

IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

\* \* \* \* \*

MICHAEL R. KOSTELNIK, JR., etc., et al., Plaintiffs

VS

STEPHEN D. HELPER, M.D., et al., Defendants

No. 290775

Doc. 358

.....  
DEPOSITION OF HOWARD CHARLES PITLUK, M.D.

April 14, 1997

Tucson, Arizona  
.....

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Page 2		Page 4	
1	A P P E A R A N C E S	1	HOWARD CHARLES PITLUK, M.D.,
2	* * * * *	2	having been first duly sworn to state the truth, the
3	CHATTMAN, CAINES & STERN	3	whole truth, and nothing but the truth, testified on
4	By John V. Scharon, Jr., Esq.	4	his oath as follows:
5	For the Plaintiffs	5	
6	-----	6	EXAMINATION
7	JACOBSON, MAYNARD, TUSCHMAN & KALUR	7	BY MR. SCHARON:
8	By William D. Bonezzi, Esq.	8	Q. Would you state your name for the record,
9	For the Defendants	9	please.
10	and	10	A. <b>Howard Charles Pitluk.</b>
11	REMYNGER C REMYNGER	11	Q. Your address, sir?
12	By James L. Mdlone, Esq.	12	A. <b>Office address?</b>
13	For the Defendants	13	Q. That's fine.
14	(Appearing Telephonically)	14	A. <b>1925 West Orange Grove, Tucson, Arizona.</b>
15		15	Q. All right. That's where we are here
16	BE IT REHEMBERED that pursuant to notice	16	today for your deposition?
17	the deposition of Howard Charles Pitluk, M.D., was	17	A. <b>Correct.</b>
18	taken at the offices of Howard C. Pitluk, M.D.,	18	Q. Dr. Pitluk, you have been identified in
19	Inc., 1925 West Orange Grove Road. Suite 100-101, in	19	this case, the case of Kostelnik versus Dr. Stephen
20	the City of Tucson, County of Pima, State of	20	Helper and others, as an expert for Defendant
21	Arizona, before Lisa Erwin, a Notary Public in and	21	Dr. Helper, and we have been furnished with a report
22	for the State of Arizona, on the 14th day of April	22	by you, and I'm here to take your deposition in
23	1997, commencing at the hour of 12:29 p.m. on said	23	preparation for trial to find out what you have to
24	day, in a certain Cause now pending in the Court of	24	say and the reasons that you hold those opinions.
25	Common Pleas, Cuyahoga County, Ohio.	25	You have been through this before, I
Page		Page 5	
1	DEPOSITION OF HOWARD CHARLES PITLUK, M.D.	1	presume. Am I right?
2		2	A. <b>Depositions?</b>
3	I N D E X	3	Q. Yes.
4	* * * * *	4	A. <b>Yes.</b>
	EXAMINATION	5	Q. So I don't need to belabor the point
	PAGE	6	about letting me know when you don't understand a
1	By Mr. Scharon	7	question so I can try to rephrase it or, you know,
	4	8	waiting until I ask my complete question and making
1	EXHIBITS	9	your responses out loud so the court reporter can
	* * * * *	10	get them. You understand all those ground rules, if
	(No Exhibits Offered)	11	you will?
		12	A. <b>Correct.</b>
		13	Q. Okay. I've been provided with your CV,
		14	Doctor, and I don't know whether that's the most
		15	recent version. Can you tell me whether it is?
		16	A. <b>When was this given to you?</b>
		17	Q. At the same time as your report, which
		18	was dated August 16th of last year.
		19	A. <b>I think there has been a slight update on</b>
		20	<b>this. My secretary will be more than happy to give</b>
		21	<b>it to you.</b>
		22	Q. Okay. I'd appreciate that. And maybe by
		23	looking at the last entries, you can tell me what
		24	needs to be added.
		25	A. <b>Basically just I think I gave one or two</b>

Page 6

1 different talks that would be added here, but  
2 nothing that's going to be pertinent to this case.  
3 Q. Is there anything reflected in the CV  
4 about your medical position in Arizona? I may have  
5 missed that.  
6 A. Position, sir?  
7 Q. What hospital you practice at, what the  
8 name of your practice is and so forth.  
9 A. My practice name should be on top, but I  
0 don't know if it is or isn't. Basically I don't put  
1 the hospitals I practice at in the CV, but ~~it~~ be  
2 more than happy to provide that to you.  
3 Q. Why don't you just tell me what hospitals  
4 you see patients at here.  
5 A. Basically I **only** practice at the one  
6 hospital called **Northwest** Hospital, and it's located  
7 basically behind my office building here in Tucson.  
8 I have courtesy privileges at St. Mary's Hospital  
9 and **at** Tucson **Medical** Center, but **basically they are**  
0 just that, courtesy only, and I do not see patients  
1 there if I can help it.  
2 Q. Okay. Do you maintain a list of the  
3 legal matters which you have been consulted on?  
4 A. A list? No, I do not.  
5 Q. Okay. Can you tell me why or what

Page 7

1 occasioned your leaving Cleveland and coming here to  
2 Arizona?  
3 A. As you look out the window, you can see  
4 the weather is fabulous. I was born and raised in  
5 Cleveland and lived my whole life in the eastern  
6 Midwest, if you will. My wife and I both dislike  
7 cold weather, and **as** we got older, we disliked it  
8 even more.  
9 We had an opportunity to relocate our  
0 practice to Arizona. We've always loved Arizona.  
1 And basically one day I said I'm going to do this  
2 about three years ago, and I started making the  
3 arrangements. And approximately a year and a half  
4 ago, we made the move.  
5 Q. Can you describe for me the nature of  
6 your practice here in Tucson?  
7 A. I'm involved in the practice of both  
8 vascular and general surgery.  
9 Q. And what procedures does that cover?  
0 A. It covers a wide range of procedures. In  
1 general surgery, I do everything from neck  
2 surgeries, such **as** thyroid, parathyroid surgery. I  
3 **also** do abdominal surgery, gastric surgery, colon  
4 surgery, gallbladder surgery, bowel surgery.  
5 As far **as** vascular surgery, carotid

Page 8

1 endarterectomy, aortic aneurism surgery. I do  
2 arterial bypass surgery of the extremities and vein  
3 surgery. Basically I do about **everything except the**  
4 chest. I stay **out** of the chest. I don't do brain  
5 surgery, and I do not do orthopedic surgery.  
6 Q. What type of procedures would a vascular  
7 surgeon usually be doing in the chest?  
8 A. Basically coronary artery bypass, and  
9 that's cardiac surgeons.  
0 Q. Okay. Can you break down for me the time  
1 that you spend in the clinical practice of medicine  
2 versus the time that you devote to consulting in  
3 legal matters?  
4 A. Well, basically my practice is over **95**  
5 percent of my time doing patient care, and maybe  
6 percent of that would be in **medical/legal**  
7 consultation.  
8 Q. Do you have any idea how many medical  
9 negligence matters you've consulted on?  
0 A. Over the past how long?  
1 Q. Well, I don't **know**. How long have you  
2 been doing it? I don't know how to break it down.  
3 A. I would say over the last **15** years I've  
4 probably consulted in the neighborhood of 30 to 40  
5 cases total.

Page 9

1 Q. **All** right. Do you draw any distinction  
2 between cases in which you have consulted versus  
3 cases in which you actually testified?  
4 A. No. I mean, all **cases** total.  
5 Q. Good. Can you estimate for me the number  
6 of depositions in malpractice cases that you give in  
7 a year?  
8 A. In a year? Probably in the neighborhood  
9 of six.  
0 Q. Okay. And --  
1 A. Five or six.  
2 Q. What about court appearances, same time  
3 frame?  
4 A. No **court** appearances. Total, I think, in  
5 the **15** years has been in the neighborhood of five or  
6 six.  
7 Q. Do you consult with other attorneys  
8 besides lawyers in the **firm** of Jacobson, Maynard?  
9 A. I don't consult with them, either.  
0 Q. Oh, **I'm** sorry.  
1 A. **What** do you mean consult? You mean do I  
2 do work for other attorneys?  
3 Q. Yes.  
4 A. Oh, I'm sorry.  
5 Q. That's the work I was referring to.

