Transcript of **William J. Schirmer, MD**

Date: November 24, 2015

Case: Hommel -v- King, M.D., et al

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VIRGINIA:
IN THE CIRCUIT COURT FOR THE
CITY OF FREDERICKSBURG
Christine Hommel, :
Plaintiff, :
vs. : Case No. CL14-349
Bradford Lynn King, M.D., and :
Surgical Associates of :
Fredericksburg, Ltd., :
Defendants. :

VIDEOTAPED DEPOSITION OF WILLIAM J. SCHIRMER, MD

Tuesday, November 24, 2015
4:21 p.m.
Anderson Reporting Services
3242 West Henderson Road, Suite A
Columbus, Ohio 43220

SHAYNA M. GRIFFIN, RPR, CRR

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APPEARANCES:
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On behalf of the Defendants.

ALSO PRESENT:
KRISTEN COLOMBO, Videographer

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EXHIBITS CONTINUED

Some pre-marked exhibits not used

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PROCEEDINGS

- - -

MR. GLASS: DVD and Etran, mini, email, regular delivery.

MR. DONNELLY: I'll have the same thing. Etran, mini is fine, and I'll take a copy of the tape.

THE VIDEOGRAPHER: Here begins tape No. 1 in the videotaped deposition of William Schirmer, MD, in the matter of Christine Hommel versus Bradford Lynn King, MD, et al., in the Circuit Court for the City of Fredericksburg, State of Virginia, Case No. CL14-349.

Today's date is November 24th, 2015. The time is 1621. My name is Kristen Colombo. I am the videographer. The court reporter is Shayna Griffin.

Counsel will now introduce themselves.

MR. GLASS: My name is Ben Glass, and I represent Christine Hommel.

MR. DONNELLY: My name is Robert Donnelly, and I represent Dr. King and his surgical group.

THE VIDEOGRAPHER: The reporter will now

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swear in the witness.

- - -

WILLIAM J. SCHIRMER, MD

- - -

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

CROSS-EXAMINATION

- - -

BY MR. GLASS:

Q. Dr. Schirmer, good afternoon. My name is Ben Glass. I'm an attorney from Fairfax, Virginia, and you've been identified as an expert to testify in this case that we have involving gallbladder surgery against Dr. Bradford King of Fredericksburg; right?

A. Correct.

Q. As we sit here today, how many open medical malpractice files do you have where the subject is gallbladder removal surgery? Open, meaning you've done work and it hasn't gone to trial and they haven't told you to get rid of the files yet.

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A. I don't -- I'm trying to remember if there are any open right now. I -- there might be a couple; but, again, it's nothing I've recently discussed with attorneys. So, you know, sometimes I don't know whether these are gone or what the status is after a discussion. I may have one or two, and that's a "may." I'm not even sure of that.

Q. Okay. In this year, 2015, have you given any depositions or testified at trial in a gallbladder removal surgery?

A. Again, I don't know that I've given depositions in gallbladder removal surgery this calendar year.

Q. All right. In this case, I take it that your view is that Dr. King violated the standard of care in his surgery; correct?

MR. DONNELLY: Object to the form of the question. Object to the relevance. It's beyond the scope of his designation. And no testimony will be elicited on standard of care from Dr. Schirmer.

MR. GLASS: Sure.

A. No, I have not -- I have not formed any

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opinion about that.

Q. What were you asked to do?

A. I was asked to review the medical records, which I have here, and then contact -- I think it wasn't Mr. Donnelly -- someone in his office, maybe a paralegal, and just share my opinions or my thoughts regarding the original medical records I reviewed.

Q. Okay. And so to be sure, you reviewed the records of his surgery, the records of the care in North Carolina, the cholangiogram. I assume you've reviewed various depositions in the case?

A. Yeah. Originally, I had not. Originally, I just reviewed the medical records --

Q. Of course.

A. -- so I've -- I've reviewed now several depositions since. But at the time I reviewed the medical records that included what you said, the gallbladder surgery, the North Carolina Hospital records, the UNC Chapel Hill records and some -- and they included some imaging studies that were actually part of the medical records.

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Q. All right. And you're telling us you formed no opinion about Dr. King's conduct of the surgery?
A. I had not formed -- I didn't have enough at that time to form an opinion. I had -- I reviewed the material, I discussed issues, I guess, or my thoughts at the time. I can't remember the even the -- exactly what I said in totality. But that was the first thing I did. I didn't --
Q. Well, I'm talking about here today, here in November, whatever it is, 23rd. You have formed no opinions, having reviewed the medical records and the cholangiogram and Dr. King's deposition testimony, about whether he violated the standard of care in doing the surgery?
A. That's correct.
MR. DONNELLY: Same objection.
BY MR. GLASS:
Q. All right. Now, for two decades you've been involved in medicolegal cases; correct?
A. Correct.
Q. Giving lots and lots of testimony in

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depositions and at trial; correct?
A. Correct.
Q. And a significant portion of that work has been in these gallbladder removal cases; correct?
A. Not the majority, but several, yes.
Q. More than several. But we'll go over it.
A. Sure.
Q. All right. And in that -- in those two decades, you have testified in gallbladder removal cases more often for the patient than for the doctor; correct?
A. Correct.
Q. And you have been critical, time and time again, of doctors who failed to identify the hepatic duct in surgery; correct?
A. I wouldn't say that -- you know, that specifically. I've been critical of physicians in the conduct of various gallbladder operations, yes.
Q. We'll go through the specifics.
You've been critical of physicians who failed to identify the triangle of Calot; correct?
A. As one of the methods for identifying the

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anatomy. I don't want to -- again, the way you're phrasing the question, it sounds like if that -- if they don't identify the triangle of Calot that I'm critical. There are other things --
Q. Sure.
A. -- so it's -- as a component, there are some requirements for the procedure to conform with the standard of care, and among those is identifying the structures of the triangle of Calot.
Q. You're been critical of physicians who should have cholangiogrammed intraoperatively that doesn't show the entire biliary tree and they proceed with the surgery; correct?
A. I can't remember a specific case in that regard, but if, you know, there are -- I'd -- if you point it out to me, I'm sure I stand by whatever I've said in the past.
Q. We will.
And that brings me to this question: Over the last ten years, at least, the science of gallbladder removal surgery has not changed in any significant way, has it?

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A. That's -- that's probably true, yes.
Q. All righty. In fact, you've testified in the past that when there's a transection and a removal of a portion of the common duct, be it the common bile or common hepatic duct, that that speaks for itself and that is negligence?
A. No. I have never -- I don't -- I've not said that. And if it came through as I said that, I would have to look at exactly what I said and clarify. I don't think it speaks for itself.
Q. Okay. All right. Well, let's -- let's start looking. Oh, you've also testified that a normal cholangiogram is a cholangiogram where the entire biliary tree lights up; correct?
A. That's part of a normal cholangiogram.
Q. And a physician who is doing a gallbladder removal surgery who does not get a normal cholangiogram needs to prove why it's not normal; correct?
A. If -- if the cholangiogram is not normal, additional steps need to be taken if there's a question about the anatomy, if that's the purpose of

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the cholangiogram.
Q. Right. And because -- because a cholangiogram is a really good tool for seeing the biliary anatomy, and seeing the biliary anatomy is a really critical part of doing these surgeries; correct?
A. I would agree with that, yes.
Q. All righty. So your -- well, we're going to mark -- actually, we've premarked all of these deposition transcripts, so each one, just so you know, Doctor, has the face sheet of the case that you testified in, and then I've got different segments taken out. And I'm just going to get you -- I want to talk about your prior deposition and trial sworn testimony.
And so the first one is simply that when you -- the majority of the medicolegal work you do is defending physicians; correct?
A. Yes.
Q. And so -- and for the record, Exhibit 1 is from -- a transcript from trial testimony almost two years ago now, January 28, 2014, when you testified

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against Dr. Linda Bailey in Greene County, Ohio.
Here's No. 2. Exhibit 2 is, again, testimony from that same case where you say every once in a while you agree to review cases on behalf of defendants, and you find them -- you'll say you can't defend it and here's why, and you'll educate the lawyer in the case; correct?
A. Correct.
Q. Have you educated Dr. King's lawyers in this case about the issues regarding the standard of care?
A. I don't believe I have. I don't think I spoke with an attorney from their firm until later in the case. I spoke with a paralegal.
Q. Okay. So let me broaden the question to include attorneys and paralegals. Have you spoken with the defense legal team here about issues about the standard of care?
A. I don't know that I have. I don't think it never came to that point.
Q. All right. Exhibit 3 is from the Kimberly Lumpkin case, which is in February of 2003, where

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you testified against John Mobley, MD.
You train doctors how to do this surgery; correct?
A. I had, yes. I mean, as part of my -- in my career I had participated in a lab where we were training physicians in laparoscopic cholecystectomy.
Q. On what we're talking about here today; correct?
A. Well --
Q. Laparoscopic cholecystectomy cases.
A. Right. I was asked today to talk about --
Q. I know.
A. -- the repair, so I've done that too.
Q. I get that. But I found all of this testimony through -- through two decades --
A. Sure.
Q. -- of you identifying and testifying against physicians about breaches of the standard of care. And I just want to get all of that on our record and then ask you some factual questions about this case. And then we'll talk about the damages.
Exhibit -- and by the way, that pile will

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go to the court reporter later, so just --
A. Okay.
Q. -- give them back.
So Exhibit 4 is -- well, Exhibit 4 is trial testimony again from the Lumpkin case where you, in a shortcut way --
MR. DONNELLY: I'm sorry. Do you mean Exhibit 3?
MR. GLASS: No, Exhibit 4. Exhibit 3 we just did.
MR. DONNELLY: Oh, I didn't get 4. I'm sorry.
MR. GLASS: I'm going to give it to you. I'm sorry.
MR. DONNELLY: Oh, okay.
BY MR. GLASS:
Q. It just talks about your experience. You have a ton of experience in the area of laparoscopic gallbladder surgery and, in fact, you were at the Lahey Clinic when laparoscopic gallbladder surgery started; right?
A. Correct.

