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

VIRGINIA
LAWYERS WEEKLY

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

ABRENIO

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 avoided the massive vertical incision and scarring.

GLASS

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 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, hepatobililary 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

Reporting & Video

VIRGINIA:

IN THE CIRCUIT COURT OF THE CITY OF FREDERICKSBURG
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CHRISTINE HOMMEL,

Plaintiff,

v. Case Number

SURGICAL ASSOCIATES OF FREDERICKSBURG, et al.,

Defendants.

****

EXCERPTED TRANSCRIPT OF PROCEEDINGS

BEFORE THE HONORABLE GORDON WILLIS

January 4-6, 2016

Fredericksburg, Virginia

HALASZ REPORTING & VIDEO

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(January 4, 2016, jury in)

OPENING STATEMENT

MR. GLASS: The events of this case take place just over about three years ago, so we're talking September of 2012. Ms. Hommel is referred to Dr. King, a surgeon, to have her gallbladder removed. A little interesting, she had had a tick bite on her breast. They did some blood work. The blood work showed some abnormalities in something called liver function tests. She had a sonogram that showed she had a gallstone in her gallbladder. Appropriate recommendation is made to have the gallbladder removed.

A little bit of anatomy just so we can all be oriented. The important parts of the anatomy for this case are we have our liver. The liver is involved in sort of managing, starting to manage the digestive system, when we eat food. One of -- the liver does a lot of cool things, but one of the things it does that's important for this case is, it produces bile. Bile is used to help digest the food that we eat.

Very cool about the gallbladder, it's a pear-shaped organ that sort of sits tucked up under

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the liver. And the gallbladder really has one function, is it stores bile. So the liver produces it at a constant level. And the gallbladder collects bile. And then when you eat and the body says you need bile, gallbladder sends bile down into the digestive tract.

So for purposes of this case then, the anatomy that's important is, these are -- this is a drawing. It's a medical drawing. One of the experts will be using this to help explain the case. Gallbladder here, liver sort of up here overlaps the gallbladder. This green duct, it's called a duct, goes up and down. I like to refer to it as the north/south highway. This duct is running from the liver down into the duodenum, the intestines, your bowels. All right. And so the purpose of this green duct is simply to take bile that's produced by the liver, send it down if need be, straight down into the intestines. But it also goes back and forth along this duct to the gallbladder to be stored. It's very cool.

So this duct is an east/west duct, is really a two-way traveling system. This duct is called the cystic duct. This duct is called the bile duct. But below where it intersects with the cystic duct,

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it's called the common bile duct. And above where it intersects, it's called the common hepatic duct. Then it actually branches into a right and left hepatic duct. So that's your basic anatomy that we'll need to understand in this case.

So when a surgeon does a gallbladder removal surgery, by and large these days he or she does it laparoscopically. So they stick some scopes in. You have a couple of really tiny incisions, and the goal is to do really three things. Number one is you cut this cystic artery. Now, before you cut anything, you identify it, you are clear that this is what you are intending to cut, and you put clips on either side of where you're going to cut so that when you cut it, the bile and the blood doesn't go everywhere.

So in this surgery you cut the cystic artery. You then cut the cystic duct. And again, before you cut the duct, you identify it, you make sure it is the cystic duct. You put a clip on one side near the gallbladder. You put a clip on the other side of where you're going to go. You actually put two clips. The closer you are to this main north/south highway, you put two clips on this, all right, and then you cut.

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

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

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

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

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

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

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

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

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

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

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

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Now, immediately after the surgery, Dr. King dictates his operate note about six, seven eight minutes afterward. You'll hear, if you're not already familiar, doctors dictate a note that says what we do in the surgery, what we did. The important part for this discussion is that Dr. King dictates about this cholangiogram. Now, remember, this is an abnormal cholangiogram. It does not show the northern part of the ductal system. But he dictates that the cholangiogram was obtained in standard fashion, demonstrating, showing normal intra and extrahepatic bile ducts. You'll hear those are the more fancy medical words for the common hepatic duct and the right and left hepatic duct.

So this operative report tells us that Dr. King knew that it was important, once you do the x-ray, to see a full biliary tree. For whatever reason, he misinterprets this. He either wasn't paying attention, didn't remember, or what. But this x-ray, everyone will agree, does not show normal intra and extrahepatic bile ducts at all. I don't think there will be any dispute about that. And he proceeds with the surgery. And the surgery causes a devastating injury, as you'll hear, to

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Ms. Hommel.

Now, that's the negligence part of the case. So our case is that Dr. King needed to carefully identify the cystic duct before he cut it. That's a standard principle of surgery; know what you're cutting before you cut it, and that he failed to do that. And he had the greatest tool ever invented, this x-ray that showed him he was about ready to get what he got in the surgery.

Now, this is outpatient surgery. You come into the surgery center, you go home after a couple hours probably in recovery. And the evidence will be that later that afternoon Ms. Hommel's husband, she or her husband, I forget which, called into the office and said this isn't feeling right, I'm in a lot of pain, could I have a different pain medication. She had been discharged on Percocet. She had had some good experience with Vicodin in the past. And this call is taken by a staff person in Dr. King's office who labels the call -- they have this system that you'll see of obviously you're keeping medical records and you're keeping another sort of electronic medical record of calls that are coming in, a system where the call comes in, patient, I need a refill or I'm having pain,

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when is my next appointment. That person sort of triages the deal, finds the answer and tells the patient.