Page 10

Page 12

1 A. Yes, I do. I'm sorry.  
2 Q. Okay. And how many firms besides  
3 Jacobson, Maynard have you done work with?  
4 A. I would have to guess in the neighborhood  
5 of seven, eight.  
6 Q. Okay. Would you say that the majority of  
7 your work is done with that firm, the majority of  
8 the legal, medical/legal work?  
9 A. Of the defense work, yes.  
10 Q. Okay. I take it, then, that you also  
11 consult with plaintiffs' attorneys on cases?  
12 A. That's correct.  
13 Q. Can you tell me how many plaintiffs'  
14 cases you've consulted on?  
15 A. I would say in the neighborhood of 10.  
16 Q. Ever testify in one?  
17 A. Yes.  
18 Q. When was the last time that you testified  
19 on behalf of a plaintiff in a malpractice case?  
20 A. In court you mean?  
21 Q. Or by deposition.  
22 A. By deposition, there was -- it was this  
23 year. In court, it's been several years or many  
24 years.  
25 Q. Okay. What percentage of the defense

1 A. Correct.  
2 Q. Have you ever been directly employed by  
3 PIE?  
4 A. No.  
5 Q. What has your experience been, if you've  
6 had any, as a defendant in a malpractice case?  
7 A. Have I been sued, is that what you're  
8 asking?  
9 Q. Well, it's really somewhat broader than  
10 that. Have there been malpractice claims made  
11 against you whether or not they resulted in suits?  
12 MR. BONEZZI: Objection.  
13 A. Yes.  
14 Q. And can you give me an idea of how many  
15 times that occurred?  
16 A. I believe three.  
17 Q. Did all three of those result in  
18 lawsuits?  
19 A. Yes.  
20 Q. So there were no other claims besides  
21 lawsuits?  
22 A. I don't think I understand the question.  
23 Q. Okay. Not all claims result in  
24 lawsuits. In other words, a patient might have a  
25 complaint, address it to you, and the matter is

Page 11

Page 13

1 cases that you consulted on would you say have been  
2 with lawyers from Mr. Bonezzi's firm?  
3 A. Of the defense work percentage-wise, I  
4 would say around 75 percent.  
5 Q. And how would you break down the percent  
6 of your work between plaintiffs and defense  
7 consulting?  
8 A. Probably 60 percent defense and 40  
9 percent plaintiffs.  
10 Q. Okay. Have you worked on medical  
11 negligence cases with Mr. Bonezzi in particular  
12 before?  
13 A. I think once.  
14 THE WITNESS: Did I, Bill?  
15 MR. BONEZZI: Yeah, one time.  
16 Q. And was that case related in any way to  
17 the area of medicine in which you are testifying  
18 here in this case?  
19 A. I don't believe so.  
20 Q. Okay. Are you insured by physicians'  
21 insurance PIE?  
22 A. No.  
23 Q. Have you been in the past?  
24 A. Yes.  
25 Q. I assume back when you were in Ohio?

1 either dropped by the patient or taken care of by  
2 you or by you and your insurer.  
3 A. Well, that's never happened.  
4 Q. Okay.  
5 A. There has never been any settlements on  
6 my behalf. Is that what you're asking?  
7 Q. That would have been the next question  
8 somewhere down the road.  
9 A. There never have been. And the three  
10 cases I can recall, they were all dropped.  
11 Q. So there has never been any settlement or  
12 decisions in the patient's favor in your case?  
13 A. No, there have not.  
14 Q. Okay. In those three matters, what were  
15 the nature of the claims, do you recall?  
16 A. They were a while ago. Misdiagnoses, I  
17 believe, on both of them. And as I said, they were  
18 dropped before they ever went to trial.  
19 Q. Okay. I thought there were three. You  
20 said both.  
21 A. Yeah, there was two, and the third one  
22 was also a misdiagnosis.  
23 Q. Do you recall who defended you in those  
24 cases?  
25 A. Yes, Jacobson, Maynard, Tuschman & Kalur.

Page 14

1 Q. Fink. Is your relationship with  
2 Jacobson, Maynard strictly professional as opposed  
3 to being either a combination of professional and  
4 social?

5 A. No, strictly professional.

6 Q. Okay. So would I be correct in assuming  
7 you are not related to anybody in the firm?

8 A. Not that I'm aware of.

9 Q. Okay. Either by blood or marriage?

10 A. Correct.

11 Q. All right. And how are other people  
12 otherwise related?

13 A. We are not related. I have no  
14 relationship other than professional with them.

15 Q. So like none of their lawyers are your  
16 kids' godfathers or parents, and you are not theirs  
17 and all that?

18 A. That's correct.

19 Q. Have any of the cases in which you have  
20 consulted been, as you would consider it, similar to  
21 the case involving Mrs. Kostelnik?

22 A. You **know**, I do surgical consultation  
23 malpractice **cases**. So in that respect they are  
24 surgically related cases, but other than that, the  
25 similarity of a specific instance such **as** this

Page 15

1 occurring, no.

2 Q. Okay. And what would be similar to me  
3 would be a case involving a back surgery with a  
4 vascular complication and the sequelae.

5 A. No.

6 Q. None of those?

7 A. None of those cases I have done.

8 Q. Great. Have you ever had a license or  
9 hospital privilege suspended, denied, or revoked?

10 A. **No**,

11 Q. Have you ever been asked to leave a group  
12 practice?

13 A. A group practice?

14 Q. Yeah.

15 A. No.

16 Q. Let's see. I believe you are board  
17 certified in general surgery?

18 A. And recertified both.

19 Q. And did you pass on first attempt?

20 A. **Yes**.

21 Q. Do you teach medicine anywhere **at** this  
22 time?

23 A. **No**.

24 Q. Have you written anything in the medical  
25 literature that you consider to be pertinent to this

Page 16

1 case?

2 A. No.

3 Q. Okay. To be more specific now about this  
4 particular case, have you -- well, why don't you  
5 start by telling me what you have reviewed to enable  
6 you to express opinions in the case.

7 A. I have in front of me everything that I  
8 have reviewed. So if I could, could I just go  
9 through and list it?

10 Q. That's fine.

11 A. I have -- this is in no particular order,  
12 by the way. I have my **own** particular letter that I  
13 wrote dated August **16, 1996**. I have a letter,  
14 actually a summary, from Mr. Michael Michelson  
15 regarding our position, quote, unquote, in this  
16 matter that I have reviewed.

17 I have a letter from Dr. George  
18 Schoedinger, **S-c-h-o-e-d-i-n-g-e-r**, III, who I  
19 believe is an expert for your **firm** in this case. I  
20 have a letter from John **S.** Wilson, also an expert  
21 from California for your **firm**.

22 Then I have the depositions of Dr. Mark  
23 Grady, Dr. John Wilson, Nurse Jo Ann Mitchell,  
24 Dr. Eric Rothfusz, **R-o-t-h-f-u-s-z**, Dr. George  
25 Schoedinger, Nurse Joseph DeCaro, Nurse John **Van**

Page 17

1 Deventer, a deposition also of Dr. Stephen Helper  
2 and Dr. Michael Bolesta, Dr. George Anton, and **the**  
3 office records regarding Mrs. Kostelnik of  
4 Dr. Stephen Helper, and then the chart from Meridia  
5 Hillcrest Hospital dated **4-26-94** regarding  
6 **Mrs.** Kostelnik.

7 Q. Okay. Have you reviewed any of the  
8 coroner's office materials, photographs, or the  
9 autopsy report?

10 A. No.

11 Q. Okay.

12 A. Well, the autopsy report I said something  
13 about, and I didn't see any photographs or the  
14 actual report, **per se**.

15 Q. Okay. Do you plan to review any  
16 additional materials before testifying?

17 A. **Unless** they are provided to me.

18 Q. But you haven't asked that any be  
19 provided that you think might be necessary at this  
20 point?

21 A. That's correct.

22 **MR. BONEZZI:** I will make the same  
23 representation everybody has; that is, if he  
24 receives any further information and that causes an  
25 addition to his opinions or deletes them, I will

Page 18

1 notify you so you have the opportunity to ask him  
2 further questions.

3 MR. SCHARON: Okay.

4 Q. Clearly some of the materials which  
5 you've just listed for us you received after your  
6 report of August of 1996 because some of those  
7 depositions weren't taken until later. Did any of  
8 the additional information which came to you cause  
9 you to make or change any of the opinions that you  
10 hold in the case?

11 A. No, they did not.

12 Q. Okay. Did they cause you to formulate  
13 any additional opinions which are not contained in  
14 your report?

15 A. Not really.

16 Q. Okay. Well, kind of? I don't mean to be  
17 flip about that.

18 A. I understand.

19 Q. But that really suggests something.

20 A. Any additional opinions, no. My opinions  
21 are still the same. They haven't really changed.  
22 They have reinforced **some** of my opinions that were  
23 provided in this report.

24 Q. All right. Have you reviewed any medical  
25 literature in preparation for this case?

Page 19

1 A. **No.**

2 Q. Do you know any of the doctors, nurses,  
3 or experts in the case?

4 A. **Yes.**

5 Q. Who?

6 A. I know Dr. Anton. I did practice at the  
7 Hillcrest Hospital before leaving Cleveland, so I  
8 professionally have known most of the people  
9 involved in this patient's care with the exception  
10 of Dr. Helper, who I never did meet that I'm aware  
11 of. But the nurses, the nurse anesthetist, the  
12 anesthesiologists, the vascular surgeon, I'm  
13 familiar with them all.

14 Q. Okay. Did you form any conclusions of  
15 your own concerning the competency of those folks  
16 that you worked with at Hillcrest?