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Q. And you all -- you doctors at the Lahey Clinic actually started a training program, and you continued that teaching of physicians when you went to Ohio State as a professor; right?
A. Correct.
Q. All right. And you have been instrumental in publishing the literature on how to do this surgery in a safe and non-complicated way. And that's from Exhibit 5 which, again, is from the Lumpkin case?
A. Correct.
Q. And Exhibit 6, which is testimony from a deposition given in 2003 in the Jennifer Sullivan versus Dr. Awender case, you listed a number of books that you found supported your views of how to do safe laparoscopic gallbladder surgery. And if you -- the print is small, you can take a moment to look at it.
A. Okay.
Q. Now, this deposition is in 2003.
A. Right.
Q. Are these still good sources for guidance

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as to doing this surgery in a safe way?
A. You know, I don't know the -- on page 42 of this, I'm not sure what the question was. I'm not -- I'm reading an answer that's somewhat highlighted. I don't know what the question was on that. And on page 43 it -- it says the question is what is that book and how does it support your opinion. I refer to a book called Maingot's Abdominal Operations, 9th Edition. It makes the point of identifying the relevant anatomy before transecting structures. Discusses the necessity of doing that before transecting what one presumes is the cystic duct. I agree with that premise. I don't -- I don't have that book. I -- at the time that's what I said, and I still agree with that.
Going to page 44, it talks about another book, Surgery of the Alimentary Tract, it's a five-volume set. I had one of the volumes. It discusses safeguards that basically is everything -- anatomy should be visualized and identified before anything is cut. I -- I agree with that.
Q. Still agree with that; right?

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A. Another book, Surgical Treatment of Digestive Diseases, a chapter on gallbladder surgery and techniques. Discussed a technique of exposing the triangle of Calot before anything is cut to clarify the anatomy. Talks about cholangiography. I agree with that.
And the final thing that's highlighted, Surgery of the Liver and Biliary Tract, a two-volume series. Talks about the operation, assessing and identifying -- yeah, I agree with -- so I agree. I don't have these books but, you know, what I've -- what I'm talking about here, I agree with that.
Q. Are they still reliable authorities in this area, which is the safe -- techniques for safe gallbladder removal surgery?
MR. DONNELLY: Object to the form.
A. I wouldn't say the books are reliable authorities. I'm just saying that these books talk about and then I specify what they talk about. I wouldn't -- I can't just say, oh, the whole book is -- these are dated. Obviously, this was a 2003 deposition and the -- and the -- I have no idea

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when these books were published, but I -- to -- you know, to what extent of what I've talked about here, I agree with what's discussed on these few pages --
Q. Right.
A. -- but I can't say the whole book, sir.
Q. Exhibit 7 is, again, from the -- well, it's from the Kimberly Thomas case, which was in Indiana. And in that case you testified that when you -- when you talk about something being a breach of the standard of care, you mean that it is not at all acceptable under any circumstances, and there's no room for that kind of thinking or judgment or action. That's when I think something is outside the standard of care. And that was from about three months ago.
MR. DONNELLY: And I'll object to the form.
Is there a question?
BY MR. GLASS:
Q. Well, is that still your view?
A. Well, in the context of this answer, I think I must have been -- I'm trying to see what I

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was trying to explain. That was the second paragraph of a -- this looks like a long-winded answer.

It's talking about robotic-assisted surgery, and I'm -- I'm just speaking in general terms about what is -- you know, what my definition in medicine is reasonable, and talking about when a physician is confronted with same or similar circumstances and whether their actions are logical or reasonable, or whether there's no -- it's outside of anything that's logical or reasonable, that's a violation.

Q. Right.

A. So, I mean, I don't know if it's maybe inartfully worded, but think in general I agree with what I said.

Q. That's cool.

So when you had testified in the past in all these cases that something is outside the standard of care, you meant that it was not logical and not reasonable to do under the circumstances; correct?

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A. For a reasonably prudent physician to do under those circumstances, yes.

Q. Okay. Exhibit 8 is from -- this is from trial testimony again in the Vernon Clay versus Linda Bailey case. And in this -- at trial you testified that the SAGES, S A G E S -- the SAGES guidelines were reliable authorities for a safe performance of laparoscopic cholecystectomy.

A. I don't think I -- I just said I agree with what's written. I don't -- I don't think I ever said they are reliable authorities. Maybe that's just a different use -- I -- the questions here have to do with the SAGES guidelines. I said -- the question was do they publish guidelines. I said they have published these guidelines. I'm talking about gallbladder -- or laparoscopic cholecystectomy and recommendations for safe. It says, do you find that those are reasonable and reliable and an authority on that particular issue. I say I've read those guidelines and I agree with them.

Q. Okay. So --

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A. So I agree with what I said.

Q. And you agree that the SAGES guidelines on safe performance of laparoscopic gallbladder removal are reliable authority?

A. I wouldn't say -- they are not -- no, guidelines are not -- I would say they are reasonable. Maybe they are reasonable guidelines. I do agree with that. But those -- I said I read those guidelines and I agree with them. In other words, I think the guidelines that they offer as to the safe conduct of cholecystectomy are reasonable. You know, those guidelines are not all encompassing because I don't do exactly what they say in those guidelines.

Q. I get it.

A. And there's more than one way to do it; but what they say is a reasonable way of doing the gallbladder.

Q. Take a look at Exhibit No. 9, and I'll proffer to you that on Exhibit 9, which is, again, more pages from the -- Linda Bailey was the defendant case -- you walked through --

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A. Here's the -- you gave me two.

Q. I gave you two?

A. You gave me 9 and 10. That's -- that's 10, so...

Q. I'm sorry.

MR. DONNELLY: I have 10 too. We'll get to 10 in a minute.

BY MR. GLASS:

Q. Again, Exhibit 9 is testimony from the Clay versus Dr. Linda Bailey case where -- my words now -- you walked through how the SAGES guidelines describe safe performance of laparoscopic gallbladder removal. And my question is: Isn't that true?

A. I talk about that, yes, the critical view, that that's what they talk about in the SAGES guidelines, yes.

So I -- I believe, yes, I'm trying to discuss the SAGES guidelines and how their approach is one way of doing safe gallbladder surgery, yes.

Q. All right. How -- how those guidelines can be used by a physician to do the surgery in a

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safe way without taking out a part of a hepatic duct; right?
A. Well, it's to do the surgeon a safe way. The SAGES guidelines describe a technique that is designed to help the surgeon be certain that the ducts that they have identified, the anatomy they have identified, are the ones that are safely clipped and -- to remove the gallbladder.
Q. And that really is the -- the ultimate principle here is that we want to -- we, as surgeons, want to make sure that before we cut, we're cutting the right duct, the cystic duct in this case; correct?
A. That's the objective, yes.
Q. All righty. So Exhibit 10 is from -- is a deposition testimony, Bob, in a case called Gloria Davis versus Dr. James Corpus, where you said that the -- that the principles of safe laparoscopic cholecystectomy were developed because we don't want to go in and make a mistake of cutting something wrong. And my question is: Isn't that right?
A. Correct.

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Q. All righty. Exhibit No. 10 is simply the SAGES guidelines that you were talking about --
A. Or 11.
Q. -- in the -- in the trial that you testified in.
MR. DONNELLY: 11.
MR. GLASS: Exhibit No. 11. Thank you, sir. Sorry.
A. Yeah, this is the SAGES -- the SAGES guidelines. These are the guidelines.
Q. All righty. Now, switching gears a bit, come off of the gallbladder; correct?
A. Well, the main duct that comes off the gallbladder is the cystic duct. There are -- there's things called ducts of Luschka which can come off variably from different parts of the gallbladder, but the main drainage from the gallbladder is the cystic duct.
Q. Of course. But you have testified before that a variety of ducts can come off of the gallbladder. I'll show it to you. It's Exhibit No. 12 --

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A. Okay.
Q. -- which is testimony in the -- deposition testimony in the Jennifer Sullivan versus Dr. Awender, A W E N D E R, case.
A. Yeah, I think that inartfully answered. What I -- and I went on to say -- I clarified in my response, there are variations in the cystic duct and they -- so what I meant was the cystic duct is the main duct that drains the gallbladder. But where the cystic duct inserts into the rest of the biliary tree is where the variability comes in; so that's the anatomic variability.
Q. But my question was, you have testified -- and I'll show you other instances right here in a moment -- that a variety of ducts can come off of the gallbladder.
A. Well, I'm trying to understand -- if I read my --
Q. It's page 29, line 6.
A. Right. And in that same answer, in that -- I continued on. I said there's typical anatomy. I could draw it for you. And that is

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present in 40 percent of the cases, so 60 percent of the cases there is variations. Among those variations is the cystic duct can empty into the right hepatic duct, not enjoin the common hepatic duct -- the common hepatic duct or common bile duct. There can be variations in the length and the course of the cystic duct. The cystic duct can be absent, so -- I got stopped.
So what I was saying here is that -- what I'm saying and clarifying in my answer here is that the cystic duct is the duct that comes off the gallbladder. But where that -- how that -- you know, where that duct goes, how it courses, into what it empties is variable. That's what -- it's not that there are -- the answer that said there are a variety of ducts that come off the gallbladder, it should be there are -- more precisely, there are a variety of ducts that can -- into which the duct draining the gallbladder can attach. In other words, there are a lot of -- the duct work is not a -- one, this is how it is in everybody. It's like this in many people, but there are a lot of

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variabilities. I tried to explain that, you know, so -- but I'm only aware of one major duct that comes off the gallbladder, it's the cystic duct. And then the other smaller ducts, the ducts of Luschka, are very small.