In this case, on the afternoon of the surgery Ms. Hommel or her husband is calling, this doesn't feel right. The call is labeled by Dr. King's staff, by the Surgical Associates of Fredericksburg staff, as a high priority call. But nobody tells Dr. King that Ms. Hommel has called. Instead, they tell her, Hey, this is probably normal, you just had surgery, you're asking for Vicodin but if Percocet isn't helping, then Vicodin won't help either, so just take some Ibuprofen in between the Percocet and just keep on going, let us know, let us know if -- how you do.

All right. So Ms. Hommel, she doesn't know because she never had her gallbladder taken out. She trusted the doctor. She doesn't get better over those next one, two, three, four, five days. And on day five she calls again to the office. And what I'm reading from you'll have in evidence later when this case is done. And she complains to the nurse, and it's a nurse whose name at the time was Nichole Brooks, and now her name is Nichole Brooks Graham. And she says this: My Percocet has not

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been providing adequate pain control. I have left shoulder pain. I have nausea. I have only been able to eat a couple of bites before feeling full. I can drink some. Ice makes it feel better. But I'm reporting this now. What should I do, because Dr. King had told her look, three to five days you're going to be, you're going to be up and about. And Ms. Hommel is concerned because not only is she not up and about, but she's not getting better at all.

Now, this call is managed by Nurse Brooks, and it is listed as a medium priority. But again, nobody tells Dr. King. There's no system in the office, no good system for letting Dr. King know how his patient is doing postoperatively. And later you'll hear Dr. King calls, now much later when Ms. Hommel is in North Carolina, he calls her and says I have to confess, they never told me. They never told me.

So that's day five after the surgery. Goes another nine days, she has traveled down because at that time, they had a place up here in Fredericksburg. Her husband worked in the area, they had a place down in North Carolina. She had asked Dr. King when the surgery was done, can I go

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down to North Carolina. He basically says yeah, if you feel good, you can go down to North Carolina. She had traveled down there.

But nine days after the day-five call, she is calling again, speaks to the same nurse she spoke to on day five, Nichole Brooks, and says, "I've been having really bad acid reflux since yesterday, I can't eat or drink anything, it's starting to turn blackish. I have a hard spot on my right upper quadrant. I can eat very little, I'm really, really sick." And the same nurse says, Well, go to the emergency department. Okay. Appropriate advice. But again, she doesn't even tell the doctor again, didn't tell him that this patient is not doing well at all following this surgery.

Well, she does get into the hands of some great surgeons down in North Carolina. And she'll tell you the story. But she presents to the emergency department. She is sick as a dog. They start to evaluate her. They find out her belly, her abdomen is full of fluids. Dr. Jeffrey Abrams takes her to a first major surgery. Now, remember, this operation with Dr. King had been minimal incision surgery with little dots really where you put the cameras in and the tools in to do it.

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Dr. Abrams cut her really from here down to here, about 82 or 85 stitches to explore her. They drained out two -- they drained out four liters, four liters, like two two-liter coke bottles of bile that was festering in her belly and her abdomen. Dr. Abrams discovered exactly what I said earlier, which is that when he finally got in there to look, they did a series of tests and some other x-rays. You'll hear about ERCPs and stuff, discovered that indeed this section of the common hepatic duct was gone right up and to the liver, and bile had been draining now for a couple of weeks into her belly.

So Dr. Abrams takes her to surgery. The best he can do at that time is to not do really anything in terms of a repair because the belly is so aggravated and so angry because of the bile. So she leaves that hospital with a huge incision, with all sorts of drains, with bags coming out. And she sees, she meets Dr. David Gerber during that first hospitalization. He's a hepatobiliary surgeon. He did a magical job ultimately in repairing her.

And what happened was several months after Dr. Abrams' surgery, when her belly has quieted down and she's had these drains now for several

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months, Dr. Gerber, who will be here to testify, is able to do the repair, basically by bringing her intestines up just under the liver, finding these what remain the remnants of the right and left hepatic duct and attaching them to her intestine so that, as the liver produces bile, now it's not going into her belly, it's not going down a drain, it's getting back to the way it's supposed to work.

The problem with that is that ain't the way God made her, and these bile ducts over time stricture and scar. I'll get to that in just a minute. So original surgery is in September 2012. Dr. Abrams' surgery is about two weeks after that. And then in November right before Thanksgiving, November of 2012 is Dr. Gerber's big-time repair. Because she had multiple surgeries, she developed a huge abdominal hernia. And so in June of 2013, she went back to the hospital and they put a piece of mesh in her belly that's about the size of this paper, wrapping it inside her belly to keep it intact.

I think everyone probably knows what a hernia is. But it's basically a weakening of the, of the abdominal wall in most cases. And so now she has a mesh barrier to help keep her abdominal wall

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intact. Just this last summer, in July -- she had done, by and large for the nature of the injury, she had done pretty well. This last summer, however, her bile ducts did stricture. When they start to stricture and scar down and prevent bile from leaving the liver, you get really, really sick. And so she got really sick. She went to the hospital. They said, Oh, my gosh, this is probably strictures; spent nine days in the hospital there getting stents placed and then several weeks later getting the stents removed. The hope is, the hope is that this will not stricture down again. But nobody can guarantee that.

Today Chris Hommel will tell you she's fairly limited in terms of, like, I'm not going to travel anywhere because I cannot predict when or if I may stricture down again and need major hospitalization. And a lot of her life has now been really compacted and limited because of this. At the end of the case, I'm going to ask you to find Dr. King breached the standard of care. That's the legal phrase for it. He committed medical malpractice by failing to correctly identify the cystic duct before he cut not the cystic duct but the common, the common bile duct by

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failing to use the greatest tool on earth intraoperatively to tell him that he was about ready to cause this injury.