17 A. When?

18 MR. BONEZZI: As it relates to this  
19 case?

20 MR. SCHARON: No, during the time he  
21 worked with them and as a result of having worked  
22 with them.

23 A. I thought they were all competent.

24 Q. Okay. Did you form any opinions as a  
25 result of your working with them at Hillcrest

Page 20

1 Hospital concerning their truthfulness or lack of  
2 truthfulness?

3 A. **No.**

4 MR. BONEZZI: Objection.

5 Q. Have you been called upon in your  
6 practice to respond to the emergency which occurred  
7 in this case, that being damage to an iliac artery  
8 and vein during a back surgery?

9 A. Not during a back surgery, but during  
10 other surgeries, **yes.**

11 Q. During what surgeries --

12 A. **Usually --**

13 Q. -- did your experience take place?

14 A. I'm sorry. Usually it would be  
15 gynecologic procedures when laparoscopic injuries  
16 occurred to these vessels. It's a similar type of  
17 an injury **as** the retroperitoneal structures being  
18 damaged. I believe, I think there might have been  
19 an orthopedic injury. That was not **during** a  
20 posterior approach but was an anterior approach,  
21 many years ago, but a similar kind of injury again.

22 Q. All right. How many times has that  
23 occurred in your practice or experience?

24 A. Maybe three times or something of that  
25 nature.

Page 21

1 Q. And were you called in at some point  
2 during the primary operation to deal with the  
3 complication that had arisen?

4 A. **Yes.**

5 Q. And do you recall what happened in those  
6 cases?

7 A. No, to be honest. I believe they all  
8 survived, but I really can't remember the specifics.

9 Q. Do you think any of them involved  
10 transection of the iliac artery and laceration of  
11 iliac vein?

12 A. **Yes.** I don't know. I don't know if it  
13 was complete transection of the artery or a major  
14 laceration of both the artery and, of course, the  
15 vein.

16 Q. You think, you said, the patient  
17 survived?

18 A. That's my recollection for all three  
19 **cases, yes.**

20 Q. Okay. Do you have any recollection about  
21 the timing of your intervention following the damage  
22 to those blood vessels?

23 A. Only in that, once it was recognized and  
24 there was a problem arising, I was called. So the  
25 time would be, peri-injury, 10 minutes, give or

Page 22

1 take.  
2 Q. Okay. So you **think** it was within the  
3 area of 10 minutes from injury or --  
4 A. From the time of recognition.  
5 Q. From recognition. **As** I understand,  
6 recognition of the injury can follow sometime after  
7 the actual injury itself?  
8 A. Oh, yes, **as** in this case.  
9 Q. Okay. Do you think in any of those cases  
10 involving the transection of the iliac artery and  
11 laceration of the vein, your intervention took place  
12 as much as 20 to 23 minutes after recognition?  
13 A. **20 to 23?**  
14 Q. Yes.  
15 A. Not **24?** 23?  
16 Q. Somewhere in that range.  
17 A. I don't mean to be facetious.  
18 Q. Was it 25?  
19 A. It's possible, from recognition.  
20 Q. Right. Okay. But as to any particular  
21 recollection --  
22 A. I really don't. The most recent, I  
23 think, was maybe six or seven years ago.  
24 Q. Okay. How do you square your experience  
25 in those cases with the opinion that you are

Page 23

1 expressing in the case involving Mrs. Kostelnik,  
2 that a delay in her case of even as much as 10 or  
3 15 minutes had no result -- had no consequences in  
4 the result?  
5 A. They seem to square very nicely.  
6 Q. Tell me how.  
7 A. Well, I don't think that time in these  
8 retroperitoneal injuries becomes the major factor **as**  
9 long **as** there is no exsanguination to the peritoneal  
10 cavity and there is tamponading taking place. And  
11 if the patient is reasonably stable, hasn't  
12 sustained cardiac compromise, under control of  
13 anesthesia conditions, there really is some leeway  
14 that's available to get to the patient and control  
15 the injuries, **as** actually happened in the **cases** I'm  
16 speaking to in my own experience.  
17 Q. That's not true in the situation in which  
18 Mrs. Kostelnik found herself?  
19 A. That is true in Mrs. Kostelnik's  
20 situation. That's what I'm saying.  
21 Q. Okay. So there is some time to deal with  
22 things?  
23 A. A little bit of time, yes.  
24 Q. Okay. How much time is there before the  
25 patient goes past the point where it's likely that

Page 24

1 he or she will survive?  
2 A. It's impossible to say. It's all  
3 individual. I think you have a young person, such  
4 as Mrs. Kostelnik, who basically is healthy,  
5 tremendous amount of cardiac reserve, tremendous  
6 amount of pulmonary reserve.  
7 Just the organism, the young organism,  
8 the human organism is tremendously resilient, and  
9 even though placed under tremendous strain, with  
10 their hemodynamic and physiologic parameters, the,  
11 can, in fact, survive for very long periods of time,  
12 hours even, in an extreme situation.  
13 **Where** somebody, for instance, who is  
14 older doesn't have the cardiac reserves, doesn't  
15 have the pulmonary reserve, physiologic responses  
16 for reasons such **as** atherosclerosis or other  
17 debilitating problems. Those individuals don't have  
18 that luxury of time, and many will succumb to their  
19 injuries sooner, so it's a very dependent thing.  
20 Q. Do I understand fairly, then, that  
21 Mrs. Kostelnik was in, if you will, the optimum  
22 position to survive something like that given that  
23 she was younger and relatively healthy?  
24 A. You would think so.  
25 Q. Okay. So why was it that she didn't?

Page 25

1 A. She sustained a fatal injury. Some  
2 injuries are fatal, and that's the point I'm trying  
3 to make.  
4 Some people, you can go for long periods  
5 of time with the younger age, even older age, but  
6 mostly the younger people. Soldiers on the  
7 battlefield who are shot lie there, and they do  
8 well. Some people will sustain an injury that, for  
9 whatever reason, they can't sustain, and they die.  
10 So physiology has a lot to do with it.  
11 But again, in general, in response to your question,  
12 you would think Mrs. Kostelnik was in a position to  
13 survive her injury vis-a-vis other people who are  
14 not physiologically as healthy **as** she.  
15 Q. Okay. There has been some talk in the  
16 depositions -- you may have seen it. I don't know.  
17 You didn't review literature, so I'm not sure that  
18 you are familiar with it.  
19 But the statement has been made that as  
20 many as perhaps 75 percent of patients in  
21 Mrs. Kostelnik's situation survive that damage. Is  
22 that a familiar statistic to you? Does that make  
23 sense?  
24 A. It's not a familiar statistic, but it's  
25 basically what I just said. It makes sense in

Page 26

Page 28

1 Mrs. Kostelnik's situation, age, physiologic  
2 condition, et cetera.

3 Q. All right. Do you have any opinion as to  
4 why -- I assume that by definition, then, she is in  
5 the 25 percent of people who don't survive?

6 A. Right.

7 Q. And do you have any opinion as to why she  
8 is in that 25 percent?

9 A. The only thing I can think of is that she  
10 physiologically sustained something that caused her  
11 heart to stop, whether there was electrical  
12 problems, whether there was fluid electrolyte  
13 problems during resuscitation. Those would be the  
14 answers I would come up with.

15 We had a woman who basically was  
16 hemodynamically pretty stable for the most part even  
17 during the time of her recognition of the injury,  
18 the brief minute or two when her pressure was at  
19 about 70, I believe, and then came back up. But  
20 more importantly, she had been salvaged, if you  
21 will, according to Dr. Anton's note in deposition,  
22 to the point where he was calling for someone to  
23 take a picture. Then all of a sudden her heart  
24 stopped.

25 That's the analytical type of events.

1 necessarily.

2 Q. Am I right, then, in taking from your  
3 comments that you don't think that Mrs. Kostelnik  
4 died because of a volume problem?

5 A. Correct. I think her volume ~~was~~ probably  
6 pretty well up to snuff.

7 Q. Right. And we can take that from  
8 Dr. Anton's description of the vein after being  
9 repaired, bulging and bleeding?

10 A. Yeah.

11 Q. And her blood pressure and pulse  
12 returning to normal?

13 A. And the anesthesiologist's record  
14 indicated she had been given a large volume of  
15 fluid, and that's partially or probably the major  
16 reason her pressure and pulse revived.

17 Q. I take it, also, from your comments,  
18 then, that you would agree that Mrs. Kostelnik died  
19 because of the transection of the iliac artery and  
20 the laceration of the iliac vein?

21 A. As a result of?

22 Q. Yes, as a result of.

23 A. As the coroner's report would go, death  
24 probably secondary to cardiac arrest ~~as~~ a result of  
25 fluid instability ~~as~~ a result of transection of the

Page 27

Page 29

1 And I have to assume, and this is again in reference  
2 to your question, that something happened during  
3 that resuscitation with the fluids, that the  
4 electrolyte situation probably changed.

