THE STATE OF OHIO.)
)
COUNTY OF CUYAHOGA.)

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IN THE COURT OF COMMON PLEAS

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Benjamin Schechter, et al.,

Plaintiffs,

Henry H. Bohlman, M.D., et al.,

Defendants.

Case No. 471455

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Video deposition of Henry H. Bohlman, M.D., a Defendant herein, called by the Plaintiffs, as if upon cross-examination under the statue, and taken before Irma A. Fares, a Notary Public within and for the State of Ohio, pursuant to the agreement of counsel and pursuant to the further stipulations of counsel herein contained, on November 25, 2002, at 2:00 p.m., at the offices of University Hospitals, Bolwell Building, Cleveland, Ohio.

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APPEARANCES:

LAWRENCE F. PESKIN, Esquire
Becker & Mishkind Co., L.P.A.
Skylight Officer Tower
1660 West 2nd Street, Suite 660
Cleveland, Ohio 44113
(216) 241-2600

On behalf of the Plaintiffs.

MARC W. GROEDEL, Esquire
Reminger & Reminger
1400 Midland Building
101 Prospect Avenue, West
Cleveland, Ohio 44115
(216) 687-1311

On behalf of Defendant
Henry H. Bohlman, M.D.

RICK MC DONALD, Esquire
Davis & Young
1700 Midland Building
101 Prospect Avenue, West
Cleveland, Ohio 44115
(216) 348-1700

On behalf of Defendant
University Hospitals.

ALSO PRESENT:

Dave Tackla, Videographer.

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P R O C E E D I N G S

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Thereupon, a document was marked for purposes of identification as Plaintiffs' Exhibit No. 1.

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HENRY H. BOHLMAN, M.D.,

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

CROSS-EXAMINATION

BY MR. PESKIN.

Q. Could you state your full name for the record?

A. Dr. Henry H. Bohlman.

Q. Dr. Bohlman, my name is Larry Peskin. We met before the deposition.

I assume you've had your deposition taken before.

A. Yes.

Q. If for any reason you don't understand my questions, please ask me to restate them or rephrase them.

If you do answer a question, we're all going to assume you understood it.

Is that fair?

A. Sure.
Q. I'm going to give you what's been marked as Plaintiffs' Exhibit No. 1. If you'd take a look at that and tell me if that is a current copy of your curriculum vitae or reasonably current.
A. It's reasonably current, revised in May of last year.
Q. It's been revised since that time?
A. No.
Q. Okay. Have there -- Are there any publications or papers that are not on your CV that's in front of you that relate to the issues in this case?
A. There may be. Let me just look --
Q. Okay.
A. -- because one came out last year.
No, it's in there.
Q. What I'd like you to do --
Do you have a pen available? since we only have one copy of this that we're working off of.
What I'd like you to do is go through your publications and book chapters in the CV and circle for me the ones that you feel relate to the issues in this case.

A. I think the main one is the last publication on thoracic stenosis.
Q. Well, could you go through and identify that and circle it for me?
A. I think that's one that's specifically related.
Q. I've lost it.
MR. GROEDEL: I think it was the last one.
Q. Surgical treatment of thoracic spinal stenosis.
Are there any other publications that relate to thoracic spine surgery other than No. 95?
A. Yes.
Q. Could you identify those for me?
A. I'll go through all 95, if you wish.
Q. Only those that have any bearing on the issue.
A. I'll go through them all, but...
MR. GROEDEL: Why don't you indicate for the record, Doctor, what --
A. No. 36 is an older publication in General Radiology on imaging thoracic disc herniation, No. 36.
No. 48 is an article on anterior excision

of herniated thoracic discs.

Indirectly, No. 54 is an experimental model of lumbar spinal stenosis.

I think those are the main articles.

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Thereupon, a document was marked for purposes of identification as Plaintiffs' Exhibit No. 2.

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BY MR. PESKIN:

Q. Handing you what's been marked as Plaintiffs' Exhibit 2, this is a list of claims that you provided in response to our discovery request. And I just wanted you to take a look at that and tell me if that basically includes all of the matters in which you've been named as a defendant in a medical malpractice.

MR. GROEDEL: Objection.

Larry, could I just have a continuing objection to any questions dealing with prior lawsuits?

MR. PESKIN: Absolutely.

A. I believe so.

Q. Okay. There's a claim -- a claimant named Richard Rinehart identified in this one.

Your staff report indicates that it was closed and settled for two and a half million dollars in July of 1984.

Can you tell me briefly --

A. Two and a half million, no.

Q. I was going to say, is that $2,500?

A. No. Well, it says 2,500.

This was a --

Q. Sorry about that.

A. This was a Cleveland policeman who we did a lumbar procedure on, low back operation, whose drain got stuck and broke off, and we had to take the drain out. He was a very angry guy.

MR. GROEDEL: Well, that's worth two and a half million.

(Discussion was held off of the record.)

A. That's like 25 years ago, I think.

Q. Any claims that you've had asserted against you that relate to decompressive surgeries?

A. Decompression of what?

Q. Lumbar or thoracic decompressions.

A. No.

Q. Dr. Bohlman, have you ever served as an expert in a medical malpractice lawsuit?

A. Sure.

Q. Have you testified on behalf of plaintiffs?
A. Yes.
Q. And I assume you've also testified on behalf of defendant physicians as well.
A. Both sides.
Q. About what percentage of your medicolegal work has been on behalf of plaintiffs?
A. About 20 percent for plaintiffs, about 80 percent -- I'm guessing -- not guessing; I'm estimating -- 80 percent for defense.
Q. Have you ever testified in a spine surgery case where the defendant was a neurosurgeon?
A. Yes.
Q. Would you agree that the standard of care for a spine surgeon is the same for neurosurgeons as it is for orthopedic surgeons?
A. Sure.
Q. Have you ever testified in a case where the issue was the use or failure to use intraoperative monitoring?
A. I had a lawsuit against myself once, which is listed here, Murray Lilley, in which that was claimed to be a problem, but I've never --

and that was dismissed, and I've never testified that that was a situation. I mean, that was supposed to be the situation.

Q. Have you --

Let me make sure I'm clear.

Have you ever testified in a medical malpractice case as an expert, not as a defendant, where you expressed an opinion that the standard of care for spinal surgery required the use of interoperative monitoring?

A. No.

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Thereupon, a document was marked for purposes of identification as Plaintiffs' Exhibit No. 3.

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BY MR. PESKIN:

Q. Doctor, I'm handing you what's been marked as Plaintiffs' Exhibit 3. I believe this is a complete copy of your office notes with regard to Ben Schechter. Can you verify that for me?

A. I don't know what that is. That's not mine.

Q. Okay. Bates No. 5 you're referring to is not yours?

A. No. The rest of them are.
Q. Do I have a complete set of your transcribed notes from your office?
A. Yes.
Q. Can you tell me how it was that Dr. Schechter was referred to you?
A. I believe the referring physician was Richard Stein, his -- one of his internists or actually rheumatologist; at least that's what I have listed.
Q. And when --
A. Excuse me.
He was seen in our group by Dr. Emery, my partner, in 1995, so the group was known to him -- I'm not sure whether it was a referral -- self referral or by Dr. Stein, but I communicated with Dr. Stein.
Q. Do you have an independent recollection of Dr. Schechter's presenting complaints or do you need to refer to your notes?
A. Well, I'll look at my notes.
Q. I want you to look at anything that will help you recall.
But what can you tell me about -- about the reason that you understood why Dr. Schechter

came to see you?
A. Well, he had had previous surgery in 1998 by Dr. Columbi here for low back. He had developed, subsequent to that, progressive numbness and pain in the legs, which was affecting his function. That was the main reason.
Q. Your notes refer to pain and numbness in his right leg; is that correct?
A. I'm not sure from my own note, to be honest.
I have here, "He has continued to have numbness which has increased and now over the past couple years has developed pain in the calf as well as numbness and is having difficulty walking distances."
I'm not -- I guess I'm not specifically stating that, unless I'm referring to the original right leg pain, with the original surgery.
Q. Well, is it fair to say, then, that you -- as you sit here today don't have an independent recollection and your notes don't state that Dr. Schechter had complaints of pain or weakness or numbness in his left leg?
A. I don't have "left leg" mentioned here. I'm not sure what my -- My sentence doesn't

specifically designate right or left.
Q. If Dr. Schechter were to testify that when he came to see you, his problems were on -- were in his right leg and not left leg, would you have any reason to disagree with him?
A. Probably not.
Q. What can you tell me about --
A. Excuse me.
I just noticed in my note here, the patient was referred by former patient of ours, Mr. Belecek, that used to do billing for his office.
Q. Okay. What can you tell me about your examination, your physical examination, of Dr. Schechter when you first saw him in September of 2000?
A. He was in no major distress. He could walk on his heels and toes without difficulty. He bent over with somewhat limited flexion. And I noted a thoracolumbar or a spine scoliosis, a curvature; and it looked like he flexed or bent mostly at his hips. I thought he probably had only about 40 degrees of flexion, which would be about that much from neutral, bending forward; and bending to the side, about 20 degrees in

either direction.

Q. What about your neurologic exam? Were there any neurologic deficits noted on your initial examination?

A. No. He had no weakness, no loss of sensation, and his deep tendon reflexes were intact.

Q. I note that your impression says that residual lumbar spinal stenosis, L5-S1, with continued L5 radiculopathy. What was the basis for that impression of that?

A. Well, on his x-ray, he had a very small hole where he'd had his previous surgery, and he had huge arthritic facet joints, the joints out on the side, which usually indicate persistent narrowing of the spinal canal, and you can't decompress the nerve roots through a very small hole. So this is what I see a lot in my office practice, are patients with recurring or persistent leg pain who have had a very small procedure before, and they have recurring leg pain and numbness and difficulty, and we work them up for spinal stenosis, which is what this turned out to be.

Q. Your note further states in the

disposition heading that you suspected he will need an additional decompression.

Why, based on your findings, did you suspect that he would require decompressive surgery?

A. Oh, because of his persistent leg pain. You should have no leg pain after an adequate decompression in the lumbar spine. So this is -- Again, this is what I see a lot in my practice.

Q. Is it, in your view, appropriate to undertake a surgical intervention where there are no neurologic findings and the only complaint is persistent pain?

A. Oh, absolutely. We do it all the time. Persistent leg pain means nerve compression.

Q. What can you tell me, if anything else, about the nature of Dr. Schechter's leg pain when he presented to you? Was it constant?

A. I think it bothered him more when he tried to walk, which is pretty classic for spinal stenosis or narrowing of the spinal canal.

It's more when people try and walk or stand. Usually goes away when people lie down.

And as he mentioned, if he tried to walk 45 minutes a day, he started limping and his

foot started slapping, indicating possibly some functional weakness when he tried to walk distances.

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Thereupon, a document was marked for purposes of identification as Plaintiffs' Exhibit No. 4.

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BY MR. PESKIN:

Q. Plaintiffs' Exhibit No. 4, this is a report from Magnatech Imaging Center of an MRI of the lumbar spine with and without contrast -- without and with contrast, dated October 20, 2000.

Did you order this MRI?

A. Yes, I did.

Q. And did you review the films or just the report?

A. I always review the films and the report.

Q. What can you tell me that was significant in this particular test?

A. Well, it was -- it was what I thought it was going to be in the lower lumbar area, in that he had some disc protrusion and some spinal stenosis residual at the L4-5 and L5-S1 levels, which are the lower two levels.

The surprise was that he had --

I should back up and say he has -- Dr. Schechter was born with a narrow spinal canal, which is called congenital stenosis just by the configuration of his spinal canal. And then they picked up on this MRI some disc protrusions and narrowing at the lower thoracic levels, T10-11 and T11-12, the lower two levels; and a small disc protrusion at T12-L1, so that was a surprise.

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Thereupon, a document was marked for purposes of identification as Plaintiffs' Exhibit No. 5.

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BY MR. PESKIN:

Q. Hand you what's been marked as Plaintiffs' Exhibit No. 5. This is a letter dated November 6, 2000, from you to Dr. Schechter.

I assume you dictated this letter.

A. Yes.

Q. Is it fair to say that this letter was your communication with Dr. Schechter about your impressions of the MRI?

A. Yeah. I always dictate a letter when I review the studies that are done after the patient

has been in the office.

I very frequently call patients, but I don't have -- I thought I did, but I don't have a phone call recorded in my records, but this for sure was a letter that I wrote to him to let him know what we found on the MRI and what I just mentioned.

Q. Would it have been your practice that if you made a telephone call to a patient, that you would have charted it?

A. Usually I do, but not always. Sometimes if I'm busy, I forget to do it.

Q. Why is it you think that you had a telephone conversation with Dr. Schechter with regard to this MRI?

A. I just -- I think I did. I can't be certain, and I can't prove it because I don't have it recorded.

Q. Well, do you have any -- other than what's said in this letter, do you have a recollection of saying something else to Dr. Schechter about the results of his MRI?

A. No. No. I think I told him what we saw here.

Q. So if you had a telephone conversation,

it would have essentially covered the same subject matter as in this letter?
A. Yeah, and that we would want to do a myelogram and CAT scan to further define the situation before his surgery.
Q. How was it --
I notice that the MRI report on this Exhibit 4, that came from Magnatech Imaging Center, how was it that you got the film for that MRI?
A. How did I receive the film?
Q. Yeah. How do you go about getting films?
A. They send them to me.
Q. Okay. Did you -- You have a standing request that when MRIs are done of your patients, they send you the films?
A. Absolutely.
Q. Typically how long does for the film to get from Magnatech Imaging Center to your office?
A. They're usually very fast. I mean, that's why we use them. They give us very good service.
Q. And their office is on Rockside Road?
A. Yes.
Q. And somehow from Rockside Road, they get films to your office here at University Hospitals;

correct?
A. Pretty quickly.
Q. By the way, where is your office located?
A. On this floor in the Bolwell Building.
Q. Okay. And so it's attached; it's part of the University Hospitals' complex?
A. Yes.
Q. Generally speaking, how soon after you receive a film such as the one that you received from the MRI on October 20th before you review them?
A. That's totally variable, depending on my travels, whether I'm on vacation, and how many studies I have to review and correspond -- or respond to. It's variable.
Q. Is it likely that you would have reviewed this MRI within a day or two of the date that you communicated with Dr. Schechter?
A. Pretty unlikely.
That I reviewed it within a day of getting it?
Q. No. No. Within a day or two of the date that you sent the letter.
The study was done on October 20th, 2000. Your letter to Dr. Schechter is November 6th, 2000.

A. Yes.

No. Again, it depends on my travels and whether I'm giving talks or on vacation or whatever -- it's totally variable -- and how many cases get stacked up on my credenza to respond to.

Q. In this letter you wrote to Dr. Schechter -- and I'm referring to your November 6th, 2000, letter -- "If your legs bother you enough, I would recommend a lumbar decompression."

Can you tell me more of what you meant about that? Are you leaving it up to him to make the decision in terms of whether it's --

It's an elective procedure, is it not?

A. It's purely an elective procedure, but I thought he was having a fair amount of difficulty or he wouldn't have come to see me in the office. But I leave it up to the patient. I think it's their decision. He had no neurologic deficit at the time. So that's usually what I say to the patient.

Q. The neurologic -- The absence of neurologic deficits that you noted in your first examination of Dr. Schechter, I assume that that -- the absence of neurologic findings persisted up

until the time that you did surgery on him on December 14th; correct?

A. Probably; although, I didn't re-examine him, but I would have to assume so.

Q. In this letter you did not mention any plan to perform any surgery other than a lumbar decompression; is that correct?

A. I didn't say "thoracic laminectomy" specifically, but I identified the thoracic problem for that reason, because I thought it was a problem based on the MRI.

Q. What do you mean by that? What --

A. I thought he would need a thoracic decompression based on what I was seeing on the MRI, but I wanted to define it further with a myelogram.

Q. Can you tell me why you didn't report in this letter to Dr. Schechter your thoughts that he might need a thoracic decompression or thoracic laminectomy?

A. I think I was waiting to see the myelogram and the CAT scan. I'm not sure why, but I did identify the problem and specifically stated that to him, that it was a problem. I wouldn't have put it in my letter if I didn't

think it was a problem.
Q. Well, what you said in your letter is, In addition, there is some small what appeared to be hard disc protrusions in the lower thoracic area, and I would want to evaluate that preoperatively if you came in with a myelogram and CAT scan; correct.
A. Yes.
Q. You didn't say anywhere in this letter that you were contemplating a surgical intervention; correct?
MR. GROEDEL: Objection. Asked and answered.
Go ahead.
A. Well, I was contemplating doing the lumbar area and probably the thoracic, yes. But I didn't say that in the letter. I just indicated that there were problems in both areas.
Q. You didn't say that to him in a telephone conversation either, did you?
A. I don't remember.
Q. Earlier when I asked you about your recommendation for a lumbar decompression, you said words to the effect that you always leave it up to the patient, an elective procedure of this

nature.

Would that be the case also for the thoracic procedure that you may be -- may have been contemplating at this point?

A. Sure. Without hard evidence of paraplegia or some neurologic deterioration, it's purely elective surgery in both areas.

Q. Did Dr. Schechter have any neurologic signs or symptoms consistent with thoracic stenosis?

A. Well, the only thing I can't tell was his complaints of numbness of the leg and pain in the legs. You can have pain in the legs from thoracic stenosis. That's a very common problem. You could have trouble walking. These are subjective complaints. He had no objective neurologic findings to indicate spinal cord compression at a higher level.

Q. What are some of the neurologic signs and symptoms that one would expect to see with someone who had thoracic stenosis?

A. The first signs are -- in the lower level of the thoracic spine, in my experience, are leg pains, back and leg pains, which can be low back pain; and leg pain very similar to what comes from

the lower lumbar stenosis; numbness and tingling.

As it progresses further on in the --

For the ladies and gentlemen of the jury, the thoracic area contains a spinal cord; and the lumbar, the lower area, only contains nerve roots, so there are different neurologic signs and symptoms in a different areas.

The thoracic cord compression can produce marked paralysis in both legs, loss of bladder control and numbness at a specific level, but also pain, numbness and tingling and difficulty walking.

Q. Is it fair to say, Doctor, that an individual can show significant pathology on an MRI or myelogram of their thoracic spine without any specific neurologic deficits?

A. That's possible.

Q. And they can persist in that condition for a lifetime; is that a fair statement?

A. I don't know about lifetime if they had severe spinal cord compression. That's not been my experience.

- - -

Thereupon, a document was marked for purposes of identification as Plaintiffs' Exhibit No. 6.

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BY MR. PESKIN:

Q. This is Exhibit 6, Plaintiffs' Exhibit 6. This is a report from a lumbar myelogram and post-myelogram CT from November 28th, 2000.

Can you recall, Doctor, when you first saw this report?

A. I don't know. I think I saw it the day of surgery. That's when I first saw it, because I didn't get it up -- I couldn't get it up to my office until then. In fact, I saw it in the operating room.

Q. I'm asking you about the report and not the films, just so we're clear. This particular --

A. That I don't know. I don't recall that.

Q. You have no recollection at all about having --

Do you recall ever seeing this report prior to surgery?

A. I don't recall whether I saw it prior to the day of surgery. Now, it's been two years. I mean, I don't remember the day I saw the report. It may have come up before the films. Sometimes it frequently does.

Q. This particular study was done here at the Department of Radiology at University Hospitals --

A. Correct.

Q. -- which is in the same complex as your office; correct?

A. Well, yeah, it's in the same hospital complex.

Q. Do you have a terminal in your office that would allow you to access the results of radiologic studies?

A. Not yet.

Q. Not yet?

A. That's coming.

- - -

Thereupon, a document was marked for purposes of identification as Plaintiffs' Exhibit No. 7.

- - -

BY MR. PESKIN:

Q. Hand you what's been marked Plaintiffs' Exhibit 7. This is a University Hospitals of Cleveland reservation request.

Is this something your office would have completed?

A. Yes. My secretary does this when I first see the patients, if I think they're going to need surgery or they're going to get scheduled for surgery.

Q. If you'll go back to your November 6th, 2000, letter to Dr. Schechter. In the last sentence, it says, "It has been brought to my attention that you have scheduled in on a cancellation slot for December 14, 2000."

So on November 6th, 2000, you were aware that Dr. Schechter was going to have a surgery scheduled for December 14th, 2000; correct?

A. Yes.

Q. And this form, Exhibit No. 7, would have been completed by your office on or about that same date, November 6th?

A. I don't know when it was completed.

We don't put the dates on there when the form is made out, that I'm aware of.

Q. You were aware on November 6th that Dr. Schechter was going to have -- that you were going to perform surgery on Dr. Schechter on December 14th, 2000; correct?

A. Yes.

Q. And the surgery request -- the

reservation request indicates that you were going to perform a lumbar laminectomy and foraminotomies at L4-5 and L5-S1; correct?

A. Yes.

Q. It also indicates that the diagnosis is lumbar spinal stenosis, L4-5 and L5-1 --S1?

A. Yes.

Q. And that the procedure was scheduled for seven o'clock a.m. on December 14th, 2000; correct?

A. Yes.

Q. Nowhere on this form does it indicate that you were contemplating or intended to perform a thoracic laminectomy and decompression; correct?

A. Well, I was contemplating it, but I wasn't positive about it at that time because I hadn't seen the definitive studies.

Q. I want you to listen carefully to my question. Does it say anywhere on this form that you intended to perform a thoracic spinal surgery on Dr. Schechter?

A. No. No. What you said -- What you asked me was, was I contemplating it? And I said I was contemplating it, but it does not state that on

the form, and I was waiting for the definitive study.

Q. Okay. And when did you --

Well, let's strike that.

- - -

Thereupon, a document was marked for purposes of identification as Plaintiffs' Exhibit No. 8.

- - -

BY MR. PESKIN:

Q. Plaintiffs' Exhibit No. 8, this is a correspondence from your office dated November 8th, 2000, to Richard Stein, M.D. Have you already identified Dr. Stein as Dr. Bohlman's primary care -- excuse me -- Dr. Schechter's primary care physician; correct?

A. Yes.

Q. And this indicates that this correspondence or memorandum is from Julie Bunkelman on your behalf; correct?

A. Yes.

Q. And it says, "To Whom it May Concern: Dr. Bohlman is requesting medical clearance along with the following routine labs for the above noted patient. We appreciate your help with this

matter," et cetera.

And on the heading of that letter, under "Surgery," it says, "Lumbar Laminectomy & foraminotomies, L4-5, L5-S1." Correct?

A. Correct.

Q. That's the same surgical procedure indicated on the reservation request; correct?

A. Yes.

Q. So in your communication with Dr. Stein, requesting medical clearance, you did not share with him that you were contemplating a thoracic procedure, did you?

A. I didn't. I don't think it's necessary, because I'm just -- I was just getting approval for a general anesthetic, not for doing a specific operative procedure.

Q. Your form that you sent to the doctor does list a specific operative procedure, does it not?

A. Sure.

- - -

Thereupon, a document was marked for purposes of identification as Plaintiffs' Exhibit No. 9.

- - -

BY MR. PESKIN:

Q. I've just given you what's marked as Plaintiffs' Exhibit No. 9. This is correspondence from your office dated November 8th, 2000, to Dr. Schechter.

What is the purpose of this communication to Dr. Schechter -- or what was the purpose?

A. I think just to identify the schedule of his procedures, the myelogram and then the eventual surgery --

Q. Okay. So you're --

A. -- and where to go.

Q. You were aware, then, that Dr. Schechter was scheduled for a myelogram and CT scan on November 28th, 2000; correct?

A. At some point I was aware. I'm not sure of exactly what day.

Q. Well, this letter indicates that on November 8th, 2000, you were aware that Dr. Schechter was going to undergo a lumbar myelogram and CT scan on November 28th, 2000; correct?

A. I said I'm not sure I was aware of what day.

My secretary types this up. And I intended to do a myelogram and CAT scan, but I don't usually see the scheduled dates until people are scheduled for surgery, and so I don't know exactly when I was aware he was going to have the exact myelogram. I usually don't bother with that.

Q. Well, let me ask you this, Doctor: You were interested in the results of the lumbar myelogram and CT scan, were you not?

A. Absolutely, and the thoracic.

Q. As you said, you were -- had wanted this procedure done so that you could evaluate the status of Dr. Schechter's thoracic spine; correct?

A. Sure.

Q. And do you recall or did you ever ask anyone in your office to follow up to see if Dr. Schechter had, in fact, had that myelogram and CT scan towards the end of November of 2000?

A. Well, I know it's going to be done if I ask my secretary to do it, but I don't necessarily pay any attention to the exact date that it's scheduled on.

Q. Well, Doctor, would you agree that it's important to have all the diagnostic studies

that you've ordered in contemplation for a surgical procedure complete and in your hands in advance of the surgery?

A. Well, that's what I usually plan, sure.

Q. I mean, how -- how is it that you can plan your operative approach if you haven't seen the diagnostic studies that you've ordered?

A. Well, as I mentioned, I was fairly certain he needed a thoracic decompression as well as a lumbar just from the MRI. I just -- Getting a myelogram or CAT scan, which, incidentally, I do routinely on repeat back surgeries because it gives me a lot more useful information, it almost never changes what I do. It just helps to define things better for me.

Q. Well, you said --

A. I think a lot of surgeons wouldn't bother with a myelogram and CAT scan and just probably rely on the MRI, but it just gives me more useful information.

Q. You had an MRI performed on Dr. Schechter back October 20th of 2000; correct?

A. Yes.

Q. And you already reviewed that; correct?

A. Yes.

Q. And you discussed those findings with Dr. Schechter; correct?
A. Yes.
Q. And in response to that test, you didn't tell him that you were intending or planning a thoracic decompression, did you?
MR. GROEDEL: Objection. Asked and answered.
Go ahead.
A. Well, in my letter, I indicated that there was a problem with the thoracic spine as well as the lumbar spine, meaning this might need attention also. I wouldn't have put in the letter if I didn't think it might need surgical attention.
Q. Who is Lynette Bennett?
A. She's our nurse clinician for my spinal patients.
Q. And what role does she play, generally speaking, in preparing your patients for surgery?
A. Well, she talked to them about medication before the myelogram, about possibly what the surgery is going to be like and the length of stay in the hospital and to educate the patient, checks on medication.
- - -

Thereupon, a document was marked for purposes of identification as Plaintiffs' Exhibit No. 10.

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BY MR. PESKIN:

Q. Handing you what's been marked Plaintiffs' Exhibit 10, this is a University Hospitals PreProcedural Admission History, Department Anesthesiology and Nursing.

This was prepared by a nurse whose name I can't make out, but at the bottom you'll see the date is November 14th, 2000.

A. That's the date.

Q. Okay. Under "Diagnosis," it says lumbar spinal stenosis L4-5 and L5-S1; identifies a procedure date of December 14th. That was the date you scheduled Dr. Schechter's surgery; correct?

A. Yes.

Q. And it indicates that the procedure was a lumbar laminectomy and foraminotomies; correct?

A. Yes.

Q. So is it fair to say as of December -- excuse me -- November 14, 2000, the Departments

of Anesthesiology and Nursing were not aware that you were contemplating a thoracic procedure with --

A. I'm sure not.

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Thereupon, a document was marked for purposes of identification as Plaintiffs' Exhibit No. 11.

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BY MR. PESKIN:

Q. This is Plaintiffs' Exhibit No. 11. This is another University Hospitals of Cleveland form, and it says "Surgical Service Physical Examination."

And is that your signature at the bottom of that?

A. That's a cosignature. This most likely is a -- I can't read the name. It's probably a physician's assistant or some nurse clinician in admitting that fills out the form. I don't recognize the name. Medical assistant or something.

Q. How does this work? Who performs these assessments? the physician's assistant?

A. Either physician's assistant or nurse clinician. Usually physicians' assistants. It's

a variety of people, depending on what the specialty is or the problem is.

Q. Are they -- Would these individuals be employed by your practice or by University Hospitals?

A. University Hospitals.

Q. And what communication do you have with the individual performing this assessment prior to their assessment?

A. I usually don't communicate with them that much. I mean, all the decisions are made and the data is there. They do this for -- I think for hospital documentation, general physical exam and for anesthesia.

Q. And your -- So the handwriting, other than the signature on this form, is not yours; is that what you're saying?

A. No. No.

Q. You didn't perform this examination?

A. No.

Q. Is that your testimony?

But you reviewed these findings before signing them; correct?

A. I look at it when I sign my charts. I sign them.

Q. Okay. And do you notice that under "Plan," it says laminoforaminotomy, lumbar stenosis, impression and plan; correct?
A. Yes.
Q. Does it say anywhere there that there's going to be a thoracic surgical procedure?
A. No. I'm sure this individual is totally unaware.
Q. You didn't add that on to the plan on November 28th, when you counter-signed this or after?
A. I countersigned this after the fact. I'm sure it was after the patient was discharged. That was November 27th.

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Thereupon, a document was marked for purposes of identification as Plaintiffs' Exhibit No. 12.

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BY MR. PESKIN:
Q. Hand you what's been marked Plaintiffs' Exhibit 12. This is a University Hospitals Cleveland consent form, signed by Dr. Schechter and dated November 28th, 2000.
Are you familiar with this form?

A. I think this is part of the consent form. This is not the whole consent form.
Q. Well there's, actually two different forms used. I'm asking if you've ever seen this one.
A. Well, I've seen the form. I don't think my signature is on this.
Q. No, it's not. I'm not suggesting it is. I'm just asking --
A. Yeah, I've seen the form.
Q. -- if you've seen the form in general.
Okay. In the first paragraph of that form -- I believe it's the third sentence, it says, I understand that, comma, except in an emergency, comma, any further treatment or procedures will be performed only after I've been informed of the benefits, material risks and complications associated with such treatment or procedures, and I have given my consent.
Do you see that?
A. Yes.
Q. What is your understanding of what's meant by that sentence in this consent form?
A. I suppose, talking to the patient and telling them what you're going to do.

Q. And what does it mean when it says that you're to discuss the material risks and complications associated with the procedure?
A. Just that, discuss risks of an operative procedure.
Q. Now, had you had discussions with Dr. Schechter about the various risks associated with the lumbar procedure you had contemplated?
A. I always, with any patient that's scheduled for surgery, discuss risks and benefits. I always discuss that with any patient that's scheduled for surgery. And I always talk to them specifically about paralysis, even if they don't bring it up, because I know they're really concerned about it, and this applies to any level of the spine that we do. And that's done in the office when I see the patient if I think they're headed for surgery, sometimes in the holding area before surgery, but in general it's usually in the office.

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Thereupon, a document was marked for purposes of identification as Plaintiffs' Exhibit No. 24.

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BY MR. PESKIN:

Q. Plaintiffs' Exhibit 13, can you identify this form for me?

A. I'm not sure I know what this is.

Q. Well, the top of it says, "UHHS Patient Care and Operation Support." It's got a date on it 11-14-00. And it says, University Hospital of Cleveland Pre-op Assessment.

Do you provide an admitting diagnosis to the hospital when you have scheduled patients for surgery?

A. Sure. The office does.

Q. And in this case, the diagnosis that was -- ICD 9 code and diagnosis that was presented to the hospital as an admitting diagnosis was spinal stenosis, dash, lumbar 724.02; correct?

A. Yes.

Q. Is there an ICD 9 code for thoracic stenosis?

A. I don't think there is. I'm not aware of one.

Q. Do you know --

A. You know, I'd have to look it up. I don't know whether there is one specifically,

because it's so rare. I don't think there -- I don't think there is one. It's only because --

I'm not even sure there's one for cervical stenosis.

Q. So it's your belief at this point, as you sit here today, that there is no ICD 9 diagnostic code for thoracic stenosis?

A. I do not think there is, and I don't think there is for cervical stenosis, because I don't use it at present.

Q. If there were one, would it have been appropriate for you to provide that code to the hospital as part of your admitting diagnosis?

A. Well, maybe so if I was sure I was going to do the procedure at that time.

Probably what I would have used is thoracic disc protrusion, because that is a code, and he does have that -- did have that to a certain extent also, but I don't think there's any code for thoracic stenosis.

Q. Well, you knew on December 14th, 2000, that Dr. Schechter had thoracic disc protrusion, did you not?

A. Yes.

Q. You suspected he had thoracic stenosis;

is that a fair statement?
A. Well, it was the stenosis I was more concerned with.

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Thereupon, a document was marked for purposes of identification as Plaintiffs' Exhibit No. 14.

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BY PESKIN:
Q. Handing you what's been marked as Plaintiffs' Exhibit 14, I believe we're on, this is a University Hospitals of Cleveland Preoperative Holding Area Nursing Notes.
Have you seen this form before?
A. I suppose I have, yes.
Q. It's dated December 14, 2000. The time at top is 0615. Do you see that?
A. Yes.
Q. Now, as I recall from looking at the correspondence -- I want you to correct me if I'm wrong -- the earlier correspondence was that -- suggested that Dr. Schechter was scheduled for surgery on December 14th at seven o'clock a.m. Does that sound about right?
A. Yes.