I'm going to ask you to find that the practice is guilty of negligence, violated the standard of care in failing on that day-five visit to get Ms. Hommel to a doctor earlier, by not -- by the nurse not giving Dr. King the message, Oh, your patient is having so much pain, she needs a new narcotic medication. By the way, what the nurse did without asking any doctor was called in a new prescription for a new narcotic medication. And so for several more weeks Mrs. Hommel had pain and accumulating bile because of that negligence.

At the end of the case, I'm going to ask you to find that he violated the standard of care and that she's entitled to very, very substantial monetary damages because of what her life will likely be like going forward.

Thank you, Your Honor.

* * * * * *

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(January 6, 2016, jury in)

STEPHEN HILL, M.D.
first duly sworn, testified as follows:
C R O S S
E X A M I N A T I O N
BY MR. GLASS:

Q Good morning, Dr. Hill.

A Hello.

Q Yesterday we heard -- well, you do not dispute that at the end of this surgery the gallbladder was out and a section of the common hepatic duct was removed with the gallbladder; correct?

A No, that's not correct. As I said, the pathology shows there's a gallbladder and a cystic duct. There's nothing to describe that the hepatic duct has been removed.

Q Isn't it true that in the surgery as he is taking out the gallbladder, Dr. King cuts across the right and left hepatic duct with a Bovie?

A That, again, that remains to be seen. I don't know what occurred at that point. All I can say is that the gallbladder was removed, the cystic duct was removed, and then he removed some other areas there. But the pathology specimen shows just a cystic duct.

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Now, there was damage, obviously. That's why we're here. But nothing was removed that was diagnosed or described on the pathology report.

Q Right. And that Bovie is that -- I think it was termed an energy instrument, is that --

A It's an instrument that we use in surgery all the time basically to coagulate bleeders or to cut across something. Again, it's used frequently. Particularly, in an inflamed gallbladder, you want to stop any little bleeding, it's used for that. And that's used both in open as well as closed gallbladders.

Q So what a Bovie does is it can cut across tissue but it also coagulates or seals bleeders, right, if you cut across something that would either bleed or leak fluid?

A Correct, depending upon the amount of energy you set it.

Q Sure.

A Yes, it will coagulate and seal.

Q All right. You agree with me, I think, that a physician violates the standard of care if they have not done their best to visualize everything that they can; correct?

A A physician should visualize everything he can see in order to proceed with the surgery.

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Q And you agree with me, I think, that a surgeon doing a gallbladder surgery should use all of the information available to him to make sure the patient has a safe operation; correct?

A Correct.

Q And I think that you just testified that at some point during the surgery, in order to comply with the standard of care, Dr. King needs to see the ducts as he described them in the operative note; correct?

A He needs to see -- in the operation, he needs to see the cystic duct. In the cholangiogram he ought to see the common ducts and the hepatic ducts.

Q Including the hepatic duct up into the right and left hepatic duct?

A Only on the cholangiogram. You never dissect up in that area.

Q I wasn't, I wasn't splitting it into seeing. I'll go with you. He needs to see it on the cholangiogram in order to comply with the standard of care in proceeding with the surgery, correct?

A He needs to see that. He does not need a static picture of it. He doesn't need to save it for posterity. He should see it.

Q We'll get there. I understand your position. And if a physician doesn't see the common

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hepatic duct, the right and left hepatic duct in doing this surgery, he violates the standard of care in going forward and creating an injury like this; correct?

A Correct.

Q You looked at the -- let me do this.

MR. GLASS: If Your Honor, please.

BY MR. GLASS:

Q In doing the surgery and looking through your scope, if you're looking at a common duct and a cystic duct, they look pretty much identical to the eye; correct?

A No, not at all.

Q Okay. So what should a physician see that's different between a common duct and a cystic duct?

A Normally I and most people don't even expose the common duct because of dangers. You look at basically the gallbladder/cystic duct junction. And again, when you look in this area, you see under a pile of fat, et cetera, off to the side, you see where there is a common duct. But you never expose it unless there is an indication to expose it because it leads to some dangers of bleeding. There are major blood vessels around there, the portal vein and hepatic artery. So you really want to stay away from that area because you could bleed massively and quickly in that area.

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So you want to basically dissect at the juncture -- junction of the gallbladder to the cystic duct. And that gives you, in some people a centimeter, and some people a millimeter distance to carefully divide the cystic duct.

Q Are you done? My question was what's the difference when you do see them. I asked you whether they are identical. You said they weren't. I asked you what's the difference. You haven't answered that question. Could you answer my question?

A The answer to that question is they go -- anatomically they are different. The cystic duct comes off at an angle. The common duct goes up. The common duct is often larger and the common duct is off to the side. Does that answer your question?

Q That's good enough.

Now, you believe that at the time that the cholangiogram was -- the static image that we've seen, that there was no clip across the common hepatic duct; correct?

A Correct.

Q Do you know today whether Dr. King used a temporary clip to hold that catheter in place?

A It would appear that way from the note that he used a temporary. Often people -- as I told you

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previously, there are different ways to hold the catheter in place. Some people use a clamp. Some people use a clip. Some people tie it in place. Sometimes these little catheters have little bulbs on them so once you get them in, they'll stay there, the purpose being that when you inject, you don't want it popping out again and filling the whole operative field with the dye, which then obviously gives you a poor picture.

Q Do you agree when I came to Roanoke and took your deposition, you didn't know the answer to that question?

A Again, I'm going by what I -- no. I remember you asked me that question and I told you there were different areas, different ways in which the cystic duct would be tangulated and how it would be held in place.

MR. GLASS: Can you do me a favor, Mr. Omar? Put up that colored cholangiogram picture real quick for me, please.