5 Q. Would you think that the fact that up  
6 until half past 3:00 of that afternoon she hadn't  
7 been given any whole blood products, that that was a  
8 factor in this, the imbalance, as you are referring  
9 to it?

0 A. I don't think it's the blood products  
1 more than it is the crystalloid that was being  
2 given. As I said, you can -- I have patients who  
3 walk into my office with blood counts of six grams,  
4 five grams, which is easily less than half of their  
5 blood volume, easily less than half, and they walk  
6 in the office. They feel fine except a little  
7 tired.

8 So I don't think the blood products,  
9 per se, was the issue here, and that's my opinion ~~as~~  
0 a surgeon.

1 Q. If she had been receiving blood products,  
2 would she have been getting less of the crystalloid?

3 A. It's hard to say. It depends on what her  
4 pressure would be doing and how fast they get the  
5 blood products in. Not necessarily, no. Not

1 vessels.

2 Q. Right. Okay. I just wanted to be sure I  
3 was clear, that it does all come back to that,  
4 though, as the starting point.

5 A. Of course.

6 Q. Okay. ~~Is~~ there any doubt in your mind  
7 but that the damage to those blood vessels occurred  
8 during the disk removal surgery?

9 A. No doubt.

10 Q. Okay. Is there any doubt but that it  
11 occurred or was caused by that -- the damage to the  
12 blood vessels was caused by instruments in the hands  
13 of Dr. Helper?

14 A. Is that the plural?

15 Q. Or an instrument?

16 A. **Yes.**

17 Q. There is doubt in your mind?

18 A. No, no, there is no doubt it was an  
19 instrument that caused it.

20 Q. And an instrument in the hands of  
21 Dr. Helper?

22 A. Correct.

23 Q. Okay. Do you have an opinion as to what  
24 instrument it was?

25 A. **Yes.**



Page 30

1 Q. What's your opinion?  
2 A. It was the 11 blade scalpel.  
3 Q. Why do you say that?  
4 A. Because of the mechanism of the injury.  
5 **There is nothing in his hands that would have caused**  
6 a clean transection and clean linear laceration  
7 other than a blade. Not a retractor and certainly  
8 not a rongeur, **as** one of your experts points out.  
9 Q. Okay. When during the operation was  
0 Dr. Helper using the 11 blade scalpel?  
1 A. When he was cutting into the nucleus  
2 pulposus and getting down to the disk. I can  
3 probably find it in his operative report.  
4 Q. Okay.  
5 A. On Page 3 of Dr. Helper's operative  
6 report, the last paragraph, about two-thirds of the  
7 way down, it says, The disk space was localized with  
8 a spinal needle, then using a No. 11 blade, the  
9 posterior longitudinal ligament was opened in a  
0 star-shaped fashion.  
1 Q. Okay.  
2 A. That's when I think the injury occurred,  
3 right there.  
4 Q. Okay. Now, are you expecting to express  
5 any opinions about whether Dr. Helper's performance

Page 31

1 of the disk surgery met acceptable standards for an  
2 orthopedic surgeon?  
3 A. I mean, I feel that they did. If you **ask**  
4 me, I'll express that opinion.  
5 Q. The reason I ask is that your report says  
6 at the bottom of the first page and moving on to the  
7 second, I can state within a reasonable degree of  
8 medical probability that Dr. Helper did not perform  
9 any acts of negligence in treating this patient.  
0 Are you including in that his performance of the  
1 disk surgery?  
2 A. Yes.  
3 Q. Okay. Tell me, if you will, Doctor, what  
4 qualifies you to possess that, enables you to  
5 discuss standard of care for an orthopedic surgeon  
6 doing **disk** surgery?  
7 A. By virtue of my certification in surgery  
8 and having been around hospitals for 20-some years,  
9 If you are **asking** me do I do that  
0 operation, no. **Am** I an expert in that operation?  
1 No. But do I feel that somebody such **as** Dr. Helper  
2 does an operation according to certain standards, I  
3 believe he does by virtue of where he is operating  
4 and the credentials that he has to pass through to  
5 get to where he is, et cetera.

Page 32

1 Q. Can you explain for me how Dr. Helper in  
2 using the 11 blade scalpel in a requisitely careful  
3 manner, what is required of orthopedic surgeons in  
4 that situation, caused the damage to the iliac  
5 artery and vein?  
6 A. Anatomically the vessels lie right up  
7 against the disk space, contiguous to it, touching  
8 it, and, by the way, touching each other, **as** well,  
9 the artery and the vein. Almost sharing a common  
10 wall, if you will. And the distances involved in  
11 working in this area are measured in centimeters,  
12 even millimeters. So it's not difficult to  
13 understand how an injury such **as** this with **an** 11  
14 blade, which is a very pointed and sharp blade, **can**  
15 occur.  
16 This is, **as** I pointed out in my letter,  
17 unfortunate. It's obviously something you never  
18 want to have happen. You don't plan on it  
19 happening, but it is something that can occur. It's  
20 a complication, not, I feel, negligence. Negligence  
21 to me is you wantonly went in there. But I don't  
22 see that's what happened.  
23 Q. Well, according to Dr. Helper's operative  
24 report, he used the No. 11 blade to incise the  
25 posterior longitudinal ligament; correct?

Page 33

1 A. Correct.  
2 Q. Do you think he used it for anything  
3 else?  
4 A. I have no evidence of that, no.  
5 Q. Okay. So in order for him to have  
6 damaged these blood vessels with the No. 11 blade,  
7 which is your theory --  
8 A. Correct.  
9 Q. -- he would have had to penetrate with  
10 the blade through the posterior longitudinal  
11 ligament, through the disk space itself, through the  
12 anterior longitudinal ligament, and then make  
13 contact with the blood vessels?  
14 A. That's correct.  
15 Q. And his star-shaped incision in the  
16 posterior longitudinal ligament was on the right  
17 side of midline?  
18 A. Well, the disk involved supposedly is  
19 right-sided, but he -- if I'm not mistaken, he  
20 mobilized 80 or so percent of the disk, so it may  
21 not have been on the right; it may have been  
22 midline, across the midline.  
23 Q. I think he said he was approaching from  
24 the right side.  
25 A. But the star-shape implies longer than

Page 34	Page 36
<p>1 just a little bit. Again, we are dealing with very 2 small spaces here. We are dealing with centimeters, 3 half an inch. 4 Q. Okay. I didn't mean to interrupt. 5 A. That's okay. 6 Q. Is it half an inch from the right side of 7 the posterior longitudinal ligament lying over the 8 disk space to the anterior longitudinal ligament on 9 the left? 10 A. On the left? 11 Q. Uh-huh. 12 A. Probably more like an inch, I would 13 imagine. 14 Q. And wasn't it? 15 A. It depends on the individual. 16 Q. Yeah. Weren't the vessels that were 17 damaged in this case the left iliac artery and vein? 18 A. Yes. 19 Q. Okay. 20 A. But understand how they run. 21 Q. Well, tell me. 22 A. The left iliac vein crosses over from the 23 right side. So it has to traverse all the way over 24 to get there. The bifurcation of the aorta is 25 really central and somewhat to the left where the</p>	<p>1 norm? 2 A. No. 3 Q. Since you hold and have expressed 4 opinions about Dr. Helper's disk surgery, I think I 5 need to ask you some more questions about that 6 particular surgery. Is it the goal of the surgeon 7 while removing the disk material to stay within the 8 disk space with his instruments? 9 A. The goal? 10 Q. Yes. 11 A. I would assume that's correct. 12 Q. Okay. 13 A. Actually the goal is to remove the 14 herniated disk. 15 Q. Right. 16 A. And if the herniated disk is not in the 17 disk space, then I would assume maybe you are not 18 supposed to stay in the disk space. As I told you, 19 I'm not an expert in this operation, but it's -- the 20 common principles are pretty clear. 21 Q. Are you aware of whether or not there is 22 a recommended depth of instrument incursion into the 23 disk space while performing the surgery? 24 A. No. 25 Q. Do you think that the surgeon performing</p>
Page 35	Page 37
<p>1 disk spaces are. 2 But the distances involved are like 3 millimeters, centimeters. We are not dealing with 4 left and right. You think of left arm, right arm, 5 opposite ends of the body. We are dealing with 6 spaces, the difference between left and right are 7 literally millimeters. 8 Q. Have you looked at any films of 9 Mrs. Kostelnik? 10 A. No. 11 Q. Okay. Do you have an opinion as to what 12 the distance was from the location at which 13 Dr. Helper made his star-shaped incision to the 14 location of the iliac artery and vein? 15 A. My opinion is that it's probably going to 16 be like most people's, nothing dramatic, not more 17 than an inch or two maximum. It may be less, I 18 don't know, in this particular individual. But 19 anatomically speaking, that's what we are normally 20 dealing with. 21 Q. Okay. So assuming her to be within norm, 22 somewhere between an inch and two inches? 23 A. Perhaps, yes. 24 Q. Okay. Have you seen any evidence in this 25 case that Mrs. Kostelnik's anatomy was outside of</p>	<p>1 the disk surgery needs to be careful not to 2 penetrate the anterior/posterior -- the anterior 3 longitudinal ligament, excuse me? 4 MR. BONEZZI: Objection. 5 A. To be careful. It's prescribed in the 6 operation, yes. 7 Q. Would you agree that, if the surgeon 8 performing the discectomy doesn't go beyond the 9 anterior longitudinal ligament, then, absent some 10 anatomical abnormality, he will not compromise the 11 paravertebral vessels? 12 MR. BONEZZI: Objection to form of the 13 question. 14 A. The iliac vessels? 15 Q. Yes. 16 A. Yes. 17 Q. Okay. Are you critical of the other 18 people involved in Ms. Kostelnik's care -- 19 MR. BONEZZI: Critical -- 20 Q. -- in any way? 21 MR. BONEZZI: Critical such as that 22 somebody other than who has been sued plays a role 23 or contributed to the death? Is that what you 24 mean? 25 MR. SCHARON: Yeah. Well --</p>