Q. That was the slot that was reserved; correct?
A. I believe so.
Q. And I think in your instructions to the patient, you asked them to arrive at the hospital an hour earlier; correct?
A. I think that's what my secretary does.
Q. Generally speaking, when do you first see a patient on the morning of surgery?
A. Usually in the holding area before they go in to surgery.
Q. Sometime in that hour before surgery?
A. Yes.
Q. At 0615 on this form, under "Plan Surgical Procedure, it says L4-5, S1 lumbar laminectomy and foraminotomies. Do you see that?
A. Yes.
Q. And it doesn't say anything about a thoracic decompression and laminectomies, does it?
A. No. It wasn't scheduled that way.
Q. And it wasn't planned that way either, was it?
A. Well, it was planned that way by me.
Q. With whom did you share your plans to perform a thoracic decompression and laminectomy?

A. I think I did with Dr. Schechter in the holding area. And I indicated my concern in my letter to him about thoracic disc protrusions.
Q. You didn't share the plan with the nurses in the holding area, do you?
A. I don't usually talk to them about what I'm going to do.
Q. Well, they are completing a form that indicates what the planned surgical procedure is, aren't they?
A. They don't get that from me verbally. They get that from a scheduled procedure.
I don't talk to the nurses in the holding area about what I plan to do surgically. I don't think that's necessary or appropriate.

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Thereupon, a document was marked for purposes of identification as Plaintiffs' Exhibit No. 15.

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BY MR. PESKIN:
Q. No. 15, this is a University Hospitals Health Systems, consent for procedural form; correct?
A. Yes.

Q. It's from December 14th, 2000.
And is that your signature under "Physician's Attestation"?
A. No.
Q. It's not.
Whose signature is that?
A. I can't read it. I'm not sure.
It may be one of the fellow's. I cannot read either signature.
I guess the patient's signature is there, and I can't read that either, but I just know it's not mine.
Q. Would it likely be either Dr. Choung or Dr. Stanford's signature?
A. It may be. I don't recognize it.
Q. Is it your practice to have your residents and/or fellows attain a consent from patients for operative procedures?
A. Oh, sure.
Q. So you charge them with the responsibility and authority to discuss with patients the upcoming operative procedure and the material risks and complications and obtain that consent?
A. They do, anesthesia does, I do. All

of us do.
Q. Okay. Well, does the anesthesiologist typically discuss with the patient the material risks and procedures of the surgery or of the anesthesia?
A. Anesthesia for surgery, sure.
Q. Anesthesia for surgery?
A. Yeah.
Q. But would not be -- you would not expect an anesthesiologist to be discussing with a patient that relative risks of a spinal surgery but the anesthetic for the surgery?
A. Anesthetic in relationship to the spine surgery.
Q. You see that this consent form says that Dr. Schechter was giving consent for lumbar decompression and foraminotomies; correct?
A. Yes.
Q. He did not consent on this form to a thoracic decompression or laminectomy, did he?
A. It's not mentioned there, no.
Q. I sent something called requests for admissions to your lawyer some time ago.
And one of those requests for admissions was, Admit that Benjamin Schechter did not consent

to a thoracic laminectomy or a thoracic decompression prior to the operative procedure. And the answer to that was denied.

I assume Mr. Groedel discussed this with you, and you told him to answer that question that way.

A. "Denying," meaning that --

Q. I asked you to admit that he did not consent --

A. Right.

Q. -- to a thoracic laminectomy?

A. Right. Right, deny. No.

Q. You deny that?

A. Yes.

Q. What is -- Tell me every basis that you can think of for your denial of that request for admission.

A. For admission to the hospital or for admission to what we said?

Q. For you to admit --

I asked you to admit that Dr. Schechter --

You know, Dr. Schechter has --

MR. MC DONALD: Can he take a look at it so he's clear?

I didn't mean to interrupt.

MR. PESKIN: That's all right.

Q. It's No. 4 at the bottom?

MR. GROEDEL: No. 3.

Q. No. 3.

A. No, I deny that.

Q. Okay. Now, you are aware that Dr. Schechter has filed a complaint, the lawsuit against you, and among the allegations in that lawsuit is his assertion that he did not consent to you performing a thoracic laminectomy and decompression.

Are you aware of that?

A. I'm aware of that.

Q. So what is the basis for your denying his allegation that he did not consent to that procedure?

A. I think because I talked to him about it.

Q. Now, you tell me -- tell me exactly when you say you talked to Dr. Schechter about this procedure.

A. I believe it was in the holding area, but it's been two years. I can't be 100 percent certain, but I usually talk to the patients there.

Q. It was not before he was in the holding

area; correct?
A. No, unless it was by phone, and I can't remember whether I talked to him by phone or not. But I didn't see him again -- And this is frequently the case. I see them in the office. They need surgery. They get scheduled for surgery, and the next time I see them is in the holding area.
Q. You didn't -- You have no idea in -- no indication in your notes that you had any communication with Dr. Schechter after the correspondence to him dated November 6th, 2000, up to the date of the surgery; correct?
A. That's correct. I don't have that documented in my notes. I thought I had talked to him by phone, but I can't be certain because it's been two years, and I don't have documentation.
Q. So you can't be certain as you sit here today that you had any conversation with Dr. Schechter over the telephone where you discussed with him the option -- let's be clear -- it was his option whether to have the thoracic surgery; correct?
A. It's his option to have both.

Q. You did not discuss with him the option of doing, in addition to a lumbar laminectomy and decompression, a thoracic laminectomy and decompression?
A. I thought I discussed it with him over the phone, and I believe I discussed it with him in the holding area.
Q. But you're not certain as you sit here today that you discussed it with him over the phone?
A. I don't have that documented. I usually do and I thought I did, but I don't always document.
Q. I hate to be pushy about this, but it's sort of important. When you say you think you did, you aren't certain that you did, are you?
A. I will say the same thing all over again. I believe I did. It's been two years. I didn't document a phone conversation of my record, which I don't do 100 percent of the time, but I think I talked to him.
Q. Is it your practice to document conversations you have with your patients that deal with the issue of informed consent?
A. Not in the holding area.

Q. I didn't mean in the holding area. I meant if you were to have a conversation with a patient in your office or on the telephone where you discussed the material risks and benefits of a planned operative procedure, that's something you would normally document, wouldn't it?
A. I frequently do. I don't go into great detail, but I always talk to them about risk of paralysis, infection, et cetera, with every patient in the office.
Q. That's not -- There's no documentation anywhere in your notes of your having discussed the risk of paralysis or anything with Dr. Schechter with regard to either procedure that you performed on him on December 14th?
A. I have it documented in my operative note.
Q. I didn't ask you about that. I asked about your office notes.
A. No. But I always, emphatically always, discuss paralysis with patients in the office that are going through any spinal surgery because they're always concerned about it, if they don't bring it up, and they frequently bring it up.
Q. Now, tell me what you remember about a

conversation you had with Dr. Schechter in the holding area.

A. Ordinarily I discuss what we're going to do with the patient and family.

Q. Okay.

A. But I don't -- at that time I don't usually go into risks, because I think they're very anxious, and at that point I don't want them to be overly concerned, but I usually discuss what we're going to do.

Q. Well, do you think it's important for patients to have time to -- adequate time to consider the risks of surgery before making a decision about whether to undergo surgery?

A. Sure.

Q. Do you think Dr. Schechter would have -- was given adequate time to consider the risks of thoracic decompression or laminectomy if, as you say, he was first told about it in the holding area approximately 45 minutes before undergoing general anesthesia?

MR. GROEDEL: Objection. That's not his testimony. Go ahead.

A. I informed him that he had a problem with his thoracic spine in my letter of November 8th or

whenever that was, November 6.
Q. November 6th, you had no discussion in your letter -- let's be clear about that -- about the risks of thoracic decompression or laminectomy? It's not in your letter, is it?
A. I had no discussion about risk of the lumbar procedure. I do that in the office.
Q. Let me ask you this, Doctor: Is thoracic spinal surgeries less common than lumbar spinal surgeries?
A. Yes.
Q. Substantially less common; correct?
A. Yes.
Q. They are substantially more risky, are they not?
A. Probably they are if you're dealing with a spinal cord, much the same as the cervical spine.
Q. The difference between -- Would you consider the difference in risk between a thoracic spinal surgery and a lumbar spinal surgery to be a material difference? Do you know what I mean by that?
A. I think if -- Again, we're dealing with the spinal cord when we're decompressing the thoracic spinal as well as the cervical; so as

far as neurologic risk, it's probably more significant than in the lumbar.

Q. But there are much greater risks of significant complications from a thoracic spinal surgery than from a lumbar spinal surgery; is that a fair statement?

A. By "complications" meaning what?

Q. The risks that you were speaking of; for example, the risk of paralysis.

A. You have a risk of a different type of paralysis when you're dealing with a spinal cord either in the cervical or the thoracic, as opposed to the lumbar, where there are just nerve roots, but the risk of paralysis is there, too.

Q. The risk of loss of sexual function, the risk of loss of bowel and bladder control, those are substantial risks from thoracic spinal surgeries?

A. With any spinal surgery.

Q. Are there -- Was it your intention to address Dr. Schechter's thoracic disc herniations through this operative procedure?

A. Oh, not at all. That would be --

My intention was to decompress from the back, what you have to do to the lumbar area, which

needed complete decompression.

And as I mentioned in the article that we published, we try to assess how much compression is in the back of the spinal cord versus the front and the thoracic stenosis problem, because it's often both ways. And if you have to do a lumbar procedure, it's probably far better to -- and most of the compression in the thoracic area is from the back -- it's better to do both from the posterior back approach.

If you have purely -- purely a disc herniation with nothing else, as we have published, it's much better to go from the front, through the chest.

Q. There were -- In Dr. Schechter's case there were, in fact, four herniated thoracic discs, were there not?

A. I think there were -- Well, there are three levels --

When you talk --

Not frank herniations, but they're what I call, as I mentioned in my letter to him, hard disc protrusions, which look like degenerate hard discs that have been there for a long time, just like the -- the degenerative arthritis in the back

of the spine, so there are multiple levels of disc protrusions in a thoracic spine.

Q. Were there alternative approaches to this surgical intervention other than a posterior approach?

A. You could have given him another anesthetic and gone anteriorly from the front through the chest at three levels. That would be a formidable procedure. And from a technical standpoint, I think that's doing him a disservice to put him through two different anesthetics and another procedure from the front, when most of the compression, by my estimation, was from the back of the spinal canal.

Q. Let me understand something. Dr. Schechter, you learned, had two separate problems, in essence. He had a problem in his lumbar spine; correct?

A. Yes.

Q. And he also had a problem in his thoracic spine; right?

A. Yes.

He has congenital stenosis of the entire spine. That's narrowing of the entire spine.

Q. At the time in December of 2000, is it fair to say that Dr. Schechter was relatively, if not completely, asymptomatic with regard to the pathological findings in his thoracic spine?
A. I told you I could not differentiate between some of the lumbar stenosis symptoms versus thoracic stenosis, because you could have numbness and tingling and low back and leg pain with thoracic stenosis, so I don't think you could be absolutely certain one way or the another.
Q. Doctor, is a posterior approach to thoracic spinal surgery generally disfavored?
A. Again, it's disfavored -- and I've written against that -- when you have a pure front anterior disc herniation; but when you have compression from the backside of the spinal cord, which is a major problem, that's the only way you could decompress the cord.
Q. Did you discuss with Dr. Schechter at any time the option of deferring surgery on his thoracic spine until some later date?
A. I don't think I did, because I didn't think it was in his best interest.
Q. You didn't think it was in his best interest to discuss that with him?

A. I didn't think it was in his best interest to do two separate procedures and two different anesthetics when you could accomplish both decompressions at the same time.

Q. Tell me everything you can recall about your conversation with Dr. Schechter.

First of all, when did you first see the myelogram?

A. I think it was that morning of the surgery.

Q. What time?

A. I don't remember.

Q. Well, would it have been before six a.m.?

A. Well, I wasn't there before six a.m.

Q. Were you there before six-thirty a.m.?

A. I don't recall what time I got in.

Q. Well, Doctor, you were waiting to see the results of that myelogram before deciding whether a thoracic procedure was necessary; is that correct?

A. No. I told you I was pretty certain he needed a thoracic decompression from the MRI.

Q. But you had not decided to perform one, had you?

A. I was very certain I was going to perform

one, yes.
Q. You hadn't decided to discuss it with Dr. Schechter, though, until sometime after 6:15 a.m. on December 14th; is that your testimony?
A. No.
What I said over and over before is that I told him in my letter of November 6th or 8th that he had a problem in his thoracic spine, just like he did in the lumbar spine, meaning that I thought that had to be dealt with also.
Q. And in your letter --
A. But I was only getting the myelogram and CAT scan to further define the situation, but I saw a severe cord compression on his thoracic MRI.
Q. Well, can you explain, Doctor, why it was that you wouldn't have included that procedure, the thoracic decompression and laminectomy, on the operative consent form or instructed Dr. Choung to include it if that was your intention?
A. I think that was an error on their part, because they weren't aware -- they probably were not -- they probably never saw the patient in the office and probably were not aware that I intended to do that.
Q. An error on Dr. --

A. I don't recall.
Q. An error on the part of whoever it was that signed this consent form; is that what you're saying?
A. No, about not including the thoracic laminectomy.
Q. Well, it wasn't included on the admitting diagnosis or admission plan, was it?
A. It wasn't in the paperwork, no.
Q. So other than you, who else knew of your plans to perform a thoracic laminectomy besides Dr. Schechter for now?
A. I don't know whether they -- either the fellows were aware or were in the office when he was there. I don't recall.
Q. Well, do you discuss with your fellows before a surgical date what is on the agenda?
A. Oh, usually or they just get it from my note.
Q. Which note?
A. My office note.
Q. So they would have seen the office notes, Dr. Choung and Dr. Stanford?
MR. GROEDEL: Objection.
You may answer.

A. Yes.
Q. Okay. And in this case if Dr. Choung and Dr. Stanford were to be reviewing your office notes for Dr. Schechter, they'd have no indication that you planned to perform a thoracic laminectomy and decompression?
A. Well, I may not have communicated with them how significant I thought the thoracic spine was.
Q. Well, let's be clear about it. Your notes -- Your office notes would not have indicated explicitly to Dr. Choung or Dr. Stanford that part of your surgical plan included a thoracic laminectomy and decompression?
A. Would not have?
Q. Would not have.
A. No, it's not listed.
Q. So on the morning of December 14th at six a.m. or whenever it was, between six and seven a.m., I assume when Dr. Choung and Dr. Stanford were getting ready for their day's activities, they would have had no idea at that point of what your surgical plan was; is that --
A. I don't know what they were aware of. I can't read their minds.

A. Yes. We used it at both levels, as a matter of fact.

Q. You used high-speed drill for Dr. Schechter's surgery?

A. Both levels.

We do it for two different reasons, since you brought it up. In the lumbar area, his bone was so thick and hard around the nerve roots, we couldn't get the instrumentation around it to bite it off, so we thinned it out.

In the thoracic area, we use it for a different reason, and that's to thin out the lamina, to very carefully pick the roof or the lamina away from the spinal cord with very fine instructions so that there's no spinal cord manipulation. So it's a different reason for using the power burr at each level.

Q. Sort of gotten lost. We were talking about your conversation with Dr. Schechter where you explained to him what you intended to do and obtained his informed consent.

Who else was present during this conversation?

A. I don't recall.

Q. Do you recall seeing Mrs. Schechter?

A. I think she was there.
Q. Okay. And she would have been there, you believe, when you were discussing with Dr. Schechter the planned operation?
A. I believe so, but I don't recall. Usually the spouse is there.
Q. It would have been an option, would it have not, for Dr. Schechter to have decided to wait for a thoracic laminectomy until some later date?
A. He could have waited for his lumbar laminectomy for a later date. I mean, it's purely elective.
Q. Both procedures were elective?
A. Yes.
Q. Did you consider, since you did not have an opportunity to look at the myelogram until the morning of the surgery, postponing the procedure so that you could better plan it?
A. No, because, you know, we were pretty experienced at doing both, and I thought it was in his best interest to proceed and take care of both levels.

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A. We don't order that. We -- When we expose the spine, we call for x-ray, and they're there, and they just come into the room.
Q. But is that part of the preoperative orders to make sure that there's an order for an x-ray?
A. No, not necessary.
Q. Plaintiffs' Exhibit 16, this is a UHHS Patient Care and Operations Support Form, again, which is a printout -- appears to be a printout of orders given -- entered for you, sometimes entered by Dr. Choung with regard to Dr. Schechter on December 14, 2000. Do you see that?
A. Yes.
Q. On the top line it says, "Lumbar Spine 1 View Tower." What is the purpose of that order? It was entered at 7:05.
A. I don't think I have the foggiest idea. I don't know what that means, "1 view tower."
Q. Don't know?
A. No.
We wouldn't be doing x-rays prior to the procedure. We would only be doing them during the procedure.
Q. Do you know what time Dr. Schechter was

under anesthetic?
A. I can look at the operative note. I think it was something like seven-thirty until eleven-something.
Q. Okay. Do you -- What medications are given to patients typically prior to general anesthetic?
A. I don't give them. I don't know. The anestesiologist does that. They're usually give them some sedation once they've signed the operative permit, and I don't know what all they give.
(Discussion was held off of the record.)
(A recess was taken.)
BY MR. PESKIN:
Q. Aside from what you saw on the myelogram, what was it about Dr. Schechter's clinical presentation that made you feel that a thoracic laminectomy and decompression was appropriate or necessary?
A. It wasn't necessarily clinical presentation. It was the severity of the spinal cord compression on his diagnostic studies, on the MRI and the myelogram, which, in my experience, puts him in great jeopardy for significant

paralysis if nothing is done; and because I've seen in -- going back in the 70s, before we appreciated thoracic spinal stenosis, I saw at least two or three patients become completely paraplegic who never had surgery, so that was a concern to me and that's why I wanted to take care of that.

Q. Did you have that conversation with -- is it your -- is it your belief that you had that conversation with Dr. Schechter?

A. Oh, I'm sure I didn't talk to him about what I used to see in 1970s about complete paraplegia. I think that just alarms people.

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Thereupon, a document was marked for purposes of identification as Plaintiffs' Exhibit No. 17.

- - -

BY MR. PESKIN:

Q. This is Plaintiffs' Exhibit No. 17. This is a three-page document.

Is this the operative report --

A. Yes.

Q. -- from Dr. Schechter's surgery?

Who prepared this report?

A. I dictate it. Somebody types it.

Q. You dictated this entire report?
A. Yes. I dictate all of my reports.
Q. And when do you dictate your reports?
A. Immediately after the surgery. I go right to the dictating room and dictate it as soon as I walk out of the operating room.
Q. The first paragraph under "Clinical Note," is that boiler-plate language that you dictate in all of your operative reports?
A. I usually dictate the procedure was explained to the patient and risks, sure, because that's what I do.
Q. If I were to look at 100 -- the last hundred operative reports that you've dictated, would I see -- would the first paragraph on those reports generally be the same?
A. Possibly, because that's what I do. I mean, that's what I talk -- that's what I talk to the patient about. And that's why I dictate it that way. I always talk to patients about the possibility of paralysis, usually spinal fluid fissula, no relief of pain. Those are the usual concerns of the patient for any spinal procedure.
Q. Is that what you believe -- Is that the conversation you believe you had with

Dr. Schechter?

A. I'm sure I discussed paralysis in the office, 'cause I always do that in any patient that's headed for surgery.

Q. And did you discuss with Dr. Schechter that by consenting to a thoracic procedure, he was at somewhat higher risk than he would be with just a lumbar procedure?

A. I don't know what that increased risk may be. I mean, it's very difficult to say that because the numbers -- you know, we've done -- I've done over 1,500 stenosis patients, and I have experienced paralysis after those on occasion; but you don't do that many thoracic procedures, so you can't compare risks really.

I mean, the paper we published has one patient that developed paraplegia from the procedure, following the procedure, out of 12 patients, so it's not 1,500 patients. So it's a very different -- But we always talk to patients about potential of paralysis because it exists.

I frequently talk to patients also about redoing their spinal surgery, because that's about 40 percent of what my practice is, and, you know, there's always scar there. I talk to them about

tearing the dura covering around the nerve roots; and if it occurs, I tell the family about it afterwards. It's not usually a big deal.

Q. You did the thoracic laminectomy first; correct?

A. Yes.

Q. That's what you dictated in your operative report?

A. Yes.

Q. Who was present in the operating room?

A. I don't recall, but it says assistant surgeons are Stanford and Choung.

Q. Where was Dr. Choung -- What level of training was he at at that point?

A. They both were spine fellows.

We have -- To explain our training program here, we have three spine fellow -- domestic spine fellows that come each year who are fully trained orthopedic or neurosurgeons before they come here. They spend an additional year here to learn about spine surgery. And they scrub-on assist, sometimes do cases at other hospitals. And both of these individuals were spine fellows at the time, both fully trained orthopedic surgeons, but they were assisting.

Q. Okay. What part -- Who opened Dr. Schechter? Who did the initial incision?
A. I'm sure I did.
Q. Okay. Well, let's carry it one --
A. I don't always do that, but, you know, sometimes I have the fellows expose the spine, but I think I did.
Q. You can't be certain?
A. Well, for physicians, dentists, VIPs, I tend to do almost everything; maybe not close the skin, but I do everything.
Q. You considered Dr. Schechter to be a VIP?
A. I think he's a professional person that I respect very much, and I would -- and if he said to me, Are you going to do the operation? which I get questioned all the time, I would say absolutely.
Q. Well, I notice that you use the term "we." You say "we" then proceeded to do the thoracic laminectomy first.
A. Oh, it's the way I dictate things, but I was doing the laminectomy, but I'm saying "we" meaning by assistants and I.
Q. Describe to me the bone cutter that you used to remove the spinous processes.

A. That's a large bone-cutting instrument, which cuts off the spines that stick out from the back of the spine in order to get down to the lamina.

Q. Okay. And then you used a Leksell rongeur. What is that instrument?

A. That's a smaller biting instrument to nibble away the lower part of the lamina, the roof of the spinal canal.

Q. And would you have used those instruments -- To the best of your recollection, was that you using those instruments?

A. Absolutely.

Q. And then it says you dissected the ligamentum flavum off the lamina with a curette.

You performed that part of the procedure as well?

A. Yes.

Q. And the next sentence says, "Using small to medium-sized Kerrison punches, we proceeded to do a laminectomy at T12, T11 and T10."

A. That was me doing all of that with the assistance of the fellows.

Q. What is a Kerrison punch?

A. A Kerrison punch is -- they're different

sizes; but in this situation, very tiny -- one, two, three-millimeter tiny biting instruments that you -- they have a little footplate on them that you put under the lamina to nibble away the lamina so that you don't manipulate the neuro structures; you just take the roof of the spinal canal off.

Q. A medium-sized Kerrison punch would be three millimeter; would that be right?

A. About three, but we start off with very small ones.

Q. You used a medium-sized Kerrison punch, which would have been a three-millimeter punch in this case; correct?

A. Small to medium size is what I said.

There is a space under the lamina in the middle of the spinal canal, and that's where we start, where they -- the lamina comes together like a roof. So there's a little space above the spinal cord where you have room to put these small instruments and start nibbling away in the midline and then we widen that out.

Q. Were you --

Strike that.

Where did the drills come in to use in this operative procedure, the high-speed drills you

were talking about earlier? I don't see them mentioned in your operative report.

A. I think it's in there. I'm positive I used it. I may not have mentioned it in the thoracic, but I know I used it there as well as the lumbar.

Q. Isn't it your -- Isn't it good practice when dictating an operative report to note all the instruments used in a procedure?

A. Well, I did notice -- I did note the high-speed drill in the lumbar procedure, but I know I used -- I can tell you as I sit here today, I used -- because this is the way I do these. I always use a power burr to thin out the lamina before I start taking the lamina off.

Q. You would agree that your operative note does not indicate that, does it?

A. It's not mentioned in the thoracic part of the procedure. It's mentioned in the lumbar, but the drill was right on the set, and I did use it in the thoracic area.

Q. Did you have a microscope in the operating room?

A. No. I used -- We do all of our spine surgery with magnifying lenses and headlights.

That's the routine. I don't think a microscope is necessary for this.

Q. Are there any risks in using a medium-sized Kerrison punch when you have a flattened cord?

A. I don't think there's any risk when you do it as I just described.

You start in the midline after the lamina is thinned out with a burr. There's just a little, thin bone left in. In the very middle of the spinal canal, we use first the small Kerrisons, very tiny biting instruments, where there is a space outside of the spinal cord; and then we widen that with maybe smaller Kerrisons, as we widen the laminectomy site. So I don't think there's any significant risk in injuring the cord doing it technically that way.

Q. Let's talk about the part of the procedure that involved Dr. Schechter's lumbar spine.

Why was it that you extended the operation to the left side of Dr. Schechter's lumbar spine?

A. I routinely take care of everything that's abnormal where I see nerve root compression.

I don't just do the systematic side. I've done this routinely in over 1,500 patients with stenosis in the last 30 years. And our results of relief of pain and paralysis, that people that have paralysis, is 92 percent good to excellent.

And I also remove the thick bone on both sides if there's no root compensation on both sides. I think it would be not be correct not to decompress all the nerve roots that are being compressed. And our long-term results, I think, bear out that philosophical approach.

Q. Where did you see evidence of nerve root compression on the right side of Dr. Schechter's lumbar spine?

A. Oh, that's on the MRI, myelogram and CAT scan.

Q. He was having no neurological symptoms on the right-hand side, though; correct?

A. No, but I can't bring myself not to decompress a nerve root that's severely decompressed even in a patient that is not symptomatic. You're right there. I think you should do the whole job.

Q. Do you -- Did you administer any intervenous steroids to Dr. Schechter prior to

surgery?
A. No.
Q. Why not?
A. No reason to do so.
Q. Is there any reason to give intervenous steroids prior to thoracic decompression surgeries?
A. No. There's no evidence to state that.
Q. Are there spine surgeons that would disagree with you?
MR. GROEDEL: Objection.
You may answer.
A. There are, I think, more neurosurgeons that do this --
There's absolutely zero evidence in the literature to say that that makes any difference in the problem with postoperative paralysis or there's no evidence whatsoever; and, plus, there can be complications from administering steroids, so we don't use it.
Q. On page 3 of your operative report, the last sentence says, Dr. Bohlman was the primary surgeon and was present throughout all the critical portions of the case.
You're referring to yourself as a third person, then?

A. Yes.
Q. Is that typical practice?
A. Yes.
Q. Now, looking at that last sentence, does that refresh your recollection that you didn't perform the entire surgery?
A. Of course not. I did.
Q. Well, then, why would you have dictated that you were present throughout the critical portions of the case as opposed to Dr. Bohlman performed the entire operative procedure?
A. Well, maybe I didn't close the skin. I mean, I don't remember that. Sometimes I don't. Sometimes the fellows are better than me. But I did the whole operation, and that's the way I dictated it.

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Thereupon, a document was marked for purposes of identification as Plaintiffs' Exhibit No. 18.

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BY MR. PESKIN:
Q. Plaintiffs' Exhibit 18, it's a nursing record from the immediate postoperative period. Would you agree with me that that's what this is?

A. Yes.
Q. The first note at 11:25, it says -- I can't read the beginning two words, but it says, "Patient is unable to move left leg." See that?
A. I'm trying to decipher the first part. Something "aware" -- It looks like "Aware patient is unable to move left leg," that's correct.
Q. Unable to wiggle toes; correct?
A. Yes.
Q. Or keep left leg bent; correct?
A. Yes.
Q. Now, prior to the surgery Dr. Schechter had no problem with his left leg, did he?
A. No, no neurologic problems.
Q. And postoperatively, he had a significant neurologic deficit; correct?
A. He did have significant weakness, mostly in the left leg.
Q. You were present at the bedside at 11:45, according to this note.
A. I was.
Q. Okay. And you became aware so at that point that Dr. Schechter had a significant neurologic deficit --
A. Yes.

Q. -- postoperatively?
A. Yes. I came in to examine him.
Q. Why did you not order an MRI at that point?
A. I don't think there was any reason to. This was --
Well, couple reasons. I mean, there was no --
First of all, this was an immediate weakness on one side that was incomplete weakness with spotty loss of sensation, which, in my humble experience of 30 years in dealing with spinal cord injuries, appeared to be a vascular impairment of the spinal cord, which was incomplete. So I wasn't concerned with --
You don't -- You don't get a hematoma instantly when somebody arrives in the -- in the recovery room. So I was not concerned about anything else compressing his spinal cord.
And in addition, as we were watching him, he started improving.
Q. Could Dr. Schechter's neurologic deficits postoperatively have been caused by some sort of trauma to his spinal cord?
A. It did not act like that from the reasons

I just mentioned. It was very -- I mean, I've never had that happen before, but -- I mean, not a direct injury to the spinal cord. It just acted like a vascular-type neurologic pattern. It was very incomplete. He had almost no weakness on the right side at all, and he had no bladder impairment and just a little bit of sensory loss on the left side, and he started to recover almost immediately, so I saw no sense in re-studying him at that moment.

Q. What do you mean by a vascular injury? How does that occur?

A. We don't know. It -- The blood supply is more sparse, we believe, in the thoracic spine, the blood supply to the spinal cord. It comes in through little fetter arteries along the nerve roots. This can happen in the cervical cord or the thoracic cord. We don't totally understand the cause of this, but it can be associated with an operative procedure.

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Thereupon, a document was marked for purposes of identification as Plaintiffs' Exhibit No. 19.

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BY MR. PESKIN:

A. And the pattern of this with the sparing sensation acted very much like a vascular -- some partial loss of blood supply to the spinal cord. This is -- And it's pretty classic for that.

The other concern that I made a note of is that we inject a long-acting local anesthetic called marcaine in the muscles before we close the wound up, and that's to control pain from the operation so they don't have as much pain.

And in the past -- we have written a paper on this, actually -- we had in a chest procedure, doing two disc herniations from the front. The thoracic colleagues injected anesthetic into the muscle, and it dripped down the spinal cord; and in the recovery room, the spinal -- the patients -- two patients with thoracic discs on the same day woke up with weakness in the recovery room, which ultimately recovered. And it was from the anesthetic. So I thought this was a possibility in Dr. Schechter.

Q. Ultimate --

I've already just handed you what's Exhibit 19. And I think that's the note you were just referring to. That's your own post-opt note

from 11:45; correct?
A. Yes.
Q. Is it fair to say that as you sit here today you do not attribute Dr. Schechter's postoperative difficulties to marcaine having been dripped down his spinal cord?
A. I don't think. That was just a possibility because we have had that happen to us in the thoracic area.
Q. That was something that you considered as a possibility, and you documented that as a possibility, but later ruled it out based on the fact that he didn't recover as you would have expected from --
A. No. I was 95 percent certain it was a vascular problem.
Q. Did you -- You did not include in your note for possible causes of Dr. Schechter's neurologic deficit trauma to his spinal cord; correct?
A. I don't think there was any trauma to the cord. That wasn't a possibility.
Q. Why are you saying that it was impossible that there would be trauma to his spinal cord?
A. There was no trauma to his cord. There

was no manipulation of his spinal cord by the technique we use.

Q. And the basis for that assertion is what?

A. I've gone all through the technique. I hope the jury can understand.

We use very tiny instruments. The spinal cord is in the spinal canal; and where the roof of the lamina occurs, when we first enter the spinal canal, there is room to put the small instruments and nibble the bone away. We nibble the bone away from the spinal cord. There's no manipulation of the spinal cord whatsoever.

Q. When you're nibbling this bone away, you're, in essence, blind, aren't you?

A. No, not blind at all. We don't do anything blind. We're looking right at the spinal cord with magnifying lenses and headlight. We have absolute direct visualization of everything you do.

Q. So you did not see at any time during the operative procedure any trauma to Dr. Schechter's spinal cord?

A. There was no trauma to his spinal cord, no manipulation.

Q. You would agree, though, Doctor, that

if one were to manipulate the spinal cord during a thoracic decompression surgery, that symptoms similar to those that Dr. Schechter exhibited postoperatively could occur?

A. That's possible. And historically specifically neurosurgeons did thoracic laminectomy for thoracic herniated discs, which were in the front of the spinal cord always. And what they did and I suppose some orthopedists, but I don't think so, they would try and get out a disc -- herniated disc in the front of the spinal cord from the laminectomy approach, which means you have to retract on the spinal cord and manipulate it and that can cause complete paraplegia, incomplete paraplegia in a very high percentage of patients. And we -- that's why we wrote our paper on front decompression of thoracic disc when that's the only pathology. But in thoracic stenosis, this a different animal. It's compression predominantly from the back, and you go very carefully through that little space and nibble the bone away from the spinal cord with no manipulation to the spinal cord.