BY MR. GLASS:

Q I think you said as we're looking at an image of a cholangiogram, this is an x-ray; correct? Right?

A Correct.

Q It's like an x-ray. And so what this dye, when you put the dye in, it becomes the darker parts of

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the x-ray; correct?

A Well, actually, it becomes the lighter parts. Again, it's hard.

Q That's what --

A I mean, again, it doesn't become green, it doesn't become yellow, and it doesn't become red.

Q Of course.

A It depends on how it's viewed. As I said, oftentimes you see the picture as you see up in the upper corner there, you see that. Or you can see on the actual x-ray film, sometimes it's white. It varies.

Q You talked about that big black area at the bottom of the duodenum --

A Yes.

Q -- being dye.

A Correct.

Q Right? And it is dye, correct?

A Correct.

Q Actually, I have the cholangiogram here. Step down. Could you come here for a second?

A Certainly.

Q Now, do you agree with me that we don't see the cystic duct at all on this cholangiogram?

A Correct. It's rare that you'll see the cystic duct because of the fact that you have the catheter in

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the cystic duct to get to the common duct.
Q Doctor, do you agree with me that you don't see the cystic duct on this cholangiogram?
A Correct.
Q And you read Dr. King's deposition?
A Yes.
Q Carefully?
A Several months ago.
Q Sure. Well, didn't you read it preparing for this?
A I skimmed it, did not memorize it. Sorry.
Q Gotcha. And do you remember Dr. King, on his deposition, talking about where he saw on this cholangiogram, on this static image, dye refluxing into the common hepatic duct? Do you remember that discussion?
A Correct.
Q And that -- did you -- did they ever send you the video that I took of Dr. King during that deposition?
A No.
Q Do you know that Dr. King, would it surprise you to know that he is talking about this section in here as being what he viewed on the static image as reflux into the common hepatic duct?

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A I'm not quite sure what you're asking.
Q When I asked Dr. King the question in his deposition, show me on the static image where you saw dye refluxing into the common hepatic duct, right, common hepatic duct is that part above the cystic duct --
A Correct.
Q -- correct? That he pointed to this darkened area, do you remember that in the deposition?
A No. I didn't remember.
Q All right. Did they ever send you, in reviewing the case, the exhibit that Dr. King marked on --
A Yes.
Q -- in that deposition?
A Yes.
Q And in the exhibit, he marked with that arrow where the tip of the catheter was?
A Correct.
Q You remember that part?
A Correct.
Q Last part. Look at this. Clip, correct?
A Uh-huh.
Q Clips, correct?
A (Indicating in the affirmative).

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Q Clip, correct?
A Correct.
Q Clip, correct?
A It looks like there's a clip there.
Q Looks like there's a clip there. Could we get a marker? Would you mark on this that last clip, please?
A I'm not sure. I see some dye here. This could have been the cystic duct. That might be a clip there.
Q It's right where the catheter -- I'm sorry. Tell me if I'm in your way, please.
It's where the catheter is coming into, enters the cystic duct; correct?
A Correct.
Q The ductotomy is in the cystic duct. A ductotomy is the hole where the catheter goes in --
A Correct.
Q -- correct? Clip there, right?
A Right over, over here it looks like.
Q Correct?
A It looks like.
Q And tip of catheter over here?
A Right.
Q And you agree that the tip of the catheter is

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

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

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anatomy. So whether this is fused from birth as a congenital defect versus severe inflammation sucking it all in together is impossible to tell.
Q And because it is one of those many varieties or variations, that leads back to what we just talked about in the beginning, which is why it's important and mandated under the standard of care for a physician to use all of the tools available to try to figure that out before he cuts through that common hepatic duct?
A Absolutely.
MR. GLASS: Thank you.

* * * * * *

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CHRISTOPHER STEFFES, M.D
first duly sworn, testified as follows:
C R O S S
E X A M I N A T I O N
BY MR. GLASS:
Q So let's talk about the injury again which is part of the case first, that part of your testimony first.
You agree with me that this is, this injury that Ms. Hommel sustained is a type of devastating injury that's described in your literature, the literature of surgeons who do laparoscopic gallbladder removal; correct?
A It's a major injury. I don't use the word devastating.
Q It is something that will change her life forever, won't it, having lost that segment of her biliary tract?
A It changed her life in the sense that she has a scar and subsequent surgery. It -- as far as the physiology of the digestive system, the bile now still has a way of getting into the small bowel, mixing with the food and aiding digestion.
Q You said that she's undergone this one

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

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

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

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

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

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

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

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cholangiogram. But this cholangiogram, this static cholangiogram clearly shows that there is no dye flowing to the common hepatic duct, the right and left hepatic ducts; correct? No disagreement with that, right?
A Correct. On that static image there is nothing in the common hepatic duct, which is the duct above the cystic duct and the right and left ducts.
Q And part of your opinion in this case relies upon, relies upon Dr. King's testimony that he saw something different and dictated something different in the operative note; correct?
A Yes. The fact that, when I was asked that, if the cholangiogram should have -- could have shown that, I said yes because that's what Dr. King dictated in his note.
Q That's part of what you rely upon to say he complied with the standard of care in this case, his testimony that he saw something different than what we see in the static image; right?
A Could you ask that again?
Q Part of the basis, the factual basis for your opinion testimony here today that Dr. King complied with the standard of care is that he saw something different, he saw the common hepatic duct, he saw the right and left hepatic duct; correct?