So I -- I think -- and I went on in this answer to explain that there is -- there is a condition called an absent cystic duct, so there are times when there is no cystic duct. But if a duct drains the gallbladder, it is the cystic duct, or it's either present or absent.

Q. I've got more of these.

A. Okay.

Q. You can keep trying to explain it. The question the -- the lawyer representing the doctor asked you, which is -- because he tried to make that point. He tried to make the point, there's only one duct coming off the gallbladder. And he said what is the only duct that comes off the gallbladder, and you said a variety of ducts can come off the gallbladder. And isn't it true that you've testified in numerous occasions that a physician who

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eyeballs a duct coming off the gallbladder cannot presume and assume that that is the cystic duct, because multiple ducts, a variety of ducts, can come off the gallbladder?

A. That's not what I've ever intended to say.

Q. Okay.

A. So if -- and I'm clarifying here. I know what I'm saying. I think if -- sometimes if I'm speaking with an attorney and we're not on the same page -- I said in this thing, the variation in the cystic duct can empty into the right hepatic duct, and so -- and so on and so forth. In other words, the duct that drains the gallbladder, which is the cystic duct, can have variable course and drain into more than one location. It's not that -- it's not -- I don't -- I don't label the ducts. The gallbladder -- the bladder is called the -- it's the cholecyst, and the duct that drains that is the cystic duct. That's by -- that's the anatomic definition. I can't rename ducts. There's only one duct that drains the gallbladder. It's the cystic duct. Now, how that -- where that duct goes is

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variable.

Q. I don't disagree with you on the anatomy. I'm concerned about sworn testimony given in other cases. And I'm going to show you another one here in just a minute. So, I mean, I can read the anatomy books as well as -- almost as well as you can, I guess.

You would agree that seeing that a physician --

A. Then I go on -- let me finish here.

Q. Go ahead.

A. On page 30, I say in this same thing that you are referencing -- I said, so the cystic duct is the duct that -- is the name of the duct that drains the gallbladder. So I'm clarifying in my answer here. There are so many variations, and what it empties into is variable. But the normal is the common -- I should say where it drains. But I say here the cystic duct is the duct -- just the name of the duct that drains the gallbladder. So that's -- that's the duct that drains the gallbladder.

Q. Gotcha. That's what I thought too. But

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you've testified that seeing -- that a physician who sees a ductile structure enter the gallbladder cannot assume that that ductile structure is the cystic duct.

A. Well, I -- and if I were to go on and clarify that, I would say the perception, if -- another surgeon's perception is not necessarily that the duct is entering. It could be adjacent to, and I -- so, yes, in many -- in many depositions in trying to explain some -- why some of the principles apply --

Q. Did I hand you -- I'm sorry. Did I hand you 13?

A. 12.

Q. So I've got just two of 13, apparently.

A. Here's 13. I'm sorry.

Q. You have Exhibit 13?

A. Yeah, it stuck to the back.

MR. GLASS: Here's one for you, Bob.

MR. DONNELLY: Thank you.

BY MR. GLASS:

Q. So 13, which was testimony -- again, this

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was the deposition testimony in the Clay versus Dr. Linda Bailey and Surgical Association of Greene County case. You testified again at line 15 -- you can read it -- and so seeing a duct entering the gallbladder is not sufficient. You need to develop more.

A. (Indicates affirmatively.) Yes.

Q. And the reason is because there can be a variety of ducts that enter the gallbladder?

A. No.

Q. All right.

A. It's not because there are a variety of ducts.

Q. Tell me the reason why. Why should a physician who perceives that they see a duct running into the gallbladder not assume that that is the cystic duct?

A. And I go on in this -- on this same answer. I'm trying to answer in this case. I said there are situations where the cystic duct and the common hepatic duct can run together parallel and be fused. So I'm talking about the difference between

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perception -- visual perception of a surgeon who says I see the duct doing this, and the possibility that there are other -- by either congenital, the way it is, the way they are born, or by disease -- can give that false impression. So what I'm trying to explain is the -- that gets into the whole principles and the fundamentals of the gallbladder operation.

So, again, it's not saying that there's more than one duct. It's saying that the -- there is -- the duct -- as I've said earlier, that there is a duct; but it can have variable courses, and it can -- in this case I gave an example of how they can run parallel, like two lanes on a highway, but they are still two lanes on a highway. So the fact that they visually have one appearance doesn't mean that is the way they are. so...

Q. Right. And that's why it's incumbent upon the physician to not assume that what he thinks is the cystic duct is, in fact, the cystic duct; right? He has to carry out one of the several techniques we have for doing safe laparoscopic gallbladder surgery

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to the end?

A. And that's why I'm, in these depositions, trying to explain some of the -- like the SAGES guidelines or other techniques for identifying the anatomy.

Q. All righty. Here it is. I hand you 14, which is, again, from the Gloria Harvey case deposition. On page 84, you said -- let's see, you see a duct going into the gallbladder, and if we presume that to be -- just because -- just because it goes into the gallbladder that it's the cystic duct, that's an incorrect assumption. Surgeons can't make that assumption.

And my question, I guess, is: Isn't it true that just because a surgeon sees a gallbladder that goes into the cystic duct, they cannot assume that it is the cystic duct. I'm sorry. I reversed that.

Just because a surgeon sees the cystic duct going into the gallbladder, he cannot assume that it is the cystic duct?

A. Well, no -- just to be clear, just because

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you see a duct, you have to -- you can't presume it to be the cystic duct, because only the cystic duct goes into the gallbladder. So if you see a duct --

Q. Read the whole sentence. A duct doing what?

A. Hmm?

Q. Read that whole sentence, so you --

A. But I said here -- so you -- I said, so you see a duct going into the gallbladder.

Q. Yeah.

A. And if we presume that to be -- just because it goes in the gallbladder that it's a cystic duct, that that's an incorrect assumption. Surgeons can make that mistake. So I said you see a duct and you don't want to -- you presume it to be. So I'm not saying -- again, this is the difference between -- I'm trying to say in these depositions, the presumption that something is the cystic duct doesn't, in fact, make it the cystic duct.

Q. Right.

A. So it's not that there are multiple ducts that go into the gallbladder. It's that the -- the

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presumption or some of the assumptions can be incorrect during surgery. There is a duct that goes in the gallbladder, and there are -- and in order -- there is an anatomic relationship of ducts that are important to understand.

Q. And just because -- and just because a surgeon sees a duct going into the gallbladder, just because it goes into the gallbladder, that's -- they assume that it's the cystic duct, that's an incorrect assumption; right?

A. I'm talking about -- I say the word -- I say the word "presume," presumption that it is. So there's a difference between presumption based on the visual and --

Q. You're right. And, in fact, what you've testified over and over again is that really you need to see, when you're evaluating a case and testifying against a doctor on -- who you say breached the standard of care, you need to see that the doctor provides objective evidence, you have said, that the cystic duct is the cystic duct?

A. I would agree, there's a -- there is a

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requirement to develop that anatomy and -- as part of a gallbladder surgery, yes.

Q. All right. So 15 is -- again, it's from the Anna Barry case in 2008. It's a deposition. And, again, I guess it just reinforces what we've just talked about, which is that -- and it's several pages -- that belief is not -- a surgeon's belief that he is seeing a duct running into the gallbladder, that that duct is the cystic duct is not enough to comply with the standard of care?

A. And -- but I do say in my answer, without having performed the necessary steps -- in other words --

Q. Uh-huh.

A. -- what I'm trying to say too is that a technical error during gallbladder surgery doesn't speak for itself as a violation of the standard of care if the surgeon follows the steps that lead that -- or the guidelines, if you want to call them, whatever you want to say; and despite having followed those guidelines, an injury occurs, that's -- that's a complication.

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But -- so what I'm talking about here is if these -- if -- I said if you believe that clipping is, you know -- here they are talking about cholangiogram, but I said it's not a matter of believing. You have to follow the steps to dissect things out or do things. So it's -- you know, my answers in these -- all these depositions is that there are -- you have to follow certain steps, I guess. Yeah.

Q. Right. And doctors can't make assumptions or presume anything without following the steps that we'll get to here in a few minutes?

A. And that's -- that's what I'm trying to say, because these are -- you've taken pages out of depositions, and I'm sure in each of these depositions -- and I'm consistent when I've given these -- is that I clarify -- the one page I agree with what I'm saying here. I'm not trying to back away from it. But I know that I tried to put it in the context of the case at hand; that in this case at hand, here are some principles, here's what happened and here's the issue I have. So I --

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that's --

Q. Yeah.

A. -- that's what I do in these cases.

Q. And just so you know, I'm not tussling with you. I think you've been very consistent over two decades of testimony about what a physician has to do to perform this surgery safely. I mean, I've read -- I didn't even bring them all. I've got boxes of deposition and trial testimony. I think you've been very consistent.

But you're not testifying to the standard of care here, and I think it's because you believe that Dr. King violated the standard. He didn't -- he didn't carry out the safe steps necessary, and I think you know that. I think you've told them that. And that's why you're being proffered as a damages witness.

MR. DONNELLY: Objection to the form of the question. It's been asked and answered.

