IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

GERALD LASKO NO. 429614

VERSUS

WILLIAM BOHL, M.D., et al.

Videodeposition of **DR. THOMAS FLYNN**, taken in the offices of The NeuroMedical Center, 7777 Hennessy Boulevard, Suite 10000, Baton Rouge, Louisiana 70808, on Thursday, the 4th day of April, 2002.

APPEARANCES:

FRIEDMAN, DOMIANO & SMITH CO., L.P.A.
(BY: DONNA TAYLOR-KOLIS, ESQUIRE)
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ATTORNEYS FOR THE DEFENDANT

VIDEOGRAPHER: MICHAEL BERGERON

REPORTED BY:
BETTY GLISSMAN
CERTIFIED COURT REPORTER

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S T I P U L A T I O N

It is stipulated and agreed by and between counsel for the parties hereto that the deposition of the aforementioned witness is hereby being taken for all purposes allowed under the Ohio Rules of Civil Procedure, in accordance with law, pursuant to notice;

That the formalities of reading and signing are specifically not waived;

That the formalities of filing, sealing and certification are specifically waived;

That all objections, save those as to the form of the question and the responsiveness of the answer, are hereby reserved until such time as this deposition, or any part thereof, may be used or sought to be used in evidence.

Betty D. Glissman, Certified Court Reporter, in and for the State of Louisiana, officiated in administering the oath to the witness.

DR. THOMAS FLYNN,

after being first duly sworn by the above-mentioned court reporter, did testify as follows:

THE VIDEOGRAPHER:

Today is the 4th day of April, 2002. The time is approximately 6:35 p.m. This is the videotaped deposition of Dr. Thomas Flynn taken at 7777 Hennessy Boulevard, Baton Rouge, Louisiana for the case entitle Gerald Lasko versus William Bohl, M.D., et al.

Would counsel please identify themselves and which party they represent?

MR. WILT:

Ronald Wilt for Dr. Bohl and Ohio City Orthopedics.

MS. TAYLOR-KOLIS:

Donna Taylor-Kolis on behalf of Gerald Lasko.

(At which time the witness is duly sworn.)

EXAMINATION BY MR. WILT:

Q. Please state your full name.
A. Thomas B. Flynn, M.D.
Q. And, Dr. Flynn, what is your area of practice?
A. Neurological surgery.
Q. Unfortunately, I don't think that I have your CV.
MR. WILT:
Did you send me a CV, Donna?
MS. TAYLOR-KOLIS:
About eight months ago.
MR. WILT:
Because you never even sent me his report until recently.
MS. TAYLOR-KOLIS:
I thought that we attached it, but we will get you one.
MR. WILT:
That's all right. Do you know what, maybe I have one over here. All right.
BY MR. WILT:
Q. Doctor, what is your present business address?
A. 7777 Hennessy Boulevard, Baton Rouge, Louisiana.

Q. And how long have you been there?
A. Approximately 12 years.
Q. And do you have any subspecialty within neurological surgery?
A. I do not formally have a subspecialty. But there is just one, and it is pediatric neurosurgery.
Q. All right. What percentage of your time would you say is spent in the area of pediatric neurosurgery as compared to adult?
A. Oh, I'm sorry. I think that you misunderstood me. I don't do pediatric neurosurgery.
Q. Okay.
A. I have no subspecialty. I'm sorry.
Q. All right. You said that you don't formally have one, do you have any informal subspecialty or any like particular area of interest that you concentrate your practice in?
A. Right now my practice is centered on surgery of the neck and the lumbar spine with instrumentation, radiosurgery, and pain management, pain surgery.
Q. All right. And I take it that in

pain management you do place dorsal column stimulators?

A. Yes. And to be absolutely accurate, I don't do comprehensive pain management. I do implants and take care of patients with chronic pain problems, the surgical part of it.

Q. All right. And about how many times a year would you guess that you placed dorsal column stimulators?

A. Right now I probably am not placing any more than maybe a dozen a year.

Q. Okay. And for about how many years has that been the rate?

A. It was higher because we had a pain management program, but the guys that were -- the other part of the team left Louisiana, which everybody seems to like to do. So I don't have a team now, and it is very difficult for me to properly evaluate patients. So I was doing probably twice that number for several years. I am not sure. I have never totaled it up or averaged it.

Q. Okay. Well, about when did you start placing dorsal column stimulators?

A. Actually, I put the first DCS in a patient in Louisiana in 1972.

Q. All right.

A. I got my picture in the paper.

Q. Good for you.

Did you undergo any specific training in order to place a DCS?

A. The placement of the stimulators, no, there was no fellowship program or workshop. I just have always, you know, been there since they started.

Q. Do you place stimulators percutaneously and through laminectomy?

A. Yes. Up until, I guess, four or five years ago, I did all of mine through laminectomy using a resumed lead. At the present time, I'm probably 80 percent of my implants are percutaneous, if I am successful. If I am not successful, I will convert to a laminectomy.

Q. All right. Let me go back. I have got a report of yours dated June 3, 2001, and I am assuming that since that period of time you have reviewed the depositions of Dr. Bohl and also Mr. Lasko; is that a fair statement?

A. Yes, sir.

Q. Okay. What's not clear to me is what materials have you reviewed prior to rendering your report dated June 3rd, 2001?

A. Yes, sir. I had the medical records of the Lutheran Medical Center.

Q. Okay.

A. And I also had Dr. Bohl's records, his own records.

Q. What were the dates of the medical records that you had from Lutheran?

A. I have them right here. Just one second.

Q. Okay.

A. I have the medical records of Lutheran Medical Center for 08/24/99 to 08/30/99, and another, I think, within the same hospital, they readmitted him from 8/30 to 9/9/99 probably to an extended care portion of the hospital.

MS. TAYLOR-KOLIS:

And one other set.

THE WITNESS:

And I also had records of that 9/9/99 to 9/22/99, an emergency room

admission of 11/21/99, and another admission to Lutheran Medical Center of 11/24 to 11/26/99.

BY MR. WILT:

Q. Do you have anything else?

A. Just the office records of Dr. Bohl.

Q. Okay. Since you've reviewed your report, and we have already talked about the depositions that you have received, have you reviewed any additional medical records?

A. No, sir.

Q. Prior to writing a report, did you -- well, actually either prior to or even up to today, have you reviewed any medical literature regarding the issues in this case?

A. No, sir. If I could?

Q. Sure.

A. My original review of records included some x-rays, which I forgot to mention.

Q. All right. What x-rays have you reviewed?

A. Those were films from Ohio City Orthopedics and Lutheran Medical Center.

Q. Do you know what dates or if you -- I mean, if Donna has any kind of an itemized or a cover letter indicating what the films are instead of reading through them all, I would be more than happy to attach that.

MS. TAYLOR-KOLIS:

Unfortunately, what I sent him I labeled all films, I didn't put a description or what the dates were. So I do apologize but I didn't.

BY MR. WILT:

Q. All right. Dr. Flynn, can you briefly summarize the films that you have reviewed, what period and whether they were an MRI or CT-Scan?

A. Yes, sir. I had a couple of notes here that I made when I was going through them and unfortunately all that I wrote down was a review of x-rays. And I said -- I will just quote my note, if that's okay?

Q. Okay.

A. I said, "There is a set of lumbar spine films, and they show the severity of his lumbar disease as well as the fact that it is extending into the lower thoracic

area."

Q. Okay.

A. And then I reviewed three thoracic MRI scans, which I said, "Confirm the nature of the thoracic stenosis and show the appearance of the spine after surgery on the thoracic disc."

Q. All right.

A. But I didn't put the first date on them.

Q. The lumbar -- in the first set of films that you referred to, the lumbar spine films, do you know if those films actually, excuse me, encompass or show the, you know, the T11 to T9 area?

A. They did not.

Q. Okay. So the only films that you've seen that actually demonstrate that area of Mr. Lasko's spine were the postoperative MRI studies; is that correct?

A. Yes, sir.

Q. All right. Back to your report, since you have reviewed the depositions of Dr. Bohl and Mr. Lasko, but nothing else, is there anything or have your opinions changed

at all since you've rendered this -- this report?

A. No, sir. I have since then reviewed one other document.

Q. What have you reviewed?

A. It's an expert report from, let's see, from Dr. Gary J. Lusgarten.

Q. All right. Did that affect, detract, add to your opinions in any way?

A. I don't think so, no, sir.

Q. Do you know Dr. Lustgarten?

A. I know his name, but I have never personally met him.

Q. All right. How is it that you know his name?

A. From reading depositions that he's given.

Q. Just so I can narrow my focus in this case then, your report then, and we will go into this in detail, but it fairly summarizes the opinion that you have in this case and the issues that you plan to address at the trial of this matter?

MS. TAYLOR-KOLIS:

I am going to interject

something because we can get to this answer a shortcut way.

Everything, obviously, that is in his report you are going to examine him about. When I got here today, I discovered that my office had not forwarded to him the Metro Health Rehab records or the Patricia Nursing Home records. So he obviously is going to offer an opinion regarding the nature of the extent of the injury itself, but he can't do that today because he hasn't seen those records. So we will give you -- I will get those records to him, and he can give you a quick supplemental report on that issue.

MR. WILT:

All right. Well, obviously, Donna, I will want to resume the deposition at that time.

MS. TAYLOR-KOLIS:

That will be fine. I can stay in Cleveland, and we can call him by phone again.

MR. WILT:

Okay.

MS. TAYLOR-KOLIS:

Okay, thank you.

MR. WILT:

We will take that up later.

BY MR. WILT:

Q. But for today, Doctor, we will concentrate on what you have reviewed and what is identified in your report.

Doctor, you mentioned earlier that you did make some notes while reviewing this case?

A. Yes, sir.

Q. What I would like you to do is give those notes to the court reporter.

MR. WILT:

We will identify those as Defense Exhibit A, and we will, you know, she can just make a copy, and I don't have a problem with you keeping the originals.

(At which time Defense Exhibit A was marked for Identification.)

BY MR. WILT:

Q. Also, just so we are sure that I do get a CV, do you have one there?

A. I don't have one here, but I will

print one out and give it to the court report at the end of the deposition.

MR. WILT:

All right. Let's do that. We will call that Defense Exhibit B. And then Defense Exhibit C, let's attach your report dated June 3, 2001.

(At which time Defense Exhibits B and C were marked for Identification.)

BY MR. WILT:

Q. Fair enough?

A. Yes, sir.

Q. All right. In this case based upon your review of the medical records, do you believe at least initially Mr. Lasko suffered from a failed back syndrome, or not initially, but that he did suffer from failed back syndrome?