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Thereupon, a document was marked for

purposes of identification as Plaintiffs' Exhibit No. 20.

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BY MR. PESKIN:

Q. Handing you what's been marked Exhibit 20. This is a note at the top of the page from you dated December 15th at eleven-thirty a.m.

A little more than 24 hours postop at this point; correct?

A. Yes.

Q. You were leaving town is that day; correct?

A. Yes.

Q. And you saw him just before you left town?

A. Yes.

Q. In that note you indicate, Will give him decadron for 48 hours.

Why did you wait 24 hours to administer steroids to Dr. Schechter?

A. I don't -- To be honest, I don't think steroids do any good, even when you have -- There's never been any proof to -- that says that a vascular injury of the cord is benefited by steroids, no proof whatsoever in the literature,

but I suppose we were trying to do everything we thought we could do, but I -- I basically don't think it improves -- the situation has never been proved.

Q. Do -- Does the literature indicate that traumatic injuries to the spinal cord are benefit from steroids?

A. In a very minimal way, and I've written extensively about that if you want to discuss that.

Q. I'm just asking if --

A. Very minimal, very minimal, if any.

Q. Why would you have ordered them at all if you felt they didn't do any good?

A. I was just trying to do everything we possibly can. Possibly even for medicolegal reasons, because it's brought up in depositions and trials because it was published that way, and I think that's very unfortunate.

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Thereupon, a document was marked for purposes of identification as Plaintiffs' Exhibit No. 21.

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BY MR. PESKIN:

Q. Plaintiffs' Exhibit 21, this is a

discharge summary from Dr. Schechter's admission dated -- discharge December 19th, 2000.

You didn't dictate this summary, did you?

A. No. Dr. Choung did it.

Q. You were out of town; correct?

A. Well, this was done much later. It was done like three months later.

Q. Right. But you were out of town on the 19th?

A. Of December?

Q. Yes.

A. Yes. I can't remember where I went, but I may have been on vacation. I'm not sure.

Q. So Dr. Schechter stayed in the hospital the 16th, 17th, 18th, four days, while you were out and somebody was covering for you; correct?

A. Yes. Dr. Emery was covering, who's one of my partners, is a spine surgeon. And I know I communicated with him by phone because I was concerned.

I'm sure that's not documented either, but I know I talked to him.

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Thereupon, a document was marked for purposes of identification as Plaintiffs' Exhibit

No. 22.

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BY MR. PESKIN:

Q. Handing you what's been marked as Plaintiffs' Exhibit 22, this is a letter from you to Richard Stein, M.D., and that's Dr. Schechter's internist.

You dictated this letter?

A. Yes.

Q. Actually before we look closely at this letter, if you look back at your office notes. I think that's Exhibit 2 or 3.

MR. GROEDEL: He's got his notes in front of him. That's okay.

Q. Look at your note for December 19th, 2000.

A. Okay.

Q. At the bottom of it, it says, "cc: Richard Stein." It looks as though you used a portion of this note in your office note to compose the letter to Dr. Stein. Is that a fair statement?

A. I didn't use this specifically. I just re-dictated a letter.

I always send the discharge summary to the primary care physician. And in this situation,

because of the complication, I sent a letter to him explaining, but I always send a discharge summary routinely, but I took it off -- out of my head when I dictated a letter to Dr. Stein.

Q. Okay. Let's look at your note first from the 19th that you put in your office notes.

This is your own discharge summary --

A. Yes.

Q. -- as opposed to with the one that Dr. Choung did for the hospital?

A. Yes. Yes.

Q. In the third sentence or so it says, Indeed, on his preoperative myelogram and CT scan, which I did not see until the morning of his surgery because it could not be brought up to the office, period. That's not a complete sentence.

But what do you mean it couldn't be brought up to the office? Did you ask that it be brought up to the office?

A. Yeah. I don't think they could find it.

Q. Who's "they"?

A. I don't know. Radiology. I don't know who is "they."

Q. When would you have asked to see it?

A. I don't remember. We try and look at

it beforehand. Usually I have the studies done -- I look at the studies a day before at least.

Q. Well, how did you know that they were going -- Did you know that they were going to be able to locate the film prior to surgery?

A. Probably not, but I assumed they would.

Q. Did it make any difference to you whether or not they could locate the film prior to surgery?

A. Well, I'm sure I could have done the same surgery on the basis of the MRI, which I said before.

Q. So you would have done the same surgery --

A. Oh, absolutely.

Q. -- even if you hadn't seen the film?

A. Yes.

Q. So seeing the film was not significant to your decision to extent the surgery beyond a lumbar decompression and laminectomy to include a thoracic?

A. No. No. I knew we had to do a thoracic just by looking at the MRI.

Q. But you didn't decide to do that until the day of surgery?

A. Oh, no, that's not true. I knew we were

going to decompress the thoracic spine.

As I mentioned before, the -- even with the lumbar -- the redo lumbar decompressions, I always do a myelogram and a CAT scan, because it gives me more useful information of how the nerve roots look like and in the thoracic area, spinal cord and the bony compression. It's a different dimension, but it doesn't change what we do.

Q. Doctor, isn't it your practice to do interoperative spinal cord monitoring when you do lumbar -- excuse me -- thoracic decompressions and laminectomies?

A. Usually.

Q. That's your practice?

A. Usually if it's available.

Q. Now, if you look at your discharge summary there, it says, "Because of when I saw the studies, we could not on the spot arrange for interoperative spinal cord monitoring, unfortunately." Do you see that?

A. Yeah.

Q. Now, Doctor, as you sit here today -- and I wonder if this refreshes your recollection about when it was that you decided you were going to do a thoracic decompression.

Isn't it a fact that you didn't decide you were going to do it until after you saw the myelogram?

A. No.

Q. Well, then why did you make that statement in your discharge summary, "Because of when I saw the studies, we could not on the spot arrange for interoperative spinal cord monitoring, unfortunately"?

A. No. I think that what happened was, my secretary, as she put in all of the preoperative schedules, it was a lumbar laminectomy, and I didn't specifically tell her I wanted thoracic spinal cord monitoring.

She's not used to seeing a lot of thoracic, necessarily, so she just thought we were doing lumbar at that time, so she didn't arrange for the monitoring technician.

Q. Well, you did --

A. It was probably my fault. I didn't tell her to line up the spinal cord monitoring technician.

Q. In that sentence, though, Doctor, you are -- isn't it true that you are indicating that it was because of when you saw the studies, that

you could not arrange for interoperative spinal cord monitoring?

MR. GROEDEL: Objection. Asked and answered.

A. No. I knew I was going to do the thoracic.

It's probably my error in communicating with my secretary.

I'm so used to her scheduling -- like if it's a thoracic disc or a big cervical decompression, I don't have to tell her. She knows automatically to schedule the spinal cord monitoring, but this is a very different situation, and she was not aware, so -- neither I, because I personally don't schedule the monitoring.

Q. You don't have your secretaries or anybody schedule interoperative spinal cord monitoring if you plan to do a simple lumbar laminectomy and decompression; is that true?

A. True.

Q. You only arrange for interoperative spinal cord monitoring when you're doing thoracic procedures; correct?

A. Thoracic and cervical. Depending on the cervical case and in general.

Q. Now, when you discovered that the monitoring equipment that you typically use for your thoracic procedures was not available, did you consider postponing the surgery?
A. Not really, because I wasn't -- to be honest, I wasn't that overly concerned about the procedure. And I don't think it would have changed what we did. I think we had to do what we did.
Q. Well, this was an elective procedure; correct?
A. Sure.
Q. The entire procedure?
A. Sure.
Q. Didn't Dr. Schechter deserve to have all of the equipment present that you typically use when you perform these surgeries?
MR. GROEDEL: Objection.
You may answer.
A. I don't think it would have made any difference in what we did. We had to do the thoracic laminectomy. I don't think it would change technically what we did. And I don't use it for all cervical decompressions.
Q. You did, however, note that it was unfortunate that it was available; correct?

A. Yeah, I think that's exactly what I said, because we usually like to have it.

Q. And what is the purpose of that interoperative spinal cord monitoring?

A. Oh, to hopefully let you know if there's a problem with the spinal cord during the procedure, like a direct injury, which I've never had.

The problem is --

I mean, it's a comfort factor for the surgeon, I guess, because you can have the monitoring --

Well, first of all, for the jury, spinal cord monitoring is an electrical stimulation of the legs -- the nerves in the legs and the arms, and the message goes up the spinal cord, in the back of the spinal cord to the brain. And this machines spits out little wave forms that look like a heart tracing, so we can kind of tell in general the function of the spinal cord.

The problem is in this situation, retrospectively, I don't think it would have shown any abnormality anyhow, because postoperatively, when he had his motor weakness in his left leg, the sensation -- the back of the spinal cord where

the monitoring gets transmitted, it's up the -- the sensory fibers, the sensory tracks in the back of the spinal cord, which were completely normal in Dr. Schechter, so I don't think it would have told us anything.

You can have a complete paraplegia and have sparing of position and vibration sense which goes up the back of the spinal cord and have normal spinal cord monitoring.

Q. Do you believe it's the standard of care when doing thoracic spine surgeries to use interoperative spinal cord monitoring?

A. I don't think you can say that that's absolutely standard of care. Some people use it, some people don't.

There are surgeons here who frequently do not, because, as they say, it's not going to change necessarily what you're going to do technically that needs to be done.

Q. Have you ever taken the position that -- that when doing thoracic surgical procedures, a surgeon should use interoperative spinal cord monitoring?

A. Well, we recommend that, but there's so many different pathologies in the thoracic area,

but we recommend that, and we do use it pretty routinely, but it doesn't usually --

I'm trying to think if it ever altered what I did in the thoracic spine. I don't think so.

MR. PESKIN: Do you want to go off the record now for a few minutes?

(A recess was taken.)

BY MR. PESKIN:

Q. Dr. Bohlman, we were looking at your discharge summary from your office notes from December 19th, 2000.

After the last sentence, we were talking about "because of when I saw the studies," et cetera.

The next sentence says, "In any case, he was taken to the operating room on the day of the admission for a lumbar laminectomy of L4-5 S1 was carried out with bilateral foraminotomies and then we carried out a very meticulous laminectomy of T10-11-12, decompressing the spinal cord at those levels." Correct?

A. Yes.

Q. What was the order of this surgery, Doctor, because the discharge summary doesn't

match the operative report?
A. Well, I don't think that makes any difference. That's not supposed to be a chronological order; just what we did. We did the thoracic part first -- I definitely recall that -- and then the lumbar, but it makes no difference.
Q. And the discharge summary you dictated, though, you had it the other direction, correct, that you did the lumbar laminectomy and then the thoracic laminectomy and decompression; right?
A. No. I didn't mean that in chronological order is what I just said. I said we did both. I simply dictated that we did the lumbar laminectomy and the thoracic laminectomy. I didn't say one was done first over the other.
Q. The next sentence says, "Although we were extremely cautious not to manipulate the thoracic cord in any way postoperatively, the patient awakened with significant motor deficit."
I'm curious about your choice of words there. When you say, "Although we were extremely cautious not to manipulate the thoracic cord," are you indicating that manipulation of the thoracic cord can cause a significant deficit?

A. I didn't -- I was simply stating openly and honestly to Dr. Stein that we purposely did a very meticulous laminectomy without manipulation of the spinal cord, but the patient woke up with a postoperative deficit.

Q. Dr. Bohlman, aren't you always meticulous in your surgical technique?

A. Sure.

Q. Don't you always -- Aren't you always extremely cautious not to manipulate the thoracic cord?

A. Sure.

Q. Do you always dictate in all of your operative notes about how cautious you are in avoiding manipulating the thoracic cord?

A. Usually, because that's what we do. Same way with cervical. I do note that there was no manipulation of the spinal cord and that this deficit was a vascular loss of blood supply related.

Q. What evidence do you have to confirm your suspicion that Dr. Schechter's postoperative deficits were the result of a vascular injury?

A. I mentioned this before and maybe it went by you. Because of the pattern of the

deficit, very incomplete, just a weakness -- a patchy weakness that did not make any neurologic sense, if you had a direct injury to the spinal cord, and classically vascular injuries to the spinal cord spare the back columns of the spinal cord, which carry position and vibration sense. And the classic form of a vascular insult called the anterior spinal artery syndrome, where the artery in the front of the cord loses blood supply or is clotted, patients develop paralysis on one or both sides, but always have sparing of position and vibration sense.

Dr. Schechter only had weakness predominantly on the left side, which was incomplete, and had sparing of most sensation. So this was pretty classic vascular injury to the cord. Plus, the other reason is, not only the pattern of the deficit but the rapidity with his recovery of neurologic function, which started happening within hours.

Q. In the postoperative -- In your postoperative care of Dr. Schechter, did he complain of significant pain?

A. No.

Q. Was he taking narcotic analgesics?

A. Well, he had operative pain for which he received narcotics, as anybody does.

Q. What about in January of 2001? What kinds of problems was he experiencing at that point?

A. That was a response to a phone call. He was doing extremely well. He had gone to physical therapy. He was actually in physical therapy when I tried to call him earlier. He was walking with two canes. He had no incontinence. He never did have any incontinence of bowel or bladder at any point.

Q. He never did?

A. He never did, never.

He only had one episode with sounds like -- which we believe was leaking of stool around the fecal impaction. And I know Lynette, our nurse clinician, talked to him and I talked to Lynette, and that's what we were sure was happening.

So once we told him he should get his bowels cleaned out and following that, there was no further episode. He had no incontinence of bladder at all.

And actually prior to that, I visited

him at the Euclid Rehabilitation Unit. He was not complaining of any pain, and he recovered very significant neurologic function. That was on the 23rd of December, so he was rapidly recovering.

Q. On the 23rd of December -- back up for a moment -- you went to see Dr. Schechter at Euclid Rehabilitation Unit.

A. Yes.

Q. Is that unusual for you to go visit a patient at a rehabilitation facility?

A. It is, unless they're here locally; although, I've done this periodically in the past.

I was concerned with his neurologic recovery, somewhat concerned, but he had already started recovering before he left the hospital, and I just wanted to see how he was doing and check in with him. And I think --

No, I don't usually make house calls.

Q. Why do you say that Dr. Schechter had no pain? Does it say that in your 12-23-2000 note?

A. I don't think he was complaining of pain. I didn't make any note of pain. He was

in good spirits.

- - -

Thereupon, a document was marked for purposes of identification as Plaintiffs' Exhibit No. 23.

- - -

BY MR. PESKIN:

Q. Take a look at Exhibit 23. It's a phone message from Dr. Schechter on January 3rd. He was complaining he was incontinent; correct?

A. That's what we later fared it out as leaking around a fecal impaction, bowel incontinence, which we didn't think was true incontinence. And the Percocet was probably still for his preoperative pain.

Q. He was taking narcotic analgesics?

A. Sure. It was only a few days after his --

Let's see. That was --

Q. Three weeks postoperative?

A. No. No. No. December 14th was the surgery, so that's --

You're right -- No. A little less than three weeks, but still people take narcotics for six weeks.

Q. What else can you recall about your postoperative care of Dr. Schechter in terms of his recovery of neurologic function?
A. Well, he came back on the 24th of January. At that time he had some shoulder pain, some right knee pain, and he was having like arthritic joint pain, but not the leg pain that he had before the surgery.

He was completely normal motor testing, motor strength at that point, which was like five weeks after the surgery. He had slight decrease sensation of pinprick in a patchy area, but otherwise was fine and that deep tendon reflexes were normal. So he had recovered all of his motor strength on neurologic examination.
Q. Based on your examination?
A. Based on my examination, which I do routinely with all patients when they come back.
Q. Your last appointment with Dr. Schechter was when?
A. Well, I saw him again in April, on the 4th.
Q. And then July; correct?
A. Yes.
Q. And then he canceled an appointment in

December; correct?
A. Yes.
Q. I have provided your attorney with records from subsequent treating physicians, Dr. Schechter's subsequent treating physician. Have you had an opportunity to review those?
A. Yes.
Q. Have you reviewed the reports from Dr. Stevens, neurologist at Cleveland Clinic?
A. Yes.
Q. Did you note in those reports that Dr. Schechter, throughout 2001 and into 2002, is continuing to complain of pain?
A. I couldn't decipher from the records where he was complaining of pain, and in --
He saw a Dr. Thomas, an osteopathic pain doctor for The Cleveland Clinic, who started putting him on MS Contin and Percocet, which he never needed when I saw him. I mean, he never had that level of pain. And I can't tell from the records where that pain was, but neurologically he was almost completely normal by Dr. Stevens' examination.
Q. When you say "almost completely normal" --

the time we don't know what it comes from, and it can be from no injury whatsoever. It can occur associated with burning stem abnormalities. It can occur with traumatic spinal cord injuries.

Where they saw it, it was pretty minuscule when it was like up at, I think, T8-9. It was above where the surgical procedure was done.

Q. Dr. Schechter didn't have a syrinx cavity in any of the radiologic studies that you performed prior to his surgery, did he?

A. I don't know. This is very minuscule -- It's above where we were. There's a very minuscule little line that I could barely see -- I don't see a frank pocket of fluid, myself. And I'm not sure it's read out on any other studies.

Q. A syrinx can be caused by trauma; correct?

A. Only large ones. You don't see anything like this. I could hardly see it. It was really -- I had to go back and really look at all the views. There's almost nothing there. Very small area up at T8-9.

Q. But that's a new finding postoperatively; correct?

A. I don't know. It's so minuscule, I don't

know that it was there on a technically different MRI or not.

Q. You had an opportunity to look at all of Dr. Schechter's films. Did you see, when you reviewed the films -- preop film on Dr. Schechter, any evidence of the syrinx cavity?

A. I didn't even see it on the postoperative one until I read the record and went back and tried to look at it. It's so small. It's very, very minuscule. I think it's unrelated.

Actually, I would be interested in some other neuroradiological interpretations. I just -- I think it's so tiny, it's questionable.

Q. Do you -- On February 25th, 2002, Dr. Stevens prepared one of several reports regarding his care of Dr. Schechter and said that his impression was that he was status post spinal cord injury with stabilization of motor function and increased pain. Would you disagree with Dr. Stevens' assessment?

A. Absolutely. It's not a spinal cord injury. This is a --

A spinal cord injury from the standpoint of loss of blood supply, not from a traumatic blood injury to the spinal cord.

A. No, but you can exclude a blunt spinal cord by doing the MRI, which has been done.
Q. Well, how --
A. Well, it shows no lesion of a blunt traumatic injury to the spinal cord.
Q. Do you know Dr. Dickman (phonetical)?
A. I know him very well. I used to give lecture out of Barrows* Neurologic Institute for about six years in a row. And I reviewed some of the papers he's published or was trying to publish.
Q. You're aware that Dr. Schechter went for a consultation with Dr. Dickman?
A. I am now. I was not aware that he was seeing other people in February, March and May while I was still seeing him. I would have welcomed it if he wanted another opinion, but he never discussed it with me.
Q. When he saw Dr. Dickman in September 2001, you weren't seeing him then?
A. Oh, it seems to me it was May, but maybe I'm mistaken.
MR. GROEDEL: I think Dr. Bohlman last saw him in July, and he was scheduled to see him again in December of 2000.
A. He saw him in May; I believe was the

consult, because he was talking to his primary care physician, Stein, and there were notes about him going out to Barrows Neurologic in May.

You're right. September 10th.

And he, too, found completely normal motor strength on examination, as did Bingham.

Q. Both noted Dr. Schechter's significant complaints of pain; correct?

A. Again, I can't be clear where his pain is. That's a little --

And the problem is, he got started on MS Contin and continued on Percocet by the pain physician way back -- where it was started -- by Dr. Thomas in July.

Wait a minute. Hang on.

And here we go. No. Actually --

Well, it was before -- sometime before December -- or September.

And the problem is, when you get started on heavy narcotics like this, you keep having pain because you become used to, if not addicted to the narcotics, and then people keep having pain until they're taken off the narcotics. So now he's a chronic pain patient, which is not his fault, because he's been placed on the narcotics. And

the last note that I've read, he's still on the MS Contin and I suspect still on the Percocet. So people keep having perceiving pain.

I didn't get from any of the note that he had specifically leg pain or pain in a specific area. That would be a concern.

Q. Did you see the notes from Dr. Potts, a neurologist that Dr. Schechter consulted with?

A. I think I missed that.

Who is that?

Q. Dr. Potts, Cleveland Clinic Foundation.

A. I may have missed that.

It's probably in there. I don't remember the name.

(Discussion was held off of the record.)

A. It says --

I know I didn't see this because he had a cystometrogram, which is a dynamic study of the body, that we recommended for him here when he was complaining of having difficulty urinating, and he declined.

And there is one here dated 18 -- 18 October, which is absolutely what he needed to have. And it looks like it was fine, because he had sensations and a very low volume, voided okay.

Q. Look at the last page and the impression here. It indicates he has a neurogenic bladder.
A. That's certainly not proved by my -- I mean, he -- I don't think he has a good capacity. He voided all the urine. I don't know how he can say that.
Q. Well, look at the last page.
A. Well, I see what they're saying.
Q. Okay. You disagree?
A. I disagree the cystometrograph doesn't prove the normal bladder. He has sensation, and he has good capacity and voids on his own. You can't do that with a neurogenic bladder. And he has never been incontinent.
Q. You're aware from review of the records that Dr. Schechter complains of difficulty with urination?
A. I know what he complains about.
Q. And he also complains of difficulties with sexual function?
MR. GROEDEL: Objection.
A. I know what he complaints about, but there is no medical evidence that there's any impairment of his bladder or sexual function because the nerves to those structures are intact.

They never were out. There's no medical basis for that.

All I can say in adding, I ran a spinal cord injury unit at the Veterans' Administration Medical Center for 27 years and dealt with neurogenic bladders, cystometrograms and, closely with the urologists, sexual dysfunction. And, again, there's no hard medical evidence that there's any loss of those nerves or spinal cord function.

Q. Would Dr. Schechter have benefited from removal of the herniated thoracic discs that were -- that are still showing on his radiologic studies?

A. You mean now?

Q. At any time.

A. Well, I wouldn't have done that in the beginning, and I didn't for the reasons I've already described.

They're still there. One -- The one -- I believe it's at T10-11 still slightly deforms the spinal cord, but I would not -- as Dr. Curtis Dickman stated, he's recovered completely neurologically; and until he deteriorated, he wouldn't think about doing that.

I would tell you that he would be at extraordinary high risk for neurologic problems with the cord if he were now to have an anterior procedure, because, you know, he might lose more blood supply to the spinal cord. And I think nobody in their right mind would do another operation if he's normal neurologically, if he's recovered. So I don't think it would benefit him in any way. It could only harm him.

Q. Give me a minute here. I may be done.

MR. PESKIN: Off the record.

(Discussion was held off of the record.)

Q. Dr. Bohlman, in your experience, do traumatic syrinxes grow?

A. They're very rare, in the first place. As I just mentioned, I was in the spinal cord injury business for 27 years, running this unit. And they can occur soon after a spinal cord injury, which is very rare, or 20 years after a spinal cord injury. And, yes, they can grow. And usually the reason they grow is because where the spinal cord injury occurred, they're so scarred down, that the fluid doesn't flow properly around the spinal cord and the syrinx grows upwards, you know, and enlarges the spinal cord and people can then

develop increased neurologic deficit.

What's being called a syrinx in Dr. Schechter is so -- I don't even see any pocket of fluids, so it's so minuscule. As I said, it could have been there before. And it's not picked up on the MRI. And I would be interested to know what our specific radiologist would think of that. But I don't think anything what he has there can grow.

Q. If it were to grow, would he experience increasing neurologic deficits?

A. Some do and some don't. I mean, if syrinx is enlarged, for whatever the reason -- I mean, traumatic or nontraumatic, if they enlarge they can cause deficit, but that's extraordinarily rare; even in traumatic injuries, very, very rare.

MR. PESKIN: I have no other questions.

MR. MC DONALD: I have some questions.

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CROSS-EXAMINATION

BY MR. MC DONALD:

Q. Doctor, my name is Rick McDonald, and I represent the hospital who is sued as a co-defendant with yourself in this lawsuit.

My understanding is that Dr -- as you've

described at the time of the surgery, Dr. Stanford as well as Dr. Choung were fellows here at the hospital. Is that correct?

A. That's correct.

Q. Let me ask you a few questions about your conversations with Mr. -- Dr. Schechter prior to the surgery.

MR. MC DONALD: And, Mark, if you have the exhibits handy somewhere here.

Q. Let me turn your attention then --

Before we go to the exhibits, your testimony, I heard it -- and I think I understood -- as far as the consent issue relative to the thoracic involvement, thoracic procedure, with Mr. Schechter was that it was certainly contemplated and considered by you to do that after your initial examination and especially after the MRI that was taken in October; is that correct?

A. Specifically after the MRI, I saw the MRI.

Q. Let's cut to the chase, then, as they say. There's no doubt in your mind as you sit here today that you had a discussion with Dr. Schechter at some point in time and during that discussion it was made clear to him by you that you were not only

going to do the lumbar laminectomies but you were also going to operate on his thoracic spine; is that true?

A. I believe that's what I discussed with him; but the letter, as you can see, was less specific. I mean, I talked about lumbar stenosis as well as a thoracic disc. In the letter I didn't get into specific technique of surgery.

Q. I'm not talking about the letter. I'm talking about your conversations with him.

At some point in time prior to actually doing the surgery, you did discuss the fact with him that you were going to do surgery not on this lumbar area but also on the thoracic area? Isn't that what I understand your testimony to be?

A. Yes.

Q. And there's no doubt in your mind about that?

A. No.

Q. And that you obtained -- You're certainly familiar, with all the surgeries you've done, with what informed consent is, obviously; correct?

A. Yes.

Q. And there's no doubt in your mind that you obtained from him the informed consent to

proceed both with lumbar surgery as well thoracic surgery?

A. I believe he was aware of it from a verbal conversation.

Q. With you?

A. Yes.

Q. And that it was your job and your responsibility as his attending physician and as the chief surgeon who did this surgery; is that correct?

A. Yes.

Q. And concomitantly or concurrently in that conversation, you would have explained the risks to him of both the exploration of the lumbar and thoracic areas?

A. Well, I believe so.

I don't recall going into specific risks in the holding area; but, again, I always -- and we didn't know about the thoracic when he was in the office, but I always discuss risks of neurologic injury to any spine patient that's scheduled for surgery, because I know they're going to worry about it, if they don't bring it up.

Q. As I understand it, based upon, without rehashing the surgical procedure itself, which

was -- the procedure -- The dictation was done by you. It's Exhibit 17. And you described that you dictated this immediately after the surgery; correct?

A. Yes.

Q. Okay. And in terms of this particular surgical procedure, any involvement with the thoracic area, it is your testimony that you were the surgeon that did the work on his spine in the thoracic area? No doubt about it?

A. I have no doubt whatsoever. I did the entire operative procedure. I don't recall whether I closed the skin, which sometimes I don't, but I did all of the laminectomy at all levels and the foraminotomies and all that.

Q. I take it, then, from your answer you have absolutely unequivocally no criticism of either Dr. Stanford or Dr. Choung in their assisting you in the surgery?

A. Oh, no. They're superb. They're fully trained orthopedist surgeons before they came here.

Q. But as it relates to this particular surgery, you obviously -- you testified that you're the one that actual did the hands-on, if you will, surgery --

A. Yes.
Q. -- of both areas.
A. I was the primary surgeon.
Q. So you have no criticism of them?
A. No. I needed them.
Q. And as far as Exhibit 15, which was the consent form, I quite frankly don't know whose signature that is; although, I suspect at this point it may be Dr. Choung's.
A. I don't know.
I could probably go back and find some other signatures and compare it, but I don't know.
Q. But the point is about Exhibit 15, on the morning that Dr. Choung obtained this consent, you don't know the details of his conversation necessarily with Mr. -- with Dr. Schechter?
A. No.
Q. Okay. And you don't know specifically in terms of a time frame when he obtained that consent? I mean, shortly before surgery, presumptively.
A. Usually they put the time on it, but there is no time.
When I do those things, when I have to -- and I usually get the fellows and residents to do

them -- I look up at the wall there, and I get the time. So that's, unfortunately, an oversight --

Q. Okay.

A. -- but it had to be before the surgery started.

Q. But I think when you were asked about -- If my notes are correct, when you were asked about this Exhibit 15 and the fact that it didn't have, I guess, another line or word on here about a thoracic decompression on here, that was not of consequence to you?

A. Not really. I think -- I thought he fully understood what we were going to do.

Q. But your testimony was that he may not have fully understood what your contemplated -- in your mind what your contemplated surgery was or necessarily what your conversation was with Dr. Schechter?

A. Oh, you mean with Choung?

Q. Yes.

A. Oh, yes.

Q. He may not have known that?

A. Yes. Yes.

I misconstrued what you said.

Q. Let's make sure the record is clear,

then.

I think you testified, if my notes are correct, that he may not have fully appreciated or understood at that time what your contemplated surgery specifically was relative to Dr. Schechter?

A. Correct.

Q. Okay. But as far as your relationship, your physician/patient relationship was concerned with Dr. Schechter, and again without beating this thing to death, there's no doubt in your mind, as expressed in your testimony as well your clinical note, that the entire operative procedure was explained to Dr. Schechter --

A. Correct.

Q. -- including the thoracic as well as the lumbar surgery?

A. Yes.

MR. MC DONALD: That's all I have. Thanks.

MR. PESKIN: I'm finished.

(Signature not waived.)

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Thereupon, the deposition was concluded at approximately 4:45 p.m.

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C E R T I F I C A T E

- - -

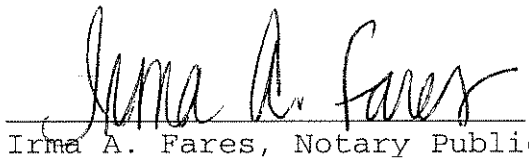
THE STATE OF OHIO:
SS:
COUNTY OF FRANKLIN:

I, Irma A. Fares, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named, HENRY H. BOHLMAN, M.D., was by me first duly sworn to testify to the truth, the whole truth, and nothing but the truth in the cause aforesaid; that the testimony then given by the above-referenced witness was by me reduced to stenotype in the presence of said witness, afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony so given by the above referenced witness.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified and was completed without adjournment.

I do further certify that I am not a relative, counsel or attorney for either party, or otherwise interested in the event of this action.

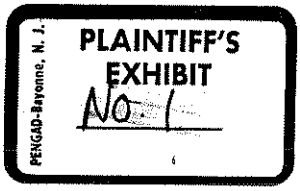
IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, this 14th day of December, A.D., 2002.



Irma A. Fares, Notary Public
Within and for the State of Ohio.
My Commission Expires 4/26/04

CURRICULUM VITAE

Name: **Henry Hubert Bohlman**
Address: 11100 Euclid Avenue
Cleveland, Ohio 44106
Telephone No.: 216-844-1025
FAX No.: 216-844-1735



Personal Data: Married: Amanda
Date of Birth: July 22, 1937 - Baltimore, Maryland
Children: Ted, Juliana

Military Status: 3535 USAF Hospital, Mather Air Force Base, California, 1970-1972, Orthopaedic Surgeon, Rank - Major

Education:

Severn School, Severna Park, Maryland - 1951-1955
Washington and Lee University, 1955 - 1959, Bachelor of Science
University of Maryland Medical School, 1960 - 1964, Doctor of Medicine

Post-Graduate Training:

University Hospital, Baltimore, Maryland - Internship (Mixed) Medicine-Pediatrics, 1964-1965

University Hospital, Baltimore, Maryland - Assistant Resident in Surgery, 1965-1966

The Johns Hopkins Hospital, Baltimore, Maryland - Junior Assistant Resident in Orthopaedic Surgery, 1966 - 1967

The Johns Hopkins Hospital and Central Anatomic Laboratory, Baltimore, Maryland National Institutes of Health - Research Fellowship in Orthopaedic Surgery, Pathologic Study of Fatal Craniospinal Injuries, 1967 - 1968

The Johns Hopkins Hospital, Baltimore, Maryland - Senior Assistant Resident in Orthopaedic Surgery, 1968 - 1969

The Johns Hopkins Hospital, Baltimore, Maryland - Chief Resident in Orthopaedic Surgery, 1969 - 1970

Hospital Appointments:

Rainbow Hospital, Cleveland, Ohio - Assistant Orthopaedist, November, 1972; Associate Orthopaedist, July 1980; Professor of Orthopaedics, June, 1987

Highland View Hospital, Cleveland, Ohio - Assistant Orthopaedist; Consultant, Spinal Cord Injury Unit, November, 1972; Associate Orthopaedist, July, 1980; Professor of Orthopaedics, June, 1987.