MR. GLASS: It's a long question.

MR. DONNELLY: And he's not formulated any opinions on standard of care.

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BY MR. GLASS:
Q. Okay. In -- again, this Linda Bailey case was interesting because it did go to trial. And in that case -- do you recall testifying as -- January of 2014? It was in --
A. That was -- yeah, that was last year. This actually went -- yeah, I recall it generally --
Q. It went to trial, all right. And, of course, if you may recall, the big issue was Dr. Bailey said, I saw the cystic duct, I convinced myself it was the cystic duct, and she injured the common bile duct. Do you remember that generally?
A. Let me just read this. I don't recall exactly what Dr. Bailey said in that case.
Q. I've got her deposition, I've got your trial transcript and I've got your deposition here if you want to see any of that.
A. So this gets into that issue that we were talking about earlier where Dr. Bailey -- this is what this says -- the attorney asked me a question that -- stating that Dr. Bailey saw with her own two eyes a ductile structure entering the gallbladder.

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And I said I don't debate that's what she saw. And the attorney asks, but nonetheless, it's your position that you don't think she adequately identified the duct. And I said that's correct. And, again, I can't -- without going through -- I don't remember -- I remember being involved in this case, but I can't remember exactly what it was that she did that -- that I felt didn't allow her to make that presumption or assumption. She hadn't perhaps -- you know, again, I don't want to say what she did or didn't do. I can't remember the details. But it gets back to what I said earlier, that there are certain prerequisites or steps that have to be followed before you can come to that conclusion -- reasonably come to that conclusion. So --
Q. Right. Because anatomy can vary; right?
A. Correct.
Q. I think you've said -- you've said in some of these transcripts that 60 percent is actually variant and 40 percent looks like the cool pictures in the book; right?
A. That's probably right, yeah.

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Q. And so you all, surgeons who do this surgery, you know that six times out of ten you can be presented with one of the variations of this biliary gallbladder anatomy; correct?
A. Correct.
Q. Including things like short or absent cystic ducts; right?
A. Yes.
Q. And part of the reason why the safe procedures that you've described and they are in the SAGES guidelines, and we carry those safe procedures out to their end, is to make sure that we don't hurt somebody who has a -- for example, a missing cystic duct, absent cystic duct or a short cystic duct; right?
A. Sure.
Q. Because the safe procedures will help -- will identify that variation to the doctor, right, and allow him to not cut out a part of the hepatic duct; right?
A. Hopefully. That's what they are designed for, yes.

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Q. Yeah, I mean, that's -- that's exactly what they are designed for; right?
A. Correct.
Q. In cases where the common duct is either injured or transected, I guess there's either -- there's one of two situations. One, the surgeon recognizes it in surgery or it goes unrecognized, right, in the immediate -- unrecognized at surgery?
A. Yeah. I mean, in cases -- generally speaking, yes. I mean, some injuries are recognized at the time and others don't become apparent until later.
Q. And you've looked at a lot of cases where you've testified there was a breach of the standard of care, there was an injury to the common bile duct or the common hepatic duct that went unrecognized at surgery, and you've always found that the doctors are surprised to find later that they caused that injury; correct?
MR. DONNELLY: Object to the form.
A. Well, I think that kind of -- in general, I think that's probably true. I don't think -- if a

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surgeon doesn't recognize the injury, they don't -- they don't recognize the injury. So when it becomes apparent later, you know, they probably wouldn't have closed the patient had they suspected or recognized injury, so...

Q. Yeah. That makes sense, but somehow it became a big point in this Vernon Clay versus Dr. Bailey deposition, and it was brought up. And you said just that; that you've never reviewed a case where there was an intentional injury, of course, and in each case the surgeon feels as though they had properly identified the anatomy before they proceeded; right?

A. Correct.

Q. And so that just gets us back to your big point, that a surgeon's belief that he's done the surgery correctly, that he identified the cystic duct, is never enough to comply with the standard of care?

A. Well, in a vacuum, by itself --

Q. Uh-huh.

A. -- there -- you know, the foundation for

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that belief has to -- there has to be a foundation, there has to be a series of things, so --

Q. And you as --

A. -- you eventually have to come that. I mean, you have to make a decision in surgery.

Q. Sure.

A. But what's -- so the question is what's -- what's your foundation for that decision --

Q. Yeah.

A. -- and belief.

Q. And you, as an evaluator of cases and as someone who's testified on a number of times against physicians, you look at the operative report and you look -- is it described how any of the safe techniques were carried out; right? And then you look at the surgeon's deposition?

A. Correct.

Q. And would you agree with me that, oftentimes, you don't find it well described in the operative report, but you see something one way or the other in the deposition? Is that your experience?

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A. It's -- that often happens where, you know, the operative report might be brief and there's an elaboration in the deposition, sure.

Q. All right. Exhibit 18, again, is from the Anna Barry case. Again, it's just another episode of you describing that most surgeons -- most of the time the surgeon will not be aware that he has caused a bile duct injury. And I think you've already said you agree with that. And that just makes -- that makes sense.

In terms of pathology reports, and looking at what a pathologist describes as cystic duct or hepatic duct, common bile duct, your experience is that in looking at hundreds of these cases that pathologists don't go to the depth of saying, oh, I saw a hepatic duct, a bile duct and a cystic duct; correct?

A. Correct.

Q. All right. And that's -- just so we have it, that's what's in Exhibit 19, if you look at page 37 there.

If you recall, because a defense -- a

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lawyer representing a doctor was saying, well, gee, Dr. Schirmer, how can you say this wasn't the -- how can you say that this was a part of the hepatic duct when the pathologist doesn't even describe it as such, and you said basically pathologists don't do that --

A. Yes.

Q. -- correct?

Okay. And Exhibit No. 24 is very similar testimony --

A. Here's 20. You handed me 19 and 20, so here's 20.

Q. And you know what? I'm screwing up here, so let me do this...

All right. And Exhibit 20 then is from the Jennifer Sullivan case, again, page 35 and 36 where you said, and I take it you still agree, that the pathology report never identifies the common bile duct.

A. I just said I have never seen a pathology report that commented -- even when retrospectively we know --

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Q. Right.
A. -- what happened, they have never -- you know, looking back at what they described, they have never described that.
Q. Now, this is an old deposition. It's from over ten years ago. Is that still the case today? I mean, when you review these cases, these gallbladder removal cases, do you see pathologists making that differentiation?
A. No. I've never seen that.
Q. All right. Now, when we talk about -- in medicine and in surgery, when we talk about something being a complication of surgery, you would agree with me that that doesn't tell us anything about whether or not if a patient suffers that complication it's because of negligence or not; right?
A. Right. In other words, I don't think they all speak for themselves.
Q. Well, I wasn't asking that. I'm asking, oftentimes, as you know, somebody will say, well, Dr. Schirmer, tell me what -- tell me what you tell

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your patients when they are undergoing this surgery, and you tell them the list. You could die, you could bleed, you could get an infection, you could get a bile duct injury, you could drain bile. You go through that list; and you have made the point over and over again that just because we say something is a known risk or a known complication does not mean that because it happens, it happens without negligence?
A. I -- I think I understand what you're saying, and I think -- correct me if I'm wrong -- you're saying that because we know something is a complication doesn't address whether that complication was the result of the normal course of events or whether it was a result of negligence. The fact that it's a known event doesn't make --
Q. Right, right. So it's just like, you know, running -- running through a green light, a complication of that or a known risk of that could be getting broadsided, but that doesn't tell you anything about whose fault the accident is; right?
MR. DONNELLY: Object to the form.

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MR. GLASS: I'm winging it --
THE WITNESS: A green light? That's okay.
MR. DONNELLY: That's my issue too.
BY MR. GLASS:
Q. So Exhibit 21, for the record -- well, right, no. You can go -- you drive your car through a green light. A risk of driving your car through a green light is you get broadsided by someone who's careless; right?
A. Yeah, I suppose that true.
Q. Okay. 21 is, again, from the trial testimony in the Linda Bailey case, just where you're describing at page 39 and 40, this point -- you're making this point. Complication is an unintended bad outcome so it's a complication, but that doesn't -- you said saying something is a risk or a complication or a recognized complication says nothing about whether the complication was a result of acceptable practice or unacceptable practice. And you still agree with that point --
A. Correct.
Q. -- right?

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And Exhibit 22, which is from the Lumpkin case, at page 175 and 176, you -- my question is: You make that point in that case?
A. Correct.
Q. And in Exhibit No. 23, on page 35 in a case called Carmen Jordan-Pereira, P E R E I R A, you make that point again on page 35.
A. Correct.
Q. You would agree, as a matter of anatomy, that the common duct and the cystic duct look identical?
A. They can look identical. They -- they can have a very similar appearance.
Q. Sure. So that's -- Exhibit No. 24 was, I think, deposition testimony in the Cotner, C O T N E R, versus Dr. Brightwell case, and it's on page 41, if you look at the paragraph that starts at line 5 down to line 10 where you said you can't tell the difference. They look identical. It's as simple as it is.
A. Correct.
Q. Do you still agree that a bile duct

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transection occurs in one out of every 1,000 to 2,000 operations, which is testimony you gave in the Huffman deposition? H U F F M A N, that's Exhibit 25. Is that -- is that statistic correct?

A. I think that's fair, that it's in about that range.

Q. I know as of the latest deposition I could find of you that you are still batting 1,000 and have had no bile duct transections in your operative course. Is that still true as we sit here today?

A. Correct.

Q. Do you still agree that most injuries to the common bile duct in this surgery are avoidable? And that's in Exhibit 26 at page 28, which is the Anna Barry case.