Page 38

Page 40

1 MR. BONEZZI: You may answer.  
2 MR. SCHARON: -- or even somebody who has  
3 been sued, principals, a hospital employee.  
4 MR. BONEZZI: I understand,  
5 Q. I'm asking whether or not you have  
6 criticisms of the care rendered to Mrs. Kostelnik in  
7 this case by any of the other people involved in  
8 that care.  
9 A. I am somewhat critical of the anesthesia  
10 department's care of this patient, to be honest. I  
11 think that they could have done a better job.  
12 Q. Okay. Tell me what you mean by that.  
13 A. Well, I think that it was clearly their  
14 responsibility, they being the anesthesiologists  
15 involved and the nurses working for the anesthesia  
16 department specifically, it was their responsibility  
17 to monitor the patient's pressure. In fact, they  
18 were using what's called controlled hypotension  
19 during this case, so it became especially critical.  
20 I think, if there was hemodynamic  
21 instability in a patient such as Mrs. Kostelnik,  
22 they needed to know it, recognize it early, and to  
23 make sure it was treated expeditiously.  
24 I think once the injury was recognized  
25 and they did the appropriate measures of getting the

1 than perhaps anesthesia's role in resuscitating her.  
2 Q. Do you think if anesthesia had done what  
3 you think should have been done she would have  
4 survived?  
5 A. I think within a reasonable degree of  
6 medical probability, yes.  
7 Q. Okay. Tell me what you consider to be  
8 anesthesia services' failures.  
9 A. Basically I just feel that they didn't do  
10 a proper job in monitoring the patient  
11 perioperatively, as well as intraoperative during  
12 the resuscitation. The pressures were dropping,  
13 they were monitoring the -- they were controlling  
14 the blood pressure.  
15 I think they had to have a better handle,  
16 if possible, as to what was going on in that  
17 patient's abdomen -- or retroperitoneum, not  
18 abdomen. They didn't seem to have that until  
19 3:00 o'clock or five minutes before 3:00. Even then  
20 they didn't, as I pointed out.  
21 My feeling is, the injury took place much  
22 before that when he first cuts the posterior  
23 longitudinal ligament and penetrated the anterior  
24 ligament, as well.  
25 Q. What time do you think that was?

Page 39

Page 41

1 patient's abdomen exposed, it became their  
2 responsibility in running the resuscitation to make  
3 sure that Mrs. Kostelnik was being properly  
4 resuscitated.  
5 Her death, in my mind, is not explained  
6 by the events that took place. By that what I mean  
7 is that she was stable. In fact, to be honest, at  
8 no time during the case did I really see that she  
9 ever really was terribly unstable. There were a  
10 couple times when her pressure was in the 60s, but  
11 to be honest with you, we see that all the time in  
12 operations, for whatever reason, too much anesthetic  
13 agent; hypovolemia will do it, but it doesn't cause  
14 death.  
15 When Mrs. Kostelnik's injury had been  
16 controlled by Dr. Anton in an expeditious fashion,  
17 she was stable, her pressure was normal or  
18 relatively normal, her pulse rate had come down to a  
19 normal rate -- or gone up to a normal rate. And as  
20 I said, he actually had called for a camera to take  
21 a picture. I think he felt things were fine. And  
22 all of a sudden, the patient arrests and dies.  
23 To me, that's an electrolyte death,  
24 anesthetic type of death almost. There is no  
25 explanation in my mind to account for this other

1 A. Probably a half hour before. I think  
2 that they just didn't know what was going on. And  
3 that may not be necessarily their fault. I'm just  
4 saying, to me, this was what was going on.  
5 In other words, they were controlling her  
6 hypotension. She was hypotensive to begin with.  
7 They made her hypotensive. They wanted her  
8 hypotensive.  
9 When you are hypotensive and have a  
10 vascular injury in the retroperitoneum, if there's  
11 no exsanguination and if there's tamponading, not  
12 brisk bleeding, things stay stable for a significant  
13 period of time, as they probably did here.  
14 But once things started deteriorating,  
15 there seemed to be a tremendous amount of commotion  
16 in the operating room. They were losing a young  
17 woman, or they thought they were. There were  
18 anesthesiologists and nurses running in. They  
19 didn't seem to be an organized approach to a medical  
20 emergency, as I would think would be instituted.  
21 Q. And that's anesthesia's function  
22 exclusively?  
23 A. In that situation, absolutely.  
24 Q. Did you not gather from the records, what  
25 I'll describe and you may take issue with it, a

Page 42

Page 44

1 difference in the descriptions between Dr. Helper  
2 and Dr. DeCaro -- and Nurse DeCaro about when the  
3 call was made for vascular assistance?  
4 A. I have seen that mentioned in multiple  
5 depositions.  
6 Q. Okay. Do you read it as I have, that  
7 there is a discrepancy?  
8 A. Between those two individuals?  
9 Q. Between those two.  
10 MR. BONEZZI: Objection.  
11 Go ahead and answer.  
12 A. Perhaps you can tell me what you mean by  
13 discrepancy.  
14 Q. Well, I mean Dr. Helper says that  
15 vascular assistance was called for from 3 minutes  
16 after the hour until 13 minutes after the hour, and  
17 Mr. DeCaro has described in his note and also in his  
18 deposition --  
19 A. His note was written post facto.  
20 Q. And obviously his deposition was given  
21 post facto, but he has indicated that the call to  
22 Dr. Anton came at 13 minutes after the hour and --  
23 A. The 10-minute discrepancy?  
24 Q. And that's what I'm talking about,  
25 right.

1 you agree that that would be unacceptable?  
2 A. If he did wait?  
3 Q. Yes.  
4 A. Yes.  
5 Q. Okay. On the other hand, if he did not  
6 wait and at approximately 3 minutes after the hour  
7 gave the order for Dr. Anton to be called but that  
8 order wasn't carried out for 10 minutes, whose fault  
9 would that be?  
10 MR. BONEZZI: Objection.  
11 Go ahead and answer.  
12 A. Whoever supposedly ~~was~~ taking the order.  
13 Q. Okay. Either way, do I understand that  
14 it's your opinion that even if Dr. Anton had  
15 received the call at 3 minutes after the hour and I  
16 think responded along the same time line --  
17 A. As he did.  
18 Q. -- as he did later, it wouldn't have made  
19 any difference in the outcome?  
20 A. I believe that's correct.  
21 Q. That response is he would have been there  
22 6 minutes after the hour, opened by 11 minutes  
23 after, and would have controlled by 13 minutes  
24 after?  
25 A. Correct. I don't think it would have

Page 43

Page 45

1 A. If that's what they are saying, if they  
2 are disputing each other, I won't dispute their  
3 dispute. I don't know if it's a big issue. I'm not  
4 sure what the true time was.  
5 I believe Dr. Helper was told at around  
6 3:00 o'clock, you know, to close her quickly and  
7 turn her over. That I know is not in dispute. I  
8 don't believe that's in dispute. I haven't noted  
9 that.  
10 I also know that he claims, and no one  
11 disputed, that it took him two minutes to finish his  
12 closure and turn her over. I also believe that,  
13 according to his testimony, and there is nobody who  
14 has disputed that, that **as** soon **as** he turned her  
15 over, it was recognized that her abdomen **was**  
16 distended and, therefore, there was an abdominal  
17 injury or vascular-type injury, they surmised. I  
18 have no reason to dispute that.  
19 So given all those Facts, why would  
20 Dr. Helper wait **10** minutes to call?  
21 Q. Well, I don't know why, but --  
22 A. What I'm saying is, I don't think he did.  
23 Q. Well, let me ask this question of you.  
24 A. Okay.  
25 Q. If he did wait for that 10 minutes, would

1 made a difference.  
2 Q. Okay. Is there a time by which you think  
3 Jackie Kostelnik's chances of survival went from  
4 being better than 50-50 to less than?  
5 A. I don't think her chances ever were less  
6 than **50-50**, to be honest.  
7 Q. Okay.  
8 A. And, you know, **as** I said, this is one of  
9 those **25** percent or so that didn't make it. I think  
10 your own expert says, if it's one in a million, if  
11 you are that one, it's a hundred percent.  
12 Q. So are you saying that, if Dr. Anton  
13 had -- if this injury had been recognized and  
14 Dr. Anton had been called or some other --  
15 A. Vascular surgeon.  
16 Q. -- vascular surgeon had been called to  
17 make this repair at a quarter until 3:00, that it  
18 wouldn't have made any difference in the outcome?  
19 A. No, I'm not saying that. We are talking  
20 about this situation in this case.  
21 Q. You have said that you think the damage  
22 was done to the blood vessels at around a half  
23 hour --  
24 A. Around then.  
25 Q. -- before it was actually recognized?