Hospital Appointments (Cont'd):

Veterans Administration Medical Center, Cleveland, Ohio: November 1972, Assistant Orthopaedist, July 1973 - 1974 Chief of Orthopaedics - Consultant, Spinal Cord Injury Service; Acting Chief of Orthopaedics, June 1980 - March 1982; Chief, Acute Spinal Cord Injury Service, September, 1974 - 2000; Chief, Spinal Surgery 2000 - present

Metropolitan General Hospital, Cleveland, Ohio - Assistant Orthopaedist, November, 1972; Associate Orthopaedist, July, 1980; Professor of Orthopaedics, June, 1987

University Hospitals, Cleveland, Ohio - Assistant Orthopaedist, November, 1972; Associate Orthopaedist, July, 1980; Professor of Orthopaedics, June, 1987; Director, University Reconstructive and Traumatic Spine Surgery Center, August, 1985 - December, 1995

Director and Administrator of the University Hospitals Spine Institute, February, 1996 - present

Medical School Appointments:

Case Western Reserve University, School of Medicine, Cleveland, Ohio:

November, 1972	Instructor, Orthopaedic Surgery
July, 1973	Senior Instructor, Orthopaedic Surgery
July, 1974	Assistant Professor, Orthopaedic Surgery
July, 1979 - 1984	Chairman, Musculoskeletal Comm, Phase II, Medical Students
June, 1980	Associate Professor, Orthopaedic Surgery, Tenure 1983
June, 1987	Professor, Orthopaedic Surgery

Professional Societies:

1968 - 1980	American Association of Automotive Medicine
1971 - 1980	American Medical Association
1972	Diplomat of the American Academy of Orthopaedic Surgeons
1972	Cleveland Orthopaedic Club
1973	Cervical Spine Research Society
1973 - 1980	American Society for Testing and Materials
1973 - 1984	International Medical Society of Paraplegia
1973	National Paraplegia Foundation
1973	Fellow, American Academy of Orthopaedic Surgeons
1973 - 1997	American Spinal Injury Association
1976 - 1998	Little Orthopaedic Club
1976 - 1980	Ohio Orthopaedic Society
1976 - 1980	Ohio State Medical Society
1977	SICOT - The International Society of Orthopaedic Surgery and Traumatology
1977 - 1982	Clinical Orthopaedic Society
1978	International Lumbar Spine Society
1978	Canadian Orthopaedic Association
1979 - 1999	Fellow-American College of Surgeons
1979 - 1992	Orthopaedic Research Society
1983	American Orthopaedic Association

Professional Societies (Cont'd):

1983	Tastavin Society of Cleveland
1988 - 1995	American Medical Association
1987	The Society of Medical Consultants to the Armed Forces
1989	Commanderie De Bordeaux
1987	Society of Medical Consultants to the Armed Forces
1990 - 1996	Orthopaedic Rehabilitation Association
1992	Academic Orthopaedic Society
1995	North American Spine Society
	National Spine Network

Awards:

President, Phi Kappa Psi Fraternity, Washington and Lee University, 1959

President of Class, University of Maryland Medical School, 1962-63; Student Council, 1960-64

National Institutes of Health, Research Fellow in Orthopaedic Surgery, The Johns Hopkins Hospital, 1967 - 1968: "Pathologic Analysis of Fatal Head and Neck Injuries"

Certificate of Merit: American Medical Association Meeting - Exhibit on "Avoidable Errors and Pitfalls in the Diagnosis of Acute Cervical Spine Injuries", Chicago, Illinois, June, 1974
Performance Award for Outstanding Service: Veterans Administration Medical Center, Cleveland, Ohio, December, 1974

Civilian National Consultant to United States Air Force, Surgeon General's Office for Orthopaedics, Spine Surgery, 1987 - present

President, Cervical Spine Research Society, 1988-1989

The Russell-Hibbs Award for Outstanding Research, Scoliosis Research Society: "Urologic Function After Experimental Cauda Equina Compression: Cystometrograms vs. Cortical Evoked Potentials", Delamarter R.B., Bohlman H.H. and Biro C., Amsterdam, Holland, September 20, 1989

Robert I. Harris Memorial Lecturer in recognition of distinction and leadership in orthopaedic surgery, Canadian Orthopaedic Association Annual Meeting, Calgary Canada, June 3, 1991

President, Federation of Spine Associations, 1994

Exhibits:

"Avoidable Errors and Pitfalls in the Diagnosis and Treatment of Acute Cervical Spine Injuries", American Academy of Orthopaedic Surgeons Meeting, Chicago, Illinois, June, 1974 (Certificate of Merit).

"Anterior and Anterolateral Surgical Approaches to the Spine for Decompression of the Spinal Cord and Fusion: Techniques and Analysis of 80 Cases", American Academy of Orthopaedic Surgeons Meeting, New Orleans, Louisiana, January, 1974 (rating by AAOS Committee 5/5, 5/5, 4.6/5) and American Medical Association Meeting, Dallas, Texas, June, 1976.

Exhibits (Cont'd.):

"Primary Tumors of the Thoracolumbar Spine", American Academy of Orthopaedic Surgeons Annual Meeting, Atlanta, Georgia, February, 1984.

Wilson, W.L., McAfee, P.C., Bohlman, H.H., Yaffe, M.B., Balourdes, G. and Bahniuk, E.: "A New Method for Determining the Load Deformation Properties of the Intact Cervical Spine", Orthopaedic Research Society, Poster Exhibit, Las Vegas, Nevada, January 21-24, 1985.

McAfee, P.C., Bohlman, H.H., Wilson, W.L., Yaffe, M.B., Balourdas, G. and Bahniuk, E.: "The Triple Wire Fixation Technique for Stabilization of Acute Cervical Fracture-Dislocations: A Biomechanical Analysis", Orthopaedic Research Society, Poster Exhibit, Las Vegas, Nevada, January 21-24, 1985.

"Magnetic Resonance Enhancement of Epidural Fibrosis by Gadolinium - DPTA: Mechanism of Enhancement and Biodistribution", Delamarter, R., Ross, J., Modic, M. and Bohlman, H.H., American Academy of Orthopaedic Surgeons Annual Meeting, Atlanta, Georgia, February 4-9, 1988.

"Anterior Retropharyngeal Approach to the Upper Cervical Spine", McAfee, P.C., Bohlman, H.H., Reilly, L.H., Robinson, R.A., Southwick, W.O. and Nachlas, N.E., American Academy of Orthopaedic Surgeons Annual Meeting, Atlanta, Georgia, February 4-9, 1988.

"Achieving Solid Arthrodesis following Anterior Cervical Decompression: Corpectomy vs. Discectomy", Hilibrand, A.S., Palumbo, M.A., Bohlman, H.H. Annual Meeting Spine Research Society, Palm Beach, FL, December 5-7, 1996.

Editing:

Consulting Editor, The Journal of Bone and Joint Surgery, April, 1977 - 1984
Consulting Editor, Journal Spine, February, 1981 - 1982
Member Editorial Board; Journal Spine, 1982 - present
Editor, Musculoskeletal Syllabus, Phase II, Case Western Reserve Univ., School of Medicine, 1979 - 1984.
Senior Grant Reviewer, National Institute for Handicapped Research, Washington, D.C., 1982
Associate Editor, Central Nervous System Trauma, 1983 - 1988
Associate Editor, The Journal of Bone and Joint Surgery, 1984 - 1988
Consulting Editor, Neurosurgery, 1987
Consulting Editor, The Journal of Bone and Joint Surgery, 1989 -
Consulting Editor, Clinical Orthopedics and Related Research, 1995
Grant Reviewer, University of Hong Kong, 1995 -

Committees:

Veterans Administration Medical Center:
Personnel Management, 1977 - 1978
Administrative Executive Board, 1979 - 1981
Chairman, Subcommittee on Animal Research, 1977 - 1980
Clinical Executive Board, 1974 - present

Case Western Reserve University School of Medicine:

Chairman, Musculoskeletal Committee, Phase II Medical Students, July, 1979 - 1984
Committee on Medical Education, Orthopaedic Dept. Representative, 1980 - 1981
Phase II Committee on Medical Education, 1979 - 1984
Committee on Medical Education, Dean's Appointment, 1981 - 1983
Comprehensive Examination Committee, 1979 - 1984
Member, Task Force on Patient Based Programs, 1984
Member, Committee on Departmental Status of Rehabilitation Medicine, 1984
Member, Working Group on the Continuing Education Continuum, Chairman,
Subcommittee on Fourth Year Options, 1983 - 1984

American Academy of Orthopaedic Surgeons:

Committee on Rehabilitation, 1980 - 1983
Committee on Nursing and Allied Health Education, 1977 - 1981
Membership Committee Region #8, 1988 - 1992
Member, Committee on Summer Institute, 1990-1993
Member, Officers of the Academy, Nominating Committee, 1997 -

American Society for Testing and Materials: Member, 1973-1980

Chairman, F8.53 Committee on Head and Neck Protective Equipment in Sports, 1973 - 1976

Cervical Spine Research Society:

Chairman, Program Committee, 1980 - 1981
Education Committee, 1980 - 1983
Chairman, Education Committee, 1981 - 1982
Morbidity, Mortality Committee, 1983 - 1984
2nd Vice President, 1986 - 1987
1st Vice President, 1987 - 1988
President, 1988 - 1989
Committee on Health Policy and Practice, 1991 -

Cleveland Orthopaedic Club:

Secretary-Treasurer, 1981 - 1982

American College of Surgeons:

Regional Committee on Trauma, 1980 - 1988

University Orthopaedic Associates:

Member, Board of Directors, 1982 - 1984; 1994
Vice Chairman, Department of Orthopaedics, 1989
Chairman, Committee on Promotions, 1989
Chairman, Committee on Credentialling, 1989
Member, Finance Committee

University Suburban Health Center:

Member, Board of Directors, 1982 - 1983

Committees (Cont'd.):

University Hospitals:

Professional Standards Board, 1989 - 1995
Performance Improvement Council, 1995 - 1998

National Spine Network:

Member of Board of Directors, 1996 -
Member, Membership Committee

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12. Bohlman, H.H., Rekate, H. and Thompson, G.H.: Problem Fractures of the Cervical Spine in Children. **Problem Fractures in Children**, Chapter 6. G. Haughton, G. Thompson, Editors; Butterworth, Boston and London, Publisher; pp. 101-124, 1983.

13. Bohlman, H.H.: Surgical Management of Cervical Spine Fractures and Dislocations: **Instructional Course Lectures**, American Academy of Orthopaedic Surgeons, E.S. Stauffer, Ed.; C.V. Mosby, Publisher; 34:163-187, 1987.

14. Bohlman, H.H.: Complications of Treatment of Fractures and Dislocations of the Cervical Spine. **Complications of Orthopaedic Surgery**, edited by Charles Epps, J.B. Lippincott Co., Publisher; pages 897-918, 1985.

15. Bohlman, H.H.: The Neck. **Musculoskeletal Disorders, Regional Examination Differential Diagnosis**, Chapter 7. R.D. D'Ambrosia, Editor, J.B. Lippincott, Publisher; pages 183-219, 1985.

16. Bohlman, H.H.: Trauma of the Cervical Spine and Cord. **American Academy of Orthopaedic Surgeons Update II**, pages 267-280, 1987.

17. Bohlman, H.H.: The Surgical Management of Post-Traumatic Lesions of the Spine. **Operative Techniques in Orthopaedic Surgery and Traumatology**. R. Roy-Camille, L.H. Riley and C.A. Laurin, Editors; Masson, Paris, France, Publisher; 1987.

18. Bohlman, H.H. and Boada, E.: Fractures and Dislocations of the Lower Cervical Spine. **The Cervical Spine**, 2nd Edition, Chapter 6. Cervical Research Society, Editor; J.B. Lippincott Co., Philadelphia, Publisher; pp. 487-514, 1988.

19. Bolesta, M.J. and Bohlman, H.H.: Degenerative Spondylolisthesis: **Instructional Course Lectures**, American Academy of Orthopaedic Surgery, Chapter 10, 38:157-165, 1989.

20. Delamarter, R.B. and Bohlman, H.H.: The Problems and Limitations of Microsurgery for the Treatment of Lumbar Disc Disease. **Microsurgery for Lumbar Disc Disease**, Chapter 30. McCullock, J.A., Young, P., and Williams, R., Editors; Aspen Publishing Co., Publisher; pp. 245-248, 1989.

21. Bohlman, H.H.: Degenerative Arthritis of the Lower Cervical Spine. **Surgery of the Musculoskeletal System**, 2nd Edition, Vol. II, Chapter 65. C.M. Evarts, Editor; Churchill Livingston, Inc., NY, Publisher; pp. 2211-2231, 1989.

22. Anderson, P.A. and Bohlman, H.H.: Late Anterior Decompression of Thoracolumbar Spine Fractures. **Seminars in Spine Surgery**, 2(62):54-62, March 1990.

Book Chapters, cont'd:

23. Delamarter, R., Bolesta, M.J. and Bohlman, H.H.: Rheumatoid Arthritis: Surgical Treatment. **The Adult Spine - Principles in Practice**, Chapter 37. John Frymoyer, Editor; Raven Press, New York, NY, Publisher; pp 745-762, 1991.

24. Bolesta, M.J. and Bohlman, H.H.: Late Sequelae of Fractures and Fracture-Dislocations of the Thoracolumbar Spine: Surgical Treatment. **The Adult Spine - Principles of Practice**, Chapter 62. John Frymoyer, Editor; Raven Press, New York, NY; Editor; pp 1331-1352, 1991.

25. Bolesta, M.J. and Bohlman, H.H.: Late Complications of Cervical Fractures and Dislocations and Their Surgical Treatment. **The Adult Spine - Principles of Practice**, Chapter 52. John Frymoyer, Editor; Raven Press, New York, NY, Publisher; pp 1107-1126, 1991.

26. Bohlman H.H. and Emery S.E.: Osteoarthritis of the Cervical Spine. **Osteoarthritis: Diagnosis and Management.** Second Edition. R.W. Moskowitz, D.S. Howell, V.M. Goldberg, and H.J. Mankin, Editors; WB Saunders, Philadelphia, PA, Publisher; 1991.

27. Bohlman, H.H. and Ducker, T.B.: Spine and Spinal Cord Injury. **The Spine**, Third edition, Vol. 2, Chapter 28. R.H. Rothman and F.A. Simeone, Editors; WB Saunders, Philadelphia, PA, Publisher; pp 973-1165, 1992.

28. Bolesta, M.J. and Bohlman, H.H.: Surgical Management of Injuries to the Thoracic and Lumbar Spine. **Surgery of the Spine**, Chapter 68. G. Findlay and R. Owen, Editors; Blackwell Scientific Publications, Ltd., Oxford, England, Publisher; pp 1115-1129, 1992.

29. Emery, S.E. and Bohlman, H.H.: Anterior Decompression and Fusion for Cervical Myelopathy Associated with Cervical Spondylosis and Deformity. **Disorders of the Cervical Spine**, Chapter 35. M.B. Camins and P.F. O'Leary, Editors; Williams & Wilkins, NY, Publisher; pp 397-405, 1992.

30. Bohlman H.H.: Spine. **Review of Orthopaedics**. M.D. Miller, Editor; WB Saunders, Philadelphia, PA, Publisher; pp 147-166, 1992.

31. Bolesta, M.J. and Bohlman, H.H.: Complications of Instrumentation and Fusion. **Lumbar Disc Disease**, 2nd Edition, Chapter 21. Russell W. Hardy Jr., Editor; Raven Press, NY, Publisher; pp 225-239, 1993.

32. Bohlman H.H. and Emery S.E.: Complications of Treatment of Fractures and Dislocations of the Cervical Spine. **Complications in Orthopaedic Surgery**, 3rd Edition, Chapter 25. Charles H. Epps, Jr., Editor; JB Lippincott, Philadelphia, PA; pp 1-33, 1994.

Research as Principal Investigator:

1. "Mechanical Factors Affecting Recovery of Incomplete Spinal Cord Injuries", supported by Orthopaedic Research and Education Foundation ($5,000) and the Veterans Administration (1974-75),($5,000); funded January, 1976, $162,000 for three years by the Veterans' Administration; Bahniuk, E. and Raskulinecz, G.

2. "Experimental Comparison of Internal Fixation Devices for Unstable Fracture-Dislocations of the Dorsolumbar Spine", Orthopaedic Research and Education Foundation ($12,000), funded June, 1978-1979; Co-Principal Investigator, Laborde, M., Bahniuk, E.

3. "Electrical Assessment of Incomplete Spinal Cord Injury and Recovery", the Veterans' Administration, October, 1979-1982 ($243,000 for three years); with Bahniuk, E., Raskulinecz, G. and Field, G.

4. "Biomechanical Analysis of Posterior Cervical Fusions", Orthopaedic Education and Research Fund, Case Western Reserve University ($8,000) funded 1981-1982; with Rechtine, G. and Zigler, J.

5. "Experimental Lumbar Spinal Stenosis", Department of Health and Human Services; with Delamarter, R., Dodge, L. and Bahniuk, E.; funded $62,700, 1984-1986.

6. "Low Back Pain and Sciatica: Factors for Success of Therapy", Principal Investigator: Donlin M. Long, M.D., Ph.D., The Johns Hopkins School of Medicine; National Multi-center Low Back Pain Study; Russell Hardy, M.D., Co-Principal Investigator; Henry H. Bohlman, M.D., Co-Principal Investigator; Department of Health and Human Services, $45,953 per year (Cleveland), April 1986 - March, 1991.

7. "Biomechanical Analysis of Various Forms of Surgical Fixation of the Atlantoaxial Joint", M. Smith and H.H. Bohlman, and J. Kotzar, supported by the Spine Research Fund, Department of Orthopaedics, July 1988 - June 1989.

8. "Experimental Cauda Equina and Conus Compression: Analysis of Neurophysiology, Histopathology and Vascularity", M. Bolesta, H. Bohlman, and P. Gambetti. Supported by The Spine Research Fund, Department of Orthopaedics, July 1988 - July 1990.

9. "Analysis of Hydroxyapatite as a Bone Graft Substitute for Spinal Fusion", R. Viere, N. Taisuke, H. Bohlman. Supported by The Spine Research Fund, Department of Orthopaedics, July, 1989 - June, 1990.

10. "The Use of Ne-Osteo, (Bone Morphogenic Protein) LS-1 for Posterior Lumbar Intertransverse Process Fusions is Patients having Degenerative Spondylolisthesis" (08-97-01), A Multi-Center National Clinical Research Project. Approved by University Hospitals Institutional Review Board and the FDA for Clinical Trials; with Emery, S.E.

Honorariums:

1. Cleveland Clinic Foundation: "The Pathology and Current Treatment Concepts of Cervical Spine Injuries", "Fatal Craniospinal Injuries", Cleveland, OH, March, 1973.

2. University of Toronto, Spinal Injury Symposium: "Dysplasia of the Odontoid in Various Forms of Dwarfism", "Fatal Craniospinal Injuries", "Pathology of Cervical Spine Injuries", "Current Treatment Concepts of Cervical Spine Injuries", "Upper Thoracic Spine Fractures with Paralysis", Toronto, Ontario, April, 1973.

3. University of Vienna, Austria: "Pathology and Current Treatment Concepts of Cervical Spine Injuries", July, 1973.

4. University of California at Davis: "Treatment of Cervical Spine Injuries", Sacramento, CA, January, 1974.

5. Arizona Orthopaedic Society: "Pathology and Current Treatment Concepts of Cervical Spine Injuries", "Upper Thoracic Spine Fractures with Paralysis", Phoenix, AZ, November, 1974.

6. Henry Ford Hospital: "The Pathology of Fatal Craniospinal Injuries", "Cervical Spine Injuries", Detroit, MI, December 14, 1974.

7. Bethesda Naval Hospital: "Treatment of Cervical Spine Injuries", "Upper Thoracic Spine Fractures with Paralysis", Washington, DC, January, 1975.

8. Portsmouth Naval Hospital: "Cervical Spine Injuries", "Upper Thoracic Spine Injuries with Paralysis", "Cervical Spondylosis", March, 1976.

9. University of Louisville Health Science Center: "Cervical-Neurovertebral Trauma", "The Avoidable Errors and Pitfalls in Diagnosis of Acute Cervical Spine Injuries", "Current Diagnosis and Treatment Concepts of Cervical Injuries", May 15, 1976.

10. Medical College of Ohio at Toledo: "Cervical Spondylosis", "Emergency Treatment of Cervical Spine Injuries", May 28-29, 1976.

11. Portsmouth Naval Hospital: "Cervical Spine Injuries", "Upper Thoracic Spine Fractures with Paralysis", "Cervical Spondylosis", Portsmouth, VA, March, 1977.

12. Cleveland Clinic Foundation, Continuing Education: "Pathology and Current Treatment Concepts of Cervical Spine Fractures", "Upper Thoracic Spine Fractures with Paralysis", Cleveland, OH, April, 1977.

13. University of Maryland School of Medicine, Program of Continuing Education in Neurosurgery, Course on Acute Spinal Cord Injury: "Anterior Decompression with Stabilization of Thoracic and Thoracolumbar Fractures with Paralysis", Baltimore, MD, May 14-15, 1977.

Honorariums, cont'd:

14. Visiting Professor, University of Maryland Medical School, Department of Orthopaedic Surgery: "Late Anterior Decompression of Spinal Cord Injuries: A Review of 65 Cases", "Cervical Spondylosis", Baltimore, MD, May 17, 1977.

15. Visiting Professor, Alfred I. DuPont Institute: "Late Anterior Decompression of Spinal Cord Injuries", Wilmington, DE, May, 1977.

16. University of Miami, School of Medicine, Department of Orthopaedics and Rehabilitation Course on the Spine: "Management of Cervical Spine Trauma", Miami, FL, March, 1978.

17. Visiting Professor, Portsmouth Naval Hospital: "Cervical Spine Injuries", "Upper Thoracic Spine Fractures with Paralysis", "Cervical Spondylosis", Portsmouth, VA, March, 1978.

18. Visiting Professor, University of Toronto and McMaster University (Hamilton), Department of Orthopaedic Surgery: "The Pathology of Cervical Spine Injuries", "Late Anterior Decompression and Fusion for Spinal Cord Injuries", "Pyogenic Osteomyelitis of the Spine", "Cervical Spondylosis", Toronto, Ontario, November, 1978.

19. Visiting Professor, Portsmouth Naval Hospital: "Pathology of Cervical Spinal Injuries", "Upper Thoracic Spine Injuries with Paralysis", "Late Anterior Decompression and Fusion for Spinal Cord Injuries", March, 1980.

20. Visiting Professor, University of Texas Medical School: "Lumbar Spinal Stenosis", "Neck Pain", San Antonio, TX, May, 1980.

21. University of Toronto, Acute Cervical Spinal Cord Injury Symposium: "Complications and Pitfalls in the Treatment of Acute Cervical Spine and Cord Injuries", "Late Anterior Decompression and Fusion for Cervical Spinal Cord Injuries", Toronto, Ontario, November, 1980.

22. Paralysis Cure Research Foundation: "Late Anterior Decompression and Fusion for Spinal Cord Injuries", Airlie House, VA, September, 1981.

23. Henry Ford Hospital: "Cervical Spine Trauma", "Thoracolumbar Spine Trauma", Detroit, MI, January, 1981.

24. Visiting Professor, The Mayo Clinic: "The Pathology of Cervical Spine Injuries", "Treatment of Fractures and Dislocations of the Cervical Spine", "Treatment of Thoracic and Lumbar Fractures with Paralysis", Rochester, MN, March, 1982.

25. Hospital for Joint Diseases, Symposium on Back Pain: "Infections of the Lumbar Spine", "Lumbar Spinal Instability", New York, NY, April 3, 1982.

Honorariums, cont'd:

50. Guest Speaker, Department of Orthopaedic Surgery, University of Hong Kong, Centennial Anniversary: "Late Anterior Decompression for Spinal Cord Injuries: Long-Term Results of Neurologic Recovery in 167 Patients", Hong Kong, September 14-15, 1987.

51. Guest Speaker, Brazilian Society of Orthopaedics and Traumatology: "Anterior Decompression and Fusion for Spinal Cord Injuries: Long-Term Results of Neurologic Recovery", "The Etiology of Paralysis of Rheumatoid Arthritis of the Cervical Spine", "Lumbar Spinal Stenosis", "Cervical Spondylosis", Sao Paulo, Brazil, November 14-16, 1987.

52. Visiting Professor, University of Southern California, Department of Orthopaedics: "Anterior Decompression and Fusion for Spinal Cord Injuries: Long-Term Results of Neurologic Recovery", Los Angeles, CA, January 8, 1988.

53. Guest Speaker, Philadelphia Orthopaedic Society: "The Evolution of Anterior Surgery for Spine and Spinal Cord Injuries", Philadelphia, PA, May 9, 1988.

54. Visiting Professor, Department of Orthopaedic Surgery, University of Minnesota: "The Treatment of Cervical Spondylosis", "The Etiology of Paralysis and Rheumatoid Arthritis", "Lumbar Spinal Stenosis", Minneapolis, MN, October 19-21, 1989.

55. Guest Speaker, The Southern Medical Association Annual Meeting: "Lumbar Spinal Stenosis", Washington DC, November 4-5, 1989.

56. Visiting Professor, Department of Orthopaedic Surgery, Ohio State University Hospitals, "Fractures of the Upper Thoracic and Lumbar Spine", "Lumbar Spinal Stenosis", Columbus, OH, January 5, 1990.

57. Guest Speaker, Spine Society of Australia, Department of Orthopaedic Surgery, University of Melbourne: "Treatment of Thoracolumbar Fractures", "Cervical Spine Surgery and Rheumatoid Arthritis", Melbourne, Australia. July 9, 1990.

58. Department of Orthopaedic Surgery, University of Adelaide: "Lumbar Spinal Stenosis: Diagnosis and Treatment", "Spinal Infection", Adelaide, Australia. July 11, 1990.

59. Guest Speaker, Spine Society of Australia: "Cervical Spine Fractures: Diagnosis and Treatment", "Upper Thoracic Spine Fractures with Paralysis", "Etiology of Paralysis in Rheumatoid Arthritis of the Cervical Spine", "Cervical Spondylosis with Radiculopathy and Myelopathy", "Thoracic Disc Disease: Treatment by Anterior Decompression", Sydney, Australia, July 14-15, 1990.

60. Robert I. Harris Memorial Lecturer in recognition of distinction and leadership in orthopaedic surgery, Canadian Orthopaedic Association Annual Meeting, Calgary Canada, June 3, 1991.

Honorariums, cont'd:

61. International Foundation for Spinal Studies: "Cervical Spine Fractures", "Etiology and Treatment of Paralysis in Rheumatoid Arthritis of the Cervical Spine", "Treatment of Thoracic Discs by Anterior Excision", "Pyogenic Infections of the Spine", London, England, September 3-5, 1991.

62. Guest Lecturer, AO/ASIF Spine Course: "Anterior Decompression for Cervical Spinal Cord Injuries", "Operative Treatment of Spondylolisthesis", "Etiology and Treatment of Paralysis Secondary to Rheumatoid Arthritis of the Cervical Spine", "Lumbar Spinal Stenosis, Experimental and Clinical", Marco Island, FL, October 13-18, 1991.

63. Visiting Professor, Department of Orthopaedic Surgery, Michigan State University: "The Etiology and Treatment of Paralysis of Rheumatoid Arthritis of the Cervical Spine", "Cervical Spondylosis", "Thoracic Disc Disease", "Anterior Decompression for Cervical Spinal Cord Injuries", "Lumbar Spinal Stenosis, Experimental and Clinical", Kalamazoo, MI, November 1-2, 1991.

64. Visiting Professor, Department of Orthopaedics, University of Alabama: "The Etiology of Paralysis in Rheumatoid Arthritis of the Cervical Spine", "Lumbar Spinal Stenosis, Clinical and Experimental", Birmingham, AL, April 10-11, 1992.

65. J.C. Kennedy Lecturer, Department of Orthopaedics, University of Western Ontario: "Lumbar Spinal Stenosis, Experimental and Clinical" and Visiting Professor: "The Etiology of Paralysis Secondary to Rheumatoid Arthritis of the Cervical Spine", London, Ontario, May 6, 1992.

66. Barrow Neurologic Institute, Fifth Annual Spine Workshop: "Anterior Decompression and Stabilization for Upper Thoracic Spine Fractures with Paralysis", "Complications of Spine Fusion", Phoenix, AZ, November 15-17, 1992.

67. Department of Orthopaedics, Northwestern University: "Cervical Spondylosis with Radiculopathy and Myelopathy", "Lumbar Spinal Stenosis: Experimental and Clinical", Chicago, IL, January 22-23, 1993.

68. Guest Speaker, Japanese Orthopaedic Association: "Lumbar Spinal Stenosis, Experimental and Clinical", "Mechanisms of Spinal Cord Injury", Kobi, Japan, April 8-11, 1993.

69. Presidential Guest Speaker, Southern Medical Association: "Lumbar Spinal Stenosis: Recent Advances", "Evolution of Anterior Cervical Spine Surgery", Vienna, Austria, August 12-14, 1993.

70. Guest Speaker, Maryland Orthopaedic Society: "Rheumatoid Arthritis of the Cervical Spine: Etiology of Paralysis", Baltimore, MD, September 30, 1993.

71. Visiting Professor, University of Maryland School of Medicine, Department of Orthopaedic Surgery: "Lumbar Spinal Stenosis: Experimental and Clinical", Baltimore, MD, October 1, 1993.

Honorariums, cont'd:

72. Guest Speaker, Israeli Orthopaedic Association: "Lumbar Spinal Stenosis: Experimental and Clinical", "Cervical Spondylosis with Radiculopathy adn Myelopathy: Treatment by Anterior Decompression and Fusion", Haifa, Israel, December 7-9, 1993.

73. J. William Hillman Visiting Professor, Department of Orthopaedics and Rehabilitation, Vanderbilt University: "The Etiology of Paralysis Secondary to Rheumatoid Arthritis of the Cervical Spine", "Thoracic Disc Herniations: Treatment by Anterior Decompression", "Lumbar Spinal Stenosis: Experimental and Clinical", "Treatment of Cervical Spine Fractures", Nashville, TN, May 18-20, 1994.

74. Charles Gregory Visiting Professor, Department of Orthopaedic Surgery, University of Texas SW Medical Center at Dallas: "Cervical Spondylosis with Radiculopathy and Myelopathy: Treatment by Anterior Decompression and Fusion", "Lumbar Spinal Stenosis: Experimental and Clinical", Dallas, TX, June 2-3, 1994.

75. Visiting Professor, Department of Orthopaedic Surgery, University of South Carolina: "Lumbar Spinal Stenosis: Experimental and Clinical", Charleston, SC, June 17-1, 1994.

76. Visiting Professor, Washington Hospital Center, Department of Orthopaedic Surgery, "Lumbar Spinal Stenosis: Experimental and Clinical", "Spinal Kyphosis: Diagnosis and Treatment", December 7-8, 1995.

77. Guest Speaker, Eastern Japanese Orthopaedic Society, "Spinal Kyphosis Diagnosis and Treatment", October 10-11, 1996. Hirosaki, Japan.

78. Guest Speaker, Korean Orthopaedic Association, 1) "Lumbar Spinal Stenosis: Experimental and Clinical", 2) "Spinal Kyphosis: Diagnosis and Treatment", October 16-19, 1996, Seoul, Korea.

79. Visiting Professor, Department of Orthopaedic Surgery, Chonbuk University College of Medicine and Chonbuk National University Hospital, October 22, 1996. "Head and Neck Injuries and Cervical Myelopathy Diagnosis and Treatment".

80. Guest Speaker, Combined Meeting of Washington Orthopaedic Society and Rheumatism Society of the District of Columbia, "Ediology of Paralysis in Rheumatoid Arthritis of the Cervical Spine, April 9, 1997, Washington, D.C.

81. Guest Speaker, Mid-American Orthopaedic Association, "Spinal Kyphosis Diagnosis and Treatment", April 23-27, 1997, Hilton Head, S.C.

92. Presidential Guest Speaker, Eastern Orthopaedics Association, "Spinal Kyphosis: Diagnosis and Treatment", Vienna, Austria, October 10-17, 1999.

93. University of California at Irvine, Department of Orthopaedic Surgery, 1) "Pathophysiology and Treatment of Cervical Spondylosis and Myelopathy", 2) "Spinal Kyphosis: Diagnosis and Surgical Correction", Irvine, California, January 18-21, 2000.