A. Well, I agree that I think the statistics speak to that, that most of the time you do gallbladder surgery, there won't be such a complication. So -- and -- and I say most -- or most injuries are avoidable. The way we avoid them is by understanding the conduct of the operation. So, yeah, I agree with that.

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Q. Okay. And do you still agree that most common bile duct injuries are avoidable by adhering to the general guides and principles? That's from Exhibit 27, the Lumpkin case, at page 186 and 187.

MR. DONNELLY: And I'll just take this time to, once again, object on the record --

MR. GLASS: Sure.

MR. DONNELLY: -- to have a continuing objection that all of this is way beyond the scope of his designation. I'm going to allow you to go ahead and go through your exhibits since you --

MR. GLASS: I worked so hard on it.

MR. DONNELLY: Exactly, since you worked so hard.

MR. GLASS: And I do think, though, that it goes to his experience and his credibility as a witness and all those things. But I understand your objection.

MR. DONNELLY: All right. And it also would completely eviscerate the John Crane decision if we're going to designate witnesses on one subject matter and then be --

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MR. GLASS: Well, let's not argue.

MR. DONNELLY: -- examine them on the other.

MR. GLASS: We all want to get out of here at some point.

BY MR. GLASS:

Q. I think that my question was on this exhibit, you still agree that most common bile duct injuries are avoidable by adhering to the general guides and principles of safe gallbladder surgery; right?

A. Yes.

Q. Now, in this case, do you agree that the common hepatic duct was removed in Dr. King's surgery?

A. I believe that what was found in the subsequent operations, that would be correct, yes.

Q. All right. And it's true, as a matter of physics, I think, that in order to get to the gallbladder, the cystic duct and to remove a portion of the common -- to remove the common hepatic duct that it means that duct -- that the common hepatic

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duct has to have been cut twice?

A. Correct. Yes.

Q. All right. So in this case there's a cut of the artery, the cystic artery; correct?

A. There were clips on -- I believe it may have been a branch of the right hepatic artery that --

Q. I'm not asking about clips. I'm asking about getting the gallbladder out.

A. Oh, yeah.

Q. He had to have cut the cystic artery, one cut; right?

A. There is a -- you have to divide the artery to get the artery of the gallbladder --

Q. Right. Divide means cut in layman's terms?

A. Sure.

Q. And then there are two cuts -- two more cuts in this case to the hepatic duct, the common hepatic duct?

A. There -- well, yeah, the common bile duct. The branches coming out of the liver were divided

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and there appears to be a division down at the common bile duct level.

Q. Right. So three cuts total in this case?

A. The duct -- that's, I think, the anatomy from what I can gather, yes.

Q. I agree with you. I heard differently a week ago in Roanoake. So -- but I think that you're right on that. And just for the record then, Exhibit No. 28 is your testimony in the Cotner case on that subject. When a piece of the common bile duct is missing, it means it was cut twice. I think you just --

A. Right, yes.

Q. -- affirmed that.

All right. One of the safe techniques is identifying the triangle of Calot. And I don't need you to tell me what it is unless you want to, because I've read it. But do you still agree that in every gallbladder operation, we dissect the triangle of Calot? And I'll refer to you Exhibit No. 29 at page 40, which is from the Cotner, C O T N E R, case.

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A. And I clarified here. I'll make sure it's -- because that's what I've said, is that we don't fully dissect it out, but we dissect sufficiently to identify the structures. Because I said when it's not possible to fully dissect it out, that's where a cholangiogram, so --

Q. Right. But to be really, really clear, you said in this case, page 40, line 9, in every gallbladder -- every gallbladder operation we dissect the triangle of Calot. That's a principle of safe gallbladder surgery is that it's clearly dissected. You then get into a discussion about whether it's fraught with risk. And then line 18, the purpose of doing a full dissection is an effort to give us a visual confirmation of our anatomy. You also talked about a cholangiogram. But this was testimony that you --

A. Correct. I just want to make sure that that fully -- I want to make sure it's understood. Fully means each of the structures are fully appreciated. And there's a difference between -- and I've said in other depositions --

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Q. You have.

A. -- it doesn't mean going corner to corner to corner of the triangle, those words "fully," you know -- as opposed to only identifying two of the three structures; so, you know, a triangle is three. And so when I say "fully," you -- what I'm referring to there and trying to clarify is identifying the three arms as opposed to just one or two or -- you know, that's what I mean by fully.

Q. Right. And --

A. As opposed to, again, the triangle -- you know, the corner to corner to corner so that's --

Q. And, again, I'll tell you, I think you've been fully consistent all of these years in that -- in that a surgeon doing this surgery, in order to do it safely, you must identify the cystic duct, the cystic duct artery and the common hepatic duct; right?

A. Correct.

Q. And you must identify the common hepatic duct by visualizing it or proving it on cholangiogram; correct?

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A. To be a separate structure, yes, I agree.

Q. To be a what?

A. To be a separate -- a separate ductile structure from the cystic duct.

Q. Exactly. And seeing it on a cholangiogram means it's lit up on the cholangiogram; right?

A. Correct.

Q. And exhibit 30 is from the Gloria Harvey case. Again, at 71 and 72, you make that point, you must account for the structures of the triangle of Calot, account for them. You must visually identify them through dissection.

I understand your testimony about not dissecting to the edges of the triangle. I get that. But you agree -- you still agree that you must account for the three structures and visually identify them through dissection. And I guess you would add or cholangiogram if you -- if it's impossible to identify it through dissection; right?

A. Right. And I should -- I want to -- we talked earlier about the other -- the other techniques, the -- that get to the same point of the

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critical view of safety, which is what's talked about in the SAGES guidelines where you basically elevate and suspend the gallbladder by two and only two ductile structures, and that's also a good and reasonable way of doing it. So --

Q. Right.

A. -- of doing that, meaning safely -- safely identifying two and only two structures and then reasonably presuming those to be the cystic duct and the cystic artery. So...

Q. Right. Do you recollect that that's exactly what Dr. Linda Bailey testified she did in the case where you testified against her at trial? And I've got her deposition, you know.

A. Yeah.

Q. I don't want to -- I don't want to be unfair with you, but she described that exactly in that case. And you said she was wrong.

A. Because she didn't -- she said she did, but when -- in her deposition, if I recall correctly, and even if she didn't -- she said she did it, but she didn't because she couldn't even

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describe that in her own deposition when given a chance to say what is that technique. And, I mean, I remember in general that that's not what -- you know, despite saying I did that, she didn't do that. It was evident.

Q. What do you recall that she failed to do even though she said she did that?

A. I --

MR. DONNELLY: I'm just going to object to the form --

A. Again, I don't -- I want to be careful, and, again, I'm -- this is over a year and a half ago, but I don't know that she separated the gallbladder from the liver bed, which is a necessary part of that technique. It's not enough to say I saw a couple of structures that appeared to go to the gallbladder, and I think that's what she -- and she described that as a critical view. And I think some people do use -- you know, they -- if you -- if they don't -- they say, I had a critical view. I had -- I think she said, I had a critical view, but the "critical view of safety" is -- in quotes is a

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label given to a technique that has multiple steps, and she didn't follow all those steps. She -- I think she just said, I had developed a critical view, and it was a matter of maybe definitions and -- because she didn't do as described in the SAGES guidelines, by the author of those, that technique.

Q. Exactly. And that's what you look for when you're evaluating these cases on a standard of care basis, again, looking at the operative report, looking at the physician's deposition. Even if they said they did, I looked at the triangle of Calot, you look to see, did you really. They say, I got a critical view. You look to see, do you actually even understand what critical view is, and did you do it; right? And if they didn't, then you've testified at trial and deposition that they violated the standard of care; right?

A. Correct.

Q. Okay. In fact, do you still agree that the standard of care requires a surgeon to identify the triangle of Calot? That's Exhibit 31 at --

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at -- excuse me, Exhibit 31 at -- looks like at page 31.

MR. DONNELLY: Same objection.

A. By itself, this is confusing, you know, without the pages that lead up to it. So --

Q. I can show them to you. I'll tell you that what happened in that case was the defendant -- the defendant made some statements in his deposition where he said, no, the standard of care does not require you to identify the triangle of Calot. And you were reading that and you said that's -- I disagree with that. I think the standard of care does require that.

In any event, as I understand --

A. That one makes more sense because it's in quotes and I was thinking --

Q. Yeah, that wasn't you. You would never say that; right?

A. Yeah, that makes more sense.

Q. Yeah, okay.

And you've testified -- again, this is from the Jordan-Pereira case -- it's a deviation

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from the standard of care of the requisite steps toward identifying the anatomy are not done. It's at page 53.

MR. DONNELLY: Same objection.

MR. GLASS: Yeah, okay.

A. Okay.

Q. Let's see. I'm going to just skip, just for the record, so that we don't get confused later, Exhibits 33, 34 and 35, just because they are more of the same on the triangle of Calot, and I'm going to honor your time.

If you want, I'm happy to give them to you.

MR. DONNELLY: No. You can keep them. Thank you for the offer.

MR. GLASS: Yeah.

BY MR. GLASS:

Q. In Exhibit No. 36, which was, again, testimony in the Gloria Harvey case, at page 74 -- this is where I got that language about a transection speaking for itself. So let's look at that, page 74. You're talking about the common

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hepatic duct, and you say, he wouldn't have cut the wrong structure had he done that, which is, he positively identified the structure; and so in some ways, it speaks for itself that he didn't identify it.

Do you remember that?