A. I do, yes, sir.

Q. All right. And if, and I've read your report, but if Mr. Lasko did not or had not had a significant thoracic herniation, and I think it was T9-T10, do you think that he was an appropriate candidate to be considered for dorsal or for DCS?

A. Yes, sir.

Q. And can we agree that Mr. Lasko prior to August of 1999 suffered from chronic pain?

A. Yes, sir, we can.

Q. And can we agree that that chronic pain had lead him to become addicted to narcotics?

A. I wouldn't disagree with that. I think that's probably the case. I don't remember exactly what his medication in-take was, but I certainly wouldn't disagree with it. It wouldn't be unusual in a patient in his state.

Q. And what, in your experience, are some of the detrimental side effects of an addiction, a long-term addition to narcotic pain killers?

A. In a patient with severe chronic pain, excuse me, an addiction to narcotic pain killers is probably less detrimental to their health than in a patient who is simply an addict without a pain problem. And these patients frequently tolerate their addiction fairly well, except that they are dependent

upon the drugs. Most of them do not progress to -- beyond prescription medication, prescription drugs, so they don't -- they are not usually exposed to the vagaries of street drug abuse.

Q. That's not really where I am going. But just generally, does addiction to prescription narcotics have any detrimental affects upon a patient specifically in a long-term usage type situation?

A. It has -- it has both psychological and physiological side effects.

Q. Okay. Let's talk about those. Let's take the physiological first.

A. It disturbs -- the addiction interferes with their liver function, their pancreatic function, their adrenal function. They tend to develop diseases such as liver failure, diabetes, hypertension. And through the psychological effects, most of these patients are heavy smokers and they tend to have the side effects of that such as hypertension and chronic lung disease.

I am not sure if I am being responsive to your question, though.

Q. You are doing fine, Doctor.

A. But it depends on the level and duration of their addiction, but most of them are not in good health after several years of drug dependency.

Q. All right. Can drug being dependent upon narcotic pain killers, can that lead to complications such as potential masking of other medical problems?

A. In terms of the side effects of the narcotics, I am not sure what you mean by masking.

Q. Well, in other words, would it potentially mask other signs and symptoms of other disease processes?

A. It would -- classically it will mask the signs and symptoms of any other disease process that is typically -- that typically presents as a painful condition.

Q. All right.

A. That's probably the most common.

Q. Can patients with chronic pain and specifically patients with chronic pain and narcotic addictions, do they have a higher incident of depression than, let's say, the

general population?

A. Oh, yes. And that is what I meant by psychological side effects. They have depression, anxiety, and it is very frequently it is manifested by alcohol dependency and heavy smoking.

Q. Okay. Can we agree that Mr. Lasko is a long-term heavy smoker?

A. Yes, sir.

Q. Did you happen to note in the medical records that Mr. Lasko had suffered a 30-some-pound weight loss in the six months prior to the operation in August of '99?

A. I honestly don't recall that, but I wouldn't be surprised.

Q. All right. Is significant weight loss in a patient like Mr. Lasko, who was not trying to lose weight at the time, is that a potential sign or side effect of the psychological problems associated with narcotic addiction?

A. One of the ways that people react to depression is through weight loss. Some people, such as myself, react to it by eating all of the time, but I don't.

(Discussion held off the record.)

THE WITNESS:

But certainly weight loss can be a sign of or a side effect of depression. It can also be simply a side effect of being involved with cigarettes, alcohol, and drugs, and not eating.

BY MR. WILT:

Q. Right. And I want us to just stay focused here on prior to August of 1999, what detrimental effects, if any, did Mr. Lasko's cigarette smoking, assuming that he had a narcotic addiction, have upon his back and physiologically how his back would do or was doing?

A. The thing such as cigarette smoking and chronic lung disease make back problems more difficult to deal with because the patient generally will have more pain because they cough, and strain, and are, you know, otherwise physiologically in poor shape.

Q. Okay. How about the narcotic addiction?

A. That has to do more with loss of activity, and muscle tone, and

de-conditioning.

Q. Did you notice in Mr. Lasko's films prior to -- taken prior to August of 1999, any signs of osteopenia?

A. Osteoporosis?

Q. Yes, or Osteoporosis.

A. I don't recall that I did, no, sir.

Q. If it is noted in the medical records that he did evidence signs of osteoporosis, what impact, if any, would that have upon his back and the future stability of his back?

A. As far as I am aware, the nature of osteoporosis is such that in a patient like Mr. Lasko, from what I know of his films and what I have seen of his MRI films, it probably didn't have any significant effect on his degenerative spine disease.

Q. Okay. Can significant osteoporosis have an effect?

A. It can. It is unusual, very unusual to see it in males. But severe osteoporosis can have several effects on the spine, the most notorious of which is a compression fracture --

Q. Okay.

A. -- with pain. I am not sure that -- I don't think that he had that complication.

Q. In your own words, Doctor, can you describe for me based upon your review of the medical records what Mr. Lasko's general condition was as far as his back and any pain or disability associated with it? And I want to limit it to prior to August of 1999.

A. I have to tell you that I did not go back and review his records before tonight, and beyond stating that he did have a chronic pain problem and was incapacitated from that and was taking narcotics regularly I would be afraid to speculate.

Q. Well, let me throw this out to you, Doctor. In your review of the films, would you at all be surprised if Mr. Lasko was unable to ambulate long distances prior to August of 1999?

A. I would not.

Q. Would you at all be surprised if Mr. Lasko needed to use a cane to help keep himself balanced prior to August of 1999

given the films that you have reviewed?

A. I don't think that I would argue with that, no, sir.

Q. All right. Would you be surprised given the films that you reviewed that Mr. Lasko had complaints of bilateral numbness in his feet when or after standing for a period of time?

A. No. No, sir.

Q. Thank you. Can we agree, Doctor, that no matter what happened in August of 1999, Mr. Lasko's back condition and chronic pain syndrome if left untreated would have continued to become more debilitating as time passed?

A. What I tell my patients when they're -- when they are at Mr. Lasko's stage, I think that he was 59 or 60 years old at the time, that while degenerative spine disease is progressive that it is not relentlessly progressive and at that age with that disease, that level of the disease, he can probably not expect significant further progression of the degenerative spine disease from the structural standpoint. That's what

I tell my patients.

Q. And, Doctor, other than Mr. Lasko's deposition, I take it that you don't have any other indications as to how he is presently doing?

A. Not really, no, sir.

Q. From his deposition, which I realize that you did not have in June 3rd, 2001 when you read his report, can we agree that he does not suffer from paraplegia?

A. I think the more appropriate term would be paraparesis. And we can agree.

Q. And the reason I just say that is because in your report on the second page, you state: The patient has experienced a persistent paraplegia as a result of initially surgery implantation of the DCS. And given what you now know, assuming that Mr. Lasko has testified honestly and appropriately, we can agree that paraplegia would not be the word to use, correct?

A. For his current condition, that's correct.

Q. All right. And do you have any reason to disagree with Mr. Lasko's testimony

that he has essentially regained all normal function in his left leg?

A. I don't have any reason to disagree with it, but I don't have any independent corroboration of that.

Q. Well, Doctor, you have reviewed Dr. Bohl's medical records, haven't you?

A. Yes, sir.

Q. Okay. And you have reviewed his evaluations of Mr. Lasko subsequent to the surgery?

A. Yes, sir.

Q. Okay. And we can agree that in those evaluations, Dr. Bohl found that Mr. Lasko's motor function in his left lower extremity appeared to be normal?

A. I would not contradict Dr. Bohl's record.

Q. All right. Doctor, have you ever testified in a case involving a dorsal column stimulator, stimulators?

A. If I have, I don't recollect it.

Q. All right.

A. I don't think so, no, sir.

Q. Okay. Have you written anything on

the subject?

A. I have not.

Q. All right. What journals do you subscribe to?

A. The Journal of Neurosurgery, the journal called Neurosurgery, which is a different journal.

Q. Right.

A. Spine, the proceedings of the North American Spine Society; the journal called Neuromodulation, which is a -- deals with implant devices. It's a -- I belong to the Neuromodulation Society.

Q. Okay.

A. And if I am curious about something nowadays, I just get on the Internet. It is rapidly supplanting the $500-a-year journals.

Q. Yes. Are those journals the ones that you still receive?

A. What I have listed, I still receive. There are a couple more I read, Contemporary Neurosurgery, which is a continuing medical education series.

Q. Okay.

A. Let me think. I am trying to think

of what's buried in that huge pile of unread journals in my office. I think that's it.

Q. Let me ask you this. The journals that you have listed thus far, if I wanted to find out information regarding DCS, would these all be fairly reliable journals to look through?

A. Everything that I have quoted, except Contemporary Neurosurgery, is peer-reviewed material.

Q. Okay. And if something is peer-reviewed, at least in the area of medicine, that's a good indicator that that's a fairly reliable journal?

A. Well, I, you know, the age-old question is, do you except any journal or textbook as authoritative, and there is so much stuff published in there, I cannot ever make a statement that any journal or publication is reliable on the face of it.

Q. But at least these are the journals that you review in your practice and what you utilize to try to stay current with the practice of neurosurgery, fair enough?

A. Yes, sir.

Q. All right. When it comes to dorsal column stimulation, are there any textbooks that you would recommend to myself or any other person who would want to find out more about that procedure?

A. Actually, the way to really find out about that procedure is to look at the presentations that have been put together by such companies as Medtronics, which has very, very good powerpoint compilations of these various procedures and how they are performed. Plus the journal that I alluded to earlier called The Neuromodulation Journal.

Q. All right. Have you ever been a presenter at one of these seminars for DCS?

A. No. I have done a lot of presentations actually using those powerpoint presentations at international meetings, but I have never been a formal presenter for Medtronics.

Q. Do you have your powerpoint presentations still on file?

A. I wish that you would have asked me that a week ago. I spent the weekend

clearing files out of my computer. I got them, I have them, I don't have them in my computer.

Q. Okay. So do you have a hard copy of it?

A. Yes, sir.

Q. What I would like for you to do, Doctor, is if you would to produce that to Ms. Kolis, and she can then forward that over to me. Can you do that for me, Dr. Flynn?

A. Yes, I can't do that tonight, but I --

Q. No, I understand. If you could just get it to her in the next week or so, I would be happy.

A. Okay.

Q. In the records that you reviewed regarding Mr. Lasko's postoperative care and his time spent in the rehab, was he a compliant patient?

A. As far as I am aware, yes, sir.

Q. So in those records, you do not recall seeing the notes by physical therapy where Mr. Lasko was noncompliant and that he refused to participate?

A. As I said, again, I would have to fall back on the fact that I haven't looked at those records for a while. It is not unusual for patients in rehab to get the back up and once in a while not want to participate.