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

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changes names.
Q We all get that. You're talking about the -- I heard you talk about sort of the fibrous joining, the stickiness --
A Yes.
Q -- of placing the two together.
A Yes.
Q Is it your testimony in this case that that stickiness that places the cystic duct along the common bile duct is at the level of -- in other words, it's sticky above and beyond its junction? Does that make sense?
A No.
Q Let me put --
MR. GLASS: Could you put that picture up, sir? I think it's Mrs. Hommel's anatomy. Thank you, Omar.
BY MR. GLASS:
Q Can you see this all right from there?
A Sure.
Q It's not the best way to see it. But you and Mr. Donnelly have described, I guess, this is stickiness, right, joining the cystic duct with the, answers my question, common hepatic duct?
A Yes.

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

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

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

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Q Right. And you said it changes names at the cystic duct, where the cystic duct enters?
A Correct.
Q Correct. So above that it's the common hepatic duct, --
A Correct.
Q -- right? And the tip of the catheter is here where this arrow is pointing. Would you be in agreement with that?
A I agree with that, yes.
Q Right. And so the catheter is actually in the common bile duct, right?
A Yes, it is.
Q You really want it in the cystic duct, correct?
A No, not necessarily.
Q Don't you really want to see, when you put the catheter in, you want to see dye in the common hepatic duct and the cystic duct, and actually, I think the -- excuse me. Let me start over because I said that wrong.
You want to see the cystic duct, the common bile duct at least, so you can see this junction, correct, when you're doing a cholangiogram?
A If you are doing a cholangiogram to identify the anatomy, then you would want to see that. Dr. King

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

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whole x-ray that you get; right?
A Well, he dictated that he saw that --
Q Right.
A -- before. And the static image shows us what's down here.
Q I understand. All right. Clip, right? That's a question. That's a clip?
A Yes, that is a clip.
Q Clips? Clips? Those are questions.
A Yes, that is a clip.
Q Clip?
A Yes.
Q Clip where that green arrow is?
A Yes.
MR. GLASS: Okay. That's all the questions I have. Thank you.
THE COURT: Thank you, Doctor. You may have a seat.

* * * * * *

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CLOSING STATEMENT

MR. GLASS: May it please the Court, ladies and gentlemen of the jury, I so much think after these relatively short trials that each one of you could get up and do the argument that I'm going to give and the argument that Mr. Donnelly is going to give. So I want to start by thanking you. You've come off the holiday and you get summoned to be here and you've put three days and this afternoon, however long it takes to deliberate, and that's inconvenient. On behalf of Ms. Hommel, I want to thank you for the inconvenience and the disruption that it has caused to your life.
So let me talk to you for a few minutes about the case and our position in the case. If this was a car accident case, you would be deciding things like maybe was the light red or green. And the judge gives you instructions which are the law of the case. So whether the light is red or green is a decision you make after hearing the testimony. The law you have to follow whether you like it, don't like it, whatever. That's the difference between instructions and evidence in the case.
The instructions and the verdict forms talk

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about two defendants, Dr. King and Surgical Associates of Fredericksburg. The second defendant, Surgical Associates of Fredericksburg, is all about the nurse because she was employed by Surgical Associates of Fredericksburg. And so that's the easy one, submit and argue to you.

We brought you a nurse expert who said that Nichole Brooks violated the standard of care, even went beyond her license in not advising Dr. King of Ms. Hommel's phone call five days post-op, calling in the new prescription for Vicodin, and that that caused a delay. And they brought you nobody. They brought you no expert witness to dispute that. So I would suggest on the issue of the negligence of Surgical Associates of Fredericksburg via their nurse, that is a closed issue.

One of the things that's important to remember, you'll have an instruction here about how you weigh evidence. And we've all watched TV and we know criminal trials. They talk beyond a reasonable doubt. The burden in this case, instructions are that whoever has the burden of proving something to you needs to prove it by what's called a greater preponderance of the evidence. It's the lady with the scales of

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justice, whichever it tips. So we don't have to prove anything beyond a reasonable doubt in the case.

But on that issue was the nurse negligent, there is no contrary evidence. Did the nurse's negligence cause damages; you just heard Dr. Steffes tell you that at the very, very least, there's no doubt in his mind that she would have avoided that whole first surgery, that she would have gotten into the hands of somebody like Dr. Gerber who would have done the whole thing all at once.

And you'll see the bills. We have, as you probably heard me say earlier in the trial, we didn't submit all of the literally hundreds of pages of bills in the case. We worked with Dr. King's lawyers. There's a bill summary there. But you can see the bills for that first hospitalization. We also know that from that day five to nine days after day five, to day 14, there is -- Ms. Hommel is getting sicker and sicker and sicker, to the point where four liters, and I mentioned this in the, I think the voir dire and the openings, four liters of bile is filling up in her, in her belly and it's causing bile

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peritonitis. Dr. Gerber told you that that makes the whole deal much more difficult once Dr. Abrams and he get involved in the case. So I would suggest and argue to you that there's no question, there's evidence in -- there's no contrary evidence in the case that on the issue of whether Surgical Associates of Fredericksburg is responsible to Ms. Hommel for damages, that the answer is yes.

Let me talk to you now about Dr. King. There's a very important instruction here, and it's instruction number four. And it talks about, you heard in the -- throughout the trial sometimes witnesses or parties will be questioned about their prior testimony because the lawyers go around, we take depositions, put people under oath, put them on a video screen. You saw the video. We ask them questions so that we can know what everybody is going to say. That's the civil justice system.

And the law is, the law is via this instruction number four that if you believe from the evidence that a party, a party is Ms. Hommel, a party is Dr. King, versus a witness like one of the experts or Mr. Hommel, they are witnesses, but when a party -- if you believe from the evidence that a party previously made a statement inconsistent with

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his or her testimony at the trial, that previous statement may be considered by you as evidence that what the party said previously was true.