Page 46

1 A. Correct.  
2 Q. So that would be around 2:30?  
3 MR. BONEZZI: Objection to the time.  
4 Q. What I'm asking is, if it took 15 minutes  
5 to recognize and 15 minutes to respond and get a  
6 vascular surgeon in there, do you think she would  
7 have survived?  
8 A. As I said, I think her chances would have  
9 been greater than 50-50 **as** it was when he did get  
10 there.  
11 Q. Do you think things would have come out  
12 differently for Mrs. Kostelnik now, aside from what  
13 the statistics, chances were?  
14 A. It depends. If she was resuscitated, if  
15 she **was** resuscitated the same way, no.  
16 Q. Tell me what it was about the  
17 resuscitation that you are critical of.  
18 A. I'm not so sure I'm critical of it. I'm  
19 just saying I believe her death was an electrical  
20 death. I believe her death was secondary to an  
21 electrolyte problem, potassium, too much, too little  
22 too much of a possible electrolyte that could cause  
23 electrical mechanical dissociation that I'm sure **was**  
24 **as** a result of the fluids administered during the  
25 resuscitation.

Page 47

1 They gave her ringer lactate. They gave  
2 her normal saline and eventually some blood  
3 products, as well, and I just believe that the  
4 combinations and the levels which were given led to  
5 this electrical mechanical dissociation and death.  
6 Q Just so I understand exactly what you  
7 mean by that, are you saying that the fluids that  
8 were given and the times at which they were given  
9 and the combinations in which they were given  
10 were -- that the way that was handled was not up to  
11 acceptable standards?  
12 A. No, I didn't say it wasn't up to  
13 acceptable standards.  
14 Q I'm trying to understand.  
15 A. I know. What I'm saying is, those fluids  
16 led to her arrest. Was it negligence? I don't  
17 believe so. But could it have been? It could have  
18 been. I don't really have an opinion on that one  
19 way or another, to be honest.  
20 I do know that I need to explain why  
21 Jackie Kostelnik was perfectly stable really  
22 throughout most of this episode with a couple  
23 notable exceptions that you all keep pointing out in  
24 the depositions, her pressure being **59** over 30,  
25 which to me is not so terribly unstable, immediately

Page 48

1 brought up, back up to **a** level that is certainly  
2 acceptable, **a** level she was running with the whole  
3 time, 100 or so, 90 something over 50 or 60.  
4 A patient who **was** perfectly stable, the  
5 arteries clamped, the venous repair effected, the  
6 picture is going to be taken, all of a sudden  
7 arrests and dies, I need to understand that and  
8 explain it. And the only thing that explains that  
9 to me is the fluid resuscitation and its  
10 administration in this particular case by the  
11 anesthesia department. That's what I have to say on  
12 that.  
13 Q. Some of the people that have been deposed  
14 in the case have said that, when Jackie Kostelnik's  
15 blood pressure dropped below a hundred and stayed  
16 there despite the administration of medications  
17 designed to bring it back up --  
18 A. Ephedrine.  
19 Q. Yes -- at five minutes until the  
20 hour --  
21 A. Correct.  
22 Q. -- that was an ominous sign. Do you  
23 agree?  
24 MR. BONEZZI: Objection.  
25 A. Ominous?

Page 49

1 Q. Yes.  
2 A. **No.**  
3 Q. That that was something about which  
4 Dr. Helper as the orthopedist should have been  
5 sensitive?  
6 MR. BONEZZI: Objection.  
7 A. Should have been sensitive?  
8 Q. Yes.  
9 A. He wasn't administering the anesthesia.  
10 Q. I understand. But when it was reported  
11 to him the blood pressure had dropped, that's  
12 something that should have been important to him?  
13 A. I'm sure it was.  
14 Q. And would you agree that presumably,  
15 knowing that damage to the blood vessels is a  
16 possibility during this surgery, that when the blood  
17 pressure dropped below a hundred and stayed there  
18 despite the effects --  
19 A. Stayed there for how long?  
20 Q. Well, you tell me. I don't think it came  
21 back up until after Dr. Anton came on the scene and  
22 got control.  
23 A. That's not my understanding.  
24 MR. BONEZZI: That's incorrect.  
25 A. My understanding is, it came back up to

Page 50

Page 52

1 the 90-some level within five minutes. Well, we  
2 have the operative report. **Do you have the**  
3 **anesthesia record there?**

4 MR. BONEZZI: Uh-huh.

5 THE WITNESS: I don't think I have a copy  
6 of that, for some reason.

7 MR. BONEZZI: Here, then it goes up  
8 here.

9 A. So here she's running around a hundred,  
10 then she at -- let me get -- it's not good insofar  
11 **as** my eyesight is concerned. It drops down for  
12 about a period of **5** minutes, I can see here,  
13 10 minutes, then it's back up to around **90**, then  
14 it's back up to around **95**.

15 Q. Tell me what time it's back up to 90. I  
16 want to make sure **I'm** looking at the right time.

17 A. I don't know if it's the same one you are  
18 looking at.

19 Q. This one?

20 A. Yes, back up there.

21 Q. Quarter after?

22 A. **Yes**, that is quarter after.

23 Q. Well, I'm looking at this time now.

24 A. **1500**, so that would be **1515**, that's  
25 correct.

1 Q. Yeah. You mean in the containers?

2 A. Yeah, yeah. Then there were sponges and  
3 stuff like that, so I would assume the blood loss  
4 would be in the neighborhood -- there shouldn't be a  
5 whole lot **of** blood in the belly at all because the  
6 **retroperitoneum**, per se, is not in the abdomen, it's  
7 retroperitoneal. You would have leaking but  
8 wouldn't have blood until you open.

9 And Dr. Anton, the blood he sucks out,  
10 scrapes out that is clotted and the blood that's in  
11 the drapes, ail added together, I would say probably  
12 in the neighborhood of **25, 26, 2700** cc's of blood.

13 Q. I thought he indicated that, after he  
14 opened the peritoneum, he was pawing down through a  
15 lot of hematoma.

16 A. He got through the retroperitoneum.  
17 That's the only way he could.

18 Q. You think that amount was 2600 or 2700  
19 **CCS**?

20 A. In addition.

21 Q. Because in addition --

22 A. Because a lot **of** that blood is in the  
23 sucker, too. A lot of that blood is in the sucker,  
24 also.

25 Q. Does that volume of blood loss tell you

Page 51

Page 53

1 Q. Okay. There's 30.

2 A. It's going up here at this point in time,  
3 so this is the only point. Here it's 90, now it's  
4 down here. As I said, this is the **59** or **60** they  
5 talk about.

6 MR. BONEZZI: 3:10?

7 THE WITNESS: Yeah.

8 A. That's the one we are missing right  
9 there. See that? So around 3:10 it's already way  
10 up, then down to **90** again. This little drop for  
11 **five minutes is inconsequential, when she drops down**  
12 that one time and she comes right back up with  
13 ephedrine, I imagine, and the fluid they gave her,  
14 we see that all the time, almost daily doing  
15 surgery, pressure fluctuations such **as** that.  
16 **Dr. Helper should not have been worried about blood**  
17 **loss at this point.** That should be one of the  
18 furthest things from his mind actually with that  
19 pressure curve.

20 Q. Have you reached any conclusion or tried  
21 to figure out how much blood loss Jackie Kostelnik  
22 sustained before the flow was stopped either by  
23 tamponade or ultimately by Dr. Anton?

24 A. By Dr. Anton, I think, right. Dr. Anton,  
25 I believe, records a 2,000 cc blood loss.

1 anything about when it likely occurred?

2 A. No. I know when it occurred.

3 Q. If you are right about what it was caused  
4 by.

5 A. I see nothing that tells me I'm wrong.  
6 Of course, if I'm right. I assume I'm right.

7 Q. I've already done a lot of these. I'm  
8 just checking them off.

9 A. That's okay.

10 Q. Your report refers to disk removal  
11 surgery as a difficult procedure. What makes it so?

12 A. It's a major procedure being done by an  
13 orthopedic surgeon. "Difficult" might be the wrong  
14 word. It's an involved procedure.