94. New York University School of Medicine, Department of Neurosurgery and Orthopaedic Surgery, 1) "Cervical Spondylosis and Myelopathy: Treatment by Anterior Decompression and Fusion", 2) "Spinal Kyphosis: Diagnosis and Surgical Treatment," New York, NY, February 17-21, 2000.

95. University of Pennsylvania, Department of Orthopaedic Surgery, 1) "Spinal Kyphosis: Diagnosis and Treatment", 2) "Cervical Myelopathy: Treatment by Anterior Decompression and Fusion", Philadelphia, Pennsylvania, May 18, 2000.

96. University of Oregon, Department of Orthopaedic Surgery, 1) "Cervical Spondylosis and Myelopathy: Treatment by Anterior Decompression and Fusion", and "Spinal Kyphosis: Diagnosis and Surgical Treatment", Portland, Oregon, June 23-25, 2000.

97. Georgia Orthopaedics Society, Presidential Guest Speaker, 1) "The Joys of Wine" 2) "Spinal Kyphosis: Diagnosis and Surgical Treatment", Sea Island, Georgia, October 5-8, 2000.

98. Philadelphia Orthopaedic Society, Presidential Guest Lecturer, "Spinal Kyphosis: Diagnosis and Surgical Treatment", Philadelphia, Pennsylvania, January 15, 2001.

99. University of Maryland Department of Orthopaedic Surgery, Spinal Kyphosis: Diagnosis and Surgical Treatment, Baltimore, Maryland, February 7, 2001.

100. Allegheny Hospital, Department of Orthopaedic Surgery, "Spinal Kyphosis: Diagnosis and Treatment", Pittsburgh, Pennsylvania, January 29, 2001.

Instructional Course Lectures:

1. American Academy of Orthopaedic Surgeons: "Cervical Spine Injuries", 1971, 1972, 1974, 1975, 1976, 1984; "Thoracic Spine Fractures", 1977, 1978, 1981, 1982, 1983.

2. Chairman, American Academy of Orthopaedic Surgeons Courses on Orthopaedic Nursing, Cleveland, OH, May, 1975; May, 1976; June, 1977; May, 1978.

3. Summer Institute, American Academy of Orthopaedic Surgeons: "Thoracolumbar Fractures", Chicago, IL, July, 1975, 1976; Denver, CO, July, 1977; Boston, MA, 1978; Snow Bird, UT, 1981; Monterey, CA, 1982; Boston, MA, 1983.

4. American Academy of Orthopaedic Surgeons, Chairman, Instructional Course: "Techniques of Anterior and Anterolateral Decompression and Fusions of the Spine", Las Vegas, NV, February, 1977.

5. American College of Surgeons Course on Trauma: "Spinal Cord Injuries", November, 1977, University Hospitals, Cleveland, OH.

6. American Academy of Orthopaedic Surgeons Course on Musculoskeletal Trauma: "Lower Cervical Spine Fractures", San Francisco, CA, April, 1978.

7. University of Miami, School of Medicine, Department of Orthopaedics and Rehabilitation, Course on the Spine: "Management of Cervical Spine Trauma", Miami, FL, March, 1978.

8. SICOT - The International Society of Orthopaedic Surgery and Traumatology Course: "Cervical Spine Injuries", Kyoto, Japan, October 1978.

9. Visiting Professor, Siriraj Hospital, Mahidol University: "Pathology and Treatment Concepts, Cervical Spine Injuries", "Late Anterior Decompression and Fusion for Spinal Cord Injuries", "Pyogenic Osteomyelitis of the Spine", Bangkok, Thailand, October, 1978.

10. Visiting Professor, University of Toronto, McMaster University at Hamilton Department of Orthopaedics: "Pathology of Cervical Spine Injuries", "Pyogenic Osteomyelitis of the Spine and Cervical Spondylosis", November, 1978.

11. American Academy of Orthopaedic Surgeons Course on the Neck and Shoulder: "Mechanism of Pain in Cervical Spine Trauma", "Closed Treatment of Cervical Cord and Cervical Spine Trauma", "Surgical Approaches to Cervical Spine Injuries", Philadelphia, PA, November, 1978.

12. American Academy of Orthopaedic Surgeons Course on the Neck: "Pathology of Atlantoaxial Injuries", "Diagnosis of Lower Cervical Spine Injuries", "Surgical Treatment of Cervical Spine Fractures", New Orleans, LA, May, 1979.

13. American Academy of Orthopaedic Surgeons Annual Meeting Instructional Course: "Surgical Management of Cervical Spine Trauma", Las Vegas, NV, January 25, 1985.

Instructional Course Lectures, cont'd:

14. American Academy of Orthopaedic Surgeons Course on the Adult Spine: "Diagnosis and Treatment of Neck Pain", Philadelphia, PA, December, 1979.

15. Chairman, American Spinal Injury Society Instructional Course on Thoracic and Lumbar Fractures, Anaheim, CA, May, 1980.

16. American Academy of Orthopaedic Surgeons Course on the Adult Spine: "Tumors of the Cervical Spine", Orlando, FL, December, 1980.

17. American Academy of Orthopaedic Surgeons Course on Spinal Cord Injuries: "Anterior Decompression and Fusion of Spinal Cord Injuries", Miami, FL, December, 1980.

18. American Society of Neurologic Surgeons Workshop on Spine and Spinal Cord Injuries: "Indications for Stabilization of Cervical Spine Injuries", Chicago, IL, September, 1980.

19. American Academy of Orthopaedic Surgeons, Annual Meeting: "Radiology of the Spine in Trauma", "Fracture-Dislocations of the Thoracolumbar Spine", Las Vegas, NV, February, 1981.

20. American Academy of Orthopaedic Surgeons Course on the Adult Spine: "Management of the Patient with Neck Pain", Aspen, CO, March, 1981.

21. Chairman, American Academy of Orthopaedic Surgeons Course on Treatment of Adult Spinal Disorders, Cleveland, OH, May, 1981.

22. American Academy of Orthopaedic Surgeons Summer Institute: "Anterior Decompression and Fusion of the Spine", "Complications and Failures of Thoracolumbar Fractures", Snowbird, UT, July, 1981.

23. American Academy of Orthopaedic Surgeons Course on Current Concepts in Management of Spinal Cord Injury: "Neurophysiology of Spinal Cord Monitoring", "Indications for Anterior Decompression in the Cervical Spine", "Indications for Anterior Decompression of Thoracolumbar Spine Fractures", Houston, TX, December, 1981.

24. American Academy of Orthopaedic Surgeons Annual Meeting: "Radiology of the Spine in Trauma", "Fracture-Dislocations of the Thoracolumbar Spine", New Orleans, LA, January, 1982.

25. American Academy of Orthopaedic Surgeons: "Orthopaedic Traumatology: Management of Cervical Spine Injuries," and "Late Management of Cord Syndromes - Principles of Cord and Canal Decompression", Seattle, WA, August 9-11, 1982.

Instructional Course Lectures, cont'd:

26. American Academy of Orthopaedic Surgeons Summer Institute: "Indications and Surgical Techniques for Surgical Treatment of Spinal Fractures", Monterey, CA, September 20-21, 1982.

27. American Academy of Orthopaedic Surgeons, Resources for Basic Science Educators V: "Pathology and Current Treatment Concepts of Cervical Spine Injuries", Monterey, CA, April 20, 1983.

28. American Academy of Orthopaedic Surgeons, Course on Current Orthopaedic Trends: "Cervical Spine Trauma", "Surgical Role After Failed Back Surgery", New York, NY, May 24, 1983.

29. Harvard Medical School Course, The Spine: "Evaluation and Treatment of Lower Cervical Spine Fractures", "Anterior Surgery for Thoracic and Lumbar Fractures", Boston, MA, June 16, 1983.

30. American Academy of Orthopaedic Surgeons Summer Institute Instructional Course Lecture: "Anterior Approaches to Fractures of the Thoracic and Lumbar Spine", Boston, MA, September 19-20, 1983.

31. American College of Surgeons: Neurologic Surgery Interdisciplinary Panel Discussion on Fractures and Dislocations of the Upper Cervical Spine, Atlanta, GA, October 18, 1983.

32. Spine Study Group Course on the Spine: "The Pathology of Cervical Spine and Cord Injuries", "Atlantoaxial Dislocations in the Arthritic Patient", "Anterior Decompression of Cervical Spine and Cord Injuries", Snowmass, CO, March 11-17, 1984.

33. Department of Orthopaedic Surgery, University of Pennsylvania Course on Fractures: "Assessment and Management of Thoracolumbar Fractures", Snowmass, CO, March 14, 1984.

34. Division of Orthopaedic Surgery, University of Washington, Seattle, Course on the Spine: "Spinal Cord Monitoring", "Cord Syndromes and the Physiology of Spinal Cord Injuries", "Management of Cervical Spine Fractures", "Late Cord Compression, Evaluation and Treatment", "Techniques for Anterior Cervical Discectomy and Fusion", Maui, HI, March 18-25, 1984.

35. Twentieth Annual St. Luke's Hospital Orthopaedic Symposium on the Cervical Spine, Update 1984: "Treatment Concepts of Lower Cervical Spine Injuries", "Late Anterior Decompression of Cervical Spine and Cord Injuries", "Cervical Spondylosis and Myelopathy," "Atlantoaxial Dislocations in the Arthritic Patient", "Pyogenic Infections of the Cervical Spine", Houston, TX, April 6-8, 1984.

Instructional Course Lectures, cont'd:

36. American Academy of Orthopaedic Surgeons Course on the Spine - Fundamental Problems: "The Recognition, Assessment and Management of Lumbar Spinal Stenosis", "The Management of Fracture-Dislocations of the Cervical Spine", Toronto, Ontario, Canada, May 9-11, 1984.

37. American Academy of Orthopaedic Surgeons Course on Trauma of the Spine: "Management of Upper Cervical Spine Trauma", "Pathologic Basis for Treatment of Cervical Spine Fractures", "Anterior Decompression and Fusion of Cervical Spine Fractures", "Upper Thoracic Spine Fractures with Paralysis", "Spinal Cord Monitoring", "Deciding When To Go Anteriorly", "Techniques of Anterior Decompression and Fusion for Thoracolumbar Fractures", "Delayed Anterior Decompression and Fusion for Thoracolumbar Fractures", Houston, TX, October 25-27, 1984.

38. American Academy of Orthopaedic Surgeons Comprehensive Review Course: "Degenerative Diseases of the Spine, Cervical and Lumbar", "Nonoperative and Operative Management of Discogenic and Arthritic Diseases of the Spine"; Breakout Sessions: "Non-operative Management of Spinal disorders", Chicago, IL, April 12, 1985.

39. American Academy of Orthopaedic Surgeons Summer Institute: "Spine Trauma", New York, NY, September 11, 1985.

40. The Spine - Advanced Concepts and Techniques: "Spinal Cord Injury, Late Anterior Decompression: Indications and Results", "Surgical Techniques of Spine Fusion, Cervical", San Diego, CA, October 25, 1985.

41. Pennsylvania Hospital, Surgery of the Adult Spine and Hip: "Spinal Cord Monitoring", "Pathology of Spinal Injuries Osseous and Neural", "Surgical Correction of Arthritic Deformities", Philadelphia, PA, December 2 through 4, 1985.

42. American Academy of Orthopaedic Surgeons Summer Institute: "Spine Trauma", New York, NY, September 11, 1985.

43. American Academy of Orthopaedic Surgeons Annual Meeting: "Degenerative Spondylolisthesis of the Lumbar Spine", "Surgical Management of Lower Cervical Spine Injuries", New Orleans, LA, February 20-25, 1986.

44. American Spinal Injury Association Annual Meeting: "Indications for Posterior Cervical Fusion in Cervical Trauma", San Francisco, CA, March 13-15, 1986.

45. The Spine - Current Concepts: "Treatment of Cervical Spondylosis by Anterior Discectomy and Fusion", "Cord Syndromes and Physiology of Spinal Cord Injuries", "Management of Cervical Spine Fractures", "Etiology and Treatment of Paralysis Associated with Rheumatoid Arthritis of the Spine", "Spinal Cord Monitoring", Maui, HI, March 16-22, 1986.

Instructional Course Lectures, cont'd:

46. American Academy of Orthopaedic Surgeons Comprehensive Review Course: "Degenerative Disease of the Spine. Pathogenesis and Treatment", Chicago, IL, April 5, 1986.

47. Orthopaedic Review Course: "Arthritis of the Cervical Spine", "Management of Cervical Spine and Cord Injuries", "Treatment of Fractures and Dislocations of the Thoracic and Lumbar Spine", Cleveland, OH, May 23, 1986.

48. Italy-U.S.A. Joint Meeting on Advances in Orthopaedic Surgery and Traumatology: "Treatment of Fractures of the Thoracolumbar Spine", Pavia, Italy, May 26-31, 1986.

49. American Orthopaedic Association International Symposium on Low Back Pain: "Lumbar Disk Prolapse", "Lumbar Spinal Stenosis", "Long-Term Followup of Lumbar Spinal Stenosis Surgical Patients", "Failed Back Surgery: Indications for Intervention", Chicago, IL, August 18-21, 1986.

50. American College of Surgeons Annual Meeting: "Complications of the Treatment of Cervical Spine and Cord Injuries", "Cervical Fractures in Children", New Orleans, LA, October 20-22, 1986.

51. Cervical Spine Research Society Course, The Cervical Spine: "Fractures and Dislocations of the Lower Cervical Spine", Palm Beach, FL, December ll-l5, 1986.

52. American Academy of Orthopaedic Surgeons Annual Meeting: "The Treatment of Lower Cervical Spine Fractures and Spinal Cord Injuries", Degenerative Spondylolisthesis Symposium", "Treatment of Cervical Disk Disease by Anterior Discectomy and Fusion", San Francisco, CA, January 22-27, 1987.

53. American Academy of Orthopaedic Surgeons Comprehensive Review Course for Orthopaedic Surgeons: "Degenerative Disk Disease of the Spine", Chicago, IL, March 26, 1987.

54. Current Trends in Orthopaedic Surgery: "Neck Pain", "Back Pain", Clearwater, FL, April 15-17, 1987.

55. American Orthopaedic Association, Combined Meeting of the English Speaking World: "Fractures of the Thoracolumbar Spine", Washington, DC, May 3-7, 1987.

56. The Spine - Advanced Concepts of Diagnosis and Treatment: "Osteotomy of the Spine, Indications and Techniques", "The Rheumatoid Spine: Actual History and Surgical Treatment", "Cervical Kyphosis: Etiology and Surgical Techniques", Kiawah Island, SC, May 15-18, 1987.

57. Orthopaedic Review Course, University Hospitals of Cleveland: "Arthritis of the Cervical Spine", "Cervical Spine and Cord Injuries", "Treatment of Fracture-Dislocations of the Thoracic and Lumbar Spine", Cleveland, OH, June 5, 1987.

Instructional Course Lectures, cont'd:

58. University of Massachusetts Medical Center, Acute Spinal Cord Injuries: Diagnosis and Management: "Anterior Decompression for Spinal Cord Injuries", Worcester, MA, October 1-3, 1987.

59. Vanderbilt University, Department of Orthopaedic Surgery, The Spine: Current Concepts and Techniques: "Late Management of Cervical Spine Injuries", "Surgical Indications for the Management of Cervical Radicular Syndromes", "Surgical Management of Cervical Spine in the Patient with Rheumatoid Arthritis", "Disk Herniation of the Thoracic Spine: Recognition and Treatment", Nashville, TN, October 26-28, 1987.

60. AO/ASIF Spine Course: "Late Consequences of Non-Operative Treatment of Thoracolumbar Injuries", Clearwater Beach, FL, October 20, 1987.

61. American Academy of Orthopaedic Surgeons Annual Meeting: "Surgical Management of Lower Cervical Spine Injuries", Atlanta, GA, February 6, 1988.

62. American Academy of Orthopaedic Surgeons Annual Meeting: "Degenerative Spondylolisthesis", Atlanta, GA, February 8, 1988.

63. American Academy of Orthopaedic Surgeons Annual Meeting, Moderator of Symposium: "Fractures of the Thoracolumbar Spine", Bohlman, H.H., with Stauffer, E.S., McAfee, P. and Eismont, F., Atlanta, GA, February 7, 1988.

64. The Spine: "Spinal Cord Monitoring", "Evolution and Treatment of Patients with Rheumatoid Arthritis of the Spine", "Spinal Cord Syndromes and Physiology of Spinal Cord Injury", Management of Cervical Spine Fractures", "Results of Late Anterior Decompression Following Spinal Trauma", Maui, HI, March 13-19, 1988.

65. American Academy of Orthopaedic Surgeons Review Course: "Degenerative Disease of the Cervical and Lumbar Spine", Chicago, IL, March 28, 1988.

66. Orthopaedic Review Course, University Hospitals of Cleveland: "Degenerative Disease of the Cervical Spine", "Management of Cervical Spine Injuries", "Management of Thoracolumbar Fractures", "Lumbar Spinal Stenosis", Cleveland, OH, June 10, 1988.

67. Spinal Disorders: "Lumbar Spinal Stenosis", "Rheumatoid Arthritis of the Cervical Spine", Goteborg, Sweden, June 26 - July 1, 1988.

68. The Spine - Current Concepts: "The Rheumatoid Cervical Spine", "Anterior Surgery for Cervical Disk Disease", "Late Anterior Decompression for Thoracolumbar Fractures", Palm Desert, CA, November 11-14, 1988.

69. Annual Spine Workshop, Barrow Neurological Institute: "Management of Thoracic Fractures", "Management of Thoracolumbar Fractures by the Anterior Approach", Phoenix, AZ, November 11-12, 1988.

Instructional Course Lectures, cont'd:

104. Campbell Clinic Symposium, 1) "Lumbar Spinal Stenosis Experimental and Clinical", 2) "Rheumatoid Arthritis of the Cervical Spine: Pathology and Treatment Concepts", Marco Island, FL January 16-19, 1997.

105. American Academy of Orthopaedic Surgeons Annual Meeting, 1) "Rheumatoid Arthritis of the Cervical Spine: Pathology and Current Treatment Concepts", 2) "Cervical Spondylosis and Myelopathy", 3) "Techniques of Anterior Cervical Decompression and Fusion", San Francisco, CA February 13-17, 1997

106. Cervical Spine and Research Society Annual Meeting, "Late Anterior Decompression and Fusion for Lower Cerivcal Spine Fractures", Atlanta, GA, December 3-6, 1998

107. American Orthopaedic Association Combined Meeting, "Cervical Spondylosis and Myelopathy", Auckland, New Zealand, February 2-6, 1998.

108. The American Academy of Orthopaedic Surgeons Annual Meeting, "Rheumatoid Arthritis of the Cervical Spine: Pathology and Treatment Concepts", Bohlman, H.H., Carlson, G.D, Emery, S.E., March 19-23, 1998, New Orleans, LA.

109. Charles Herndon Alumni Society, Spine Symposium, "Spinal Kyphosis: Diagnosis and Treatment," June 19-20, 1998.

110. Cervical Spine Research Society, 1) "Lower Cervical Spine Trauma", 2) "Delayed Anterior Decompression for Cervical Spine Fractures", Atlanta, Georgia, December 3-5, 1998.

111. American Academy of Orthopaedic Surgeons Instructional Course Lecture, "The Techniques of Anterior Cervical Decompression and Fusion", Anaheim, California, February 4-8, 1999.

112. International Congress on Spine Surgery, "Treatment of Degenerative Cervical Spine Disorders", Istanbul, Turkey, June 22-24, 1999.

113. Spine Symposium, University of Chicago, "Spinal Kyphosis: Diagnosis and Treatment", Chicago, Illinois, July 20, 1999.

114. Cervical Spine Research Society, "Anomalous Vertebral Artery: Cadaveric and Clinical Case Study," Curylo, L.J., Mason, H., Bohlman, H.H., and Yoo, J., Seattle, Washington, December 16-18, 1999.

115. American Academy of Orthopaedic Surgeons, Instructional Course Lecture, "Indications and Techniques of Anterior Cervical Decompression and Fusion", Orlando, Florida, March 15-19, 2000.

116. Spine Symposium, Anne Arundel Medical Center, "Cervical Spondylosis and Myelopathy: Treatment with Anterior Decompression and Fusion", Annapolis, Maryland, April 28, 2000.

Lectures and Paper Presentations:

1. Accident Pathology, an International Conference: "Pathology of Fatal Craniospinal Injuries", Washington, DC, June 6-8, 1968.

2. Quad City Orthopaedic Meeting: "The Pathology of Fatal Craniospinal Injuries", Philadelphia, PA, April 3, 1970.

3. University of California at Stanford and Santa Clara County Medical Society: "The Pathology of Fatal Craniospinal Injuries", "Current Treatment Concepts of Cervical Spine Injuries: A Review of 300 Cases", San Jose, CA, September 21, 1971.

4. American Academy of Orthopaedic Surgeons, Instructional Course Lectures: "The Pathology and Current Treatment Concepts of Cervical Spine Injuries", Chicago, IL, January, 1971; Washington, DC, January, 1972.

5. University of California, San Francisco Medical Center: Panel on Cervical Spine Injuries, February 12, 1972.

6. University of California at Davis: "Fatal Craniospinal Injuries", "Current Treatment Concepts of Cervical Spine Injuries", Sacramento, CA, March, 1971.

7. Cleveland Orthopaedic Club, Continuing Education Course: "Errors and Pitfalls in the Diagnosis and Treatment of Cervical Spine Injuries", Cleveland, OH, March 2, 1974.

8. American Academy of Orthopaedic Surgeons Course on the Neck: "Errors and Pitfalls in the Diagnosis and Treatment of Acute Cervical Spine Injuries", New York, NY, April 8, 1974.

9. American Academy of Orthopaedic Surgeons, Orthopaedic Nurses Course: "Care of Acute Cervical Spine Injuries", Cleveland, OH, May, 1974.

10. Ohio State Medical Association Conference on Sports Medicine: "Sports Injuries of the Cervical Spine", Cleveland, OH, November, 1974.

11. American Academy of Orthopaedic Surgeons and Veterans Administration Course on Management of Acute Spinal Cord Injuries: "Pathology and Current Treatment Concepts of Cervical Spine Injuries", "Upper Thoracic Spine Fractures with Paralysis", Scottsdale, AZ, November, 1974.

12. University of California at Los Angeles: "Pathology and Current Treatment Concepts of Cervical Spine Injuries", "Upper Thoracic Spine Fractures with Paralysis", Los Angeles, CA, November, 1974.

13. California Medical Association Course on Emergency and Immediate Care of Head and Neck Injuries: "Errors and Pitfalls in the Diagnosis and Treatment of Acute Cervical Spine Injuries", "Treatment Concepts of Cervical Spine Injuries," Los Angeles, CA, February, 1975.

Lectures and Paper Presentations, cont'd:

14. American Academy of Orthopaedic Surgeons: "Late Anterior Decompression of Spinal Cord Injuries, A Review of 36 Cases", San Francisco, CA, March, 1975.

15. American Physical Therapy Association, Sports Medicine Section: "Sports Injuries of the Cervical Spine: 86 Cases", Dallas, TX, March, 1975.

16. Veterans Administration Course on Acute Spinal Cord Injuries: "Decompression and Stabilization Procedures of Spinal Cord Injuries", "Surgical Treatment of Spasticity in Spinal Cord Injuries", Palo Alto, CA, April, 1975.

17. American Academy of Orthopaedic Surgeons, Chairman, Course on Orthopaedic Nursing: "Treatment of Acute Spinal Cord Injuries", Cleveland, OH, May, 1975.

18. Veterans Administration Course on Spinal Cord Injuries: "Current Treatment Concepts of Spinal Cord Injuries", Cleveland, OH, June, 1975.

19. American Academy of Orthopaedic Surgeons, Summer Institute, Instructional Course Lecturer, Course on Thoracolumbar Fractures: "Upper Thoracic Spine Fractures with Paralysis, 180 Cases", August, 1975.

20. Bethesda Naval Hospital: "Late Anterior Decompression of Spinal Cord Injuries, Review of 50 Cases", Washington, DC, September, 1975.

21. The Cleveland Orthopaedic Club: "Cervical Spondylosis", "Pathology and Current Treatment Concepts, Cervical Spine Injury", Cleveland, OH, October 4, 1975.

22. Cervical Spine Research Society: "Massive Epidural Hemorrhage in Fractures of the Cervical Spine in Ankylosing Spondylitis", Toronto, Ontario, November, 1975.

23. Veterans Administration, Central Office: "Results of Late Anterior Decompressions in Spinal Cord Injuries", Washington, DC, November, 1975.

24. American Academy of Orthopaedic Surgeons: "Late Progressive Paralysis and Pain Following Fractures of the Thoracolumbar Spine, Treatment and Results of 10 Cases", New Orleans, LA, January, 1976.

25. Cleveland Orthopaedic Club Continuing Education Course: "Sports Injuries of the Cervical Spine", Cleveland, OH, April 3, 1976.

26. The Arthritis Foundation, Northeastern Ohio Chapter: "The Surgical Treatment of Cervical Spondylosis", Cleveland, OH, April 21, 1976.

27. American Academy of Orthopaedic Surgeons, Chairman, Course on Orthopaedic Nursing: "Treatment of Acute Spinal Cord Injuries," Cleveland, OH, May 14-16, 1976.

Lectures and Paper Presentations, cont'd:

28. American Academy of Orthopaedic Surgeons, Summer Institute Instructional Course on: "Treatment of Upper Thoracic Spine Fracture with Paralysis", Chicago, IL, August, 1976.

29. Veterans Administration Spinal Cord Injury Conference: "Late Anterior Decompression and Fusion for Spinal Cord Injuries: Results of 65 Cases", Castlepoint, V.A.H., Fishkill, NY, September, 1976.

30. Detroit Academy of Orthopaedic Surgery and Wayne State University: "Pathology and Current Concepts in Treatment of Cervical Spine Injuries", "Upper Thoracic Spine Injuries with Paralysis", "Surgical Treatment of Cervical Spondylosis", Detroit, MI, October, 1976.

31. Cleveland Veterans Administration Fourth Annual Conference on The Care and Treatment of the Spinal Cord Injured: "Current Treatment Concepts of Spinal Cord Injuries", Cleveland, OH, November, 1976.

32. Cervical Spine Research Society: "Treatment of Cervical Spondylosis with Myelopathy: Report of 17 Cases of Anterior Discectomy and Fusion", Philadelphia, PA, November, 1976.

33. Case Western Reserve Medical School, Medicine Today, Medical Grand Rounds: "Pyogenic Osteomyelitis of the Spine: A Review of 53 Cases", Cleveland, OH, November, 1976.

34. American Academy of Orthopaedic Surgeons Annual Meeting: "Pyogenic Osteomyelitis of the Spine: A Report of 50 Cases With and Without Paralysis", Las Vegas, NV, January, 1977.

35. Portsmouth Naval Hospital, Hampton Road Orthopaedic Society: "Cervical Spine Injuries", "Upper Thoracic Spine Fractures with Paralysis", "Cervical Spondylosis", Portsmouth, VA, March, 1977.

36. Cleveland Emergency Medical Services: "Spinal Cord Injuries", Cleveland, OH, March, 1977.

37. Cleveland Clinic Foundation, Continuing Education: "Pathology and Current Treatment Concepts of Cervical Spine Injuries", "Upper Thoracic Spine Fractures with Paralysis", "Cervical Spondylosis", Cleveland, OH, April, 1977.

38. Visiting Lecturer, Alfred I. DuPont Institute: "Late Anterior Decompressions Spinal Cord Injuries", Wilmington, DE, May 20, 1977.

39. Little Orthopaedic Club: "Late Anterior Decompression and Fusion of Spinal Cord Injuries", Hilton Head, SC, May, 1977.

40. American Academy of Orthopaedic Surgeons Course on Orthopaedic Nursing: "Atlantoaxial Dislocations in the Arthritic Patient - A Threat to Life", "Current Treatment Concepts of Spinal Cord Injuries", Cleveland, OH, June, 1977.

Lectures and Paper Presentations, cont'd:

67. St. Luke's Hospital, Continuing Education Course: "Anterior Decompressions and Fusion for Spinal Cord Injuries", Cleveland, OH, March, 1980.

68. Cleveland Arthritis Society: "Atlantoaxial Dislocations in the Arthritic Patient", Cleveland, OH, March, 1980.

69. American Spinal Injury Association: "Late Anterior Decompression and Fusion of Spinal Cord Injuries", Anaheim, CA, April, 1980.

70. Canadian Orthopaedic Research Society: "Mechanical Factors Affecting Recovery of Incomplete Spinal Cord Injuries", Calgary, June, 1980.

71. Cervical Spine Research Society: "Complications of the Treatment of Cervical Spine Injuries", Palm Beach, FL, December, 1980.

72. American Academy of Orthopaedic Surgeons Course on The Spine, Surgery and Rehabilitation: "Primary Tumors of the Cervical Spine", Kissimmee, FL, December, 1980.

73. American Academy of Orthopaedic Surgeons Course on Spinal Cord Injuries: "Spinal Cord Monitoring", "Late Surgical Intervention in Thoracolumbar Injuries", Miami Beach, FL, December, 1980.

74. American Academy of Orthopaedic Surgeons Annual Meeting: "Highlights of Adult Spine", Las Vegas, NV, March, 1981.

75. American Academy of Orthopaedic Surgeons Course on Priorities and Management, Acute Multi-System Orthopaedic Trauma: "Fractures of the Thoracolumbar Spine", Chicago, IL, April, 1981.

76. Spine Study Group: "Indications and Planning for Surgery in Cervical Disc Disease", "Cervical Myelopathy", Snowmass, CO, March, 1981.

77. International Society for the Study of the Lumbar Spine: "Complications of Harrington Rod Fixation for Fractures of the Thoracolumbar Spine", Paris, France, June, 1981.

78. Uniformed Services, University of Health Sciences - SOMOS Meeting: "Initial Management of Spinal Injuries", Washington, DC, November, 1981.

79. Johns Hopkins Hospital, Department Orthopaedic Surgery: "Pathology and Current Treatment Concepts of Cervical Spine Injuries", Baltimore, MD, March 20, 1982.

80. Cleveland Clinic Foundation: "Cervical Spine Injuries", "Thoracolumbar Fractures", Cleveland, OH, April 20, 1982.

Lectures and Paper Presentations, cont'd:

81. University Hospitals, Trauma Update 1982: "Cervical Spine Injuries", Cleveland, OH, June 11, 1982.

82. Lakewood Hospital, Continuing Education Department: "Neck Pain", "Back Pain", Lakewood, OH, October 13, 1982.

83. Cleveland Orthopaedic Club, Continuing Education Program: "Osteomyelitis of the Spine", Cleveland, OH, October 20, 1982.

84. University Hospitals, Department of Radiology, Continuing Education Program: "Cervical Spine Injuries", "Thoracic Spine Fractures with Paralysis", Cleveland, OH, November 10, 1982.

85. Cervical Spine Research Society Annual Meeting: "Robinson Anterior Cervical Discectomy and Fusion: Long-Term Results of 103 Patients", New York, NY, December 1-4, 1982.

86. Canadian Orthopaedic Association Annual Meeting: "Robinson Anterior Cervical Discectomy and Fusion: Long Term Results in 103 Patients", Quebec, Canada, June 5-9, 1983.

87. American Orthopaedic Association Annual Meeting: "Robinson Anterior Cervical Discectomy and Fusion: Long Term Results in 103 Patients", The Homestead, VA, June 27-30, 1983.

88. Visiting Professor, University of Massachusetts, Department of Orthopaedic Surgery: "Fractures of the Thoracolumbar Spine", "Complications of Harrington Instrumentation for Thoracic Lumbar Fractures", Worcester, MA, September 19, 1983.

89. St. Joseph's Hospital, Rheumatology Seminar: "Low Back Pain", "Lumbar Spinal Stenosis", Akron, OH, September 21, 1983.

90. Little Travel Club, Dalhousiana University, Division of Orthopaedic Surgery: "Failed Back Surgery", Halifax, Nova Scotia, September 30, 1983.

91. Cervical Spine Research Society Course n The Cervical Spine: "Fractures and Dislocations of the Lower Cervical Spine", Palm Beach, FL, December 7, 1983.

92. Cervical Spine Research Society: "The Etiology of Paralysis with Atlantoaxial Dislocations in the Arthritic Patient", Palm Beach, FL, December 8, 1983.

93. American Academy of Orthopaedic Surgeons Annual Meeting: "Robinson Anterior Cervical Discectomy and Fusion. Long-Term Results of 103 Patients", Atlanta, GA, February 11, 1984.