That's important on this whole issue of what did Dr. King actually see that day, because again, let's move back for a moment. I thought until maybe 15 minutes ago that there was going to be no dispute about what the standard of care required with this cholangiogram. I brought you two experts. And Dr. Hill, the first expert this morning, said the standard of care required that the cholangiogram show flow into the common hepatic duct, right and left hepatic ducts before a surgeon can know that it is safe to move forward. Dr. Steffes wouldn't go with me on that. He said, Oh, no, you can basically ignore the northern part of the cholangiogram because you're only looking for a stone, which as I know you know now really doesn't make sense because stones can be anywhere.

But I would suggest to you that on the issue of what does the standard of care require -- and I asked Dr. Hill, I said I don't think you and I disagree on this. The standard of care requires that cholangiogram be good, be good up and down, and Dr. Hill said yes. Their expert witness said

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yes. So I would suggest and argue to you that on the issue of what the standard of care required, again, the preponderance of the evidence is the standard of care requires a good cholangiogram you can see up and down.

So then we get to the issue well, what did Dr. King see. He tussled with me on Monday morning with that whole deal about I said you didn't see the common hepatic duct. And I said didn't we talk about it in this deposition. He says, Well, no, all I said in the deposition was that this cholangiogram was representative, was representative of what I had seen over that 15 to 20 seconds.

And we showed you the video. And yesterday when Dr. King was testified -- was testifying, I said to him, Isn't it true that during the deposition, that we talked to -- that you told me that you didn't see anything else that was significantly different than what is on this static image. And he said, Yes, that's what I said at my deposition. All right.

That's what that instruction is for. You can consider that evidence as true vis-a-vis the tussling that he did with me on Monday morning

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about whether or not this static image was representative of what was seen on the entire 15 to 20 seconds of the fluoroscopy.

The other thing you think about there, too, is that there's no reason to take a picture of a cholangiogram that isn't representative of the 15 to 20 seconds. And so either he saw the whole thing lit up like he said in his operative, his operative note, in which case you would make darned sure if you're a surgeon, that that's the picture that becomes a part of the medical record, or he didn't. And I would suggest to you that he, because he was focused on the southern part of the cholangiogram, that by rote, he dictated that, that when I talked to him at his deposition -- now, think about this. You're being deposed. There's a video camera on you. There is a court reporter that is sworn to you -- sworn you to tell the truth. And I believe he did at the deposition. And you know the cholangiogram is the essential part of the case. You know it's the most important piece of evidence in this case. And I'm asking him there, Gee, is this cholangiogram what you saw, and he says in the deposition, Yes, this is representative of the 15 or 20 seconds.

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Well, if you're being sued for malpractice and what you want the other team to know is that no, no, I saw other stuff, you say, No, no, I saw, I saw more, I saw dye flowing into the common hepatic duct. That's what you say at a deposition. But there's more.

You've all heard that term, right? It was a famous guy that sells stuff on infomercials, Ron Popeil, and he always said that there's more, "But wait, there's more." You're really familiar with this cholangiogram by now. But we played the video this morning, and I asked Dr. Hill about this. And the fact is that when I talked to Dr. King at his deposition about show me where, when you're saying dye flowed into the common hepatic duct in the northern part, show me what you mean. And he said, Mr. Glass, it's between here, this arrow which is the end of the tip of the catheter, and it's this darkened area here. Okay.

And Dr. King, remember -- and Dr. Steffes I think just drew this red circle around what they think is the cystic duct. And that's important because Dr. King tells you now, when his good lawyer team argues now that he saw dye into the common hepatic duct, that's not what he said in his

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deposition. He said, I saw dye here, and this is the cystic duct I think, and so this is the common bile duct, not the common hepatic duct.

The thing that's very interesting about the cholangiogram -- and what you'll have as an exhibit is the original. We've got the original, original picture that they took at the ambulatory surgical center. And look real closely. Dr. Hill confirmed this. Dr. Steffes confirmed this. But clip, clip, clip, there is a clip. Now we've kind of marked it over on this exhibit. But you look at the original. There is a clip right across right where this dye ends.

The dye ends not because it has flown or traveled back south because of gravity or anything else. The dye ends because there is a clip. This is exactly the cholangiogram as Dr. Sandler told you the other day that predicts the injury that she has. And we're going to go over these medical drawings here in a minute.

But I suggest to you this is exactly what Dr.-- why Dr. Sandler and Dr. Leitman and indeed Dr. Hill this morning say that you need to see a full cholangiogram. There's a clip there. It's likely, I would argue to you, that catheter clip.

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And it's blocking travel. And you need to, you need to know that because you're going to cut there. That's where you're going to cut.

Now, there's another thing that's interesting about this, is that we talk -- Dr. King talked about this darkened area, and you heard that this is dye down here. And Dr. Leitman I think told you, you know, it gets grayer and grayer and grayer here. There's less dye. This is showing you where dye is pooled. It's darker. Why is dye pooled? It's because it's been pushed under pressure with a catheter. It can't go north because there's a clip on it. And there's a clip across the common hepatic duct. And there is no way, there's no way that could have been dye going north.

That's not what Dr. King said in his deposition. He said, No, I -- what I saw was from here to here, I interpreted that as a common hepatic duct and I thought that I was fine. And he was wrong. I think that his cholangiogram tells you that he's wrong. Three of the four experts told you that he's wrong.