15 Q. How about easy?

16 A. No. "Easy" is not the right word,  
17 either. Involved, complicated, complex. Difficult  
18 when compared to things like setting a bone, like an  
19 orthopedic surgeon does.

20 Q. Well, irrelative of what word you chose  
21 to put in the report, what did you mean?

22 A. I mean complicated, complex, requiring a  
23 great deal of expertise.

24 Q. Okay. Would you think that it also  
25 requires a great deal of practice?

Page 54

Page 56

1 MR. BONEZZI: Objection.  
2 A. My feeling on this is that, if you have  
3 gone through a residency program specifically in  
4 orthopedic surgery, it's accredited, as his was at  
5 Luke's Hospital, Clyde Nash I believe was the  
6 program director, who is an outstanding back  
7 surgeon, my feeling is that anybody coming out of  
8 that program doing that operation is more than  
9 qualified.  
10 Q. For the rest of their life?  
11 A. For the rest of their life as long as  
12 they are doing it.  
13 Q. How often do they have to do it to  
14 maintain their competency?  
15 A. I have no opinion on that.  
16 Q. Do you think really that doing this  
17 surgery or doing disk surgery three times a year is  
18 enough to maintain competency at this complicated  
19 procedure?  
20 A. No opinion.  
21 Q. So is it your opinion, then, that until  
22 Dr. Anton -- or I'm sorry, until Dr. Helper observed  
23 and palpated Jackie Kostelnik's abdomen, there was  
24 no reason for him to have suspected blood loss?  
25 A. Dr. Helper?

1 Q. Have you seen blood vessels, iliac blood  
2 vessels, that have been damaged by rongeurs?  
3 A. Yes.  
4 Q. What do they look like?  
5 A. Like somebody took a bite out of them,  
6 like an actual defect in the wall.  
7 MR. SCHARON: That's not coaching.  
8 THE WITNESS: What's that?  
9 MR. SCHARON: I heard Mr. Bonezzi sighing  
10 over here.  
11 Q. Is it your testimony that the only  
12 instrument used by Dr. Helper that could have caused  
13 the damage described in the records you have seen is  
14 the scalpel?  
15 A. Within a reasonable degree of  
16 probability, yes.  
17 Q. Are you familiar with this thing that's  
18 been called a hockey stick penfield?  
19 A. Depends. What, a retractor?  
20 Q. I've never heard it called a retractor.  
21 You are adding that into the mix. Is it a  
22 retracror?  
23 A. Basically it's to retract the material  
24 around the disk space, also to use on -- it is a  
25 wedging device, at least that's the way it was used

Page 55

Page 57

1 Q. Dr. Helper. I think I went back and  
2 corrected. I hope I did.  
3 A. Correct, there was no reason to.  
4 Q. Okay.  
5 A. Well, let me back up real quick. There  
6 was reason when the anesthesiologist said to close  
7 the abdomen and turn her over. I think at that  
8 point they were all thinking about it. And that was  
9 before he palpated the abdomen, so that would be  
10 around 3:00 o'clock.  
11 Q. Okay. Fair enough. I understand that.  
12 At that point, that is when he was told to close her  
13 up and turn her over, do you think that Dr. Helper  
14 should have presumed that there was a blood loss  
15 problem?  
16 A. No. He should have presumed that there  
17 was a problem. They wanted the belly evaluated for  
18 whatever reason. They could have perforated the  
19 bowel, for all we know, that is by penetrating into  
20 the anulus with the rongeur. There's other reasons  
21 to have hypotension, such as peritonitis, shock,  
22 et cetera, et cetera, other than transection of  
23 blood vessels. What he had to assume is what he  
24 assumed, this belly has to be looked at, and he  
25 expeditiously did that.

1 here. I am not familiar with it, per se. I think I  
2 have seen it, but I'm not sure exactly which one it  
3 is we are talking about.  
4 Q. Okay. Given that, what is it that allows  
5 you to conclude that that could not have caused the  
6 damage to the vessels?  
7 A. You know, I think the description is in  
8 there by Dr. Helper, in his deposition, also, that  
9 points that out. It's not a sharp instrument; it's  
10 a blunt instrument. It's not used as a cutting  
11 device. There is nothing about this thing that  
12 would really make you -- I just can't imagine how it  
13 could cut an iliac artery.  
14 An iliac artery is a tough structure,  
15 muscular layers on it. It's got a surrounding  
16 envelope, and the tissue is pretty strong tissue,  
17 especially in a younger woman. To cut it with a  
18 blunt instrument like that, so clean a cut, then a  
19 longitudinal clean laceration of the vein, it just  
20 wouldn't happen unless there was a really clean,  
21 sharp instrument. And that is the 11 scalpel blade.  
22 Q. The bottom line for you is that, even if  
23 Dr. Helper did damage these iliac vessels with the  
24 No. 11 scalpel, which he was using to incise the  
25 anulus --

Page 58

1 A. **Right.**  
2 Q. -- that that does not mean that he wasn't  
3 being careful enough during the surgery?  
4 MR. BONEZZI: Could you rephrase that?  
5 There's too many double negatives.  
6 Q. There may have been two or three. I'll  
7 try to rephrase it.  
8 If Dr. Helper, indeed, damaged these  
9 iliac vessels using the No. 11 scalpel to make his  
10 star-shaped incision in the anulus, that's not  
11 evidence to you of a lack of care?  
12 A. **Correct.**  
13 Q. Would you defer on that point to  
14 orthopedic surgeons who have performed the  
15 procedure?  
16 A. **Defer?**  
17 Q. Yes.  
18 A. **No.**  
19 Q. So you know as much as them about this?  
20 A. **I know about as much as them about how to**  
21 **use a knife blade and what can happen in doing these**  
22 **delicate operations, yes.**  
23 Q. Okay.  
24 A. **Are we done?**  
25 Q. We are done.

Page 59

1 MR. BONEZZI: Jim, do you have any  
2 questions?  
3 MR. MALONE: I've got to be honest, this  
4 has been hard to hear. I think the doctor has one  
5 of those mics that picks up when you start talking.  
6 So no, I guess I don't. I guess I heard enough of  
7 it that I won't clutter up the record because I  
8 don't want to misstate.  
9 MR. BONEZZI: That would be good.  
10 MR. MALONE: Bill, give me a ring. Are  
11 you done now?  
12 MR. BONEZZI: Yeah.  
13 MR. MALONE: Bill, when you're back, give  
14 me a ring.  
15 MR. BONEZZI: Okay.  
16 MR. MALONE: And we'll talk about  
17 transcript, all that stuff.  
18  
19 (The deposition was concluded at 1:38.  
20 Signature was waived.)  
21  
22  
23  
24  
25

Page 60

1 **CERTIFICATION**  
2 \* \* \* \* \*  
3 **BE IT KNOWN** that I, Lisa Erwin, took the  
4 foregoing deposition at the time and place stated in  
5 the caption hereto; that I was then and there a  
6 Notary Public in and for the State of Arizona; that  
7 by virtue thereof I was authorized to administer an  
8 oath; that the witness, Howard Charles Pitluk, **M.D.**,  
9 before testifying was first duly sworn to state the  
10 truth; that the testimony of said witness was  
11 reduced to writing under my direction; and that the  
12 foregoing 59 pages contain a full, true and accurate  
13 transcription of my notes of said deposition.  
14 **I FURTHER CERTIFY** that I am not of counsel nor  
15 attorney for either or any of the parties to said  
16 cause or otherwise interested in the event thereof;  
17 and that I am not related to either or any of the  
18 parties to said action  
19 **IN WITNESS WHEREOF**, I have hereunto subscribed  
20 my name and affixed my seal of office this 24th day  
21 of April 1997.  
22  
23 .....  
24 **LISA ~ WENne, LISA ERWIN, NOTARY PUBLIC**  
25 My Commission Expires: 6/15/98