Q. All right.

A. I don't recall seeing a pattern of behavior, though, but I just don't remember.

Q. Let's see. Are you aware as to whether Mr. Lasko is still taking narcotics for management of his pain?

A. Since I have not seen those current records, I am not aware of it. I judge patients that I do DCS implants on not by the fact that they stopped taking narcotics but by the fact that they reduce their dosage to a very reasonable level. So it wouldn't surprise me if he was taking some.

Q. Would you be surprised if he is not taking any?

A. No. I would say a good 20, 25 percent of patients or maybe a little more will, you know, be medication free up to -- within three to five years of an implant.

Q. Well in this case, we also know that Mr. Lasko did not receive an implant, a permanent implant. Do you have any opinions as to how it is that he is now able to manage his pain without narcotics, or implants, or anything else?

A. Without being facetious, it may well be because he has enough spinal cord injury so that he's not as sensitive, you know, to pain. It may be a conduction, a spinal cord conduction phenomenon.

Q. All right. In fact, you know, just off the top of my head, aren't there some spinal cord procedures for treatment of pain where it actually involves manipulation or, you know, purposeful destruction or injury to the spinal cord or something like that? I am just thinking out loud.

A. Yes, there are several procedures like that that are really good procedures, but they have fallen into disrepute because of all of this fancy electronic stuff. But I am from an era when that's all that we had, and I have done many of those procedures, but --

Q. What are some of them?

A. People look down their nose at you now if you do them.

Q. I am not looking down my nose at you, Doctor.

A. I don't do them anymore.

Q. Tell me what some of those are. I just vaguely remember reading about that.

A. The most common blading procedure involving the spinal cord itself has always been an anterolateral chordotomy, which literally consists of placing an incision in the spinal cord to disrupt what's called the spinal coelomic tracts that conduct pain, so that's classically the most common procedure. Up higher, there is a procedure called a percutaneous chordotomy in which you insert a needle into the spinal cord and actually make a lesion electrosurgically within the spinal cord. And then going higher for patients with certain types of problems, there is procedure called deep brain stimulation in which you implant electrodes in the thalamus. And by using the same technique, you can blake part of the thalamus, it is called a

thalamotomy, it is an electrosurgical technique.

Q. Thank you, Doctor. Now in this case, Doctor, I am assuming that you are not critical of Dr. Flynn -- no Dr. Flynn, but Dr. Bohl for proceeding or performing a laminectomy before trying to place the electrode?

A. No. I think that's a pretty standard technique. A lot of people define that laminectomy in different ways. But a laminectomy for implantation of the paddle electrode or resume lead is fairly standard.

Q. Let me ask you, what are some of the recognized risks associated specifically with laminectomy placed on top of an electrode?

A. In performing the laminectomy, in a patient with a compromised spinal canal at the site of the laminectomy, there is a risk of injury to the spinal cord, the lower spinal cord or conus. Hematoma formation in the incision site with a cauda equina or lower cord compression is another. And then, I suppose, the third most common would be

infection.

Q. Okay. And then the placement of the electrode?

A. The placement of the electrode itself, again, in a patient who has a severely compromised spinal canal, you have to be very careful.

Q. Okay. Why?

A. Because the electrode itself is not -- can take up a significant part of the spinal canal. And one of the reasons that we will resort to percutaneous leads is if a patient has a severely compromised canal, that paddle electrode, the resume lead and the dilator that you have to use to put it in sometimes presents too much of a risk.

Q. Isn't it true that in placement of DCS, the most common patient that receives these are failed back syndrome patients?

A. Yes, sir.

Q. Okay. And almost by definition, a failed back syndrome patient has degenerative spine disease?

A. That's a fair statement.

Q. Okay. And by definition, a patient

with failed back syndrome and degenerative spine disease is likely going to have some narrowing of the spinal canal?

A. That's a fair statement.

Q. All right. Now, all right, we were talking about the electrode and in the placing of it and how you have to be careful. What types of steps do you take to place this electrode carefully and make sure that there is not unwanted compression upon the spinal canal?

A. The way this electrode is put in, I think everybody uses the provided epidural dilator, paddle, or whatever you want to call it, and you have to slip that in under the lamina upward from your laminectomy in order to provide a space for the resumed lead, which is somewhat flexible and can't be introduced on its own. And you have to do that very gently. That paddle is made out of plastic and is very stiff. It's curved and designed theoretically to stay in the dorsal or posterior spinal canal.

Q. All right. And anything else, Doctor?

A. I don't think so. I've forgotten the question.

Q. Excuse me. I'm sorry. If you are inserting the electrode or the paddle into the spinal canal and you meet resistance, should you stop?

A. It's very prudent to stop if that paddle -- if you run against resistance and the paddle begins to deform because it will bow downward. It is curved like --

Q. Right.

A. -- a shoehorn. And if you push against it, it doesn't just stop. It will bow downward and compress the spinal cord.

Q. And that was, and you have anticipated my next question. I am trying to understand because how you know when there is so much resistance that you need to stop, and I am assuming that there is a certain amount of pressure that needs to be exerted to get this into the proper position. I mean, how do you, I mean, do you look for the bowing or is there something else that a surgeon needs to be aware of when inserting this?

A. When that -- when you are putting

that paddle in, and there is no big significant resistance, the first thing that you feel is simply that the paddle is not going up any more, and you have got to decide at that point when to stop pushing because that paddle will begin to bow and the way that thing is constructed, and at that point you can actually see it start to do that.

Q. Okay.

A. It is not a blind procedure.

Q. Right.

A. So you should know well when to back off.

Q. Right. I mean, in fact, the paddle isn't something that is extremely rigid such that it is, I mean, you are really going to have to put some serious pressure on it to get it to bow, are you?

A. It's rigid enough so that in the context of what you are dealing with in this spinal canal.

Q. Right.

A. It is very rigid. And if it does bend, if you push it hard enough so that it bows downward and, I mean, it's a rigid piece

of equipment.

Q. Okay. In this case, is there any indication, you know, by the operative record or Dr. Bohl's testimony, and I think that Ms. Taylor-Kolis did a very good job of cross-examining him about exactly what he did in this case, is there any indication that there was any bowing or that he witnessed any bowing when he placed this paddle?

A. Excuse me just a minute, I am getting his operative note.

Q. Sure.

A. All that he uses is the term block which I would take to mean that he got stopped cold. And that is really all that he says.

Q. Okay.

A. There is no mention in his deposition of the paddle bowing.

Q. All right. And if Dr. Bohl was inserting the paddle and met resistance as is described in his operative report and stopped at that point, would that have been appropriate?

A. It should have stopped before there

was any compression of the spinal cord from the paddle.

Q. Okay. But my point is, is when you are inserting this paddle, you are inserted and if you meet significant resistance such as if you feel like there is block, you should stop at that point?

A. That's a fair statement.

Q. All right. And at least according to Dr. Bohl's operative report and, I think, his deposition testimony, that would appear to be what he did in this case, he stopped when he met the resistance?

A. As far as the written record is concerned, that's correct.

Q. All right. Now, are you aware of the medical literature that indicates that compression of the spinal cord is a complication that is or has a higher incidence associated with laminectomy electrode placement as compared to percutaneous electrode placement?

A. That was the point of my answer earlier on. If the patient has difficulty such as a compromised spinal canal, I will go

to the percutaneous lead, which is an entirely different animal than that paddle lead.

Q. Well, let's talk about this: Before you place a DCS in a patient, do you always, and let's keep our patients to failed back syndrome patients because that's what we are talking about here, okay?

A. Yes, sir.

Q. All right. So before you place a DCS in a patient, do you always obtain MRIs of the spine?

A. The answer is no.

Q. All right. Do you more often than not obtain MRIs of the spine?

A. The answer to that would be yes.

Q. All right. In what circumstances do you not obtain MRIs?

A. Typically when patients get to the stage of requiring a dorsal column stimulator for a failed back syndrome, they have had so many x-rays that their spine is so thoroughly radiographed that it is not necessary for me to take any more x-rays. They have been x-rayed from head to toe. If I don't have

any films that show the area where I am going to be operating, then I will get usually a CAT scan because it is cheaper, sometimes a MRI, but the CAT scan gives a much better picture of the bony detail in the spine, and I will usually use that.

Q. All right. Is disc herniation more commonly found in the lumbar spine, thoracic spine, or cervical spine?

A. It's most commonly found in the cervical and lumbar spine and less frequently in the thoracic spine.

Q. All right.

A. And this man in terms of disc herniation, he had a hard disc, not a soft disc herniation.

Q. Okay. How early in time to the actual surgical procedure would a surgeon have needed to had a or to have a study of the spine; would a year or two prior be sufficient, or could it be longer, or would it have to be closer in time?

A. I would say that it's probably a little bit dangerous to make a complete generalization, but I will use 6 to

12 months.

Q. Okay.

A. After 12 months, I think it's pretty accepted that you need to redo the studies.

Q. And when you are talking about doing the studies of the spine does -- well first, do you place DCS in all of the different areas of the spine?

A. Do I?

Q. Or can you?

A. Yes, sir, you can.

Q. All right. And I think that we can agree, given your prior testimony, that when placing a DCS in the thoracic spine, you would be far less likely to encounter a herniated disc than when placing it in the lumbar or cervical spine?

A. Statistically.

Q. Yes.

A. That's a fair statement.

Q. Okay. And over the years I am sure that you have read articles, treatises on DCS stimulators and placement of them, fair enough?

A. Yes, sir.

Q. Okay. Can you point me to any article that indicates that an MRI of the thoracic spine is indicated before placement of a DCS in that area?

A. I cannot, no, sir. And I have not meant to imply that.

Q. Okay. When do you think that studies must be performed of the thoracic spine before placement of a DCS?

A. I think before you attempt to implant, to do a laminectomy and do an implant, that you need to know the anatomy of the area where you are going to do this surgery. With a percutaneous lead placement, it is not nearly so important. But I think -- and as I said, the vast majority of these patients have had x-rays before they get to the pain surgeon or whatever.

Q. Right.

A. And usually you don't have to do a lot of x-rays. But I would not go in there and do a laminectomy and attempt a paddle implant without knowing my anatomy.

Q. Okay. And you bring up an

interesting point. When you place the electrode percutaneously in the thoracic spine, in that situation, does the standard of care require a radiographic studies of the spine?

A. I don't think -- from my experience, I don't think you are going to find anyone that will say that the standard of care requires specific procedures such as an MRI, or CT, or an x-ray because, I mean, you are just not going to find that.

Q. Okay.

A. You are going -- if you talk to people that do this type of work, I think, and they are straightforward, they are going to give you the same answer that I am giving you about the prudence of knowing where you are at.