Let's look at these diagrams because, because you say, All right, well wait, there's more. So they come in here -- if I can sit down, Your Honor,

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just for a second -- and they tell you that there is this stickiness between the common hepatic duct and the common bile duct. Okay. They can't even get on the same page about this, because Dr. Hill says, Well, it's very, very unusual. And Dr. Steffes says, No, that's very, very, very usual. Okay. Well, which is it? Doesn't really matter.

Let's assume for a moment that they are correct. Again, now this drawing becomes very, very consistent with that cholangiogram. You have a catheter. You have a catheter with its tip down south of the clip. This is the temporary clip to hold the catheter. It's pushing dye into here. And either it does or it doesn't go north, all right? I asked Dr. King, Hey, we're putting this clip on to hold down this thin little catheter so the whole thing doesn't move. And he says, Yeah, but it's not enough to prevent dye from going up. Okay. Let's run with that argument here for a moment.

If it's not enough to prevent dye going up, then why is there no dye also going up in the common -- excuse me, in the cystic duct, right? They're alleging sticking together. There is a

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clip across here. We're pushing dye here. And how come we can see, according to Dr. King, dye running up the common hepatic duct, but we can't also, at the same time, then figure out that the cystic duct and the common hepatic duct are running parallel with each other. You can't have it both ways. Dye runs up, one, but dye does not run up the other. Again, this is why they, doctors, experts call the cholangiogram really the golden tool to use to understand the anatomy in the case.

Now, we would argue to you that it's much more likely that if this drawing is accurate, that this clip is across the common hepatic duct, the common bile duct as they have drawn it, and that is why there is no dye running north. And that's exactly the clip, when you look at the original cholangiogram, the clip that both Dr. Hill and Dr. Steffes identified. It's a clip, you'll see right here. You see it even better on the original cholangiogram that's in the exhibit. We've marked it up a little bit, but it goes right across where they say, where the dye ends and where you are getting ready to cut.

And the injury occurs because you do now, not having, not having noticed that you have no flow

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north, you cut right across where the common hepatic duct and the common bile duct are allegedly sticking together, creating the injury.

Now, Dr. King, to his credit, told you yesterday, you know, way up top near the liver where the right and left hepatic duct were left just tiny little pieces, that I likely cut that with the Bovie. Dr. Hill wouldn't even, like, be on the same page with that. And I think when you hear somebody like Dr. Hill testify that, Oh, he didn't violate the standard of care but he doesn't agree with a basic fact of the case, you have to say to yourself why is Dr. Hill here, what is he doing, can he be believed on anything when he won't agree with even one of the basic facts of the case.

Let me show you one other thing, too, that I found very interesting, and you may. There's this whole business in this case about, well, normal anatomy went up here and her anatomy went to the left. Okay. Again, that's why you do a cholangiogram, because if indeed he's seeing dye run up the hepatic duct and right and left hepatic ducts, if he actually saw it, he would see, Oh, this isn't normal, I may have a problem here if I'm not careful. So for them to come in here and say,

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

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

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

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

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

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

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

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

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

The last big one cost her nine days in the hospital. It's a $70,000 deal when they go in to implant these tents. And then you've got to go back to have the stents removed. That's the mental, the mental anguish part of the case.

Disfiguration, we're asking for $500,000.

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

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

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

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to be involved with a doctor, that's the inconvenience that I am arguing to you. Past medical bills are probably the easiest of all this. They're a touch under $340,000. You will see that in the exhibit summary.

We're asking for a hundred thousand dollars for future medicals. Let me tell you why that's reasonable. Because as Dr. Steffes told you today, he can't guarantee that she won't stricture down sometime between today and the day that she dies. And we know that the last one was a $70,000 admission. She's going to need medical monitoring. She kind of downplays that. Dr. Gerber told you she's going to need bile thinners for the rest of her life. She's going to need to see doctors for the rest of her life. As so a reasonable protection, a reasonable protection for future medical damages, we're asking for a hundred thousand dollars there.

So we're asking for your verdict of $3,540,000. That's what we ask. I know that you have spent time in the case. You will spend time today as you eat lunch, I guess, and beyond into this afternoon. I want to thank you for that time and attention on behalf of Ms. Hommel and really

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her husband. I want to tell you that we know that you-all will do the right thing in this case. Thank you.

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FURTHER CLOSING STATEMENT

MR. GLASS: I like trying cases with really, really, really good lawyers. And my friend Bob is a really, really good lawyer. And it makes things interesting. I think it makes things interesting probably for the Court, too, to have good lawyers here. And so I use a lot of words and he uses a lot of words, but I'm going to show you how it's Dr. King's words that tell this case. And, no, we're not calling Dr. King a liar.

A couple things. The pathology report thing, that's like an interesting nonissue. There's no dispute that Dr. King took out, because he agreed with us, the gallbladder and everywhere from down here to up to the right and left hepatic ducts, and he cut those with a Bovie. There's no dispute that they all came out. It isn't like it got left inside the abdomen or anything like that. So it's an interesting nonissue as to what the pathologist wrote and why.

On the issue of the temporary catheter clip, again, not my words, not Mr. Donnelly's words, Dr. King's words, I asked him -- again, we had to go back to his deposition to talk about this. But

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we talked about it. And I said -- he described, "You start to squeeze down when I'm doing the cholangiogram, as I start to squeeze it down, I don't want to apply it one hundred percent. Of course you don't want to cut the duct in half with a clip by applying it one hundred percent." And he said, "You do it just enough to keep the dye from refluxing and leaking back out. Of course. You apply that temporary clip just enough to keep the dye from refluxing and leaking back out." So this isn't where he put it in just enough to hold the catheter but the dye goes up and down. It isn't my words, Mr. Donnelly's words, but Dr. King's words, just enough to keep the dye from refluxing and leaking back out.