94. American Academy of Orthopaedic Surgeons Annual Meeting, Symposium on Modern Decision Making in Spinal Disease: "Fractures of the Thoracic and Lumbar Spine", Atlanta, GA, February 13, 1984.

Lectures and Paper Presentations, cont'd:

95. American Academy of Orthopaedic Surgeons Annual Meeting: "Surgical Treatment of Lumbar Spinal Stenosis: Long Term Follow-Up of 142 Patients", Atlanta, GA, February 14, 1984.

96. American Orthopaedic Association; "Surgical Treatment of Lumbar Spinal Stenosis: Long-Term Follow-Up of 142 Patients", Palm Beach, FL, May 14-17, 1984.

97. Surgical Grand Rounds, University Hospital, Department of Surgery: "Lumbar Spinal Stenosis", Cleveland, OH, September 8, 1984.

98. SICOT - The International Society of Orthopaedic Surgery: "Robinson Anterior Cervical Discectomy and Fusion: Long Term Results of 103 Patients", London, England, October 5, 1984.

99. Symposium on Sports Injuries: "Sports Injuries of the Cervical Spine", Groningin, Holland, September 28, 1984.

100. University of Maryland, School of Medicine, Orthopaedic Division, "Treatment of Thoracolumbar Fractures", Baltimore, MD, October 12, 1984.

101. University of Miami, Course on Advances in Spinal Surgery - VI: "Cervical Spondylosis and Myelopathy", "Treatment of Herniated Thoracic Discs", Miami, FL, November 26-27, 1984.

102. American Academy of Orthopaedic Surgeons Annual Meeting: "Surgical Treatment of Herniated Thoracic Discs by Anterior Excision: Results of 19 Cases", Las Vegas, NV, January 25, 1985.

103. American Academy of Orthopaedic Surgeons Annual Meeting: "Complications of Harrington Instrumentation in Thoracolumbar Fractures: A Ten Year Experience", co-author Paul McAfee, Las Vegas, NV, January 29, 1985.

104. American Academy of Orthopaedic Surgeons Course on Management of Spinal Cord Injuries: "Spinal Cord Monitoring", Physiology and Pathology of Spinal Cord Injuries", "Application of Late Anterior Decompression of Cervical Spinal Cord Injuries", "Anterior Decompression of Thoracolumbar Injuries", Keystone, CO, March 18, 19 and 20, 1985.

105. Barrow Neurological Institute, Department of Neurosurgery: "The Treatment of Thoracolumbar Fractures", Phoenix, AZ, September 6, 1985.

106. The American Paraplegia Society: "Late Anterior Decompressions for Spinal Cord Injury: Review of 167 Cases with Long-Term Results of Neurologic Recovery", Las Vegas, NV, September 6, 1985.

107. Course on Surgery of the Spine: "Pathology of Spinal Injuries, Osseous and Neural", "Spinal Cord Monitoring and Alternatives", "Surgical Correction of Arthritic Deformities", Philadelphia, PA, December 2-4, 1985.

Lectures and Paper Presentations, cont'd:

108. Cervical Spine Research Society Annual Meeting: "The Treatment of Cervical Kyphosis with Myelopathy by Anterior Corpectomy and Strut Graft of Fusion", with Zdeblick, Boston, MA, December 4-7, 1985.

109. American Academy of Orthopaedic Surgeons Annual Meeting, Moderator of Symposium, Complications of Spinal Surgery and Their Management: "Complications of Cervical Trauma", New Orleans, LA, February 2, 1986.

110. American Academy of Orthopaedic Surgeons Annual Meeting: "Late Pain and Paralysis Following Fractures of the Thoracolumbar Spine: Long Term Results of Anterior Decompression and Fusion in 41 Patients": "Failure of Methylmethacrylate in Spinal Stabilization" with McAfee, P.C., Ducker, T., Eismont, F.J. and Regan, J.J.; "Nuclear Magnetic Resonance in the Diagnosis of Cervical Spinal Cord Compression" with McAfee, P.C., Han, J.S. and Salvagno, R.T.; "The Triple Wire Stabilization Technique for Fracture-Dislocations of the Cervical Spine" with McAfee, P.C., Wilson, W.W. and Britt, J.; "Anterior Decompression of the Cervical Spine Following Traumatic Quadriplegia" with Anderson, P.A., New Orleans, LA, February 20-25, 1986.

111. Federation of Spine Association's First Annual Meeting: "Late Anterior Decompression for Cervical Spinal Cord Injuries", New Orleans, LA, February 19, 1986.

112. American Spinal Injury Association Annual Meeting: "Late Anterior Decompression for Spinal Cord Injuries: A Review of 417 Patients with Long Term Results of Neurologic Recovery", San Francisco, CA, March 13-15, 1986.

113. American Paraplegia Society: "Late Pain and Paralysis Following Fractures of the Thoracolumbar Spine: Long-Term Results of Anterior Decompression and Fusion in 41 Patients", Las Vegas, NV, September 3-5, 1986.

114. Cervical Spine Research Society: "Indications and Technique of Occipital Cervical Fusion" with Wertheim, S.B.; "Anterior Extraoral Approach to the Atlas and Axis" with McAfee, P.C.; "One Stage Anterior Decompression and Fusion for Fixed Cervical Kyphosis" with McAfee, P.C.; "Pathophysiological Changes with Non-Acute Spinal Cord Trauma", Palm Beach, FL, December 10-13, 1986.

115. Federation of Spine Association Annual Meeting: "Late Anterior Decompression for Spinal Cord Injury: Review of 167 Patients with Long-Term Results of Neurologic Recovery", "Late Pain and Paralysis Following Fractures of Thoracolumbar Spine: Treatment by Anterior Decompression with Fusion", "Pathophysiologic Changes in Non-Acute Spine Cord Trauma", San Francisco, CA, January 21-22, 1987.

Lectures and Paper Presentations, cont'd:

116. American Academy of Orthopaedic Surgeons Annual Meeting: "Selection of Long-Term Results and Salvage Operations for the Patient with Failed Lumbar Spine Surgery: Report of 82 Patients", co-authors Delamarter, R. and Martin, J., San Francisco, CA, January 22-27, 1987.

117. American Academy of Orthopaedic Surgeons Annual Meeting: "Epidural Hematomas as a Complication of Posterior Lumbar Surgery", co-authors Anderson, P., Wilber, G. and O'Leary, P., San Francisco, CA, January 22-27, 1987.

118. American Academy of Orthopaedic Surgeons Annual Meeting: "Anterior Extraoral Approach to the Atlas and Axis", co-authors McAfee, P.C., Robinson, R.A., Nakelis, N. and Southwick, W., San Francisco, CA, January 22-27, 1987.

119. American Academy of Orthopaedic Surgeons Annual Meeting: "Cervical Spinal Cord Compression from Ossification of the Posterior Longitudinal Ligament", co-authors McAfee, P.C. and Regan, J., San Francisco, CA, January 22-27, 1987.

120. American Academy of Orthopaedic Surgeons Annual Meeting: "The Treatment of Cervical Kyphosis with Myelopathy by Anterior Corpectomy and Strut Graft Fusion", co-author Zdeblick, T., San Francisco, CA, January 22-27, 1987.

121. American Academy of Orthopaedic Surgeons Annual Meeting: "The Etiology of Paralysis and Rheumatoid Arthritis of the Cervical Spine", co-authors Dodge, L. and Rechtine, G., San Francisco, CA, January 22-27, 1987.

122. Little Orthopaedic Club: "Late Pain and Paralysis Following Fractures of the Thoracolumbar Spine: Treatment by Anterior Decompression and Fusion", Sedona, AZ, April 26-29, 1987.

123. The International Society for the Study of the Lumbar Spine: "Diagnosis of Lumbar Arachnoiditis by Magnetic Resonance Imaging", Delamarter, R. and Bohlman, H.H., "Late Pain and Paralysis Following Fractures of the Thoracolumbar Spine", Rome, Italy, May 24-28, 1987.

124. American Paraplegia Society: "Paralysis Secondary to Rheumatoid Arthritis of the Cervical Spine: Pathogenesis and Treatment", Las Vegas, NV, September 22-24, 1987.

125. American Academy of Orthopaedic Surgeons Annual Meeting: "Experimental Lumbar Spinal Stenosis: Cortical Evoked Potential and Neuropathologic Analysis", Delamarter, R.B., Bohlman, H.H., Dodge, L.D. and Biro, C., Atlanta, GA, February 6, 1988.

126. Federation of Spine Association Third Annual Meeting: "The Complications of Cervical Spine Surgery", Atlanta, GA, February 7, 1988.

Lectures and Paper Presentations, cont'd:

127. The International Society for the Study of the Lumbar Spine Annual Meeting: "Diagnosis of Recurrent Lumbar Disk Herniation Versus Post-Operative Scar by Gadolinium - DPTA Enhanced Magnetic Resonance Imaging", Delamarter, R., Bohlman, H.H. and Masaryk, T., Miami, FL, April 13-17, 1988.

128. Medical Grand Rounds, University Hospitals, Case Western Reserve University School of Medicine: "Low Back Pain and Spinal Stenosis", Cleveland, OH, May 21, 1988.

129. American Orthopaedic Association: "Post-Operative Epidural Fibrosis Versus Recurrent Lumbar Disk Herniation Diagnosis by Gadolinium - DPTA Enhanced Magnetic Resonance Imaging", Delamarter, R., Bohlman, H.H, Modic, M. and Ross, J., Hot Springs, VA, June 20-23, 1988.

130. Cleveland Orthopedic Club: "Thoracic Intervertebral Disk Herniation", Cleveland, OH, November 5, 1988.

131. University Hospitals of Cleveland, Comprehensive Management of Spinal Disorders: "Thoracic Disk Disease", "Infections of the Spine", "Cervical Spine Trauma", Saw Mill Creek, Huron, OH, November 19, 1988.

132. Orthopaedic Research Society: "Decompression of Experimental Spinal Stenosis: Cortical Evoked Potential Vasculature and Histopathology Analysis", Delamarter RB, Bohlman H.H. and Biro C., Las Vegas, NV, February 6, 1989.

133. Orthopaedic Research Society: "Treatment of Cervical Kyphosis with Myelopathy by Anterior Corpectomy and Strut Fusion", Zdeblick T.A. and Bohlman H.H., Las Vegas, NV, February 6, 1989.

134. International Society for the Study of the Lumbar Spine: "Decompression of Experimental Spinal Stenosis: Analysis of Cortical Evoked Potentials, Vasculature and Histopathology", Delamarter R.B., Bohlman H.H. and Biro C., Kyoto, Japan, May 26-27, 1989.

135. American Orthopaedic Association Annual Meeting: "Decompression of Experimental Spinal Stenosis: Analysis of Cortical Evoked Potentials, Vasculature and Histopathology", Delamarter, R.B., Bohlman, H.H. and Biro C., Colorado Springs, CO, June 12-13, 1989.

136. Civilian National Consultant, United States Air Force, Wilford Hall USAF Medical Center, Brook Army Medical Center: "Treatment of Thoracolumbar Fractures", "Degenerative Cervical Spine Disease", "The Etiology of Paralysis and Rheumatoid Arthritis", "Late Anterior Decompression for Spinal Cord Injury - Long Term Results", San Antonio, TX, July 6-8, 1989.

137. Presidential Address, Cervical Spine Research Society: "The Evolution of Anterior Cervical Spine Surgery", New Orleans, LA, December 6, 1989.

Lectures and Paper Presentations, cont'd:

138. The Spine - Current Concepts of Diagnosis and Treatment: "Management of Thoracic Disc Disease", "Anterior Surgery for Cervical Disc Disease", San Diego, CA, April 29-30, 1990.

139. Visiting Professor, University of Melbourne: "The Treatment of Upper Thoracic Fractures with Paralysis", "Thoracolumbar Fractures with Paralysis", "The Etiology of Paralysis in Rheumatoid Arthritis of the Cervical Spine", Melbourne, Australia, July 9, 1990.

140. Visiting Professor, University of Adelaide, Department of Orthopaedic Surgery: "Lumbar Spinal Stenosis", "Pyogenic Infections of the Spine", Adelaide, Australia, July 11, 1990.

141. International Society of Orthopaedic Surgery and Traumatology: "Etiology of Paralysis in Rheumatoid Arthritis of the Cervical Spine", Bohlman H.H., Dodge L.D. and Rechtine G.R., Montreal, Canada, September 8-15, 1990.

142. European Cervical Spine Research Society: "Paralysis Secondary to Rheumatoid Arthritis of the Cervical Spine - Pathogenesis and Treatment", Bohlman H.H., Dodge L.D. and Rechtine G.R., Taormina, Italy, September 26-29, 1990.

143. Cervical Spine Research Society: "A Tribute to Dr. Robert A. Robinson", "Injury to the Spinal Cord", San Antonio, TX, November 28 - December 2, 1990.

144. Brazilian Orthopaedic Society, ORTRA International: "Anterior Decompression for Cervical Spinal Cord Injuries", "Cervical Spondylosis - Treatment by Anterior Decompression and Fusion", "Lumbar Spinal Stenosis", "Rheumatoid Arthritis of the Cervical Spine", "Herniated Thoracic Discs - Treatment by Anterior Decompression", "Anterior Decompression for Thoracolumbar Spinal Injuries", Rio de Janeiro, Brazil, July 11-13, 1991.

145. Cervical Spine Research Society: "Decompression of the Spinal Cord: A Canine Model", Bolesta M.J. and Bohlman H.H., Philadelphia, PA, December 6, 1991.

146. Federation of Spine Associations: "Robinson Anterior Cervical Discectomy and Fusion for Cervical Radiculopathy, Long Term Follow up of 122 Patients", Emery S.E., Bohlman H.H. and Goodfellow D.G., Washington, DC, February 23, 1992.

147. European Cervical Spine Research Society: "Anterior Decompression and Fusion for Cervical Spinal Cord Injuries", Athens, Greece, June 24-27, 1992.

148. International Foundation for Spinal Studies, Arthrodesis and Instrumentation of the Spinal Column for Pain Syndromes: "Anterior Cervical Decompression and Fusion for Cervical Myelopathy", "Treatment of cervical Kyphosis", "Complications of Cervical Spine Surgery", "Surgery for the Failed Back", "Surgical Management of Spondyloptosis", "Complications of Lumbar Spinal Surgery", London, England, September 1-4, 1992.

Lectures and Paper Presentations, cont'd:

149. American Academy of Orthopaedic Surgeons Summer Institute: "Anterior Cervical Decompression and Fusion (live demonstration and lecture), "Lumbar Spinal Stenosis", "Anterior Decompression and Fusion for Thoracolumbar Fractures", Seattle, WA, September 19-20, 1992.

150. American Paralysis Association Annual Meeting: "Indications for Decompression and Stabilization of Spinal Cord Injury", with Bolesta M.J., Las Vegas, NV, September 8-10, 1992.

151. Argentinean Society of Pathology of the Vertebral Column: "Treatment of Herniated Thoracic Disc by Anterior Excision", "Treatment of Cervical Radiculopathy and Myelopathy", "Lumbar Spinal Stenosis", "Treatment of Cervical Spine and Spinal Cord Injuries", "Treatment of Fractures of the Thoracic Spine with Paralysis", "Treatment of Fractures of the Lumbar Spine with Paralysis", Buenos Aires, Argentina, October 22-24, 1992.

152. University of California at San Francisco: "Treatment of Lumbar Spinal Stenosis: Experimental and Clinical", "Cervical Spondylosis with Radiculopathy and Myelopathy", San Francisco, CA, November 6-8, 1992.

153. Cervical Spine Research Society Annual Meeting: "Degenerative Spondylolisthesis of the Cervical Spine", with Bolesta M.J., New York, NY, December 3-5, 1992.

154. Course on Techniques in Spinal Instrumentation: "Lumbar Spinal Stenosis: The Influence of Olisthesis", New York, NY, December 11-12, 1992.

155. American Academy of Orthopaedic Surgeons Annual Meeting: "Degenerative Spondylolisthesis of the Cervical Spine", San Francisco, CA, February 18-23, 1993.

156. Spine Study Group: "Treatment of Fractures of the Cervical Spine", "Cervical Radiculopathy and Myelopathy: Treatment by Anterior Approaches", "Herniated Thoracic Discs: Treatment by the Anterior Approach", "Fractures and Dislocations of the Cervical Spine", Naples, FL, April 29 - May 2, 1993.

157. Herndon Society: "Lumbar Spinal Stenosis", Park City, UT, March 22-24, 1993.

158. Topics in Geriatric Medicine, Case Western Reserve University: "Lumbar Spinal Stenosis: Experimental and Clinical", Cleveland, OH, May 21, 1993.

159. Western Orthopaedic Association Annual Meeting: "The Etiology of Paralysis", "Rheumatoid Arthritis of the Cervical Spine", Sacramento, CA, May 17, 1993.

160. Orthopaedic Grand Rounds, University of California, Davis: "Lumbar Spinal Stenosis, Experimental and Clinical", Sacramento, CA, May 18, 1993.

161. UOA Review Course: "The Management of Cervical Spine and Cord Injuries", "Spinal Infections", Cleveland, OH, May 20, 1993.

Lectures and Paper Presentations, cont'd:

162. State of the Spine from A-Z: "Cervical Myelopathy: Diagnosis and Treatment", Las Croabas, Puerto Rico, November 14, 1993.

163. The Spine - Current Concepts: "Upper Cervical Spine Lesions: Evaluation and Management", "Cervical Myelopathy and Radiculopathy", "Cervical Management of Cervical Spine Injuries", "Late Decompression Following Spine Trauma", "Thoracic Disc Herniations", Maui, HI, 1994.

164. Visiting Professor, Argentinean Congress of Orthopaedics and Traumatology: "The Treatment of Thoracolumbar Fractures with Neurologic Deficit by Anterior Decompression and Fusion", "Fractures and Dislocations of the Lower Cervical Spine", "Lumbar Spinal Stenosis: Experimental and Clinical", "Cervical Kyphosis and Myelopathy: Treatment by Anterior Corpectomy and Strut Grafting", "Results of Treatment of Acute Injuries in the Upper Thoracic Spine with Paralysis by Anterior Decompression and Fusion", Buenos Aires, Argentina, October 30 - November 2, 1994.

165. American Academy of Orthopaedic Surgeons, Goldstein, J.A., McAfee, P.C., Bohlman, H.H., Ducker, T.B and Ziedman, S.M. "One Stage Anterior Cervical Decompression and Posterior Stabilization with Circumferential Arthrodesis: The Study of 100 Patients". Orlando, FL, Feb. 16-21, 1995.

Ghanayem, A.J., Leventhal, M., Bohlman, H.H., "Occipital Cervical Pain in Atlanto Axial Ostearthrosis: Long Term Follow-up of Treatment by Arthrodesis".

166. North American Spine Society, "Re-Operation for Lumbar Stenosis: Good Long-Term Results?", Carlson G.D., Phillips F.M., MacNamara T.J. and Bohlman, H.H.

"Adjacent Lumbar Segment Degeneration: Is Surgery Efficacious", Phillips F.M., Carlson G.D., Hughes S.S. and Bohlman H.H.

Iatrogenic Lumbar Spondylolisthesis: "Treatment by Anterior Fibular and Iliac Arthrodesis", Ghanayem A.J., Heller J.G., McAfee P.C. and Bohlman H.H., Washington, D.C., October 18 - 21, 1995.

167. The Fifth Congress of Brazilian Pathology of the Vertebral Column, "Lumbar Spinal Stenosis: Experimental and Clinical", "Spinal Kyphosis: Diagnosis and Treatment", Round Table Discussions: Cervical Spine Fractures, Degenerative Pathologies to the Cervical Spine, and Degenerative Pathologies of the Lumbar Spine, Sao Paulo, Brazil, October 31 - November 4, 1995.

168. Cervical Spine and Research Society, Palm Beach, FL, December 5-7, 1996, "Complications of Anterior Cervical Corpectomy and Post Laminectomy Patients", Reau K.D., Palumbo M.A., Hilibrand A.S., Carlson G.D. and Bohlman H.H.

Lectures and Paper Presentations, cont'd:

168. "Achieving Solid Arthrodesis Following Anterior Cervical Decompression: Corpectomy vs. Discectomy", Hilibrand A.S., Palumbo M.A., and Bohlman H.H.

"The Success of Anterior Cervical Arthrodesis Adjacent to a Previous Fusion", Hilibrand, A.S., Yoo, J.U., Carlson, G.D., and Bohlman, H.H.

"Higher Instances of Pseudoarthrosis in Poor Outcomes for Three Level Anterior Cervical Discectomy and Fusion", Emery, S.E., Fisher, R.S., and Bohlman, H.H.,

"Radiculopathy Due to Age Adjacent Segment Degeneration Following Anterior Cervical Fusions", Hilibrand, A.S., Carlson, G.D., Palumbo, M.A., and Bohlman, H.H.

169. The Liverpool Spine Course, "Spinal Kyphosis Diagnosis and Surgical Correction"

"Surgical Techniques and the Management of Spondylolyses and Spondylolisthesis"

"Management of Primary Tumors of the Spine", Liverpool, England, Oct 30-Nov 1, 1996,

170. Cervical Spine and Research Society, "Complications of Anterior Cervical Corpectomy and Post Laminectomy Patients", Reiw, K.D., Palumbo, M., Hilibrand, A.S., Carlson, G.D., and Bohlman, H.H., Palm Beach, FL, December 5-7, 1996.

171. American Academy of Orthopaedic Surgeons Annual Meeting, "At Risk Levels for Adjacent Segment Disease of the Cervical Spine", Hilibrand, A.S., Carlson, G.D., Palumbo, M., and Bohlman, H.H.

"Stenosis of the Thoracic Spinal Canal: Diagnosis and Treatment Concepts", Hilibrand, A.S., Hardy, R., Palumbo, M., and Davis, J.A.

"Diagnosing Basiler Invagination of the Rheumatoid Arthritis Patient: Are Plain Radiographic Criterior Reliable?", Riew, K.D., Palumbo, M., Hilibrand, A.S., and Bohlman, H.H.

"Anterior Cervical Pseudoarthrosis: Natural History and Treatment", Philips, F., Carlson, G.D., Emery, S.E., and Bohlman, H.H.

"Outcome of Anterior Cervical Fusions Adjacent to a Prior Fusions", Hilibrand, A.S., Yoo, J.U., Carlson, G.D., and Bohlman, H.H., San Francisco, CA, February 13-17, 1997.

172. North American Spine Society, "Smoking Impairs the Outcome of Anterior Cervical Interbody Grafting", Hilibrand, A.S., Fye, M., Palumbo, M., Bohlman, H.H.

"Improve the Arthrodesis After Multi-Level Anterior Cervical Decompression Through Strut Grafting", Hilibrand, A.S., Fye, M, Palumbo, M., and Bohlman, H.H.

Lectures and Paper Presentations, cont'd:

172. "The Management and Long-term Results of Patients with Dural Tears from Lumbar Spine Surgery", Wang, J.C., Bohlman, H.H., Riew, D.

"Diagnosing Basilar Invagination in the Rheumatoid Patient: Are Plain Radiographic Criteria Reliable?", Riew, K.D., Hilibrand, A.S., Palumbo, M., Emery, S.E., and Bohlman, H.H.

"Surgery of the Lumbar Spine for Spinal Stenosis in Patients Ages 70 years or More: A Clinical Radiographic Outcome Study in 162 Patients", Fye, M., Ragab, A.A., and Bohlman, H.H.

"Incomplete Decompression: Clinical Radiographic Outcomes", Fye, M., Emery, S.E., and Bohlman, H.H.

173. Cervical Spine and Research Society Annual Meeting, "Early Decompression for Spinal Cord Injury: Time Dependent Factors of Recovery", Carlson, G.D., Minato, Y, Okada, A., Gorden, C.D., Warden, K.E., Bohlman, H.H. and LaManna, J.C.

"Reoperation of the Cervical Spine for Incomplete Decompression: Clinical and Radiographic Outcomes", Fye, M.A., Emery, S.E. and Bohlman, H.H., Rancho Mirage, CA, December 4-6, 1997.

174. North American Spine Society, "Smoking Impairs the Outcome of Anterior Cervical Interbody Grafting", Hilibrand, A.S., Fye, M., Palumbo, M., and Bohlman, H.H.

"Improved Arthrodesis After Multi-Level Anterior Cervical Decompression Through Strut Grafting", Hilibrand, A.S., Fye, M., Palumbo, M., and Bohlman, H.H.

"The Management and Long-Term Results of Patients with Dural Tears from Lumbar Spine Surgery", Wang, J.C., Bohlman, H.H. and Riew, K.D.

"Rheumatoid Basilar Invagination: Are X-ray Criteria Reliable?", Riew, K.D., Hilibrand, A.S., Palumbo, M., Emery, S.E., and Bohlman, H.H.

"Surgery of the Lumbar Spine for Spinal Stenosis in Patients Ages Seventy Years or More: A Clinical and Radiographic Outcome Study in One Hundred and Sixty-Two Patients", Fye, M., Ragab, A.A., and Bohlman, H.H.

"Re-Operation of the Cervical Spine for Incomplete Decompression: Clinical and Radiographic Outcomes", Fye, M., Emery, S.E., Bohlman, H.H. New York, NY, October 22-25, 1997.

Revised: May 15, 2001

Henry H. Bohlman, M.D.
Professor, CWRU
Director, University Hospitals Spine Institute
Reconstructive & Traumatic Spine Surgery

11100 Euclid Avenue
Cleveland, Ohio 44106
Telephone: 216-844-1025
Fax: 216-844-1735
Appointments: 216-844-7200

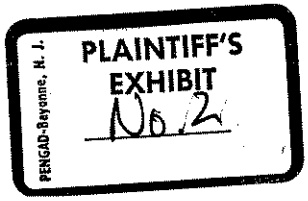
UNIVERSITY ORTHOPAEDIC ASSOCIATES, INC.
Claim History

CLAIMANT:	**Lucija Stele**
OCCURRENCE DATE:	**3/6/90**
REPORTED DATE:	**3/4/91**
STATUS:	**A lawsuit was filed on August 20, 1991 in the Cuyahoga County Court of Common Pleas and assigned Case No. 216533. This lawsuit is still pending and is being handled by the law firm of Jacobson, Maynard, Tuschman & Kalur.** **Closed without payment.**

CLAIMANT:	**Murray Lilley**
OCCURRENCE DATE:	**7/7/88**
REPORTED DATE:	**1/3/89**
STATUS:	**A lawsuit was filed on April 5, 1990 in the Cuyahoga County Court of Common Please and assigned Case No. 187723. This lawsuit is being handled by the law firm of Jacobson, Maynard, Tuschman & Kalur.** **Went to trial – unanimous decision in favor of Dr. Bohlman.**

CLAIMANT:	**Eleanor L. Petrie**
OCCURRENCE DATE:	**8/2/90**
REPORTED DATE:	**8/12/91**
STATUS:	**This claim was closed without payment. It was handled by the law firm of Jacobson, Maynard, Tuschman & Kalur.**

CLAIMANT:	**Charlotte Magill**
OCCURRENCE DATE:	**1/16/90**
REPORTED DATE:	**7/22/91**
STATUS:	**This claim was closed without payment and was being handled by the law firm of Jacobson, Maynard, Tuschman & Kalur.**



UNIVERSITY ORTHOPAEDIC ASSOCIATES, INC.
Claim History

CLAIMANT:	Raymond H. Brandt
OCCURRENCE DATE:	7/9/88
REPORTED DATE:	7/26/89
STATUS:	This claim was closed without payment in February, 1990 due to the expiration of the Statute of Limitations. This file was handled by the law firm of Jacobson, Maynard, Tuschman & Kalur.

CLAIMANT:	John M. Emerson
OCCURRENCE DATE:	12/6/90
REPORTED DATE:	12/11/90
STATUS:	This claim was closed without payment in June, 1991 due to the expiration of the Statute of Limitations. This file was handled by the law firm of Jacobson, Maynard, Tuschman & Kalur.

CLAIMANT:	David O. Harbert
OCCURRENCE DATE:	4/12/84
REPORTED DATE:	3/15/85
STATUS:	This claim was closed without payment in December, 1985 due to the expiration of the Statute of Limitations. This file was handled by the law firm of Jacobson, Maynard, Tuschman & Kalur.

CLAIMANT:	Joseph Laughlin, M.D.
OCCURRENCE DATE:	7/20/82
REPORTED DATE:	6/20/83
STATUS:	This claim was closed and settled for $100,000.00 in August, 1984. This file was handled by the law firm of Jacobson, Maynard, Tuschman & Kalur

CLAIMANT:	Robert Gordon Lord
OCCURRENCE DATE:	6/8/89
REPORTED DATE:	9/12/90
STATUS:	This claim was closed without payment in April, 1991 due to the expiration of the Statute of Limitations. This file was handled by the law firm of Jacobson, Maynard, Tuschman & Kalur.

UNIVERSITY ORTHOPAEDIC ASSOCIATES, INC.
Claim History

CLAIMANT:	Robert W. Reinhard
OCCURRENCE DATE:	12/14/82
REPORTED DATE:	12/13/83
STATUS:	This claim was closed and settled for $2,500.00 in July, 1984. This file was handled by the law firm of Jacobson, Maynard, Tuschman & Kalur.

CLAIMANT:	Ellen Levy
OCCURRENCE DATE:	4/10/98
REPORTED DATE:	4/17/00
STATUS:	Voluntarily dismissed January 2, 2001.

SCHECHTER, DDS, BENJAMIN DOB: 12/3/1947

DATE OF VISIT: 09/27/00 LOCATION: BHC

Dr. Schechter is a dentist who saw Dr. Emery in 1995 for his cervical spine problems and he worked part-time in a dental practice, but now is a consultant to Medicaid and our HMO healthcare programs and is actually doing a study out in California that he received a grant for. In any case, four years ago he was involved in an auto accident and developed symptoms of numbness and leg pain on the right side with weakness. He fell a couple of times and wound up seeing Dr. Ben Columbi when he first came to University Hospitals and at that time underwent a partial laminectomy. The pain decreased in his leg, but the numbness remained. He has continued to have numbness which has increased and now over the past couple of years has developed pain in the calf as well as the numbness and is having difficulty walking distances. He tries to walk 45 minutes a day but begins limping and his foot starts slapping. He saw Dr. Columbi in follow-up, but was then dismissed. Dr. Richard Stein is his rheumatologist who checked him out and did not think he had any weakness. Standing increases his pain. He has had no other particular injuries. He was actually referred by Mr. Belecek, one of our patients who used to do billing for his office.

Physical examination reveals that the patient is no major distress. He can walk on his heels and his toes without difficulty. He bends over with somewhat limited flexion with a thoracolumbar scoliosis. He flexes mostly at his hips. He probably has 40° of flexion. Lateral bend and extension are 20° without major pain. He has no positive straight leg raising. No atrophy to measurement.

Neurologically I can not pick up any other weakness. There is no sensory loss to pin prick. Deep tendon reflexes are 2+ and equal without pathologic reflexes.

X-rays show what appears to be idiopathic thoracolumbar scoliosis and appearance of congenital stenosis with a laminotomy at L5-S1. It appears as though he has a little laminotomy at L5-S1 with huge hypertrophic facets.

Impression: Residual lumbar spinal stenosis L5-S1 with continued L5 radiculopathy.

Disposition: I think he probably has continued root stenosis and I would obtain a lumbar gadolinium enhanced MRI at Magnatech. I suspect he will need an additional decompression. Henry H. Bohlman, M.D./jab

cc: Richard Stein, M.D.

Henry H. Bohlman MD

DATE: 10/20/00 MISC.: MRI REVIEW

I reviewed Dr. Schechter's MRI carried out on October 20, 2000 and he has marked spinal stenosis at L4-5 and L5-S1 with huge hypertrophic facets, especially at the neural foramen. In addition, he has what appeared to be some hard disc protrusions at T10-11 possibly and T11-12. I think he most likely needs an adequate decompression of the lower lumbar, but I would obtain a myelogram and a CAT scan ahead of time and run the dye up to include the lower thoracic area. Henry H. Bohlman, M.D./jab

CASE NO. _____ PATIENT'S NAME Benjamin Schechter Sr.

DATE MO. DAY YR. SUBSEQUENT VISITS AND FINDINGS 5240

11 3-00 WT: 191 1/2 lbs 6 shots
PCP: RLS
CC: Re-Op Spinal Surg. 12/4/00 Bohlman, M.D.