A. Well, yeah. In this context I'm answering a specific --

Q. Uh-huh.

A. -- I think I'm trying to, again, respond to what maybe what was said by someone else, either in their deposition, and I -- and I said in this case -- let me see my previous answer is -- and I'm saying "Someone else said I positively identified that structure," and I said that would be fine. But I'm not sure he did, because had he, then he wouldn't have cut the wrong structure. So in this case, it speaks for itself, that what he -- what he positively identified, he didn't, which is -- again, in this case, I'm trying to explain an answer or, you know --

Q. Right.

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A. -- answer another question. Yes, I agree with what I say here.

Q. If we look up on 73 what you all you were talking about was the junction of the cystic duct and the common duct. And you said, had he actually seen that junction -- this is now on page 74, line 13 -- he wouldn't have cut across the common bile duct as he did.

A. Correct.

Q. So is it your view then that if a surgeon does cut across the common bile duct, it means -- that necessarily means that he did not visualize, either with his eyes or with the cholangiogram, the common bile duct?

MR. DONNELLY: Object to the relevance.

A. I don't think you would -- a surgeon would intentionally transect the common hepatic duct. I -- but what you said right at the beginning of this is that it speaks for itself, that such injuries are the result of negligence. And I don't agree with that. There are times when, by virtue of the degree of inflammation of the gallbladder to

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adjacent structures, that in the course of developing anatomy or even removing the gallbladder after having properly identified ductile structures, one can still injure and even transect the common bile duct without deviating from any standard of care as part of a difficult surgery.

So that's why I've always said they don't speak for themselves. And I've defended cases where I believe that to be the case, where the anatomy was correctly identified, but in the course of removing the gallbladder, complications, including ductile transections, have occurred, because it wasn't a anatomic misidentification that got the surgeon and the patient in trouble, it was the severity of the inflammation.

Q. Uh-huh.

A. So you can have ductile transections by not -- by improper anatomic identification and also ductile transections and injuries by virtue of challenging dissections.

Q. In the severe inflammation cases that you just referred to, have you then seen not just

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ductile transections, but removal of a portion of the common bile duct which you've already said necessitates two cuts?

A. I have seen complex injuries, I guess, you know. We refer to them often as tangential injuries where the gallbladder might be stuck to that -- that area, the area that is the common hepatic duct courses. And in coming around the gallbladder, the complex ductile injury occurs. It's different than, you know, the two clips or the two points of division. But I've seen high hilar common hepatic ductile injuries that I think develop as the result of inflammation and adherence of the gallbladder to that neighborhood.

Q. What's the sort of description in an operative note that would describe that level of inflammation?

MR. DONNELLY: Same objection.

A. Such -- those injuries often occur in the presence of acute cholecystitis or chronic cholecystitis with thickening of the tissues and dense scar tissue, either one of those.

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Q. Okay. So just for the record, I'm going to take out 37, 38 and 39, because I think we've made those points.

Do you still agree it's not good judgment for a physician to say, I never did see or account for the common hepatic duct? And the reference is in Exhibit 40 at page 77, which is from the Jordan-Pereira case.

MR. DONNELLY: Same objections. Relevance.

A. I would agree with that.

Q. All right. You have -- would you agree that you have been critical of physicians over and over who have not adequately identified the common hepatic duct in surgery?

MR. DONNELLY: I'll object to the form.

A. I -- you know, there have been several cases where I've been critical of that, yes.

Q. Several. More than several; right? I mean, that's been with one of the principal -- hasn't this been one of the principal criticisms in cases, Dr. Schirmer, where you have testified at

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trial or deposition under oath of a physician who gets a major biliary injury in a gallbladder case that they did not describe identifying the common hepatic duct?

A. Or make -- through dissection of their efforts follow the steps that would hope to safely avoid the ductile injury.

Q. Right.

And my question is: Hasn't that been a common theme of testimony you have given in cases like this, gallbladder removal cases?

MR. DONNELLY: Same objection. Relevance, beyond the scope.

A. Yes. It's, to me, just echoing those -- that belief, yes.

Q. Okay. In this case, do you agree, based upon your review of the operative note and Dr. King's deposition, that he did not visually identify the common hepatic duct?

MR. DONNELLY: Object to the form. Beyond the scope of his designation.

A. I -- I will -- whatever he said, he said.

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I'm not going to try to -- whatever he said speaks for itself.

Q. Okay. So you'll agree that whatever he said in his operative note and his deposition speaks for itself; right?

A. Yeah. And I am not going to argue with what he described and what he said in his note and deposition.

Q. Do you -- well, let's go back to my question. Do you agree that he doesn't describe anywhere? In fact, he says the opposite, that he didn't visualize the common hepatic duct in the surgery? Do you remember that from reading his deposition?

MR. DONNELLY: Same objection.

A. Again, I don't remember that, but I don't debate that he said it.

Q. Okay.

A. If he said it, obviously, he can defend that aspect of his care.

Q. Fair enough.

Just because a surgeon has done thousands

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of these doesn't necessarily mean they can't be careless in one of these surgeries; right?
MR. DONNELLY: Same objection.
A. I would agree with that.
Q. Dr. Bailey, who you testified against in January of 2014, had done almost 4,000 of these laparoscopic gallbladder removal cases without incident --
MR. DONNELLY: Same objection.
BY MR. GLASS:
Q. -- until this -- until the one you've testified in. Do you remember that?
A. I -- again, I don't remember the records in that detail; but if that's what they say, that's -- I won't disagree.
Q. Okay. I think we made this -- you still agree that a short -- if a patient has a short cystic duct, that really doesn't -- that's not -- that's not an excuse for taking out part of that common -- taking out part of the common hepatic duct; right?
MR. DONNELLY: Same objection.

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A. In general, yes, I agree with that.
Q. And the same thing, if it's not short, but it's absent, if it's -- what you all call -- do you use the term "absent"?
A. Absent or -- yeah.
Q. Right. That that's something that a physician should know can happen, and that these techniques we've been talking about help that physician identify that; correct?
A. Correct.
Q. And sometimes you doctors use the phrase or the term "aberrant anatomy"?
A. Yes.
Q. What does aberrant anatomy mean to you?
A. It's -- aberrant is, I think, something other than the norm, other than the normal. So, you know, if it's -- either something is a normal configuration or it's outside the norm.
Q. Would you agree that aberrant anatomy does not mean abnormal anatomy, period? It's a variation of normal?
A. Yes. I mean, I guess -- trying to talk

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about definitions. But aberrant, meaning other than the normal configuration, I think that's that 40/60 thing we talked about earlier.
Q. Yeah. It's interesting, because 60 percent can be "different from normal"?
A. Well, here's -- yeah, there's the most common and then there's variations on that, so...
Q. Gotcha.
Do you still agree that a cholangiogram is extremely helpful and rarely misleading in these surgeries?
MR. DONNELLY: Same objection.
A. Yes, I agree with that.
Q. Do you agree that -- do you still agree that a cholangiogram is required under the standard of care when the physician suspects there may be a stone, a cystic duct stone?
MR. DONNELLY: Same objection.
A. It's -- I don't know. Maybe I stopped short of saying it's a requirement. I think if -- there's more than one way to assess that, but cholangiography is -- is one of the ways to assess

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that.
Q. Do you still agree that a -- the performance of an intraoperative cholangiography is reserved for two general situations? One is when there's suspicion of bile duct stones and the other is when you have difficult anatomy?
A. Yes. I'd probably elaborate on that and say --
Q. Uh-huh.
A. -- when you have a suspicion of bile duct pathology, stones or strictures or tumors or other things -- in other words, that's a -- cholangiogram is a useful fool for assessing the anatomy of the bile duct if you have concerns. That's one. And then the other category is if, in the course of an operation, you can use it to help clarify anatomy.
Q. Right. But a cholangiogram is -- is required in the standard of care when you have elevated liver function tests, you suspect there may be a stone in the duct; right?
A. It's -- again, I stop short of saying it's a requirement, because there are other ways of

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assessing that potential preoperatively other ways.
Q. Sure.
A. But it's a -- if -- and there are other -- so I wouldn't say in every case of a gallbladder surgery, every time you operate on someone's gallbladder who has abnormal liver function tests, there's a standard of care requirement to do a cholangiogram. I wouldn't want to say that. But --
Q. Because there's other things you can do?
A. Right, and there are other potential explanations -- plausible explanations for the liver function abnormalities that may already be known. But if -- you know, it's a very useful tool for identifying what we call filling defects in the ducts. Among those are stones. They are not always stones. There are other --
Q. You said stones?
A. Stones, tumors.
Q. Tumor.
A. Strictures. And then there's a variety of bile duct pathologic conditions that will present as abnormal with elevated liver function test and

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abnormal cholangiograms, so...
Q. Okay. But stones, tumors and strictures can occur anywhere along that path from the -- from the liver down in the biliary tract and from the gallbladder over in the biliary tract; right?
A. Well, the -- yes. I mean, the cholangiogram is designed to look at the bile duct from the duodenum into the liver, so that -- it's not looking at the gallbladder.
Q. Correct. Right. But it is -- it is -- a cholangiogram is designed to look at that biliary tract or path from the liver to the duodenum, that -- my words -- "highway"; right?
A. Correct.
Q. And these stones, strictures and tumors can occur anywhere along that highway from the liver to the duodenum; right?
A. Correct.
Q. And can cause elevated liver function results; right?
A. Correct.
Q. And one of the -- I think what you just

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said is one of the tools a physician has then to investigate elevated liver function results is cholangiogram?
A. Correct.
Q. Which is an x-ray. And we all know it's an x-ray of the biliary tree?
A. Correct, with contrast. Yeah.
Q. And do you still agree that if you're doing a cholangiogram to look for stones that, as a matter of anatomy and science, you can still learn a lot about the anatomy because the cholangiogram is the same cholangiogram you would do if you had difficult anatomy in the surgery; right?
A. Correct.
Q. It's the same technique?
A. Yes.
Q. I think we talked about this earlier, but a normal cholangiogram is one that lights up the entire biliary tree? And that's language you've used in the past.
A. That is part of it, yes.
Q. Right. So you see the right and left

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hepatic ducts, the common hepatic duct, the bile duct or the common bile duct, I guess you call it, down to the duodenum; right?
A. And -- and flow into the duodenum.
Q. Right.
A. And absence of filling defects, including stones, stricture or tumors.
Q. So a cholangiogram that doesn't light up the entire biliary tree is an abnormal cholangiogram as a matter of science; right?
MR. DONNELLY: Object to the form.
A. It doesn't -- well, it could either be abnormal because there's abnormal pathology or incomplete because it wasn't -- it didn't completely fill the ductile system.
Q. Right. And if in doing these surgeries, if it doesn't completely fill, there could be a number of reasons for that; right?
A. Correct.
Q. And it's incumbent upon the physician to make sure it's not because he's about ready to transect the common hepatic duct; right?