Lastly, next-to-last is, again, we get back to what, when Dr. King is back dictating six minutes after this operation, what he saw. I'm not calling him a liar. He misinterpreted the cholangiogram. He -- and this is why we brought to you the video this morning and why I asked both of their experts this question. Again, we'll go back to his deposition. And I said, Tell me what you were looking at when you dictated I saw intra and extrahepatic ducts.

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And he had shown me on the video where the tip of the catheter is. And I said, So when you say you saw dye into the hepatic duct, you're talking about this blackened area here? "Yes, sir." And he said this is what he believed to be the cystic duct. And we know, we all know because now we are educated in this, that this is not the hepatic duct, this is the common bile duct.

So for whatever reason, he looks at the image, he sees this darkened area, he's got the catheter down here, and he says and dictates believing it to be true, not lying, believing it to be true that I see dye into the common hepatic duct, but it simply cannot be. This is not, no expert said this is a common hepatic duct. In fact, Dr. King said it's the cystic duct there, a little spot. Dr. Steffes I think agreed with me this morning that that might be, he thought that that was a part of the cystic duct. And so Dr. King is looking at that, he's simply misinterpreting the x-ray. He's not lying. We're not saying he's a liar.

Let's see. The last thing. Sympathy. Not asking for sympathy because she got all the sympathy she wanted, all the sympathy she needed over these last three, over three years from her

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husband, from her friends, from doctors like Dr. Gerber who took care of her. Not asking for sympathy.

By the same token, you can't say, Well, what will this do to Dr. King. I mean, he's a professional. It's no fun for anybody to be sued. It's really no fun for a professional to be sued. But you can't go back there and go, Gee I wonder what this -- what will happen to Dr. King, or I wonder how he feels. That would be the same thing. That would be sympathy.

We're asking for your verdict -- by the way, all of those words, and no dispute, no dispute whatsoever as to my argument as to the $3.5 million in damages. I think Mr. Donnelly says we don't disagree with what she's gone through, we don't disagree with her pain, so no dispute there. So again, I'm asking for your verdict for just over 3 and-a-half million dollars.

I thank you on behalf of Ms. Hommel and I'm sure on behalf of Mr. Donnelly and Dr. King. Thank you very much.

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VERDICT

THE COURT: All right. All seven members of the jury have returned to the courtroom.

Let's see. Who was elected foreman? What's your number?

JUROR 16: Sixteen.

THE COURT: Foreman is 16. All right.

I understand the jury has reached a verdict, is that correct?

JUROR 16: That's correct.

THE COURT: All right. Read the verdict, please.

THE CLERK: Thank you, Your Honor.

"We, the jury, find our verdict as follows: In favor of the plaintiff, Christine Hommel, against defendant Bradford King: No.

"In favor of plaintiff, Christine Hommel, against the defendant Surgical Associates of Fredericksburg, LTD: Yes.

"Having found for the plaintiff against the defendants, we award the plaintiff the following amount in compensatory damages: 1,875,000. We, the jury, do not award interest."

This is your verdict, so say you all?

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THE JURY: (Indicating in the affirmative).

THE COURT: All right. Are there any motions before the Court discharges the members of the jury?

MR. DONNELLY: Poll the jury, please.

THE COURT: Let's poll the jury, please.

THE CLERK: Juror number seven, is this your verdict?

JUROR 7: Yes.

THE CLERK: Thank you. Juror number 12, is this your verdict?

JUROR 12: Yes.

THE CLERK: Juror number 15, is this your verdict?

JUROR 15: Yes.

THE CLERK: Juror number 16, is this your verdict?

JUROR 16: Yes.

THE CLERK: Juror number 19, is this your verdict?

JUROR 19: Yes.

THE CLERK: Juror number 20, is this your verdict?

JUROR 20: Yes.

THE CLERK: Juror number 25, is this your

verdict?
JUROR 25: Yes.
THE CLERK: Thank you.
THE COURT: Any other motions before the Court discharges the members of the jury?
MR. GLASS: No, sir.
THE COURT: Ladies and gentlemen of the jury, I want to thank you for your service to the Court and our community over the last three days. Through your service you have guaranteed and ensured that both sides received a fair and impartial trial, and the Court greatly appreciates it. Of course you will not need to be here tomorrow or Friday, but if you have other days later in the month when you're to be here for jury service, make sure you check the jury hotline the evening before.
Thank you for your service. You're free to leave. Have a good day.

(Conclusion of excerpted proceedings)

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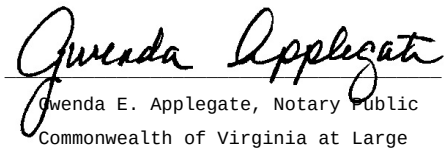
COMMONWEALTH OF VIRGINIA AT LARGE, to wit:

I, Gwenda E. Applegate, Court Reporter, Notary Public in and for the Commonwealth of Virginia at Large, and whose commission expires November 30, 2017, do certify that I reported verbatim the proceedings in the Circuit Court for the City of Fredericksburg, in Fredericksburg, Virginia, in the captioned cause, heard by the Honorable Gordon Willis, Judge of said court, on January 4-6, 2016.

I further certify that the foregoing transcript, numbering pages 1-75 inclusive, constitutes a true, accurate and complete transcript of said excerpted proceedings.

Given under my hand and notarial seal at Charlottesville, Virginia, this 15th day of February, 2016.



Gwenda E. Applegate, Notary Public
Commonwealth of Virginia at Large
Registration Number 115863

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