Q. All right. And I understand that. But as you well know, standard of care is an important term for us lawyers. And I guess, I mean, is it unreasonable for a doctor to place an electrode, a DCS, in a patient in the thoracic spine without getting studies 6 to 12 months prior?

A. Right. I think in a patient who has known significant degenerative spine disease, that it is not reasonable to perform major spine surgery like that without knowing the anatomy, which is what I said before.

Q. All right. And are you differentiating, though, between percutaneous and a laminectomy?

A. Actually, I would not even want to put in a percutaneous lead without knowing what the spine looks like. But I think that the risk is lower, much lower or the likelihood of harm is much lower with the percutaneous lead because you are simply not instrumenting the spinal canal like you are with a paddle electrode.

Q. All right. What do you believe was the mechanism of injury in Mr. Lasko?

A. I think that the -- in the course of dilating the dorsal spinal canal preparatory to putting in the dorsal column stimulator lead, that pressure was placed on the lower thoracic spinal cord, probably by the dilator. It is not impossible to do damage with the lead itself, but it is much

less likely.

Q. If that was -- well, let me go back. Is spinal cord compression following placement of the DCS, is that a recognized complication of this procedure, albeit rare?

A. At the time of the procedure?

Q. Let's take it two ways; at the time of the procedure first, and then subsequent to the procedure.

A. Yes. There are reported cases of spinal cord injury at the time of the procedure. It is a known complication of the procedure.

Q. All right. And is it a complication, albeit rare, that can occur even though a doctor is exercising reasonable care?

A. In my opinion, you should not have that complication unless there is some very extenuating circumstance. And, I mean, I am sitting here trying to think of what that might be, but.

Q. Well, Doctor, we can agree that any time that you operate in and around the spinal cord, there is a risk of injury to the

cord that can be catastrophic?

A. Yes. I mean, I operated on two patients today, and I told them both exactly that.

Q. All right. And, in fact, Doctor, in your experience, have you ever had a patient who suffered a catastrophic injury following or during a procedure that you performed?

A. Following, but not during.

Q. All right. And do you believe that you acted in any way inappropriately?

A. Actually, in that instance, I do not.

Q. Did you ever figure out what caused it?

A. No, I never did.

Q. Did a lawsuit come out of that?

A. Yes, sir.

Q. So we can agree that, you know, the spinal cord is an exquisitely, I guess can be exquisitely sensitive area that just through manipulation, necessary manipulation of the cord, albeit rarely, it can result?

A. That's a fair statement. I don't,

I don't want to be put in a position of making a generalized statement that each and every time, rare or not, that the spinal cord is injured during the spinal procedure.

Q. Right. And I guess the point though is, Doctor, that the fact, just the fact that an injury has occurred, that fact alone -- well, operating in and around the spine does not indicate the fact of negligence?

A. Neither does it indicate the absence of negligence.

Q. Right. But it does not, in other words, a doctor performs a discectomy, a patient comes out with a paraplegia, with nothing, no more information, you can't say that that doctor acted negligently or acted perfectly appropriately, the injury itself does not bespeak negligence; can we agree on that?

A. Provided with the caveat that in order to determine whether there was negligence or not, you have to know the specifics of each incident.

Q. Right, right, I understand that.

A. Okay. Yes, sir, I agree then.

Q. Okay. Do you perform anterior thoracic discectomies?

A. I do not any longer. I have spine surgeons here that do all the fancy stuff.

Q. All right.

A. That's a young man's game.

Q. Can it be difficult to locate the proper level when performing a discectomy from an anterior approach in a thoracic spine?

A. Depending on the level, it can be a problem, that's true.

Q. Why is it a problem sometimes?

A. From anteriorly?

Q. Exactly.

A. Just counting the vertebral body levels, you have to be extraordinarily careful.

Q. When you perform an anterioral -- I just combined anterior and vetebral, anterior discectomy, who actually exposes the disc?

A. It depends on the surgeon. Actually, one of our spine surgeons here does it all himself, and one of the others has a

thoracic surgeon do it for him.

Q. Is that uncommon to have a thoracic surgeon do the exposure?

A. I wouldn't say so, no, sir.

Q. Okay. And what -- specifically what steps do you or did you take when you operated on thoracic spines from an anterior approach to determine whether you were at the right level?

A. Intraoperative fluoroscopy and plane film marking of the patient. We generally would start with a preoperative marking under fluoroscopy. Then during surgery, depending on the patient's anatomy, we would -- I would utilize intraoperative fluoroscopy or flat film x-ray --

Q. Okay.

A. -- using needle markers.

Q. Do you know whether or not Dr. Bohl utilized those methods when trying to locate the proper level when he operated on Mr. Lasko? Now, of course, we are referring to his September surgery.

A. When he did the second operation?

Q. There you go.

A. Yes. I am not -- I do not recall.

Q. All right. If, you know, Dr. Bohl testified and will testify that indeed multiple flat films were obtained at the time, that markers were put on the thoracic spine, and also there was the preoperative MRI that was performed a week before it was utilized. Were those all appropriate steps to take to try to determine the proper level?

A. Yes, sir.

Q. All right. And when determining the proper level, does the surgeon who is doing the exposure have some responsibility as well as the spine surgeon in finding and identifying the proper level?

A. Well, you know, from my viewpoint, the neurosurgeon is the guy that's got to do that. I don't think thoracic surgeons are that experienced at determining spinal level.

Q. I understand that the neurosurgeon or orthopedic surgeon you believe is the ultimate person, but does the thoracic surgeon who is actually exposing the disc, do they have some responsibility also in assisting them in determining the proper

level?

A. My opinion is that the responsibility is on the shoulders of the spine surgeon.

Q. Okay. So the thoracic surgeon or exposing surgeon has no responsibility; am I correct?

A. Yes. I don't believe they do. Well, I just don't believe they do.

Q. All right. Now, Doctor, can we agree that when operating on the thoracic spine that if a physician takes all of the appropriate steps to determine that they are at the right level that they can still end up at the wrong level, and that fact alone does not mean that they have acted negligently so long as they have taken all of the appropriate steps?

A. In this day and age, in a patient who has no anomalies of the spine.

Q. Okay.

A. By that I mean transitional vertebra or other anomalies, I don't think that it is appropriate in a thoracic spine to wind up at the wrong level.

Q. All right.

A. If a patient has an anomalous spine, and particularly in thoracic spinal surgery, in spite of the best efforts of a surgeon, you can operate at the wrong level.

Q. Did Mr. Lasko's spine have any anomalies?

A. He did not have a transitional vertebra, no, sir.

Q. Is that the only anomaly that you would say would be an acceptable anomaly that such that a surgeon could justifiably end up at the wrong level?

A. Any anomaly which makes for a -- shoot, a risk of misinterpreting the spinal level radiographically, the most common is transitional vertebra. There are other deformities such as congenital non-segmentation and what's called a carpal failed deformity that can make it very difficult to determine appropriate level radiographically.

Q. Can collapsed discs be -- make it difficult?

A. They shouldn't so long as you can

identify each individual segment. In extreme cases, I have seen one or two examples in which a patient has had such severe compression and collapse of the spine that you couldn't distinguish the spinal levels, that is something that can happen.

Q. All right. Barring all of the instances we have now talked about as far as anomalies with the spine, is it going to be your opinion that it is not ever acceptable for a surgeon to end up at the wrong level when operating on the thoracic spine from an anterior approach?

A. Barring extenuating circumstances, in this day and age, I don't think that's reasonable.

Q. All right. Now, you indicated in your report on the third page, the last sentence, "In the mid thoracic area, there are some excuse for selecting the improper spinal level during surgery." What is the excuse?

A. Just what I enumerated.

Q. Okay. Just those anomalies?

A. Yes, sir.

Q. All right. What permanent injury do you believe Dr. Bohl's operation at the wrong level caused to Mr. Lasko?

A. I think probably the consequence of that wrong level surgery in terms of permanent injury was probably not great.

Q. Can we agree that on the preoperative MRI film that there was some evidence, and I think he operated at the T8-T9 level on the first surgery, that there was some evidence of spinal stenosis at that area, some bulging of the discs?

MS. TAYLOR-KOLIS:

You can look. You have got your record.

THE WITNESS:

Yes, just excuse me just a minute.

MR. WILT:

Sure. Take a look at the report.

(Discussion held off the record.)

THE WITNESS:

Actually, I had pulled the report of his 08/26/99 MRI. I have his report

of a thoracic MRI of 08/26/99.

BY MR. WILT:

Q. Yes.

A. And it does show spinal stenosis to some degree at 8-9.

Q. All right. Let me look at your report.

(Discussion held off the record.)

BY MR. WILT:

Q. If the injury occurred at the time and placement of the dilator.

A. Yes, sir.

Q. Would you have expected the patient to exhibit immediate loss of motor function and sensation?

A. The usual case would be, yes.

Q. Okay. Can electrodes migrate?

A. They often do.

Q. In fact, that is probably the most common complication associated with this procedure, isn't it?

A. Yes, sir, it is. With either percutaneous or paddle electrodes.

Q. In this case, could there be any other explanation for the postoperative loss

of motor function and sensation in Mr. Lasko other than direct, quote, compression?

A. You know, excuse me, I hate to be dogmatic, but I can't come up with another one.

Q. All right. Assume for me that immediately after the operation Mr. Lasko was able to move his legs and had motor function in the immediate period but sometime between the transfer from the operating table and when the patient arrived in the recovery room five to ten minutes later he lost motor function in his legs, would that in any way contradict your theory as to how this injury occurred?

A. I would say that a -- that a delay by several minutes, the onset of paraplegia after spinal cord contusion is unusual but not unheard of.

Q. Okay.

A. And I am taking that in the context of spinal cord trauma. It's not unusual to have a patient have an injury to the spinal cord intraoperatively and for it not to show up on evoked response monitoring, for

instance, because you are only covering about 3 percent of spinal cord with that. But the answer to your question is, no, it certainly can occur.

Q. All right. Was it good medical care for Dr. Bohl after removal of the electrode to postpone further surgery on the spine until a few weeks later?

A. Well, I think that was very appropriate.

Q. And it would be appropriate, I take it, because for one, you want to give the patient some time period to see if they can recover on their own, correct?

A. That's correct, yes, sir.

Q. And also given that the patient had just had a laminectomy and then another procedure to remove an electrode, you would not want to go in immediately and cause more trauma to the cord?

A. That's correct. And just for purposes of threat of infection.

Q. Right. Speaking of potential complications, the ones that you listed earlier; swelling, infection, hematoma, all

of those can cause permanent neurological injury?

A. Yes, sir.

Q. I am sorry, Doctor, I didn't hear your answer.

A. I'm sorry. Yes, sir, they can.

Q. Did you note in the medical records that between the removal of the electrode and when Dr. Bohl took the patient back to surgery that the patient was having a difficult time sitting up and that sitting up, for whatever reason, seemed to exacerbate the patient's lower extremity symptoms?