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A. That's among those, yes.
Q. Yeah. And that would be like the most important reason to prove to yourself -- if you don't have a normal cholangiogram, to prove to yourself that it's -- that you can make it normal; right? Does that question make sense?
Let's -- let me ask it a different way. The worst thing that can happen if you operate in the face of an abnormal cholangiogram is you're going to injure the common bile duct/common hepatic duct; right?
A. Well, there's worse things that can happen. But I guess the --
Q. From that, though, really --
A. Well, no, I mean -- I'm just speaking in broad terms --
Q. Right.
A. -- that -- and not all abnormal cholangiograms are because of anatomic abnormalities. We talked about normal means, you know, the complete visualization, the normal flow into the duodenum, which is part of it, and the

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absence of filling defects. And so there's all kinds of things that are abnormal that you want to -- that the purpose of cholangiogram is to identify those abnormalities and then hopefully perceive and, you know, recognize the abnormalities.
Q. Right. And if you're doing this surgery and you get a cholangiogram that's not lighting up the entire tree, you've got to figure out why; right?
A. Right. Well, you just said if it's abnormal. But there's a lot of reasons. I just -- you know, there's a lot of reasons it could be abnormal.
Q. I think we're on the same page. Again, Dr. Schirmer, I think you've been entirely consistent for 20 years on this -- on this -- these topics.
When a surgeon does a cholangiogram because of elevated liver function results, it's incumbent upon the surgeon to look at the entire cholangiogram; right?
MR. DONNELLY: Same objection.

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A. I would -- I agree with that in general, yes.
Q. Yeah. And I'll just -- for the record, we'll -- I'll give you Exhibit No. 73, which was a certificate of merit, I think, in a case called the Huffman case. And I'll give it to you -- which, I mean, you said exactly that. It was a case in -- I guess it's in Ohio, Butler County.
You make that point exactly, that if you get a cholangiogram for elevated liver functions, you've got to look at the whole thing. It's incumbent upon the surgeon to do that because a cholangiogram is a great tool for a safe gallbladder surgery; right?
A. Correct.
Q. Okay. Okay. Let's talk about this -- this case, what maybe you're here for.
Here's the cholangiogram from this case. And, first of all, would you agree with me that it's an abnormal cholangiogram?
MR. DONNELLY: Object to the form of the question.

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MR. GLASS: Can you get that cholangiogram on the --
MR. DONNELLY: Same objection.
MR. GLASS: Sure.
A. It's -- I'd call it abnormal in that it's certainly incomplete in terms of identifying the entire biliary tree.
Q. Right. And so, actually, I've got a marker. If you could just mark a couple things for us.
So do you see the cystic duct?
A. No.
Q. All right. So on this cholangiogram, the cystic duct is not seen separate and apart from the common bile duct/hepatic duct; right?
A. No, I don't see the cystic duct.
Q. Okay. And, of course -- I think of course, because I've been in this case a long time, but the hepatic -- the common hepatic duct is not seen here; correct?
A. Correct.
Q. And the right and left hepatic duct is not

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seen here; right?
A. Correct.
Q. And this is kind of the classic cholangiogram, isn't it, of an -- in gallbladder surgery that says, gee, if I keep doing this operation, I'm going to injure the patient?
MR. DONNELLY: Object to the form.
A. Yeah. I don't know exactly the way you said that, but it's an abnormal cholangiogram.
Q. I mean, in your world, in the doctor's world, don't you guys call this cholangiogram of doom. You ever heard that phrase?
MR. DONNELLY: Object. Object to the form.
A. I've not heard that phrase.
Q. Okay. If you were proctoring a young surgeon and you're there side by side and you're doing -- he's doing a gallbladder surgery and he gets this cholangiogram, you don't tell him, proceed; right?
MR. DONNELLY: Object to the form.
A. I would say there's more to do.

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Q. Right, there's more to do. He has to prove -- or discover, I guess, is a better word -- why this cholangiogram isn't filling in the cystic duct and it's not filling in the hepatic duct; right?
MR. DONNELLY: Same objection.
A. Yeah. Primarily why it's not filling in a retrograde fashion up into the common hepatic duct.
Q. Right. I mean, that's a -- my words -- it's a classic stop sign in these cases, isn't it?
MR. DONNELLY: Object to the form.
A. I guess those are your words.
Q. Yeah.
A. I'm not going to disagree.
Q. You won't disagree. I know you won't, because you've been consistent. And everybody I talked to said you are a straight shooter.
And you would agree, I think, that the cholangio catheter is in the common bile duct?
A. It appears to be, yes.
Q. Right.
And the object in these cases is to get it

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into the cystic duct, shoot the dye in, see the cystic duct separate and apart from the common duct/common bile duct; correct?
A. Correct.
Q. And even if the cholangiogram is, again, shot for elevated liver function results, it just doesn't matter. You've got to look at the whole thing; right?
MR. DONNELLY: Same objection.
A. Yes.
Q. Okay. All right. What do you think the injury was as of the time Dr. King's surgery is over?
A. I -- well, I think, just, you know, going from what was discovered later, it appears that there was -- that there were clips on the common bile duct lower, and that later, meaning at subsequent operations, the common hepatic ducts or the right and left hepatic duct coming out of the liver were transected. So there is likely that missing a segment of bile duct taken or resected during the operation. Whether or not the status of

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the ducts at the level of the liver -- I don't know what that was. I mean, I -- Dr. Gerber and his -- who operated said that, and I would agree with him, you don't know by seeing something sometime down the line whether -- whether those ducts were initially clipped or whether they were simply transected. And you can have ducts transected and some of the techniques actually coagulate -- like we coagulate vessels, we can coagulate ducts.
Q. Sure.
A. So I don't know, you know, exactly. I just -- I know the levels of the injury, but whether -- you know, what it exactly looked like at that time, I don't know.
Q. You -- you know that there is an important phone call five days postop; correct?
A. Correct.
Q. Let me ask you before I get there: Have you ever heard of anything in your world, gallbladder removal surgery, that would suggest that while bile is festering in and around the -- where the common hepatic duct has been transected that the

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bile is eating away at the common hepatic duct and eating its way into the right and left hepatic duct?
A. I would not agree that that even happens. The bile doesn't do that.
Q. Right. And that's bad science for someone to suggest that bile moves up and destroys ducts; right?
A. It sets up inflammation.
Q. Sure.
A. But it's not -- it's -- inflammation is inflammation of the surrounding structures. It wouldn't be digestion.
Q. Right. That's crazy?
MR. DONNELLY: Object to the form.
BY MR. GLASS:
Q. It's not science, is it? It's not good science for a doctor to say that; right?
A. I -- it's my understanding -- I know what it does. I've seen it. It causes inflammation.
Q. Sure. Okay. So let me ask maybe a better question. Do you agree that what Dr. Gerber found in terms of the -- sort of the level or, you know,

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where the right and left hepatic ducts were cut or divided that that is what existed at the end of Dr. King's surgery? Does that make sense to you?
A. Yeah. And I think Dr. Abrams -- the operation -- the one operation, I think it was Dr. Abrams who operated --
Q. He did the first one, right.
A. Yeah. I think that's what he found, and he didn't do anything to alter that. So I think it's likely that the level of injury identified during the first operation is -- and later by Dr. Gerber is the -- probably the level that the ducts were injured at the -- during the gallbladder operation.
Q. Uh-huh. Right. And do you believe that she was draining bile from the end of Dr. King's surgery?
A. That can't be -- that's not clear.
Q. Okay.
A. And it doesn't always happen because there are ways of transecting ducts that will cause them to temporarily coagulate, fuse. Just like we do

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with vessels, we coagulate and close vessels. They divide. Most of time that stays that way. Sometimes they can open. So I don't know. I don't know if it start -- if the bile started leaking or was leaking immediately or whether it started leaking later after the coagulum that holds that together fell off.
Q. That makes sense from a scientific standpoint. Do you -- it makes sense to me and I'm just a lawyer.
Do you think that in any way there were clips on the common hepatic duct remnant that fell off sometime after surgery?
A. That could happen. I mean, that's -- the clips fall off. We know the most common bile leak issue we have after gallbladder surgery are clips that we place on the cystic duct that fall off, so that's far -- that happens in a couple percent of the operations we do. So we do know that clips applied can later fall off.
Q. But --
A. I don't know in this case whether that

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happened.
Q. Yeah. I want to ask you, because there was no common hepatic duct remnant in this case; right? Once Dr. King closes, the common hepatic duct is gone. And she has very, very short right and left hepatic duct remnant; right?
A. Correct.
Q. Okay. So as I understand it then, you're saying it didn't really matter to the patient whether she was seen on day five or not; right?
A. I -- well, I believe the damage was done, and that by day -- postoperative day five --
Q. Uh-huh.
A. -- that injury was the same as was found later, and it didn't change or evolve further; and that the corrective surgery that was required would have been required had it been -- had the injury been discovered on postoperative day five or day twelve or at any time going forward.
Q. Right.
A. That the injury was -- the damage was done and that there was a reconstructive surgery

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necessitated by that, and it would have been the same whenever discovered.