Meds NKDA

Diovan/HCT 12.5 QD
Pravachol 40mg QD
Celebrex 100mg BID DD

Spinal Stenosis
numbness + pain + weakness in (R) leg

Instructed worse with Or Diovan
If he does not take it he feels better

Suggested Vit C E
Running daily

after Anesthesia → Good HA's

CASE NO. _____ PATIENT'S NAME _____

RECEIVED DATE : 11/15 09:59'00 FROM :4406461928

SCHECHTER, DDS, BENJAMIN **DOB: 12/3/1947**

DATE: 12/19/00 **MISC.: DISCHARGE SUMMARY**

Dr. Schechter was admitted to University Hospital on December 14, 2000 with a diagnosis of lumbar spinal stenosis L4-5 and L5-S1 having had a remote laminectomy at L5-S1 in 1998 with persistent L5 radiculopathy. In addition, it was noted on his lumbar MRI at the upper levels that he had the appearance of thoracic spinal stenosis also. Indeed on his pre-operative myelogram and CAT scan which I did not see until the morning of his surgery because it could not be brought up to the office. He indeed has severe thoracic stenosis at T10-11 and T11-12 with severe compression of the spinal cord. Because of when I saw the studies we could not on the spot arrange for intraoperative spinal cord monitoring unfortunately. In any case he was taken to the operating room on the day of admission for a lumbar laminectomy of L4-5 to S1 was carried out with bilateral foraminotomies and then we carried out a very meticulous laminectomy of T10-11-12 decompressing the spinal cord at those levels. Although we were extremely cautious not to manipulate the thoracic cord in any way postoperatively the patient awakened with significant motor deficit in both legs, left greater than the right. In addition he had some left-sided sensory deficit and a patchy fashion to pin prick in the left lower extremity but no specific sensory level. Over a period of hours the patient improved significantly and by afternoon he was significantly better in the right leg and had fairly normal sensation. When I saw him again on December 15, 2000 prior to by going out of town he had significant improvement on the right side with almost normal hip and leg function. On the left he was still profoundly weak with a trace to 2 function and most muscle groups with the exception of the quadriceps, which was about 3/5. Because of this complication I had a long discussion with he and his wife postoperatively. His wife immediately postoperatively when we noted this in the recovery room and told her that I thought his prognosis for recovery was quite good based on my experience with spinal cord injuries over the years and previous vascular thoracic cord insults, mainly because he was so incomplete and had almost normal function on the right-side I thought his recovery would be quite good, although I could not put a time element on it. I later explained the same thing to the patient and once again to Mrs. Schechter and I think they understood. Because of his deficit and difficulty with ambulation he was transferred to Euclid Rehabilitation on December 19th. At that time according to Pam Miller, R.N., he was walking short distances in a walker with a left-sided AFO. He was asked to return to the office in **six weeks from the surgery for a follow-up in the office and at that time we will obtain an AP and lateral x-ray from T10-L5**. Henry H. Bohlman, M.D./jab

cc: Richard Stein, M.D., 5850 Landerbrook, #100, Mayfield Hts., OH 44124

SCHECHTER, DDS, BENJAMIN **DOB: 12/3/1947**

DATE: 12/23/00 **MISC.: REHAB VISIT**

I made a house-call visit to Dr. Schechter on December 23, 2000 at the Euclid Rehabilitation Unit and he seemed to be in good spirits and his neurologic function revealed completely normal motor strength on the right side from the hip distally, on the left side he has still a trace of hip flexion, but hip abduction and adduction are normal, quadriceps and hamstring function are normal and distally his dorsi-flexion is trace on the left and plantar flexion is 4-5/5. So all and all I think he has had very significant improvement over a ten day period and I think he will continue to improve. I think as soon as he is able to take stairs he will be discharged home, which hopefully will be in the next few days.. Henry H. Bohlman, M.D./jab

DATE: 01/04/01 **MISC.: PHONE**

Dr. Schechter called on January 4, 2001 and really has been doing extremely well. He has gone to physical therapy, was actually there today when I tried to call earlier. He is actually now walking with two canes. He really does not have any incontinence of bowel or bladder. He only had that one episode, which sounds like some leaking around the fecal inpaction which now is all straightened out. He is significantly better with his balance. He is going out to shopping centers and is using an electric chair and then getting up and walking around and really pushing his stamina. I told him that was great. He is going to see me in the office on January 24th for his six week follow-up and we will take a look then. We will obtain an **AP and lateral of the lower thoracic and lumbar spine with a long cassette.** Henry H. Bohlman, M.D./jab

cc: Richard Stein, M.D., 5850 Landerbrook, #100, Mayfield Hts., OH 44124

DATE OF VISIT: 01/24/01 **LOCATION: BHC**

Dr. Schechter comes back doing much better. He has had some shoulder pain and right knee pain, but had gone to two canes and then back to walker because of his joint problems.

Repeat neurologic examination reveals completely normal motor strength now, which is a pleasant surprise and I told him he did not need his left-sided orthosis anymore. He has a slight decreased sensation to pin prick in patchy areas in both legs but otherwise he is fine. Deep tendon reflexes are 2+ and equal.

X-rays show the laminectomy sites in the thoracic and lumbar spine and everything looks fine. I asked him to continue with his physical therapy and muscle strengthening and return in two months for a check. He will not need x-rays at that time. Henry H. Bohlman, M.D./jab

cc: Richard Stein, M.D., 5850 Landerbrook, #100, Mayfield Hts., OH 44124

Henry H. Bohlman MD

SCHECHTER, DDS, BENJAMIN DOB: 12/3/1947

DATE OF VISIT: 04/04/01 LOCATION: BHC

Dr. Schechter comes back doing reasonably well. He is still using two canes to walk and I am not sure why. His wife is anxious about the fact that she says he can not put on his own shoes and can not get in and out of a car and flex his hips, can not walk distances, etc, etc...

However on repeat neurologic examination as before he has 5/5 motor strength and I really do not see any reason why he can not do it. In reality I got him to lie down on his back and he could straight leg raise against gravity which indicates very significant and strong hip flexion. In addition when we were all through and I asked him to return in three months he was able to put on his shoes and socks for us, so I am not sure what the problem is, but I think he maybe has some functional weakness when he tries to walk distances, but on testing he is 5/5. Sensation is fairly intact to pin prick. I reinforced the fact that he is only three months from his surgery and he is significantly recovered. I think he will keep improving from a functional standpoint.

He asked about disability and I told him I would be happy to support him in that endeavor until he gets back to normal functioning. He is back to work part-time. Henry H. Bohlman, M.D./jab

cc: Richard Stein, M.D., 5850 Landerbrook, #100, Mayfield Hts., OH 44124

DATE OF VISIT: 07/11/01 LOCATION: BHC

Dr. Schechter comes back for long-term follow-up. He still has similar complaints of not being able to raise his legs up from the sitting position to get into a car and dress himself, etc., but he is on a tremendous exercise program. He is doing work-outs in the swimming pool, physical therapy and lower extremity exercises. He is back to work about 3 hours a day 3 times a week and the rest of time he is exercising.

Repeat neurologic examination once again he has 5/5 motor strength in all groups of lower extremities. His reflexes are somewhat brisk and he has sustained clonus bilaterally and negative Babinski's. I suggested that he continue his regime. I think he is going to continue to improve from a functional standpoint. I would like to see him in **six months for a check and at that time we will obtain AP and lateral of the lumbar spine to include the lower thoracic**. Henry H. Bohlman, M.D./jab

cc: Richard Stein, M.D., 5850 Landerbrook, #100, Mayfield Hts., OH 44124

DATE: 12/03/01 MISC.: CANCEL APPT

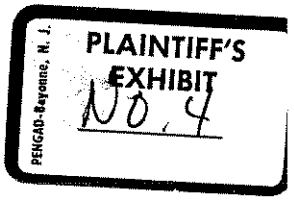
Patient called this morning and spoke with Lynette Bennett, RN - apparently patient is canceling upcoming follow-up appointment with Dr. Bohlman. Scheduling notified on December 3, 2001. /jab

REFERRING PHYSICIAN:

HENRY BOHLMAN, M. D.
UNIVERSITY HOSPITALS OF CLEVELAND
BOLWELL-5TH FLOOR
11100 EUCLID AVE.
CLEVELAND, OH 44106

MAGNATECH IMAGING CENTER
NO: 03-61-34
NAME: SCHECHTER, BENJAMIN DDS.
AGE: 52

DATE: 10-20-2000
EXAM: MRI OF THE LUMBAR SPINE WITHOUT AND WITH CONTRAST



MAGNATECH IMAGING CENTER * 216-642-9444 * 1-800-414-7700
4400 ROCKSIDE RD. INDEPENDENCE, OH 44131

CLINICAL: RECURRENT STENOSIS.

TECHNIQUE: LONG TR AND SHORT TR AND POST CONTRAST IMAGES WERE OBTAINED THROUGH THE LUMBAR SPINE.

MRI OF THE LUMBAR SPINE:

At T10-T11, there is focal disc herniation measuring approximately 5.5 to 6mm causing mass effect on the spinal cord. Centrally it is extruding approximately 7mm below the disc space level and approximately 3 to 4mm above the disc space level.

At T11-T12, there is focal disc herniation seen to the left of midline measuring approximately 4.5 to 5mm causing mass effect on the central and left aspect of the spinal cord. This is extruding approximately 3mm above and below the disc space level.

At T12-L1, there is focal disc herniation seen to the left of midline measuring approximately 6mm causing mild flattening of the left aspect of the spinal cord. This is extruded approximately 3mm below the disc space level. At L2-L3, there is mild canal stenosis predominantly secondary to bilateral posterior facet and ligamentum hypertrophy.

At L3-L4, there is moderate canal stenosis secondary to a combination of bilateral posterior facet and ligamentous hypertrophy as well as a mild 2mm bulging disc with accompanying osteophyte formation. At L3-L4, there is loss of disc space height and signal intensity consistent with disc desiccation. There is broad-based disc herniation seen asymmetric to the right measuring approximately 5.5 to 6mm. This is contributing to mass effect on the thecal sac and contributing to moderate canal stenosis. There is also bilateral moderate foraminal stenosis. At L5-S1, there is broad-based disc herniation to the right laterally with accompanying osteophyte formation contributing to severe right-sided foraminal stenosis. There is mild mass effect on the anterior aspect of the thecal sac and there is moderate to severe foraminal stenosis on the left.

IMPRESSION:

1. Diffuse degenerative disc disease as described in detail above. At T10-T11, T11-T12 and T12-L1 there are focal disc herniations as described above causing flattening of the spinal cord. There is canal stenosis seen within the lower lumbar spine as described above. At L4-L5, there is broad-based disc herniation to the right contributing to foraminal stenosis as well as canal stenosis.
2. At L5-S1, there is broad-based disc herniation to the right laterally contributing to severe foraminal stenosis on the right. There is also left sided foraminal stenosis at L5-S1.

D. M. PLECHA, M. D./mw 10-23-2000
SIGNATURE OF RADIOLOGIST
ELECTRONICALLY SIGNED BY D. M. PLECHA, M. D.
PROFESSIONAL INTERPRETATION BY UNIVERSITY RADIOLOGISTS OF CLEVELAND, INC.

University Orthopaedic Associates, Inc.

Department of Orthopaedic Surgery Case Western Reserve University

Henry H. Bohlman, M.D.
Professor, CWRU
Director, University Hospitals Spine Institute
Reconstructive & Traumatic Spine Surgery

11100 Euclid Avenue
Cleveland, Ohio 44106
Telephone: 216-844-1025
Fax: 216-844-1735
Appointments: 216-844-7200

November 6, 2000

Benjamin Schechter, DDS
4010 Hemlock Drive
Orange Village, OH 44122

Dear Dr. Schechter:

I reviewed your MRI that was carried out on October 20, 2000 and you do have fairly severe lumbar spinal stenosis and narrowing of the spinal canal at L4-5 and L5-S1, especially where the nerve roots exit the spinal canal. If your legs bother you enough, I would recommend a lumbar decompression, I do not think you would need any fusion, but you would need a complete laminectomy and foraminotomies and I think this would relieve your legs quite nicely. In addition, there is some small, what appear to be hard disc protrusions in the lower thoracic area and I would want to evaluate that preoperatively if you came in with a myelogram and a CAT scan. It has been brought to my attention that you have scheduled in on a cancellation slot for December 14, 2000.

Very sincerely,

Henry H. Bohlman, M.D.

Henry H. Bohlman, M.D.

HHB/ab

PENGAD-Bayonne, N. J.
PLAINTIFF'S EXHIBIT
NO. 5

19

University Hospitals HealthSystem
University Hospitals of Cleveland

DEPARTMENT OF RADIOLOGY

Schechter, Benjamin

01976405

Sex: M DOB: 12/03/1947
Bohlman, Henry H, MD
LAKESIDE PAVILION 40
Pat. type: O

Bohlman, Henry H, MD
11/28/2000 1:19 PM
CT L-SPINE S/P WITC MYELOGRAM
Acc. #4548721
History:

4548719 11/28/200012:20 PM
LUMBAR MYELOGRAM.

LUMBAR MYELOGRAM & POST-MYELOGRAM CT:

CLINICAL DATA: Rule out stenosis.

TECHNIQUE: The risks, benefits and alternatives of fluoroscopic-guided lumbar puncture were discussed with the patient. Informed written consent was obtained by Dr. Blackham. A lumbar puncture was performed at the L2-3 level. Contrast was infused under direct fluoroscopic guidance. No immediate complications occurred and the patient tolerated the procedure well. The procedure was supervised by Dr. Bangert.

FINDING:

Alignment is normal. Anterior epidural impresses are seen at levels T10-11, T11-12, L1-2, L2-3 and L4-5. A lack of nerve root sleeve filling is seen on the right of the L5 nerve.

Specifically, concentric stenosis is seen at T11-12.

Serial axial CT images were obtained from mid-T1 thru mid-S1 with a slice thickness of 2mm.

At level T10-11, central broadbased disc herniation is seen which flattens the cord. The bilateral neural foramina are patent.

At level T11-12, central diffuse disc bulge is seen, with central calcification of the herniated disc. Additionally, ligamentum flavum hypertrophy is seen. This results in deformity of the cord.

At the T12-L1 level, asymmetric disc herniation is seen, on the left. This results in focal effacement of the subarachnoid space, without cord deformity.

At the L1-2 level, diffuse disc bulge is seen which slightly flattens the subarachnoid space. However, no cord deformity is seen and the bilateral neural foramina are patent.

At the L3-4 level, bilateral facet hypertrophy is seen. Asymmetric

5-2 07

UniversityHospitals HealthSystem
University Hospitals of Cleveland
DEPARTMENT OF RADIOLOGY

Bohlman, Henry H, MD
11/28/2000 1:19 PM
CT L-SPINE S/P WITC MYELOGRAM
Acc. #4548721
History:

lateral disc bulge is seen, on the left. This results in narrowing of the left neural foramen.

At the L4-5 level, a right lateral laminotomy defect is seen. Bilateral facet hypertrophy is seen, as well as bilateral neural foraminal stenosis.

At the L5-S1 level, postsurgical changes are also seen without significant foraminal narrowing.

Congenitally short pedicles are seen bilaterally from the L3-4 level to the L5-S1 level.

IMPRESSION:

1. Multilevel thoracic disc herniations, as described above.

2. Multilevel lumbar spondylosis as described above.

3. Postoperative changes, as described above.

Kristine Md Blackham

Electronically signed by: Robert W Tarr, MD

Transcribed on: 11/29/2000 7:57 PM by Elma Flemister
Finalized on: 11/30/200012:39 PM by Robert W Tarr, MD

NIVERSITY HOSPITALS
F CLEVELAND
ERVATION REQUEST

FOR MEDICAL ONLY ☐ COVERED ☐ UNCOVERED

CHECK ONE ☐ ELECTIVE ☑ SD SURG ☐ TEST

☐ PT<23HRS ☐ URGENT ☐ AMB SURG ☐ PT INHOUSE

FOR OB ONLY EDC _____

☐ VIP

PATIENT INFORMATION

HOSPITAL NO.-MRN: 1976405 | MAIDEN NAME | HOME PHONE 282-4484 | ALTERNATE PHONE 292-6102

NAME: LAST-FIRST-INITIAL Scheechter, DDS, Benjamin | BIRTHDATE 12/3/47 | AGE 52

ADDRESS 4010 Hemlock Dr. | SOCIAL SECURITY NO. 073-40-7327 | SEX ☑ M ☐ F

CITY Orange Village | STATE OH | ZIP 44122 | RESPONSIBLE INDIVIDUAL | RELATIONSHIP

REFERRING PHYSICIAN

ADMITTING PHYSICIAN Henry H. Bohlman, M.D. | SERVICE Ortho | PRIMARY CARE PHYSICIAN Richardstein, MD | PHONE

REFERRING PHYSICIAN | REFERRING FACILITY | PHONE

ADMITTING INFORMATION

PATIENT PLACEMENT: ☑ ADULT ☐ RB&C ☐ PSYCH ☐ OB ☐ GYN ☐ _____ | DIV.REQ. Neuro 4 | ☐ PRIVATE ROOM | CODE | ISOLATION: ☐ TB ☐ MRSA ☐ VRE ☐ LATEX ☐ _____

PRIMARY DIAGNOSIS Lumbar Spinal Stenosis L4-5, L5-S1 | CODES | ICD-9 | SECONDARY DIAGNOSIS | CODES | ICD-9

JUSTIFICATION FOR ADMISSION PRIOR TO SURGERY: | ELOS 2

ADMIT DATE 12/14/00 | SURGERY/PROCEDURE DATE 12/14/00 | SCHEDULED TIME 7:00 AM | ANESTHESIA TYPE General | OR SITE ☐ BISHOP ☑ MATHER

SURGERY INFORMATION

SURG CODE BOHLHE01	3 hr.
PROC CODE SPINLDEC	Lumbar laminectomy + foraminotomies L4-5, L5-S1
SURG CODE	
PROC CODE	
SURG CODE	
PROC CODE	

NOTIFY: (CIRCLE). ☐A ☐CT ☐X ☐B ☐H ☐I ☐P ☐ID ☐* ☐PC ☐S

PRE-AD. ON ASSESSMENT/TEACHING

OPTIONS:
☐ TESTS ON ADMISSION/ DAY OF SURGERY
☐ PATIENT APPOINTMENT NEEDED BEFORE ADMIT.
DATE _____
TIME _____
SITE _____
☐ WORKUP COMPLETE
☐ INFO TO BE FAXED

TESTS – INDICATE IF STAT

☑ CBC	☑ UA	☐ CULTURE ☐ UCG
☐ DIFF	☑ TYPE & SCREEN	
☑ PT/PTT	☐ T & C _____	# UNITS
☑ CHEM 7	☐ DIRECT	☐ AUTOLOGOUS
☐ CHEM 23	☑ EKG	
☐ SICKLE	☑ CXR	☐ PA ☐ PA/LAT
☐ _____	☐ OTHER FILMS	
☐ _____	☐ _____	
☐ _____	☐ _____	

ALL SDA PATIENTS EVALUATED PRIOR TO ADMISSION ARE SCHEDULED FOR AN H & P ANESTHESIA CONSULT AND NURSING ASSESSMENT.

COMMENTS/OTHER APPOINTMENTS: CT/MyElo - 11/28 @ 10:30 AM

INSURANCE INFORMATION

	PRIMARY INSURANCE	SECONDARY INSURANCE		PRIMARY INSURANCE	SECONDARY INSURANCE
INSURANCE	United Healthcare		VERIFICATION PHONE	800 621-1811	
CONTRACT HOLDER NAME	Ben Scheechter		CERT/AUTHORIZA NUMBER		
BIRTHDATES	12/3/47		CERT/AUTHORIZA CONTACT PERSON		
RELATIONSHIP TO PATIENT	—		CERT/AUTHORIZA PHONE		
CONTRACT # RECIPIENT #	073407327		BILLING ADDRESS	PO Box 740800	
GROUP # POLICY #	98400			Atlanta, GA 30374-0800	
GROUP NAME					

REQUEST COMPLETED BY Julie Bunkelman | PHONE 41025 | FAX 41735

PLAINTIFF'S EXHIBIT NO. 7

University Orthopaedic Associates, Inc.

Department of Orthopaedic Surgery Case Western Reserve University

Henry H. Bohlman, M.D.
Professor, CWRU
Director, University Hospitals Spine Institute
Reconstructive & Traumatic Spine Surgery

11100 Euclid Avenue
Cleveland, Ohio 44106
Telephone: 216-844-1025
Fax: 216-844-1735
Appointments: 216-844-7200

November 8, 2000

TO: **Richard Stein, M.D.**
FAX: 440 646-2209

FROM: **Julie Bunkelman for**
Henry H. Bohlman, M.D.

RE: **Medical Clearance and Routine Lab Work**

PATIENT: **Ben Schechter, DDS** **DOB: 12/3/47**

SURGERY: **Lumbar laminectomy & foraminotomies L4-5, L5-S1**

DX Code: 724.02

SX DATE: 12/14/00

To Whom it May Concern:

Dr. Bohlman is requesting medical clearance along with the following routine labs for the above noted patient. We appreciate your help with this matter. If you could please fax the results to the **Attention of Lynette Bennett,** R.N. (Dr. Bohlman's Nurse Clinician) at **216 844-1735**. If you have any questions please do not hesitate to contact me at 216 844-1050 or Lynette at 844-1614.

Once again thank you for your assistance with this patient's care.

Routine Lab Work to include:

CBC	UA	Chest X-ray
PT/PTT	Chem 7	EKG

University Orthopaedic Associates, Inc.

Department of Orthopaedic Surgery Case Western Reserve University

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Appointments: 216-844-7200

November 8, 2000

Benjamin Schechter, DDS
4010 Hemlock Drive
Orange Village, OH 44122

RE: CT/Myelogram & Surgery Information

Dear Dr. Schechter:

The following arrangements have been made for your upcoming hospital admission and surgery.

Please note that you may receive a phone call from University Hospital's Admitting Department regarding Pre-Admission Testing if they deem it necessary.

Lumbar myelogram:	**Tuesday, November 28, 2000**	**Time: 10:30 am**
Report to:	Admitting Office/Humphrey Bldg/1st Floor (see map)	
CT Scan:	**Tuesday, November 28, 2000**	**Time: 12:00 pm**
	Follows myelogram	
Surgery Date:	**Thursday, December 14, 2000**	**Time: 7:00 am**
Arrive at Hospital:	One hour before scheduled surgery time	
Report to:	Information Desk - Mather Pavilion (see enclosed map)	
Length of Stay:	2 days (estimated)	

We have enclosed the following IMPORTANT INFORMATION & INSTRUCTIONS - PLEASE READ IT VERY CAREFULLY:

1. Pre-operative instructions
2. Map of University Hospitals
3. Myelogram Pamphlet

IMPORTANT: All patients are seen six weeks after surgery. **Please call patient scheduling NOW at (216) 844-7200** to arrange this follow-up appointment. Please do this prior to coming in for your surgery to assure getting an appointment.

Lynette Bennett, R.N. is the Orthopaedic Nurse who will be following your progress while you are hospitalized. She will contact you prior to your surgery with further instructions. However, if you have any medical related questions or concerns feel free to contact her at (216) 844-1614.

Please call me if you need clarification of this information or if you have any questions at (216) 844-1050.

Very sincerely,

Julie Bunkelman
Secretary to Henry H. Bohlman, M.D.

Enc.

University Hospitals of Cleveland
Preprocedural Admission History
Departments of Anesthesiology and Nursing

SCHECHTER, BENJAMIN
01976405 11/07/00
M 12/03/1947
12:25:21 PAT

Diagnosis: Lumbar Spinal Stenosis L4-5, L5-S1
Procedure Date: 12/14 Surgeon: Bohlman
Procedure: Lumbar laminectomy + foraminotomies

GENERAL

Age: 52 Age>59? Yes
(Male) Female
Patient Request APEC
Surgeon Request APEC
Ht. ____ cm Wt. ____ kg 6' 183
Hospitalized/Rehab in past 6 mo's?
Seen a physician in past 6 months?
Cardiologist/Internist/Primary MD
Name
Phone # ( )
✓ blood tests ✓ EKG Stein 11/13
___ stress test., echo., cath (1 yr)
other
___ new symptoms since visit?.

CARDIOVASCULAR

Congenital Heart Disease
MI/angina/anginal equivalent
Atypical chest pain
Hypertension, usual BP ___/___
Arrhythmias
CHF
PVD/claudication
Valvular disease or murmur
Cardiac surgery, angioplasty
Pacemaker/ICD
Hx of abnl EKG
Family Hx CAD father
High Cholesterol
PND, orthopnea, DOE
other

PULMONARY

Recent pneumonia (2 months)
Recent cold/URI, fever, chills (2 wks)
Chronic cough: ? Sputum
Asthma: at baseline?
COPD/Emphysema Home O_2?
Cystic fibrosis
Sleep apnea
Home vent, CPAP, BiPAP
Pulmonary embolism
Other

RENAL

Chronic renal failure
Dialysis: schedule
Incontinence, diff voiding

BPH, prostate cancer
Diuretics
Urinary tract infection
Kidney stones
Other

HEPATIC

Recent hepatitis
Hx hepatitis or jaundice
Cholelithiasis
Cirrhosis/ascites?
other

Endocrine/Metabolic

Diabetes
Hypo/Hyper thyroid
other

GASTROINTESTINAL

GE Reflux/Hiatal Hernia
Peptic ulcer disease
Diarrhea/constipation
Pancreatitis
Irritable bowel
other GERD in past

NUTRITIONAL

Restrictions low fat
Unintentional wt loss/gain 30 lbs
Obese/morbid obesity
Diet medications
other

REPRODUCTIVE

Breast disease
LNMP:
Pregnant/possibly pregnant?
other

HEMATOLOGIC

Sickle Cell Disease/Trait
Anemia
Bruising or bleeding disorder
DVT/Superficial phlebitis
Transfusion past 3 months
Anticoagulants
other

NEUROLOGIC

(Headaches/migraines)
Seizures: ___ well controlled?

CVA/TIA
MS/myasthenia gravis/paralysis
other

PSYCHIATRIC

Depression/Anxiety
Bipolar disorder
other

HEENT

Dentures/Partials ↑↓
TMJ slight
Hearing deficit
Sight-deficit glasses
Glaucoma
Speech/language problem
other

MUSCULOSKELETAL

Rheumatoid/Osteo (Arthritis)
C. T. L. S (Spine problems)
Muscular Dystrophies (R) foot
other cramping weakness

SKIN

___ Rashes / Lesions
___ Eczema, Psoriasis
other

FUNCTIONAL CAPACITY

Lifestyle: Active/Sedentary
Poor / Mod / Excellent swims
Impaired Mobility walks
Walking aids:
Assistance with Care
History of Falls/at Risk
other

MALIGNANCY

Type:
Location
Chemo past 3 months
Radiation past 3 months
other

INFECTIOUS

HIV/AIDS
other

PAIN/DISCOMFORT

Location: numbness
Describe:

Duration:
other

ANESTHESIA DIFFICULTIES

Difficult intubation
Personal/Family History
Malignant Hyperthermia
Severe Nausea/Vomiting
Other migraine p̄ last surg

SOCIAL

ETOH occas wine /day /week
Smoking: pk yrs.
Quit:
Cocaine/Marijuana
Other

PSYCHO/SOCIAL

Occupation dentist/consultant
Support person/system
Housing lives c̄ wife
Use of home health agency (+) plan
Name
Location
Ability to manage at home after d/c
other

ADVANCED DIRECTIVES

Living will
Durable power of att'y for healthcare

[redacted]

Surgical Classification 1 (2) 3
Estimated ASA Class: 1 (2) 3 4

RECOMMENDATIONS

✓ 1. APEC Appointment
Pt/(Surg request)
Procedure class 3 or 4
Age>59 [illegible]
ASA 3 or 4
2. Patient Education
NPO guidelines reviewed
Medication instructions reviewed
Other
3. Labs/Studies: See Att'd Copy
4. Other

Interviewer Comments:

Informant: patient (Reliable ✓) Interviewer: P. Deane, RN Date: 11/14/00

Key: ■ = Yes ⊟ = No

PLAINTIFF'S EXHIBIT NO. 10
PENGAD-Bayonne, N.J.

421

University Hospitals of Cleveland

Surgical Service
Physical Examination

SCHECHTER, BENJAMIN
01976405 11/27/00
M 12/03/1947
11:45:29 PAT

Findings below are within the normal limits. If an assessment item is not performed, it is crossed out, marked N/A and initialed. If an assessment is found abnormal, the statement is crossed out, initialed and appropriate finding noted.

Temp. _____ Pulse _____ Respiration _____ Blood Pressure _____

General: Age 52 Race Cauc Gender M *Patient is in no apparent distress*

Skin: *No rashes, no ecchymosis, no lesions, no erythema, no cyanosis, no jaundice, no bruises*

Head & Neck: **Pharynx:** *No inflammation, no masses, no edema, no exudate.* **Teeth:** *No apparent decay or disrepa*

Trachea: *Midline* **Nodes:** *Nonpalpable* **ROM:** *Supple extension, flexion and lateral bending without discomfo*

Thyroid: *Midline, smooth* **Carotid Bruits, Bilateral:** *Negative*

Eyes: **Sclera:** *No redness, jaundice, or discharge* **EOM's:** *Fields intact* **PERRL:** *Intact bilaterally*

Thorax & Lungs: **Expansion:** *Equal bilaterally* **Auscultation:** *Clear anterior and posterior to all five lobes*

Heart: **Rhythm:** *Regular* **Murmur:** *Negative* **Extra Sounds:** *Negative*

Abdomen: **Organomegaly:** *Negative* **Masses:** *Negative* **Tenderness:** *Negative* **Distention:** *Negative*

Bowel Sounds: *Normal* **Abdominal Bruits (Epigastric, Renal, Iliac, Femoral):** *Negative*

Genitalia, Pelvic, Rectal: *Deferred*

Back & Extremities: **Spinal Tenderness:** *Negative* **ROM:** *Normal for age* **Edema:** *Negative*

Neurological: **Alert:** *Positive* **Oriented:** *To person, place, time and situation* **CN II - XII:** *Grossly intact*

Special System Exam:	Pulses	R	B	C	F	P	DP	PT
0 Absent 1+ Weak 2+ Strong	Right	+	2					
	Left	+	2					

Reflexes: +/- 5 clonus

Romberg
Babinski
toes b/l

Comments:
SLR
Motor Sensory grossly intact
ROM
Flex 40°
ext 20°
Lat Bend 20°
DNP - Limb Stenosis
PMN - Limb Fasciculations

(Signature/Title/Date)

(Print Name)

PLAINTIFF'S EXHIBIT No 11

PENGAD-Bayonne, N. J.

SP 13381 (1/9/98)

422

UNIVERSITY HOSPITALS OF CLEVELAND
CONSENT FORM

Schechter, Ben +
1976405

Authorization for Treatment

I [patient/patient's legal representative] agree to permit authorized personnel of University Hospitals of Cleveland [the Hospital] to perform such diagnostic and therapeutic procedures that my treating physician(s) deem necessary for care. By signing below I agree to permit x-rays, laboratory tests, routine medical treatment (for example, medications, injections, drawing blood for tests), emergency procedures as necessary and hospital services performed at the request of physicians assisting in my care. I understand that, except in an emergency, any further treatment or procedures will be performed only after I have been informed of the benefits, material risks and complications associated with such treatment or procedures and I have given my consent. I further understand that the Hospital is a teaching institution and that physicians, nurses and other healthcare personnel in training may assist, be present and participate in providing my care and that my medical records may be used for educational purposes.

I recognize and understand that the physicians, including, but not limited to emergency department physicians, who provide services at the Hospital, with the exception of residents, are independent practitioners and not employees or agents of the Hospital. The Hospital is not responsible for the acts or omissions of physicians who are not directly controlled by the Hospital.

Authorization to Release Information

The undersigned hereby permits University Hospitals Health System, the Hospital, its affiliated health care providers, and/or their authorized personnel to access and/or release all or any part of the patient information (including information regarding substance abuse, HIV testing, AIDS and psychiatric treatment) to, including but not limited to, the appropriate health care insurer(s), third party payor(s), and/or the Hospital's agent(s), attorney(s) and/or consultant(s) for purposes including collecting payment for services, improving patient care, performance improvement initiatives, discharge planning, risk management and/or as required by law.

Assignment of Benefits

In consideration of the Hospital's and/or physician(s)' services received or to be received for medical/surgical services, I assign to the Hospital and/or my physician(s) all benefits herein specified, not to exceed the above hospital/physician(s) charges. I direct such insurer(s) to pay such benefits directly to the Hospital and/or my physician(s). I hereby agree to pay any and all hospital and/or physician(s) fees that exceed or that are not covered by my insurance coverage and waive any and all notices and demands in the event of non-payment therefor.