A. I don't recall that specifically.

Q. If we assume that to be the case, what would you attribute that to?

A. If he had a -- excuse me. If he had a partially compromised spinal canal coupled with a swollen spinal cord from -- from trauma and he sat up, he would further narrow his spinal canal and could produce an exacerbation of his symptoms, you know, that would be the most common mechanism, simply mechanical.

Q. All right. And it was appropriate,

I take it, for Dr. Bohl, although I know that you disagree with him operating at the wrong level, it was appropriate given this patient's signs and symptoms, and condition to take the patient back to surgery in September and remove the large calcified herniated disc?

A. I think that's correct, yes, sir.

(Discussion held off the record.)

BY MR. WILT:

Q. A couple of quick ones. What are the risks that you discuss with your patients before performing a laminectomy DCS?

A. I tell them just -- we covered this briefly earlier, but I tell them that any time that you operate on the spine, there is a risk of injury to the nerves or the spinal cord depending on where you are that they can be paralyzed, lose bowel and bladder and sexual function, that that's the worse thing that can happen to them but I've never really had that happen to any of my patients. And that it is very rare, after I get through scaring the heck out of them. And then I go through the lesser complications such as

infection, failure of the operation, and things that we can fix.

Q. And, Doctor, I may have misspoke earlier. Would osteoarthritis have any impact on Mr. Lasko's long-term prognosis for his back?

A. I think that you asked me earlier about degenerative spine disease and its progress. And I answered that at his age, I tell my patients that degenerative spine disease, which I think we can include osteoarthritis.

Q. Okay.

A. And usually is pretty much settled down by the time you get to be his age. It doesn't relentlessly progress.

Q. Can you point me to any literature that would support that opinion?

A. Gee, I --

Q. Or a journal or something like that I could go look?

A. I don't know that I can, to tell you the truth.

Q. All right.

A. That's just something that I said

for years, maybe I am wrong. I don't think so, though.

Q. Doctor, what are you charging me here today?

A. We just went through the first hour and into the second hour, so I am going to charge you for two hours, and it will be $1,400.

Q. All right. What are you charging Ms. Taylor-Kolis for your time spent reviewing the chart?

A. She has a fee schedule or has seen one, and I charge $400 an hour for review of records and just about anything writing reports and that sort of thing.

Q. All right. And what will your charges be when you come to the trial of this matter?

A. I will charge you $700 an hour door-to-door for an 8 hour day.

Q. First, Doctor, you are not going to be charging me anything to come to trial.

A. I'm sorry, Ms. Kolis, I'm sorry. I charge for an 8-hour day, and it is generally two days plus expenses.

Q. And, Doctor, I seem to recall that you used to take these moneys and would give them to some foundation; is that still the case?

A. The majority of it is, yes, sir. It has changed though. I've formed my own foundation now, it's called the Southeast Asia Medical Aid and Teaching Fund. It is a 501C3 corp.

Q. You are way ahead of me. All that I eve deal with is medicine, I don't deal with that corporate stuff.

Do you know if preoperatively Mr. Lasko had a normal range of motion in his lower extremities?

A. I would be amazed if he did.

Q. All right. Would you be surprised if preoperatively Mr. Lasko was having difficulty sleeping due to the pain in his back?

A. No, sir.

Q. Doctor, what percentage of the cases, medical malpractice cases that you've reviewed over, let's say, the last five years have been for the plaintiff as compared to

the defendant?

A. I am sure that it's about even now or, you know, over the last five years.

Q. How about the last two to three years?

A. Same. I think that it's about 50/50.

Q. Have you ever worked with Ms. Kolis before?

A. No, sir.

Q. Do you know how she happened to get your name?

A. I do not.

Q. About how many cases, take this two different ways, about how many cases do you review and give an opinion to an attorney, first; and then second, about how many depositions do you give in medical/legal actions per year?

A. I would say now that it is probably running two or three a month and, you know, that I review, that I read. As far as depositions are concerned, maybe one every other month probably, yeah.

Q. Two to three a month, so 24 to 30

or so a year?

A. Probably now, yes, sir.

Q. How long has that been the case?

A. For the last four or five years. I don't think that it is 30, maybe 25.

Q. For how many years, the last 25 years?

A. No. I said maybe about 25 a year. I didn't think that it was 30 because that seems like a lot.

Q. All right, 25 a year. But for about how many years has that been about the average number?

A. The last five years.

Q. Okay. Doctor, are there any other opinions that you have in this matter other than what are illuminated in your report dated June 3rd, 2001 or that have been stated in this deposition?

A. The only, I would say no with the exception that I have not been provided with the recent records on this patient. I do not believe that they would necessarily alter my opinion.

Q. All right. Doctor, subject to your

review of these subsequent records, I am assuming that the opinions that you have given me today are going to be the same opinions that you will have at the trial of this matter, just a little over a month from now?

A. That's a fair statement, yes, sir.

Q. Doctor, finally, what percentage of patients with failed back syndrome achieve more than a 50 percent alleviation of pain with DCS placement?

A. It depends on how long you follow the patients. Within the first two years, the percentage runs about 75 to 80 percent, and then it falls off fairly rapidly. But in a 5-year follow-up, it's going to be less, less than 50 percent. I just saw those numbers the other day, and I can't remember the exact numbers. The Journal of Neuromodulation actually published an article on that sometime within the last six months.

Q. And can we agree a physician can perform surgery within the standards of care but that a patient still have a bad outcome?

A. Absolutely.

Q. Doctor, for any reason you should change your opinions or you should after you review this additional information and that in any way changes your opinions, you will be sure to let Ms. Kolis know so that she can let me know?

A. Yes, sir, I will.

MR. WILT:

Just for the record, I will and would specifically object to any change in the doctor's opinions once he receives these subsequent records as it regards the care and treatment rendered in 1999.

MS. TAYLOR-KOLIS:

I understand what you are saying. The purpose for him obviously to look at those his records isn't to amend or alter his standard of care criticisms.

MR. WILT:

Right.

MS. TAYLOR-KOLIS:

It is something to allow him the benefit of at least medical documentation indicating the status of the patient at present.

MR. WILT:

I am done as far as the videographer is concerned, so they can shut that down.

WITNESS' CERTIFICATE

I have read or had had the foregoing testimony read to me and hereby certify that it is a true and correct transcription of my testimony with the exception of any attached corrections or changes.

_____

(Witness' signature)

PLEASE INDICATE

( ) NO CORRECTIONS

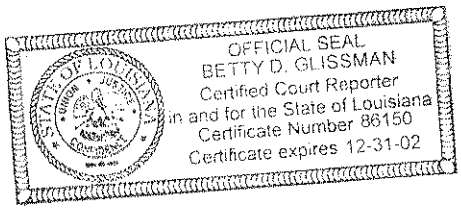
( ) CORRECTIONS; ERRATA SHEET (S) ENCLOSED

REPORTER'S CERTIFICATE

I, Betty D. Glissman, Certified Court Reporter, do hereby certify that the above-named witness, after having been first duly sworn by me to testify to the truth, did testify as hereinabove set forth;

That the testimony was reported by me in shorthand and transcribed under my personal direction and supervision, and is a true and correct transcript, to the best of my ability and understanding;

That I am not of counsel, not related to counsel or the parties hereto, and not in any way interested in the outcome of this matter.



BETTY D. GLISSMAN
CERTIFIED COURT REPORTER
CERTIFICATE #86150

Gerald Lasko vs. William Bohl, M.D., et al

For Donna Taylor-Kolis, Esq.

4/2/01

Lutheran Medical Center Admission of 8/24-8/30/99

Admitted as a failed back syndrome, with drug dependency, epilepsy and multiple medical problems.

Discharge diagnosis was that of "Postlaminectomy syndrome, thoracic region"

Secondary diagnoses were:

Mechanical Complication of nervous system device/implant/graft.
Drug dependency
Cervical spondylosis with myelopathy
Epilepsy
Diabetes
Thoracic disc displacement without myelopathy
Intervertebral disc disorder with myelopathy, thoracic region(? See 6 above)

Procedures listed were:

insertion of spinal neurostimulator
removal of spinal neurostimulator

Discharge summary:

The patient had a multiply assaulted back with numerous neck and back operations.

he was taken to OR and an lam performed and a DCS implanted. Pt said to have "assisted in transfer from op. table to stretcher and then later developed paraplegia.

several hours later, taken back to OR and DCS removed.

SUBSEQUENTLY DISCOVERED TO HAVE A LARGE LOWER THORACIC CALCIFIED DISC at T-10-11 by postop. MRI

Operative note:

laminectomy @ T-10-11.

When inserting the paddle, noted obstruction but persisted with putting the

Defense
EXHIBIT
"A"

lead in.

States that testing went well (?)

ANESTHESIA RECORD:

THE OP WAS STARTED AT 7:15 AM AND ENDED AT 8:30 AM(THE ANESTHESIA RECORD ENDS AT THIS TIME.

THERE IS NO RECORD TO BE FOUND, WRITTEN IN THE CHART, THAT THIS PATIENT MOVED HIS LEGS AT ANY TIME AFTER THE OPERATION.

PACU NOTES OF NURSES:

8:20 am, THE FIRST NOTE STATES THAT THE PATIENT CAN'T MOVE HIS LEGS.

Second operative note:

This was for removal of the lead

Easily removed.

No hematoma noted.

Admission diagnosis was, among other things, "spinal steonosis"

Progress notes:

Untimed.

Can't tell when he stopped moving

all notes indicated that the patient was moving when he left the OR(?)

Lutheran Medical Center admission of 8/30/99-9/9/99:

All rehab notes.

Lutheran Medical Center Admission of 11/24/99:

The patient was readmitted and had a thoracic discectomy and fusion at the site of his hard disc.

It would appear that he has maintained a dense paraparesis.

Office records of Dr. Bohl:

I can find no record of a thoracic study done preop. Plain or otherwise.

Dr. Bohl had performed 6-8 neck and back operations on this man through the years, but he never investigated his thoracic spine.

Review of x-rays:

There is a set of lumbar spine films, and they show the severity of his lumbar disease, as well as the fact that it is extending into the lower thoracic area.

There are two or three thoracic MRI scans, which confirm the nature of the thoracic stenosis and show the appearance of the spine after the surgery on the thoracic disc.

I BELIEVE THAT THIS PATIENT WAS INJURED AT SURGERY.

I THINK THAT HE NEVER MOVED HIS LEGS AFTER THE OPERATION, AT ANY TIME.