Q. Yeah. So the major injury, the damage to the -- to the highway, right, the biliary highway is done. But she's draining bile at some point, right, into her -- what's that, the peritoneum?

A. Yes. The peritoneal cavity, yes.

Q. And that's going on by day five; right?

A. I would -- I would guess. I mean, again, that can't even be said with certainty. But I wouldn't be surprised if it wasn't going on day five.

Q. And you know the standard in these cases is not beyond a reasonable doubt, but it is within a reasonable degree of medical probability; right?

A. Yes. I --

Q. So -- so not guessing and not saying beyond a reasonable doubt, as I understand what you just said, in your view, more likely than not, within a reasonable degree -- reasonable degree of medical probability, as of day five, she's draining bile?

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A. I -- that would be my guess in this case, yes.

Q. All right. And so that's -- and that's causing her some injury, even if the major injury -- the major repair is going to be the same, she's being injured, right, because she's got bile that's draining into her peritoneum causing scarring; right?

A. It causes inflammation...

Q. Yeah, it's not good. It's damage; right?

A. It's -- yeah, it's inflammation.

Q. Yeah. And if a patient like that comes to you on day five or day six, you're not going to say, wait ten days, let's see what happens; right? You're going to -- you're going to intervene somehow?

A. Well, the first thing you do is try to figure out what happened --

Q. Yeah.

A. -- what it is, you know, what's the injury. And then you try to tailor a treatment for that injury, whatever that happens to be.

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Q. Right. So including, you know, okay, let's get her in the hands of a great hepatobiliary surgeon if we can; right?

A. Well, I mean -- that's -- I don't know about -- that's not a standard of care --

Q. No, I didn't ask that. But that's what you would do; right? You would -- you would try and find the best surgeon you could. And maybe that's you. I think you've done a lot of these; right?

A. I would manage it myself.

Q. Yeah, you would do it yourself. And you would give her some -- you would at least give her some medicine; right?

A. Well, you -- again, you try to investigate what it is -- again, what it is and this -- whatever case it is and then try to tailor a treatment for whatever that is.

Q. Right.

A. It's there's so many possibilities.

Q. Right. Sure. And if you think she's draining bile, then she's likely to have pain from that; right?

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A. It causes pain, yes.

Q. You're going to take care -- you're going to try to make her feel better at the very least; right?

A. Sure.

Q. Does the fact that it's draining bile from day five up until the time of Dr. Abrams' surgery make his surgery any more involved or difficult?

A. I don't think so.

Q. Okay. You don't look at what Dr. Abrams did and say he violated the standard of care; right?

A. No.

MR. GLASS: Okay. If we can go off the record, just give me a minute to look at my notes.

THE VIDEOGRAPHER: One moment. Off the record at 1758.

(Recess taken.)

THE VIDEOGRAPHER: On the record at 1802.

BY MR. GLASS:

Q. I know you haven't seen the patient in this case, but what do you think her course will be from here?

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A. My understanding -- well, what happened from the records is she had the repair. She did later go on to develop a stricture that was treated with stenting -- dilatation and stents. The statistics on that are that she has about a two out of three chance of being done, that no further intervention should be required; about a one out of three chance that a similar stenting procedure would be necessary in the future.

Q. If she has a similar stenting procedure, does that change statistics for her going forward? Is that -- is that an indication that she may need more frequent stenting?

A. Again, it depends -- some -- there are -- I don't want to just say something. We have hunches on that, but the data are basically the two-thirds success rate of being no further intervention. There are -- those who fail might have an underlying reason that they fail and therefore might be in a statistically more probable group to have -- you know, to fail a second or third or fourth time. So it depends on the etiology of the stricture. And

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once it plateaus, it tends to plateau. Once -- you know, once the scar tissue settles and forms, it tends to stay. It depends on why it's formed in the first place; blood supply issue, other things like that.

Q. She was stented and then they removed the stents, I think.

A. Yes.

Q. Why do they do that?

A. Why do they remove the stent?

Q. Why do that? Yeah, is that part of the normal --

A. Yeah. That's normal.

Q. If someone gets a stent from this, then at some point later, they are going to get the stent removed?

A. Yes.

Q. Why is that?

A. Stents -- you don't want to leave stents in indefinitely. They have -- they can cause problems. They can clog. They can fail to work.

Q. Uh-huh.

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A. They can erode through structures. It's foreign material. But the purpose of the stent is to, in general, identify the narrow spot to open it --

Q. Uh-huh.

A. -- and then a new scar forms around the stent. The stent sort of is the limiting size of the scar. You want to leave it in long enough for new scar tissue to form and you know you have a defined caliber or diameter, so you say, okay, we know that the diameter of the new scar will be about this (indicates). You leave it in for several weeks until that scar forms and you remove it and hope that the scar stays about that size.

Q. Okay. So what's the procedure, very briefly -- because it's getting late -- for the stenting? Is it done under anesthesia? Is this a radiology -- is this interventional radiology?

A. It's an interventional radiology, yes.

Q. Okay.

A. The patient might be sedated, but not necessarily put to sleep.

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Q. Okay. And on the reverse, taking it out, is it -- is it basically the same thing, just in reverse, interventional radiology?

A. No. The taking out is much simpler than the putting in. The putting in is more involved. It requires, you know, a needle and cannulating and putting the catheter -- taking them out is something you can do in the office.

Q. When you -- okay. That's interesting. You have the vessel so you have the duct. I'm going to show my ignorance now. Is the stent going around the outside of the duct or is it intralumenal?

A. Intralumenal. You try to go into the lumen of the duct. You bridge --

Q. Uh-huh.

A. -- the stricture is the narrow spot --

Q. Right.

A. -- between the duct and the bowel that is sewn up to it. You want to -- first a wire goes through that. Once you get a wire to go through there --

Q. Sure.

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A. First, the radiologists cannulate the duct and squirt dye and define the anatomy, and then through that needle that they have done that, they pass a wire and try to get the wire to go through the stricture. Once a wire goes through the stricture, you take the needle off and then you put a stent over the wire until it goes all the way in and goes across the bridges, the stricture.

Q. Okay.

A. So part of the stent is in the intestines, the reconstruction, and part is in the liver. And there are side holes, so now bile can get through all that and flow through the duct, through the stent until the new scar forms.

Q. So the radiologist must be poking a hole in someplace.

A. Correct.

Q. With what? Is it a catheter of some sort?

A. It's a -- it's called a fine needle. A chiban. It's like a small needle, long needle, so about this long (indicates).

Q. Okay. But you can then remove it in the

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office?

A. You can remove it anywhere. You could remove it --

Q. Not a safe way, but --

A. Yeah, it's easy to remove.

Q. Okay.

A. It requires -- you have to do it under fluoroscopic guidance to put it in. But once -- to remove it is simply -- you just pull them out. They come out easily.

Q. I don't want to go in too deep. I'm still not getting it. It's inside now the lumen of the -- of the duct. So you have to get back inside the duct, right, to take this -- I take it --

A. No, it comes out -- it comes out -- oh, it goes in. It's not -- there's different kinds. There's kind you can -- called indwelling where you can kind of -- you put that plastic catheter in and you break them off and they sit there. But in this case, in a reconstruction case, it actually sticks out.

Q. Gotcha.

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A. It's hanging outside. It's a long tube with an external drainage.

MR. GLASS: That's all I have. Thanks.

You good?

MR. DONNELLY: I have no questions for you, Dr. Schirmer. Thank you.

MR. GLASS: All right. Thank you, sir.

THE VIDEOGRAPHER: One moment. Off the record. End deposition at 1808.

(Signature not waived.)

- - -

And, thereupon, the deposition was concluded at approximately 6:08 p.m.

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ACKNOWLEDGMENT OF DEPONENT

I, WILLIAM J. SCHIRMER, MD, do hereby acknowledge that I have read and examined the foregoing testimony, and the same is a true, correct and complete transcription of the testimony given by me and any corrections appear on the attached Errata sheet signed by me.

_____ _____

(DATE) (SIGNATURE)

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CERTIFICATE

State of Ohio :
SS:
County of Franklin:

I, Shayna M. Griffin, Notary Public in and for the State of Ohio, duly commissioned and qualified, certify that the within named witness was by me duly sworn to testify to the whole truth in the cause aforesaid; that the testimony was taken down by me in stenotypy in the presence of said witness, afterwards transcribed upon a computer; that the foregoing is a true and correct transcript of the testimony given by said witness taken at the time and place in the foregoing caption specified.

I certify that I am not a relative, employee, or attorney of any of the parties hereto, or of any attorney or counsel employed by the parties, or financially interested in the action.

IN WITNESS WHEREOF, I have set my hand and

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affixed my seal of office at Columbus, Ohio, on this 8th day of December, 2015.

_____

SHAYNA M. GRIFFIN, Notary Public in and for the State of Ohio and Registered Professional Reporter, Certified Realtime Reporter.

My Commission expires June 12, 2018.

Q