Medicare/Champus Payment

I certify that the information I gave if applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim (including Champus/Champus claims). I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

	PLEASE CHECK THE APPROPRIATE BOX:	Yes	No	N/A
1.	I acknowledge that if I am a Medicare and/or Champus Beneficiary, I have been provided with a copy of the notice from Medicare and/or Champus regarding my rights as a Medicare and/or Champus patient and that the form has not been altered.	___	✓	___
2.	I agree to release my Social Security number to the manufacturer of any Medical device that I may receive, in accordance with both federal law And regulations. I further understand that my Social Security number May be used by the manufacturer to help locate me if there is a need to Contact me regarding my use of a medical device. I release the Hospital from any liability that might result from the disclosure of this information.	✓	___	___
3.	I hereby agree to be liable for and pay the Hospital the difference between the established hospital rate for the private room accommodations, all telephone charges and the payment rate provided for in my benefits contract.	✓	___	___

Record Retention Policy

The Hospital retains patient medical records for 22 years following the last patient visit and they may be confidentially destroyed after that time.

Computer Data

I understand that my medical records will be accessible to authorized Hospital personnel through computers and that the Hospital will comply with certain safeguards established by federal state and local law as well as Hospital policy.

Certification

I certify that to the best of my knowledge and belief the information provided is complete and correct.

Patient Personal Property

I understand that the Hospital is not responsible for loss or damage to money and valuables, unless these are placed in the hospital safe.

I AM THE PATIENT OR AUTHORIZED TO SIGN THIS DOCUMENT. I HAVE READ ALL THE ABOVE AND UNDERSTAND ITS TERMS.

Patient Name

1976405
Hospital No.

Signature of Patient or Legal Representative

Self
Relationship

11-28-00
Date

Witness

11-28-00
Date

PENGAD-Bayonne, N. J.
PLAINTIFF'S EXHIBIT No. 12

SP-14633 (3/1/00)

XXXX XXXX XXXX XXXX XXXX
X X X X X X X X X
XXX XX X XXX X X XXX
X X X X X X
X X X XXXX XXXX X
PRE-OP ASSESSMENT REPORT

SCHECHTER, BENJAMIN M 52
MR#: 01976405
SERV: ADLT RAOR
MD: BOHLMAN, HENRY ADM: 11/28/00

UNIVERSITY HOSPITAL OF CLEVELAND PRE-OP ASSESSMENT

ADMIT DIAGNOSIS: SPINAL STENOSIS-LUMBAR 724.02

ADMISSION PROFILE

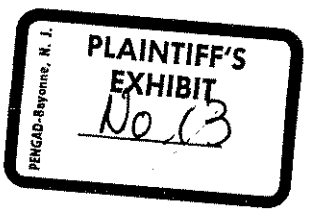
02/26 18:54	MEDICAL HISTORY: HYPERTENSION	KBAI
02/26 18:54	MEDICAL HISTORY --ESOPH REFLUX , --DISC HERNIATION, --HYPERCHOLESTEROLEMIA	KBAI
02/26 18:54	ALLERGY: NKDA	KBAI
02/27 09:24	MEDICAL HISTORY: ARTHRITIS	KBAI
02/27 09:24	MEDICAL HISTORY: --ARRHYTHMIA	KBAI
11/14 13:20	SURGICAL HISTORY: 1998 LUMBAR LAMI	PSAO
11/14 13:20	SURGICAL HISTORY: 1999 HEMORRHOIDS	PSAO
11/14 13:20	SURGICAL HISTORY: 1980'S HYDROCELE	PSAO
11/14 13:20	ALLERGY: --NUTRASWEET , REACTION: HEADACHE	PSAO

ADMISSION SCREENINGS

11/14 13:20	ADVANCE DIRECTIVE : THE PATIENT OR A SURROGATE HAS BEEN ASKED IF HE/SHE HAS EXECUTED AN ADVANCE DIRECTIVE (LIVING WILL OR DURABLE POWER OF ATTORNEY FOR HEALTH CARE). PATIENT HAS NO LIVING WILL OR DUR. POWER OF ATTY.	PSAO

INFORMATION CHARTED BY: BAKER, KATHRYN KBAI
SHAUGHNESSY, PATRICIA L RN PSAO

CONTINUED



ND

University Hospitals of Cleveland
Pre-Operative Holding Area
NURSING NOTES

[redacted] BENJAMI
19[redacted] 12 14 0[illegible] E
242-A[illegible] HP PHA
[illegible]M 12 0[illegible] 1947 P
T BOHLMAN HENRY
152 [illegible]

DATE: 12-14-00 TIME: 0615

PLANNED SURGICAL PROCEDURE: L4-5 -S1 Lumbar Laminectomy + Foraminotomy AVAILA

PAST MEDICAL HISTORY: ☑ See Nursing Admission History /Preop Evaluation Form ☐ None

☐ Arthritis	☐ Diabetes	☐ Hepatitis	☐ Seizures	☐ Thyroid Disease	
☐ Asthma	☐ Dialysis G tube	☑ HTN	☐ Sickle Cell	☐ Vascular Disease	
☐ Blood Clots	☑ GI Disease	☐ Kidney Disease	☐ Stroke	☐ Other:	
☐ Cancer	☐ Hallucinations	☐ Liver Disease	☐ Transplant		
☐ Depression	☐ Heart Disease	☐ Respiratory Disease	☐ TB		

PAST SURGICAL HISTORY: ☑ See Nursing Admission History/Preop Evaluation Form ☐ None

Comments:

MEDICATIONS: 12/14/00 ☑ None ☐ See MTR ☐ See Nursing Admission History/Preop Evaluation Form

Medication	Dosage	Time of Last Dose

ALLERGIES: ☐ None

Nutraweets → H.A.

ALCOHOL/RECREATIONAL DRUG HISTORY: ☐ See Nursing Admission History/Preop Evaluation Form ☐ None

Comments:

SMOKING HISTORY: ☐ See Nursing Admission History/Preop Evaluation Form ☐ None

Comments:

PHYSICAL ASSESSMENT: ☐ Deferred (see daily flowsheets/nursing notes)

VS: T 36 1/6 ☐ Axillary ☐ PO / P 52 / R 14 / BP 134/69 / Height 6'0" in. / Weight 59.4 Kg

NEUROLOGICAL

Level of Consciousness: ☐ Alert ☐ Unresponsive ☑ Oriented ☐ Other: ☐ Confused ☐ Drowsy

Emotional Status: ☐ Nervous ☑ Calm ☐ Other:

Able to Express Self: ☐ Yes ☐ No

Mobility: ☐ Moves All Extremities ☑ Limitations; Describe: (a) foot "numbness"/ weakness

RESPIRATORY

O_2 SAT 97 % ☐ Room Air ☐ FiO_2

☑ Respirations Easy and Regular ☑ Breath Sounds Equal and Clear ☐ Other; Describe:

CARDIOVASCULAR

Apical: ☑ Regular ☐ Irregular

Pedal Pulses: ☐ Palpable ☐ Audible with Doppler ☐ Other

Extremities: ☐ Warm ☐ Cool Color(Describe):

GI/GU

Abdomen: ☑ Soft ☑ Nontender ☐ Firm ☐ Tender, Location ☐ NG ☐ Ostomy:

Bladder: ☐ Nondistended ☐ Foley

SKIN INTEGRITY

Sacrum: ☑ Intact ☐ Not Intact

Heels: ☐ Intact ☐ Not Intact

Comments:

PLAINTIFF'S EXHIBIT NO. 14

PENGAD-Bayonne, N. J.

SP-8650

NURSING NOTES

SEE ON REVERSE

NURSING NOTES

PREPARATION FOR SURGERY CHECKLIST

	YES	NO	COMMENTS		YES	NO	COMMENTS
ID BAND	✓			GEN AUTH FORM	✓		
ALLERGY BAND		✓		ADV DIRECTIVES ADDRESSED		✓	
H&P COMPLETED	✓			Equipment sent to OR		✓	
CONSENT FORM	✓			SKIN PREP		✓	
NPO SINCE: 12/13 @ 2200		TIME	LAST VOID:	PERSONAL BELONGINGS	✓		glasses

Lab Results: ☐ See Pre-Admit Note

LAB RESULTS	YES	NO	Not Ordered	COMMENTS	LAB RESULTS	YES	NO	Not Ordered	COMMENT
CBC			✓	HCT:	EKG	✓			
ELECTROLYTES 12/13	✓			K: 3.3	X-RAY			✓	
PT/PTT	✓			11.6/31	TYPE/SCREEN 11/28	✓			AT
UA	✓			TNTC/10	TYPE/CROSS				
OTHER					# OF UNITS				

ADDITIONAL DOCUMENTATION

Pain has no pain @ present.

Preop/Recovery Room Routines Reviewed: ☑ YES ☐ NO

Comments: _____

Swan-Ganz Line Insertion Performed: ☐ YES (If YES, See Back of Form) ☑ NO

Time to OR: 0730

Pre-op Nurse: _____ (signature) _____ Joy Makela (print)

University Hospitals Health System

University Hospitals of Cleveland

CONSENT FOR

- **PROCEDURE**
- **ANESTHESIA OR CONSCIOUS SEDATION**
- **BLOOD AND BLOOD COMPONENTS**

M 12 03 1947 P
BOHLMAN HENRY
152 3389

Patient's Name _____ AVAILAB
(LAST) (MI) (FIRST)

1. You have been informed of the material risks, benefits, need, and alternative treatments related to the procedure(s) scheduled to treat your medical condition. You understand the procedure(s) and have had all of your questions answered. You agree that Dr. BOHLMAN, and/or his/her assistants who may be selected by your doctor, may perform the following procedures, explained in lay language and without abbreviations:
LUMBAR DECOMPRESSION & FORAMINOTOMIES

2. You have been informed of the material risks, benefits, need, and alternative ways to ensure your comfort through anesthesia or conscious sedation, and you consent to its use.

3. You have been informed of the material risks, benefits, need, and alternatives to receiving blood and blood components, and you consent to their use.

4. You recognize that unexpected complications can happen in all aspects of medical care and that this may require additional care that was not described to you already. You agree that your doctor(s) and his or her assistants may perform additional or different procedures that may be necessary and desirable.

5. You know or have been told that there are unavoidable risks associated with all procedures and with receiving blood and blood components, anesthesia, or conscious sedation. Among these risks are severe loss of blood, infection, mouth and teeth injury, nerve damage, reaction to receiving medication, reaction to receiving blood and blood components, permanent or partial disability, cardiac arrest, and death.

6. You agree that no absolute promise or guarantee has been made to you concerning the final result or cure.

7. You authorize that your tissues, organ parts, or body fluids that are removed as part of the procedure(s) may be examined, retained, discarded, or preserved for scientific and/or educational purposes. You understand that if studies are conducted on your retained tissues, your identity will be concealed and your privacy maintained.

PHYSICIAN'S ATTESTATION

I have discussed the above with the patient or his/her representative.

Physician's Signature _____ Date 12/14/00 Time _____

PATIENT OR PATIENT REPRESENTATIVE'S ATTESTATION

I have discussed the content of this consent form with my physician. I have read it (or have had it read to me) and, of my own free will, consent and agree to the following:

Step 1			Step 2 Initial Each Choice
Circle Your Choices	Yes	No	___ Procedure(s) listed in paragraph 1
	Yes	No	___ Receiving blood and blood components
	Yes	No	___ Receiving anesthesia or conscious sedation

PLAINTIFF'S EXHIBIT NO. 15
PENGAD-Bayonne, N. J.

X _____ 12/14/00
Signature of Patient or Representative (indicate relationship) Date Time

5-0264-2 (Revised 10/20/00)

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 *****  *****  *****
 *   *  *   *  *
 *   *  *****  *****
 *   *  *          *
 *****  *      *****
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SCHECHTER, BENJAMIN M 53
MR#: 01976405 ACCT#: 12653520
SERV: ADLT ORTHO G MOR
MD: BOHLMAN, HENRY ADM: 12/14/00
DX: SPINAL STENOSIS-LUMBAR

OPERATIVE SERVICES SUMMARY

SUMMARY: 12/14 06:00 TO 11:30

NEW ORDERS ENTERED FOR THE DAY:

12/14/00 07:03 RADIOLOGY ENTERED
ENTERED BY: IDXUSER ENTERED FOR: BOHLMAN,HENRY H,MD

118 LUMBAR SPINE 1 VIEW TOWER, ACC# 4565499, VIA: PT, SCHEDULED FOR 12/14/00, 07:05, <12/14/00>, (RIDX)

12/14/00 11:10
ENTERED BY: CHOUNG MD, STEVEN C
119 ADMIT TO-T4, <12/14/00-..>, (SCAK)
120 ATTEND MD: BOHLMAN, <12/14/00-..>, (SCAK)

12/14/00 11:11
ENTERED BY: CHOUNG MD, STEVEN C
121 DIET: NPO EXCEPT ICE ADVANCE TO REGULAR AS TOLERATED, <12/14/00-..>, (SCAK)
122 NASAL CANNULA O2 FLOW RATE-LPM 1.5, TARGET PAO2 92, INDICATION: POST-ANESTHESIA RECOVERY, SCHEDULE: CONTINUOUS MAY ADJUST L/MIN AS NEEDED FOR PT TO MAINTAIN PAO2 OF 90% D/C IF PULSE OX 92%, <12/14/00-..>, (SCAK)
123 OCCUPATIONAL THERAPY CONSULT (SEE & TREAT), <12/14/00-..>, (SCAK)
124 PHYSICAL THERAPY EVAL SEE & TREAT, <12/14/00-..>, (SCAK)
125 ACTIVITY/MOBILITY OOB (DECOMPRESSION PTS) SAME DAY AS TOLERATED, <12/14/00-..>, (SCAK)
126 POSITIONING: LOGROLL SIDE TO BACK TO SIDE Q2HR, (12/14/00 14:00-..), (SCAK)
127 T/P/R Q4H X24HRS, (12/14/00 13:00-12/15/00 09:00), (01 OF 02), (SCAK)
128 T/P/R Q SHIFT, <12/15/00 09:00-..>, (02 OF 02), (SCAK)
129 BP Q4H X24HRS, (12/14/00 13:00-12/15/00 09:00), (01 OF 02), (SCAK)
130 BP Q SHIFT, <12/15/00 09:00-..>, (02 OF 02), (SCAK)
131 CONVERT IV TO HEPLOCK WHEN TAKING PO WELL, <12/14/00-..>, (SCAK)
132 DRESSINGS/WOUND CARE REINFORCE DRESSING PRN, <12/14/00-..>, (SCAK)
133 HEMOVAC DRAIN TO CONTINUOUS DRAIN, <12/14/00-..>, (SCAK)
134 HEMOVAC DRAIN EMPTY & RECORD QSHIFT, (12/14/00 07:00-..), (SCAK)
135 NEURO CHECKS Q4H X24HRS, (12/14/00 13:00-12/15/00 09:00), (01 OF 02), (SCAK)
136 NEURO CHECKS QSHIFT, (12/15/00 16:00-..), (02 OF 02), (SCAK)
137 PULSE OX MONITORING QSHIFT IF APPLICABLE, (12/14/00 16:00-..), (SCAK)
138 TED HOSE KNEE LENGTH PER ROUTINE, <12/14/00-..>, (SCAK)

CONTINUED

UniversityHospitals
of Cleveland

PATIENT NAME: SCHECHTER, BENJAMIN
HOSPITAL NO.: 1976405
DATE OF SURGERY: 12/14/2000
DIVISION: T04

*cc: HENRY BOHLMAN, M.D.
cc: RALPH STANFORD, M.D.
cc: STEVEN CHOUNG, M.D.

PREOPERATIVE DIAGNOSIS: LUMBAR SPINAL STENOSIS, L4-5, L5-S1. REMOTE LUMBAR LAMINECTOMY, L5-S1, WITH PERSISTENT RADICULOPATHY AND NEUROGENIC CLAUDICATION.
THORACIC SPINAL STENOSIS AT T10-11, T11-12 WITH NEUROGENIC CLAUDICATION AS MANIFEST ON THE MYELOGRAM AND CT SCAN.

POSTOPERATIVE DIAGNOSIS: LUMBAR SPINAL STENOSIS, L4-5, L5-S1.
REMOTE LUMBAR LAMINECTOMY, L5-S1, WITH PERSISTENT RADICULOPATHY AND NEUROGENIC CLAUDICATION.

THORACIC SPINAL STENOSIS AT T10-11, T11-12 WITH NEUROGENIC CLAUDICATION AS MANIFEST ON THE MYELOGRAM AND CT SCAN.

OPERATION: LUMBAR LAMINECTOMY, L4-L5; BILATERAL FORAMINOTOMIES, L4-5 AND L5-S1; LYSIS OF EPIDURAL SCAR AND ADHESIONS, L5-S1; THORACIC LAMINECTOMY T10, T11, T12 WITH DECOMPRESSION OF THE SPINAL CORD.

SURGEON: HENRY BOHLMAN, M.D.

ASSISTANT SURGEON: RALPH STANFORD, M.D.
STEVEN CHOUNG, M.D.

ANESTHESIA: GENERAL ANESTHESIA.

ESTIMATED BLOOD LOSS: 450 CC.

TIME OF SURGERY: TWO AND ONE-HALF HOURS.

CLINICAL NOTE:
The entire operative procedure was explained to the patient including the potential hazards of paralysis, spinal fluid fistula and no relief of pain, as well as the hoped for benefits of relief of pain and restoration of more normal activities. He elected to go ahead.

OPERATIVE NOTE:
The patient was brought to the operating room where he was given general anesthetic. He was carefully turned on the knee-chest frame. Care was taken to pad all bony prominences so there was no pressure over the peripheral nerves. The thoracolumbar area was prepped and draped in the usual manner. A solution of saline and epinephrine was injected along the erector spinae muscles from T10 to T12 and from L4 to S1.

A midline incision was made over the thoracic spine from approximately T10 to T12. Subcutaneous bleeders were clamped and cauterized. Dissection was carried down to the spinous processes and using subperiosteal elevators,
CONTINUED:

the erector spinae muscles were dissected off of them and the laminae. We placed self-retaining retractors and controlled bleeders with Bovie and bipolar coagulation. We then made an incision over L4 to the sacrum. Subcutaneous bleeders were clamped and cauterized. Dissection was carried down through the old scar and using subperiosteal elevators, we elevated the erector spinae muscles off of the laminae and sacrum. Two Kocher clamps were placed on the spinous processes of L5 and also of T11. A check x-ray identified the correct positions.

We then proceeded to do the thoracic laminectomy first. We removed the spinous processes of T10, T11 and T12 with a bone cutter. We entered the spinal canal at T12-L1 by removing the inferior lamina of T12 with a Leksell rongeur and dissecting the ligamentum flavum off of the lamina with a curette. Using small to medium-sized Kerrison punches, we proceeded to do a laminectomy at T12 and T11 and T10. With very gentle palpation, we could feel the ventral hard disk mass in the lateral gutters. We were very careful not to manipulate the spinal cord with any palpation or instrumentation.

Once the laminectomies were completed, the dura expanded quite nicely. Bleeders were controlled with bipolar coagulation. A strip of Gelfoam was applied over the entire dura.

Attention was then drawn to the lumbar area where the spinous processes of L4 and L5 were removed with the bone cutter. The inferior lamina of L5 was removed with a Leksell rongeur and we almost immediately encountered epidural scar. We then moved up to the L4-5 space and removed the inferior lamina of L4 and the ligamentum flavum and dissected the dura off of the undersurface of the ligamentum flavum and lamina. We then proceeded to do a laminectomy of L4 with a Kerrison punch. The laminae and facet joints were extraordinarily thick. Once the L4 lamina had been completed, we dissected the epidural scar off of the L5 lamina with curettes and Penfield elevators. Once it was free, we completed the laminectomy of L5 with a Kerrison punch. We then proceeded to do foraminotomies at L4-5, first on the right which was extremely tight. We had to use a Hall burr to burr away the thickened facet joint and undermine it in order to get the Kerrison in to complete the foraminotomy and decompress the fourth nerve root. Once that had been done, Gelfoam was placed over the root itself.

We then moved down to L5-S1 where there was a huge hypertrophic facet and once again we had to use the Hall power burr to burr away the thickened bone in order to get the medium Kerrison under the facet and complete the foraminotomy. Finally, we used a small curved osteotome to remove a bony lip and hard disk over S1 that was compressing the ganglion of the fifth nerve root. Once that had been done and curettes cleaned out the disk, the nerve root and ganglion were totally free. Gelfoam was placed over the nerve root and we then carried out a minimal foraminotomy on the L4-5 level on the left and minimally at L5-S1 on the left. Gelfoam was placed over these nerve roots.

CONTINUED:

The wound was irrigated with antibiotic solution multiple times in both places and suction drains were placed. Both wounds were closed with #0 Vicryl interrupted sutures in the erector spinae muscle fascia, #2-0 Vicryl in the subcutaneous tissue and a running #4-0 subcuticular Vicryl in the skin. Prior to closure, we injected the erector spinae muscles with 0.75% Marcaine with epinephrine diluted in half to control pain and Anesthesia gave the patient 30 mg of Toradol. Dr. Bohlman was the primary surgeon and was present throughout all the critical portions of the case.

_____
PHYSICIAN SIGNATURE

HENRY BOHLMAN, M.D.
HB/MRC#30/9101
D: 12/14/2000 T: 12/15/2000

DOCUMENT #: 502268

Initials, Signature, & Printed Name of Nursing Personnel

MA M. Austin RN M. AUSTIN RN

NAME Schechter, Benjamin

HOSP NO. 1876405 DATE 12.14.10

SEX AGE DR.

SERVICE ortho

DIVISION Bohlman ROOM NO.

OUTPUT

Time	Urine	hvac ①	hvac ②			
1115	0	0	0			
1130	200 220	—	—			
1200 1230	200 120	60	0			
1300	200 120	60	0			
Column Totals	860	120				

TOTAL OUTPUT 980 | FLUID BALANCE

NEUROLOGICAL ASSESSMENT

... but responds poorly or ...

...rbal stimuli, but responds to pain ...nful stimuli

MOTOR STRENGTH KEY
5 - able to move against full resistance
4 - able to move against gravity or resistance
3 - able to move against gravity only
2 - weak movement, unable to overcome gravity
1 - flicker of muscle movement
0 - no movement

PUPIL SIZE AND REACTION
N - Normal
S - Sluggish
F - Fixed

9 8 7 6 5 4 3 2

Grasp R/L	Bicep R/L	Tricep R/L	Quad. R/L	Plantar R/L	Dorsi R/L	back dsg	
3/3	3/3	3/3	3/0	3/0	3/0	dry	ped pulses strong (B)
3/3	3/3	3/3	3-4/0	4/0	4/0	dry – pulses strong feet B/L	
4/4	4/4	4/4	4/0	4/0	4/0	dry "	" "
4/4	4/4	4/4	4/0	4/0	4/0	dry "	" "

SIGNIFICANT EVENTS

Time	Medications • Test • Procedures
1125	Dr. Quigley aware pt. is unable to move (L) leg. Unable to wiggle toes or keep (L) leg bent — MA
1130	Dr. Quigley & Dr. Cheung – @ bedside evaluating patient's neuro vasc. status, movement of lower extremities — MA
1140	Dr. Bohlman at bedside assessing patient — MA
1145	Pt able to feel (+) sensation c pin test to toes. Unable to complete (+) push pulls c (L) foot / Unable to keep (L) leg in bent position. Able to discriminate to touching of toes — MA Dr Bohlman & team aware MA —
1200	Pt awakening. Able to answer questions & keep eyes open without constant reminder to follow commands. O2 NC off → 24/ic On. Back dressing dry. Drains to SS. Assessment of LE: (+) movement & sensation (R) leg & foot. (+) sensation of (L) leg & foot – unable to move toe / foot or bend knee. (+) (R) hip strength & movement — MA
1230	Wife at bedside visiting w/patient — MA
1250	Dr. Bohlman at bedside assessing pt — MA
1255	Dr. Bohlman approves d/c to division now. Pt. meets all d/c PACU criteria. — MA

PLAINTIFF'S EXHIBIT No 18

PENGAD-Bayonne, N. J.

10 A

UNIVERSITY HOSPITALS OF CLEVELAND

PATIENT'S NOTES-SURGICAL

Name SCHECHTER, BENJAMI
Hosp. No. 1976405 Date 2 14 00
Sex 242-ADRTHO MBr. PHA
Age
Service M 12 03 1947 P 0
T BOHLMAN
Division 162 8389 Rm. No.

DATE	PROB. NO.	
		11:45 AM Attending's Note:
14 Dec	00	Patient is relatively awake and responds to commands but lethargic. He appears to have some leg weakness left greater than right. Reflexes are 2+ and equal in knee + ankles. Sensation appears intact to pin prick on the right down to foot with patchy + sensation in (L) thigh medially + over medial foot. Intact position + vibration sense
		Motor exam: Rt Lt
		Hip Flex 5/5 3/5
		Abd 5/5 4/5
		Add 5/5 4/5
		Knee Ext 5/5 3/5
		Flex 3/5 1/5
		Ankle DF 5/5 1/5
		PF 4/5 1/5
		Toe wiggle present
		I + is possible we dropped some of the .75% marcaine on the dura during muscle injection before closure as concurrently there could be an ischemic problem with the thoracic cord from the laminectomy but there was no cord manipulation. Will inform his wife and observe over next few hours.
		Bohlman

PLAINTIFF'S EXHIBIT No. 19
PENGAD-Bayonne, N. J.

5-1826-3 (5/00)

15 Dec 00 11:30 AM

Significant recovery today. Rt leg is normal (L) side 2/5 hip Flex, 3/5 Add, Abd. (L) knee extension 4/5 flex 2/5, ankle DF 3/5 PF 3/5. Will give him Decadron for 48 hrs. Dr Embry will Follow While I'm out of town thru Mon. [signature]

12/15/00 NOON Note: Neuro: Assisted OOB - only able to bear wgt on (L) leg & required staff to help keep knee from flexing when he stood. Sat in chair for ≈ 20min. Sensation intact. GI: Taking clear fluids, one brief bout of nausea, ∅ emesis. Diet to full liquids. UO good. IV fluids & antibiotics continue. Med c̄ 10mg decadron IV @ 545AM - (E) Some improvement in (L) leg strength. MSO4 effective analgesic for back pain. [signature]

12-15-00 Physical Therapy
Orders received, chart reviewed & eval complete.
See eval for details. Michelle Kacmarek, PT
30292

PLAINTIFF'S EXHIBIT NO. 20
PENGAD-Bayonne, N.J.

UniversityHospitals
of Cleveland

PATIENT NAME: SCHECHTER, BENJAMIN
HOSPITAL NO.: 1976405
ADMITTED: 12/14/2000
DISCHARGED: 12/19/2000
PHYSICIAN: HENRY BOHLMAN, M.D.

*cc: HENRY BOHLMAN, M.D.
cc: STEVEN CHOUNG, M.D.

UNIVERSITY HOSPITALS
OF CLEVELAND

DISCHARGE SUMMARY

CLINICAL NOTE: The patient is a 53-year-old, white male who was evaluated by Dr. Bohlman in clinic and noted to have lumbar spinal stenosis. He was admitted following elective thoracolumbar decompression and foraminotomies.

PAST MEDICAL HISTORY: Hypertension.

MEDICATIONS: Maxzide one q.d., Celebrex 100 mg b.i.d., Pravachol 40 mg q.d., and niacin 1000 mg q.d.

ALLERGIES: The patient has no known drug allergies.

PAST SURGICAL HISTORY: Notable for lumbar laminectomy in 1998, hemorrhoidectomy in 1998, and hydrocele in the 1980s.

The patient underwent elective thoracolumbar decompression by Dr. Henry Bohlman on December 14. There were no intraoperative complications. Please see the operative note for details of the procedure. The patient was transferred to the PACU in stable condition. He did have two Hemovac drains in place. He was also fit for TED hose and SCDs. He was maintained on antibiotics for a total of 48 hours.

The patient was noted in the immediate postoperative period to have some left lower extremity weakness. He was noted to have 2 out of 5 hip flexor strength on the left, 4 out of 5 hip abductor and hip adductors, 2 out of 5 knee extensor, and 1 out of 5 knee flexors, and 1 out of 5 ankle dorsiflexor and plantar flexors. It was felt at this time that perhaps some of the Marcaine used locally had been dripped on the dura. Alternatively there may have been an ischemic problem to the cord secondary to decompression. The cord, however, was not manipulated intraoperatively.

We elected to observe this patient's neurologic exam. In the immediate postoperative period again he was noted to have decreased strength in his quadriceps, hamstrings, as well as dorsiflexors. However, on postoperative check later he did have some return of strength of his plantar flexor to 3 out of 5.

On postoperative day number 1 the patient did have some interval improvement in his strength. At this point his hip flexor were 2 out of 5, his hip abductor and adductors were 4 out of 5, his quadriceps was 3 out of 5, his hamstrings were 1 out of 5, his plantar flexors were 4 out of 5, and his dorsiflexors were 1 out of 5. He was otherwise doing well. On postoperative day number 2 his Hemovac drain was removed. His antibiotics were stopped. Physical Therapy was consulted to assist with mobilization of the patient. His incision was examined on postoperative day number 2 and noted to be clean and dry without evidence of infection.

Postoperative day number 3 he continued on interval improvement. By day of discharge on postoperative day number 5 he was noted to have 4 out of 5
CONTINUED:

quadriceps and hamstrings, 4 out of 5 plantar flexors and EHL, and 2 out of 5 dorsiflexor. He was mobilizing reasonably well with physical therapy. He will be transferred to Euclid for further rehabilitation. He was restarted on preoperative medications as well as given a prescription for pain control. We will continue to follow his neurological exam postoperatively. He is going to follow up with Dr. Bohlman in two weeks.

FINAL DIAGNOSIS: THORACOLUMBAR SPINAL STENOSIS.

_____
PHYSICIAN SIGNATURE

STEVEN CHOUNG, M.D. FOR HENRY BOHLMAN, M.D.
SC/MRC#30/6670
D: 03/26/2001 T: 03/26/2001

DOCUMENT #: 526071

University Orthopaedic Associates, Inc.

Department of Orthopaedic Surgery Case Western Reserve University

Henry H. Bohlman, M.D.
Professor, CWRU
Director, University Hospitals Spine Institute
Reconstructive & Traumatic Spine Surgery

11100 Euclid Avenue
Cleveland, Ohio 44106
Telephone: 216-844-1025
Fax: 216-844-1735
Appointments: 216-844-7200

December 23, 2000

Richard Stein, M.D.
5850 Landerbrook, #100
Mayfield Hts., OH 44124

RE: Dr. Benjamin Schechter

Dear Rich:

I am enclosing a copy of my discharge summary on Dr. Benjamin Schechter. On the pre-operative myelogram, which I did not see until the morning of the surgery, it was apparent that he not only lumbar stenosis, but severe thoracic spinal stenosis, which is quite a rare entity on which we have composed a paper with our 20+ year experience. Ordinarily I would use intraoperative spinal cord monitoring in this situation, but because of the timing we could not arrange it on the morning of the surgery. In any case, although we were extremely meticulous in dealing with the thoracic cord, he awakened with significant deficit, although incomplete both sensory and motor. Within a period of hours and over the next 24 hours he improved significantly. As I explained to he and his wife I think his prognosis for recovery is excellent.

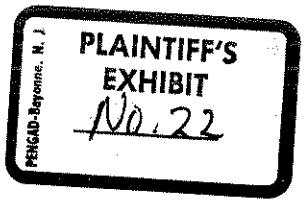
Because I went away on vacation after the surgery and only saw him one day, I took a trip over to Euclid Rehabilitation Center, which is where he is now. He is actually in excellent spirits I believe and he has no leg pain and he has been ambulating in a walker with an AFO on the left. Re-examination revealed completely normal motor strength on the right side from the hip distally, on the left side he has still a trace of hip flexion, but hip abduction and adduction are normal, quadriceps and hamstring function are normal and distally his dorsi-flexion is trace on the left and plantar flexion is 4-5/5. So all and all I think he has had very significant improvement over a ten day period and I think he will continue to improve. I think as soon as he is able to take stairs he will be discharged home, which hopefully will be in the next few days. I remain cautiously optimistic that he will have very good recovery.

Very sincerely,

Henry H. Bohlman MD

Henry H. Bohlman, M.D.

Enc.
HHB/jab



IMPORTANT MESSAGE

FOR

DATE 1/3 TIME A.M. P.M.

M Ben Schechter

OF

PHONE 292-4984
AREA CODE NUMBER EXTENSION

TELEPHONED		PLEASE CALL	
CAME TO SEE YOU		WILL CALL AGAIN	
WANTS TO SEE YOU		RUSH	
RETURNED YOUR CALL		SPECIAL ATTENTION	

MESSAGE ? myelogram ? neurologist
incontinent of bowel.
able to control urine
Percocet for pain

SIGNED

1184

PENGAD-Bayonne, N. J.
PLAINTIFF'S EXHIBIT No. 23