I BELIEVE THAT IT WAS SUBSTANDARD, KNOWING THE STATE OF HIS SPINE TO TRY TO INSERT A RESUME LEAD WITH THE USE OF THE PADDLE WITHOUT ASSSESING HIS SPINE BY SCAN.

I BELIEVE THAT IT WAS SUBSTANDARD TO PROCEDE WITH THE OPERATION AFTER ENCOUNTERING THE RESISTANCE THAT THEY DID.

I BELIEVE THAT THE TESTING THAT THEY DID INTRAOPERATIVELY WAS INADEQUATE AND THE PATIENT HAD JUST ENOUGH SENSORY SPARING TO REPSOND TO QUESTIONS ON INTRAOPERATIVE TESTING, EVEN THOUGH HE HAD LOST MOTOR FUNCTION.

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June 3, 2001

Donna Taylor-Kolis, Esq.
Third Floor – Standard Building
1370 Ontario Street
Cleveland, Ohio 44113-1791

Re: Gerald Lasko vs. William Bohl, M.D., et al.

Dear Ms. Taylor Kolis:

I have completed review of the materials that your office forwarded to me concerning the treatment of Mr. Lasko by Dr. Bohl.

Briefly, Mr. Bohl was a 59 year old gentleman who was admitted to Lutheran Medical Center on 8/24/99 with a diagnosis of pain problem secondary failed back syndrome. Dr. Bohl had been his surgeon for many years and had performed numerous surgeries on his lower back. During the course of his treatment of this patient x-rays of the lumbar spine were taken on many occasions, documenting that fact that the patient had severe spondylosis or degenerative spine disease.

On 8/24/99 Dr. Bohl took the patient to surgery and implanted a dorsal column stimulator in the lower thoracic area, using a paddle electrode. It is standard procedure during this operation to use a plastic "paddle" to dilate the dorsal epidural space, and Dr. Bohl did use this instrument, which is provided in the stimulator set, during the course of his surgery.

The operative note indicates that when the "paddle" instrument or epidural dilator was used, resistance was encountered. In spite of this, Dr. Bohl persisted with insertion of the lead at the T10-11 level, having done a laminectomy to facilitate electrode insertion.

The very first note in the chart regarding the patient's neurological status is the nurses note, entered upon his arrival in the PACU. This note, which is timed 8:20 AM, states "Pt. states he cannot feel or move his legs - sensation above nipple line – Dr. Bohl notified..."

Thereafter the patient was determined to be paraplegic.

Mr. Lasko was taken back to surgery and the DCS removed.

Subsequent evaluation revealed the fact that the patient had, as would be expected from knowledge of his prior spine films in the lumbar spine, significant spondylosis of the lower thoracic spine. Specifically at T9-10, or just one level above the previous laminectomy site.

Dr. Bohl then took the patient to the operating room and performed a laminectomy for decompression of the spinal cord at this level (that is, T9-10). Unfortunately the operation was carried out at the wrong level and was done at T8-9. This resulted in the need to perform yet a third spinal operation on Mr. Lasko at the proper level, or T9-10.

The patient has experienced a persistent paraplegia as a result of his initial surgery for implantation of the DCS.

My opinions would be as follows:

- This patient, with known severe lumbar spondylosis or degenerative spine disease should have undergone evaluation of his dorsal spine and spinal canal by either MRI or CT prior to attempting to place the DCS. The DCS lead that was used in this instance is relatively large and one has to be certain that the dorsal epidural space will accommodate it. This was not done. I feel that with a reasonable degree of medical certainty this is representative of substandard care.

- At the time of the surgery for implantation of the DCS, significant resistance to the epidural dilator or "paddle" was encountered. The epidural space should not have been probed further, until the source of this resistance was established. It is my opinion that the spinal cord injury which Mr. Lasko suffered occurred at this point in the operation and could have been avoided had more gentle technique been utilized and had the operation been stopped before applying further pressure with the dilator. Of course, had the spinal canal been assessed before the operation, this complication would have been avoided in the first place. I feel with a reasonable degree of medical certainty that the occurrence of this intraoperative spinal cord injury represents substandard care on the part of Dr. Bohl.

- There is no credible evidence in the record that his patient had motor function in his legs at any time after the operative procedure. The first notation by the nursing staff in the PACU indicates that he was paraplegic upon arrival there. This further strengthens the argument that the

paraplegia was the result of intra-operative trauma.

- The subsequent diagnosis of significant spinal stenosis at T9-10 also strengthens the argument that there was obstruction of the spinal canal and tight compression of the lower spinal cord at that level, the very level that was probed with the epidural paddle during surgery.

- Finally, after the obstructive lesion at T9-10 was diagnosed, Dr. Bohl attempted to surgically decompress the canal, but he operated at the wrong level and was forced to perform yet a third spinal procedure in an attempt to correct the spinal stenosis. I feel that this wrong-level surgery was, to a reasonable degree of medical certainty, representative of substandard care on the part of Dr. Bohl. In the mid thoracic area, there is some excuse for selecting the improper spinal level during surgery, but in the case of a lower thoracic lesion such as this, the proper level should not be missed.

Sincerely,

Thomas B. Flynn, M.D.

TBF:tbf
encl: 1
cc:

CURRICULUM VITAE

THOMAS B. FLYNN, M.D.

April 4, 2002

PERSONAL DATA:

Business Address: The NeuroMedical Center
7777 Hennessy Blvd.
Suite 10000
Baton Rouge, LA 70808

Residence: 4555 Highway 966
Jackson, Louisiana 70748

UNDERGRADUATE EDUCATION:

University of the South
Sewanee, Tennessee
B.S. Degree 1954 - 1958

DOCTORAL EDUCATION:

Doctor of Medicine
Tulane University
New Orleans, Louisiana
1958 - 1962

POSTDOCTORAL EDUCATION:

Internship	Straight Surgical Internship Charity Hospital of Louisiana New Orleans, Louisiana 1962 - 1963 Neurological Surgery
Fellowship	The Ochsner Foundation New Orleans, Louisiana 1963 - 1965 Neurological Surgery
Residency	Tulane University Medical School

Defense EXHIBIT C

New Orleans, Louisiana
1965 - 1967

Residency	Chief Resident in Neurological Surgery Charity Hospital of Louisiana Tulane Service New Orleans, Louisiana 1966 -1967
Honorary Degree	Doctor of Medicine in Neurosurgery Khon Kaen University Khon Kaen, Thailand September 6, 1994

Humanitarian Award of the American Association of Neurological Surgeons,
April 27, 1999

Honorary Member	Neurosurgical Association of Thailand, July, 2000

PRESENT POSITION:

Private Practice of Neurological Surgery
The NeuroMedical Center
Baton Rouge, Louisiana
1967 - Present

President and Managing Partner, The NeuroMedical Center
7777 Hennessy Blvd., Suite 10000
Baton Rouge, Louisiana 70808

BOARD CERTIFICATION:

Diplomat of American Board of Neurological Surgeons; May, 1970

PROFESSIONAL AFFILIATIONS:

1. Fellow of American College of Surgeons
2. Member of The Congress of Neurological Surgeons
3. Member of American Association of Neurological Surgeons
4. Member of Southern Neurosurgical Society

5. Member of The Houston Neurological Society

6. Member of Louisiana Neurosurgical Society; President, 1977

7. Member(Honorary), Neurosurgical Association of Thailand, July 12, 2000-present

8. Member of Baton Rouge Oncology Group

9. Associate Professor of Neurological Surgery; Louisiana State University Medical School

10. Consultant in Neurological Surgery; Earl K. Long Hospital, Baton Rouge, Louisiana

11. Chief of Neurosurgical Services; Baton Rouge General Hospital; 1974, 1975, 1976, 1983, 1987

12. Chief of Surgical Services; Baton Rouge General Hospital 1975, 1976, 1977

13. Former Instructor in Neurological Surgery; Tulane University Medical School, 1967 - 1968

14. Member of Louisiana State Medical Society

15. Member of East Baton Rouge Parish Medical Society

16. Vice-Chief of Staff; Baton Rouge General Hospital; 1978 – 1979

17. Chief of Medical Staff; Baton Rouge General Hospital; 1980

18. Secretary of Staff; Baton Rouge General Hospital; 1979 - 1980

19. Physician's Recognition Award - AMA; 1973-1975, 1975-1978, 1979-1981, 1982-1984, 1986-1988

20. Continuing Education Award in Neurosurgery –AANA-CNS; 1976, 1979,1986-1988

21. Clinical Assistant Professor, in the Department of Neurosurgery, Tulane University Medical School, 1979 to present.

22. American Society for Stereotactic and Functional Neurosurgery, elected active member; July 1, 1979

23. Member of Advisory Council, Alcohol and Drug Abuse Prevention Program Baton Rouge School System; 1984

24. Fellow of International College of Surgeons, 1982 - 1990

25. "Chairman of the Board, ESI, Inc.; Medical Office Computers"; 1983

26. Vice chief Neurosurgery; OLOL Hospital; 1982

27. Chief of Neurosurgery; OLOL Hospital; 1983

28. President; Baton Rouge Surgical Society; 1983

29. Member of American Academy of Medical Directors; 1984

30. Instructor Midas Rex Psychomotor Institute; The Department of Neurological Surgery, Montefiore Hospital Medical Center; 1984

31. Albert Einstein College of Medicine and Midas Rex Psychomotor Institute; September 1984

32. Who's Who in the Southwest, Marquis - Who's Who; 1984

33. Managing Partner; The NeuroMedical Center; 1984-present

34. Camelot Club; Board of Directors; 1986-Present

35. Board of Directors, Medalliance, Inc.; A Nashville based company developing and managing medical practices, 1986 - 1995.

36. Governing Board of the South Louisiana Rehabilitation Hospital of Baton Rouge; January, 1988 - 1995.

37. South Louisiana Rehabilitation Hospital of Baton Rouge; active staff; January, 1988 - present.

38. West Feliciana Parish Hospital, Consulting Staff; March, 1991 - present.

39. Member of Christian Medical and Dental Society.

40. Credentials Committee, Our Lady of the Lake Regional Medical Center; 1992-1995.

41. Credentials Committee, Baton Rouge General Hospital, Chairman; 1985-1995.

42. Clinical Assistant Professor in the Department of Neurosurgery of Tulane University School of Medicine; 1992-Present.

43. Board of Directors, Louisiana Health Care Alliance, liaison representative for East Baton Rouge Parish Medical Society; 1992 to 1993 with reappointment to a new one year term through October, 1995.

