dr. King's words,  
14 just enough to keep the dye from refluxing and  
15 leaking back out.  
16 Lastly, next-to-last is, again, we get back to  
17 what, when Dr. King is back dictating six minutes  
18 after this operation, what he saw. I'm not calling  
19 him a liar. He misinterpreted the cholangiogram.  
20 He -- and this is why we brought to you the video  
21 this morning and why I asked both of their experts  
22 this question. Again, we'll go back to his  
23 deposition. And I said, Tell me what you were  
24 looking at when you dictated I saw intra and  
25 extrahepatic ducts.

<p style="text-align: right;">Page 70</p> <p>1 And he had shown me on the video where the tip 2 of the catheter is. And I said, So when you say 3 you saw dye into the hepatic duct, you're talking 4 about this blackened area here? "Yes, sir." And 5 he said this is what he believed to be the cystic 6 duct. And we know, we all know because now we are 7 educated in this, that this is not the hepatic 8 duct, this is the common bile duct. 9 So for whatever reason, he looks at the image, 10 he sees this darkened area, he's got the catheter 11 down here, and he says and dictates believing it to 12 be true, not lying, believing it to be true that I 13 see dye into the common hepatic duct, but it simply 14 cannot be. This is not, no expert said this is a 15 common hepatic duct. In fact, Dr. King said it's 16 the cystic duct there, a little spot. Dr. Steffes 17 I think agreed with me this morning that that might 18 be, he thought that that was a part of the cystic 19 duct. And so Dr. King is looking at that, he's 20 simply misinterpreting the x-ray. He's not lying. 21 We're not saying he's a liar. 22 Let's see. The last thing. Sympathy. Not 23 asking for sympathy because she got all the 24 sympathy she wanted, all the sympathy she needed 25 over these last three, over three years from her</p>	<p style="text-align: right;">Page 72</p> <p>1 2 VERDICT 3 THE COURT: All right. All seven members of 4 the jury have returned to the courtroom. 5 Let's see. Who was elected foreman? What's 6 your number? 7 JUROR 16: Sixteen. 8 THE COURT: Foreman is 16. All right. 9 I understand the jury has reached a verdict, 10 is that correct? 11 JUROR 16: That's correct. 12 THE COURT: All right. Read the verdict, 13 please. 14 THE CLERK: Thank you, Your Honor. 15 "We, the jury, find our verdict as follows: 16 In favor of the plaintiff, Christine Hommel, 17 against defendant Bradford King: No. 18 "In favor of plaintiff, Christine Hommel, 19 against the defendant Surgical Associates of 20 Fredericksburg, LTD: Yes. 21 "Having found for the plaintiff against the 22 defendants, we award the plaintiff the following 23 amount in compensatory damages: 1,875,000. We, 24 the jury, do not award interest." 25 This is your verdict, so say you all?</p>
<p style="text-align: right;">Page 71</p> <p>1 husband, from her friends, from doctors like 2 Dr. Gerber who took care of her. Not asking for 3 sympathy. 4 By the same token, you can't say, Well, what 5 will this do to Dr. King. I mean, he's a 6 professional. It's no fun for anybody to be sued. 7 It's really no fun for a professional to be sued. 8 But you can't go back there and go, Gee I wonder 9 what this -- what will happen to Dr. King, or I 10 wonder how he feels. That would be the same thing. 11 That would be sympathy. 12 We're asking for your verdict -- by the way, 13 all of those words, and no dispute, no dispute 14 whatsoever as to my argument as to the \$3.5 million 15 in damages. I think Mr. Donnelly says we don't 16 disagree with what she's gone through, we don't 17 disagree with her pain, so no dispute there. So 18 again, I'm asking for your verdict for just over 3 19 and-a-half million dollars. 20 I thank you on behalf of Ms. Hommel and I'm 21 sure on behalf of Mr. Donnelly and Dr. King. Thank 22 you very much. 23 24 * * * * * 25</p>	<p style="text-align: right;">Page 73</p> <p>1 THE JURY: (Indicating in the affirmative). 2 THE COURT: All right. Are there any motions 3 before the Court discharges the members of the 4 jury? 5 MR. DONNELLY: Poll the jury, please. 6 THE COURT: Let's poll the jury, please. 7 THE CLERK: Juror number seven, is this your 8 verdict? 9 JUROR 7: Yes. 10 THE CLERK: Thank you. Juror number 12, is 11 this your verdict? 12 JUROR 12: Yes. 13 THE CLERK: Juror number 15, is this your 14 verdict? 15 JUROR 15: Yes. 16 THE CLERK: Juror number 16, is this your 17 verdict? 18 JUROR 16: Yes. 19 THE CLERK: Juror number 19, is this your 20 verdict? 21 JUROR 19: Yes. 22 THE CLERK: Juror number 20, is this your 23 verdict? 24 JUROR 20: Yes. 25 THE CLERK: Juror number 25, is this your</p>

1 verdict?  
2 JUROR 25: Yes.  
3 THE CLERK: Thank you.  
4 THE COURT: Any other motions before the Court  
5 discharges the members of the jury?  
6 MR. GLASS: No, sir.  
7 THE COURT: Ladies and gentlemen of the jury,  
8 I want to thank you for your service to the Court  
9 and our community over the last three days.  
10 Through your service you have guaranteed and  
11 ensured that both sides received a fair and  
12 impartial trial, and the Court greatly appreciates  
13 it. Of course you will not need to be here  
14 tomorrow or Friday, but if you have other days  
15 later in the month when you're to be here for jury  
16 service, make sure you check the jury hotline the  
17 evening before.  
18 Thank you for your service. You're free to  
19 leave. Have a good day.  
20  
21 (Conclusion of excerpted proceedings)  
22  
23 \* \* \* \* \*  
24  
25

1 COMMONWEALTH OF VIRGINIA AT LARGE, to wit:  
2 I, Gwenda E. Applegate, Court Reporter, Notary  
3 Public in and for the Commonwealth of Virginia at  
4 Large, and whose commission expires November 30, 2017,  
5 do certify that I reported verbatim the proceedings in  
6 the Circuit Court for the City of Fredericksburg, in  
7 Fredericksburg, Virginia, in the captioned cause,  
8 heard by the Honorable Gordon Willis, Judge of said  
9 court, on January 4-6, 2016.  
10 I further certify that the foregoing transcript,  
11 numbering pages 1-75 inclusive, constitutes a true,  
12 accurate and complete transcript of said excerpted  
13 proceedings.  
14 Given under my hand and notarial seal at  
15 Charlottesville, Virginia, this 15th day of  
16 February, 2016.  
17  
18  
19   
20 \_\_\_\_\_  
21 Gwenda E. Applegate, Notary Public  
22 Commonwealth of Virginia at Large  
23 Registration Number 115863  
24  
25

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