44. Regional Advisory Board, Louisiana Heath Care Alliance, 1995 to present.

45. Chief of Neurosurgery Service, Our Lady of the Lake Regional Medical Center; 1993-1994.

46. President, The NeuroMedical Center, Inc.; 1978 to present.

47. Member of the board for Our Lady of the Lake Foundation; December 31, 1993 to present.

48. Board of Directors, LAMMICO, Louisiana Medical Mutual Co., 1995 to present.

49. Board of Directors, LAMMICO Insurance Agency, Inc., 11/99-present.

50. Executive Committee, LAMMICO, present.

51. Senior Vice President, Risk Management, LAMMICO, current

52. Chairman, Compensation Committee, LAMMICO, current.

53. Chairman Governance Committee, LAMMICO, 1998-2000

54. Chairman, American Association of Neurological Surgeons Task Force on Neurosurgical Practice Assessment; 1995,1996.

55. American Association of Neurological Surgeons, Committee on Quality Assurance, 1996 to present.

56. Louisiana Health Care Alliance, Vice President of Regional Board for provider Relations, 1996.

57. Consultant Evaluator, Neurosurgery for the American Medico-Legal Foundation; 1996.

58. Clinical Assistant Professor in the Department of Neurosurgery of Tulane University School of Medicine for the academic year 1997-1998.

59. Neurosurgery Service of the Medical Staff of the Baton Rouge General Medical Center and Baton Rouge General Health Center, Active Staff privileges.

60. American Association of Neurological Surgeons, Committee on Outcomes, 4/99 to Present.

61. Committee on Quality Assessment and Credentialing, Blue Cross and Blue Shield of Louisiana, May 1999 to present.

62. Louisiana Healthcare Alliance, Managed Care Advisory Commission, Work Group for Plan Benefit Design, October, 1999 to present.

MEETINGS AND COURSES:

1. Choosing and Using a Computer System in a Private Medical Practice; Chicago, Illinois; February, 1982

2. International College Surgeons Course, Chicago, Illinois; October, 1982

3. The Second International Evoked Potentials Symposium; Cleveland, Ohio; October, 1982

4. Theodore Gildred Microsurgical Education Center: Gainesville, Florida; December 6-10, 1982

5. SANS (Computer scored) AANS; Chicago, Illinois; January, 1983

6. Intradiscal Therapy January Chicago Series, Chicago, Illinois; January, 1983

7. Western Federation Societies of Neurological Science, Los Angeles, California; February, 1983.

8. Posterior Lumbar Interbody Fusion Symposium, Philadelphia, Pennsylvania; April 23, 1983

9. Neurosurgery Laser Workshop, Dallas, Texas; September 12, 1983

10. Congenital Cytomegalovirus Infection and Early Care and Management of the Spinal Cord Injury Patient, Birmingham, Alabama; 1984

11. CT Stereotaxic Surgery, University of Utah, Salt Lake City, Utah; August, 1984

12. American Group Practice Association Annual Meeting; September, 1984

13. American Association of Neurological Surgeons Annual Meeting, New York, New York; September, 1984

14. American Academy of Neurological and Orthopedic Surgeons Convention Las Vegas, Nevada; October 5, 1984

15. American Academy of Medical Directors; Tampa, Florida; March, 1985

16. American Group Practice Association Fifth Annual Meeting; Washington, D.C.; May, 1985

17. IX Meeting of the World Society for Stereotactic and Functional Neurosurgery; Toronto, Canada; July 4-7, 1985

18. 8th International Congress of Neurological Surgery; Toronto, Canada; July 7-13, 1985

19. American Academy of Medical Directors; Charlotte, North Carolina; September, 1986 – PIM I

20. American Academy of Medical Directors; Charlotte, North Carolina; November, 1986 - PIM II

21. Bi-Weekly Reviews, Volume 9, Emory Clinic; 1987, 40 hours

22. Louisiana Neurological Society Annual Meeting, New Orleans, Louisiana; January, 1987

23. Third Annual Houston Conference on Neurotrauma, Houston, Texas; February, 1987

24. Southern Neurological Society Meeting, Kiawah Island, South Carolina; March, 1987

25. American Association of Neurological Surgeons Annual Meeting, Dallas, Texas; May, 1987

26. Ninth Annual Meeting, July 4, 1987

27. American Group Practice Association, 38th Annual Conference, New Orleans, Louisiana; September 15-18, 1987

28. American Academy of Medical Directors; Tucson, Arizona; November 17-18, 1987

29. American Academy of Medical Directors, Tucson, Arizona; November 19-20, 1987

31. Southern Neurosurgical Society Annual Meeting; March 29, 1988

32. Automated Percutaneous Discectomy Workshop; Arlington, Virginia, April, 16-17, 1988

33. American Academy of Medical Directors; San Diego, California; May 5-7, 1988

34. Society of Magnetic Resonance; Berkeley, California; June, 1988

35. Symposium on Stereotactic Irradiation For Brain Tumors; Sloan-Kettering Institute, N.Y.; February 23-24, 1989

36. American College of Physician Executives' Summer Executive Symposium; August 21-24, 1989; (28 hours)

37. American Association of Neurological Surgeons; April 28, 1990; (40 hours)

38. Baton Rouge General Medical Center Tumor Conference; June 15, 1990; (1 hour)

39. Baton Rouge General Medical Center Tumor Conference October 19, 1990; (1 hour)

40. Baton Rouge Oncology Meeting; Our Lady of the Lake Regional Medical Center; June 4, 1991; (1 hour)

41. Neuropathology Grand Rounds; Our Lady of the Lake Regional Medical Center; January 7, 1991; (1 hour)

42. Neuropathology Grand Rounds; Our Lady of the Lake Regional Medical Center; September 9, 1991; (1 hour)

43. Third Annual Neuroscience Symposium; Our Lady of the Lake Regional Medical Center; (1 hour)

44. CIS Training; Our Lady of the Lake Regional Medical Center; (1 hour)

45. MISPA International Conference: Assessing Value; California Pacific Medical Center; November 14-17, 1991; (20.5 hours).

46. Tumor Conference; Our Lady of the Lake Regional Medical Center; November 22, 1991; (1 hour)

47. Tumor Conference; Our Lady of the Lake Regional Medical Center; November 22, 1991; (1 hour)

48. Tumor Conference Our Lady of the Lake Regional Medical Center; July 26, 1991; (1 hour)

49. Tumor Conference; Our Lady of the Lake Regional Medical Center, September 27, 1991; (1 hour)

50. American Association of Neurological Surgeons and The Congress of Neurological Surgeons Lumbar Spine Segmental Stabilization; December 14, 1991; (11.50 hrs)

51. Neuropathology, Grand Rounds; Our Lady of the Lake Regional Medical Center; January 6, 1992 (1 hour)

52. Southern Methodist University, Edwin L. Cox School of Business Corporate Cash Management; January 13-14, 1992.

53. Neuropathology Meeting, Our Lady of the Lake Regional Medical Center; July 6, 1992 (1 hour)

54. Neuropathology Rounds, Our Lady of the Lake Regional Medical Center; May 4, 1992; (1 hour)

55. Neuroscience Symposium; Our Lady of the Lake Regional Medical Center; September 19, 1992; (3.7 hours)

56. Congress of Neurological Surgeons 1992 Annual Meeting; Scientific Sessions; Washington, D.C.; October 31 to November 5, 1992; (22 hours)

57. CIS Training; Our Lady of the Lake Regional Medical Center; January 31, 1993 (2 hours)

58. Louisiana Neurosurgical Society, Annual Meeting; New Orleans, Louisiana; January 15-16, 1993.

59. Neuropathology Grand Rounds; Our Lady of the Lake Regional Medical Center; February 1, 1993 (1 hour).

60. Educational Symposia, Inc., Snowmass 1993: MR and CT of the Head and Spine; February 6 - 13, 1993; (20 hours)

61. Pain Management in Cancer; Our Lady of the Lake Regional Medical Center; March 30, 1993 (1 hour)

62. American Group Practice Association's 13th Annual Congressional Forum, "Patchwork or Tapestry"; April 25-28, 1993; (12.55 hours)

63. American Association of Neurological Surgeons, Annual Meeting, Boston, Massachusetts; April, 1993.

64. Tumor Conference Our Lady of the Lake Regional Medical Center; August 25, 1993 (1 hour).

65. "Techniques in Management of Pain" - CNS Vancouver, B.C.; October 2, 1993

66. Congress of Neurological Surgeons, 1993 Annual Meeting, General Scientific Sessions; Vancouver, B.C.; October 2-7, 1993; (34.75 hours).

67. Our Lady of the Lake Regional Medical Center On-Site Management Education Program; Baton Rouge, Louisiana, January 21-22, 1994; (6 hours)

68. American Association of Neurological Surgeons, San Diego, California; April 10-14, 1994. (35 hours)

69. American Association of Neurological Surgeons, Practice Assessment Task Force, Seminar on Practice Assessment, San Diego, California (April 9, 1994).

70. American Association of Neurological Surgeons, Annual Meeting. (32.50 hours).

71. Congress of Neurological Surgeons, Annual Meeting. (34.75 hours)

72. ACPE - 1995 Future Forum, (24 hours)

73. MGMA - Preparing for Managed Care. Denver, CO., March 12-16,1995. (23 hours)

74. American Association of Neurological Surgeons, Annual Meeting. Orlando, Florida, April 22-27, 1995. (26.75 hours)

75. Congress of Neurological Surgeons, Annual Meeting. October 14-19, 1995. (21.75 hours).

76. Florida Neurosurgical Society the Department of Neurosurgery and the Department of Radiation Oncology, Annual Meeting. Gainesville, Florida, December 6-10, 1995. (24 hours).

77. American Association of Neurological Surgeons and Congress of Neurological Surgeons. January 1, 1993 - December 31, 1995. (90 hours).

78. Approaches to the Carotid Artery, Saint Louis University School of Medicine, St. Louis, Missouri, January 22, 1996. (9 hours).

79. American Association of Neurological Surgeons, Minneapolis, Minnesota, April 1996.

80. American Association of Neurological Surgeons, Annual Meeting, April 27, 1996 o March 2, 1996. (35.5 hours).

81. American Medical Group Association, "Re—Engineering Health For The 21st Century," January 22-25, 1997. (15.5 hours).

82. MicroEndoscopic Discectomy, Medical Education and Research Institute, Memphis, Tennessee, November 13, 1997.

83. MicroEndoscopic Discectomy, Medical Education and Research Institute, Memphis, Tennessee, February 19, 1998.

84. American Association of Neurological Surgeons Annual Meeting, Philadelphia, PA, April 25 – 30, 1998, (21.75 CME credit hours).

85. Special course, "Stereotactic Surgery for Movement Disorders", AANS Annual Meeting, Philadelphia PA, 4/27/98, (2.0 CME credit hours).

86. Special course, "Spinal Cord Stimulation", AANS Annual Meeting, Philadelphia, PA, 4/28/98, (2.0 CME credit hours).

87. American Association of Neurological Surgeons Annual Meeting, New Orleans, LA, 4/24-4/29/99. General Sessions, 19.50 CME Credit Hours.

88. Seminar on Spinal cord Stimulation, AANS Meeting, New Orleans, LA, 4/99, 2 CME Credit Hours.

89. Seminar on Management of Spasticity, AANS Meeting, New Orleans, LA, 4/99, 2 CME Credit Hours.

90. **Continuing Education Award in Neurosurgery. From the coordinating Committee on Continuing Medical Education of The American Association of Neurological Surgeons. 93.75 hoursof CME. Valid through December, 2001**

91. Participation in the administration of the Neurosurgical Mock Boards, Tulane University Neurosurgical Service, July 24, 1999.

92. Congress of Neurological Surgeons, 10/30-11/4/1999, Boston, Massachusetts, 23 CME credit hours

93. American College of Physician Executives, 1999 Fall Institute, November 8-12, Indian Wells, CA. 24 CME credit hours.

94. Mary Bird Perkins Cancer Center, "Advances in Therapy for Bladder Cancer, 8/11/99, CME Cat. 1, 1 hour.

95. American Association of Neurological Surgeons, Annual Meeting, San Francisco, CA, April 9-13, 2000. General Sessions-CME Category 1 credit, 20 hours.

96. Management of Pain in the Trigeminal Distribution, AANS Breakfast Seminar, April 10, 2000, CME Category 1, 2.0 hours.

97. Cost Management in Contemporary Neurosurgical Practice, AANS Breakfast Seminar, April 11, 2000, CME Category 1, 2.0 hours.

98. Developing Competitive Advantage in Contemporary Neurosurgical Practice, AANS Breakfast Seminar, April 12, 2000, CME Category 1 , 2.0 hours.

99. Physician Insurers Association of America, PIAA Leadership Boot Camp, Washington, DC, May 31, 2000, CME Category 1, 7.25 hours

100. Physician Insurers Association of America, 2000 Annual Meeting, May 30-June 3, 2000, J.W. Marriott, Washington, DC. 9.25 hours, Category 1, CME.

101. Annual Meeting of the Neurosurgical Association of Thailand, Central Plaza Hotel, 12-13 July, 2000

102. Annual Meeting of the Royal College of Surgeons of Thailand, Royal Cliff Beach Hotel, Pattaya, Thailand, 14-16 July, 2000

103. LAMMICO, 17th Annual Defense Counsel Meeting, Orange Beach Resort, Alabama, August 10-11, 2000.

104. NeuroMedical Center/Our Lady of the Lake Case Conferences encompassing dates of 1/10/2000 through 8/14/2000, Category 1 CME Credits, 21.00

105. Congress of Neurological Surgeons Annual Meeting, San Antonio, TX, September 23-28, 2000, 22.25 Category 1 CME Credit Hours.

106. American Association of Neurological Surgeons 69th Annual Meeting. Toronto, Canada.

107. 2001 Neurosurgical Leadership Development Conference. AANS. Washington DC. 8.00 Category 1 Credit Hours.

PAPERS AND Presentations:

1. Report on a method for long term follow-up ventriculoperitoneal shunt with pressure determinations; Ninth Annual Meeting Federation of Western Societies of Neurological Science; March, 1972.

2. Early stabilization following cervical fracture dislocation; Pre-Convention Session, Congress of Neurological Surgeons 23rd Annual Meeting; October, 1973.

3. Complications of anterior cervical fusion. *A* survey of currently practicing neurological surgeons. Paper read before the Annual Meeting of the American Association of Neurological Surgeons; San Francisco, California; 1976.

4. Intraoperative monitoring of CSF pressure during anterior cervical discectomy and fusion. A preliminary report. Paper read before the Third Annual Meeting of Louisiana Neurosurgical Society, 1977.

5. Use of a small computer for Reporting Medical Examinations: Edelman, Joseph M., and Flynn, Thomas B., Decus, 1968.

6. "Transient Quadriparesis Following ACDF, A Case Report '. Paper read before the Fifth Annual Meeting of the Louisiana Neurosurgical Society, 1979.

7. "Combining the Electrocautery with a Suction Irrigator". Paper read before the Fifth Annual Meeting of the Louisiana Neurosurgical Society, 1979.

8. "Myelopathy Following Anterior cervical Discectomy and Fusion Case Report and Discussion of Recent Literature". Paper read before the Southern Neurosurgical Society, Hilton Head, South Carolina, 1979.

9. Radiation Necrosis of the Scalp and Skull - Report for the Louisiana Neurosurgical Society Meeting, New Orleans, Louisiana, January, 1981.

10. The Syndrome of Ischemic Myelopathy Following ACDF —Report for the Louisiana Neurosurgical Society Meeting, New Orleans, Louisiana; January, 1981.

11. Intraoperative Monitoring of CSF and Systemic Blood Pressure During Anterior Cervical Discectomy and Fusion. Paper read before the 7th. International Congress of Neurological Surgery; Munich, Germany; July 12 - 18, 1981.

12. "Dermal Graft for Dural Defect". Report for the Annals of Plastic Surgery, Volume 6, No. 4, April, 1981.

13. "Neurologic Complications of Anterior Cervical Interbody Fusion" Thomas B. Flynn, M. D.; Spine, Vol. 7, Number 6; 1982, pages 536—539.

14. Computers, Private Practice and Survival in the Eighties (an incomplete guide). Meeting at Louisiana Neurosurgical Society, New Orleans, Louisiana; January 29, 1983.

15. Member Survey and Technical Report - ACDF. Meeting at Louisiana Neurosurgical Society, New Orleans, Louisiana, January 29, 1983.

16. Computers, Private Practice and Survival in the Eighties (an incomplete guide) Revised, presented at the 20th Annual Meeting; Western Federation of Societies of Neurological Science; Santa Monica, California; February 26, 1983.

17. "Neurologic Complications of Anterior Cervical Discectomy in Louisiana"; Thomas B. Flynn, M.D.; Journal, Louisiana State Medical Society; Vol. 136, Number 7; July, 1984, pages 6-8.

18. "Midas Rex Instruments and the Posterior Lumbar Interbody Fusion"; Thomas B. Flynn, M. D.; American Academy of Neurological and Orthopedic Surgeons Annual Meeting; October 17, 1984.

19. "Neurologic Complications of ACDF", 1974—1984, Poster Presentation 8th International Congress of Neurological Surgeons; Toronto, Canada; July 7—13, 1985.

20. "CT Based Stereotactic Brain Biopsy Experience" Paper read at Louisiana Neurosurgical Society Meeting; New Orleans, Louisiana; July, 1985.

21. "Complications of ACDF" — 10 year follow—up survey, presented at Louisiana Neurosurgical Society Meeting; January, 1987.

22. "Fibrocartilaginous Embolization" — Review of literature — Possible etiology of myelopathy following ACDF, presented at Louisiana Neurosurgical Society Meeting; January, 1987.

23. "Neurological Complications of ACDF", presented at Southern Neurosurgical Society Meeting; March, 1987.

24. "How To Remain Entrepreneurial As A Member Of A Group Practice"; presented at Lovelace Clinic, Albuquerque, New Mexico; October, 1988.

25. "Neurosurgical Fare in Thailand"; Louisiana Neurosurgical Society; New Orleans, Louisiana; January 28, 1989.

26. "Spinal Cord Trauma", Speaker: Thomas B. Flynn, M. D., Annual CME and General Membership Meeting, Louisiana Academy of Physician Assistants, Bossier City, Louisiana, April 27, 1991.

27. "Hang Together or Hang Separately", a presentation regarding current concepts in managed care presented at Mission Memorial Medical Center, Ashville, North Carolina, October 8, 1992.

28. Management of Spinal Trauma, Earl K. Long Hospital, emergency medicine residents; July, 1993.

29. "Developing a short stay program for spinal surgery—moving into the twenty—three hour stay setting", Sixth Annual Neuroscience Symposium for Nurses, Baton Rouge, LA, March 10, 1995.

30. Lecture, "Delayed Intracerebral Hematoma" Annual Meeting, RCP,Th; Korat, Thailand, 02/18/97.

31. Lecture, "Neurovascular Emergencies in Neurosurgery" Annual Meeting RCP, Th; Khon Kaen University, Khon Kaen, Thailand, 02/19/97.

32. Lecture, "Guidelines for the Management of Severe Head Injury Annual Meeting, RCP, Th; Khon Kaen University, Khon Kaen, Thailand, 02/20/97.

33. Lecture "Hospital Accreditation in the Managed Care Environment" – Faculty of Medicine, Khon Kaen University Medical School, Khon Kaen, Thailand, 03/09/99.

34. Lecture "Managed Care Overview" – Faculty of Medicine, Khon Kaen University Medical School, Khon Kaen, Thailand, 03/03/99.

35. Lecture "Management of Spinal Cord Tumors" – Neurosurgical Association of Thailand, Siriraj Hospital, Bangkok, Thailand, 03/05/99.

36. Breakfast seminar presentation, "Private Group Practice Management Strategies", Presentation @ AANS Annual Meeting, April 11, 2000.

37. "Implant Devices for the Control of Pain", Annual Meeting of the Neurosurgical Association of Thailand, Central Plaza Hotel 13 July, 2000.

38. "Vagal Nerve Stimulation for the Control of Epilepsy and Depression", Annual Meeting of the Royal College of Surgeons of Thailand, Royal Cliff Beach Hotel, Pattaya, Thailand, July 14, 2000.

39. "Managing a Neuroscience Group Practice", Annual Meeting of the Royal College of Surgeons of Thailand, Royal Cliff Beach Hotel, Pattaya, Thailand, July 14, 2000

40. "Cervical BAK-C© Cage Implant, Results of Clinical Trial, The NeuroMedical Center", Annual Meeting of the Royal College of Surgeons of Thailand, Royal Cliff Beach Hotel, Pattaya, Thailand, July 15, 2000.

AMENDED ABNS DEFINITION OF NEUROLOGICAL SURGERY

Neurological Surgery is the discipline of medicine and that specialty of surgery which provides the operative and non-operative management (i.e. prevention, diagnosis, evaluation, treatment, critical care, and rehabilitation) of disorders of the central, peripheral and autonomic nervous system, including their supporting structures and vascular supply; the evaluation and treatment of pathological processes, which modify function or activity of the nervous system, including the hypophysis; and the operative and non-operative management of pain. Neurological Surgery encompasses treatment of patients with disorders of the nervous system: the brain, meninges, skull and their blood supply, including the extracranial carotid and vertebral arteries, disorders of the pituitary gland; disorders of the spinal cord, meninges and spine, including treatment by fusion or instrumentation; and disorders of the cranial and spinal nerves throughout their distribution.