# WORD INDEX

<b>-&amp;-</b>			<b>-4-</b>			56:6			37:9 40:23		
& [5]	1:21	2:3	4 [1]	3:7		added [3]	5:24	6:1	anterior/posterior [1]		
2:7	2:11	13:25	4-26-94 [1]	17:5		52:11			37:2		
<b>-1-</b>			40 [2]	8:24	11:8	adding [1]	56:21		Anton [14]	17:2	19:6
10 [8]	10:15	21:25	<b>-5-</b>			addition [3]		17:25	39:16	42:22	44:7
22:3	23:2	43:20	5 [2]	8:15	50:12	52:20	52:21		44:14	45:12	45:14
43:25	44:8	50:13	50 [1]	48:3		additional [4]		17:16	49:21	51:23	51:24
10-minute [1]		42:23	50-50 [3]	45:4	45:6	18:8	18:13	18:20	51:24	52:9	54:22
100 [1]	48:3		46:9			address [3]		4:11	Anton's [2]		26:21
100-101 [1]		2:19	520 [2]	1:24	1:25	4:12	12:25		28:8		
11 [11]	30:2	30:10	59 [3]	47:24	51:4	administer [1]		60:7	anulus [3]	55:20	57:25
30:18	32:2	32:13	60:12			administered [1]		46:24	58:10		
32:24	33:6	44:22	<b>-6-</b>			administering [1]		49:9	aorta [1]	34:24	
57:21	57:24	58:9	6 [1]	44:22		administration [2]		48:10	aortic [1]	8:1	
12:29 [1]	2:23		6/15/98 [1]	60:25		48:16			appearances [2]		9:12
13 [3]	42:16	42:22	60 [3]	11:8	48:3	affixed [1]	60:20		9:14		
44:23			51:4			afternoon [1]		27:6	Appearing [1]		2:14
1309 [1]	1:22		60s [1]	39:10		again [5]	20:21	25:11	appreciate [1]		5:22
14 [1]	1:15		523-1681 [1]	1:25		27:1	34:1	51:10	approach [3]		20:20
14th [1]	2:22		<b>-7-</b>			against [2]	12:11	32:7	20:20	41:19	
15 [5]	8:23	9:15	70 [1]	26:19		age [3]	25:5	25:5	approaching [1]		33:23
23:3	46:4	46:5	75 [2]	11:4	25:20	26:1			appropriate [1]		38:25
1500 [1]	50:24		<b>-8-</b>			agent [1]	39:13		April [3]	1:15	2:22
1515 [1]	50:24		80 [1]	33:20		ago [5]	7:12	7:14	60:21		
16 [1]	16:13		135719-5824 [1]	1:23		13:16	20:21	22:23	area [3]	11:17	22:3
16th [1]	5:18		1384-9041 [1]	1:24		28:18		37:7	32:11		
1925 [2]	2:19	4:14	<b>-9-</b>			44:1	48:23	49:14	arisen [1]	21:3	
1996 [2]	16:13	18:6	90 [5]	48:3	50:13	ahead [2]	42:11	44:11	arising [1]	21:24	
1997 [3]	1:15	2:23	50:15	51:3	51:10	al [2]	1:5	1:7	Arizona [9]		1:16
60:21			90-some [1]	50:1		allows [1]	57:4		2:21	2:22	4:14
1:38 [1]	59:19		95 [2]	8:14	50:14	almost [3]	32:9	39:24	6:4	7:2	7:10
<b>-2-</b>			<b>-A-</b>			51:14			7:10	60:6	
2,000 [1]	51:25		abdomen [8]	39:1		along [1]	44:16		arm [2]	35:4	35:4
20 [2]	22:12	22:13	40:17	40:18	43:15	always [1]	7:10		arrangements [1]		7:13
20-some [1]		31:18	52:6	54:23	55:7	amount [4]		24:5	arrest [2]	28:24	47:16
23 [3]	22:12	22:13	55:9			24:6	41:15	52:18	arrests [2]	39:22	48:7
22:15			<b>-3-</b>			analytical [1]		26:25	arterial [1]		8:2
24 [1]	22:15		3 [4]	30:15	42:15	anatomical [1]		37:10	arteries [1]		48:5
24th [1]	60:20		30 [3]	8:24	47:24	anatomically [2]		32:6	artery [13]	8:8	20:7
25 [5]	22:18	26:5	51:1			35:19			21:10	21:13	21:14
26 8	45:9	52:12	3:00 [6]	27:6	40:19	anatomy [1]		35:25	22:10	28:19	32:5
26 [1]	52:12		55:10			anesthesia [8]		23:13	32:9	34:17	35:14
2600 [1]	52:18		3:10 [2]	51:6	51:9	38:9	38:15	40:2	57:13	57:14	
2700 [2]	52:12	52:18	<b>-3-</b>			40:8	48:11	49:9	side [1]	46:12	
290775 [1]	1:8		3 [4]	30:15	42:15	50:3			ssistance [2]		42:3
2:30 [1]	46:2		44:6	44:15		anesthesia's [2]		40:1	42:15		
<b>-3-</b>			30 [3]	8:24	47:24	41:21			Associates [1]		1:21
3 [4]	30:15	42:15	51:1			anesthesiologist [1]	55:6		assume [8]	11:25	26:4
44:6	44:15		3:00 [6]	27:6	40:19	anesthesiologist's [1]		28:13	27:1	36:11	36:17
30 [3]	8:24	47:24	55:10			anesthesiologists [3]		19:12	52:3	53:6	55:23
300 [6]	27:6	40:19	<b>-3-</b>			19:12	38:14	41:18	assumed [1]		55:24
40:19	43:6	45:17	3 [4]	30:15	42:15	anesthetic [2]		39:12	assuming [2]		14:6
55:10			44:6	44:15		39:24			35:21		
3:10 [2]	51:6	51:9	51:1			anesthetist [1]		19:11	atherosclerosis [1]		24:16
<b>-3-</b>			3:00 [6]	27:6	40:19	aneurism [1]		8:1	attempt [1]		15:19
3 [4]	30:15	42:15	55:10			Ann [1]	16:23		attorney [1]		60:15
44:6	44:15		<b>-3-</b>			answer [3]	38:1	42:11	attorneys [3]		9:17
30 [3]	8:24	47:24	3 [4]	30:15	42:15	44:11			9:22	10:11	
51:1			44:6	44:15		answers [1]		26:14	August [3]	5:18	16:13
3:00 [6]	27:6	40:19	51:1			anterior [6]		20:20	18:6		
40:19	43:6	45:17	3:10 [2]	51:6	51:9	33:12	34:8	37:2	authorized [1]		60:7
55:10			<b>-3-</b>			<b>-3-</b>			autopsy [2]		17:9
3:10 [2]	51:6	51:9	3 [4]	30:15	42:15	<b>-3-</b>			<b>-3-</b>		

17:12		54:1	56:9	58:4	centimeters [3]	32:11	complaint [1]	12:25
available [1]	23:14	59:1	59:9	59:12	34:2 35:3		complete [2]	5:8
aware [3]	14:8 19:10	59:15			central [1]	34:25	21:13	
36:21		Bonezzi's [1]	11:2		certain [2]	2:24	complex [2]	53:17
AZ [1]	1:23	born [1]	7:4		certainly [2]	30:7	53:22	
<b>-R-</b>								
B [1]	3:9	bottom [2]	31:6	57:22	certification [1]	31:17	complicated [3]	53:17
battlefield [1]	25:7	bowel [2]	7:24	55:19	certified [1]	15:17	53:22 54:18	
became [2]	38:19 39:1	brain [1]	8:4		CERTIFY [1]	60:14	complication [3]	15:4
becomes [1]	23:8	break [3]	8:10 8:22		cetera [4]	26:2 31:25	21:3 32:20	
begin [1]	41:6	brief [1]	26:18		55:22 55:22		compromise [2]	23:12
behalf [2]	10:19 13:6	bring [1]	48:17		chances [4]	45:3	37:10	
behind [1]	6:17	brisk [1]	41:12		45:5 46:8	46:13	concerned [1]	50:11
belabor [1]	5:5	broader [1]	12:9		change [1]	18:9	concerning [2]	19:15
belly [3]	52:5 55:17	Broadway [1]	1:22		changed [2]	18:21	20:1	
below [2]	48:15 49:17	brought [1]	48:1		27:4		conclude [1]	57:5
better [3]	38:11 40:15	building [1]	6:17		Charles [6]	1:14	concluded [1]	59:19
45:4		bulging [1]	28:9		2:17 3:1 4:1		conclusion [1]	51:20
between [7]	9:2	bypass [2]	8:2 8:8		4:10 60:8		conclusions [1]	19:14
11:6 35:6 35:22		<b>-C-</b>			chart [1]	17:4	condition [1]	26:2
42:1 42:8 42:9		C [4]	2:1 2:18		CHATTMAN [1]	2:3	conditions [1]	23:13
beyond [1]	37:8	60:1 60:1			checking [1]	53:8	consequences [1]	23:3
bifurcation [1]	34:24	California [1]	16:21		chest [3]	8:4 8:4	consider [3]	14:20
big [1]	43:3	camera [1]	39:20		8:7		15:25 40:7	
Bill [3]	11:14 59:10	caption [1]	60:5		chose [1]	53:20	consult [4]	9:17 9:19
59:13		cardiac [5]	8:9 23:12		City [1]	2:20	9:21 10:11	
bit [2]	23:23 34:1	24:5 24:14	28:24		claims [5]	12:10 12:20	consultation [2]	8:17
bite [1]	56:5	care [9]	8:15 13:1		12:23 13:15	43:10	14:22	
blade [12]	30:2 30:7 30:10 30:18 32:2	19:9 31:15 37:18			clamped [1]	48:5	consulted [7]	6:23
32:14 32:14 32:24		38:6 38:8 38:10			clean [5]	30:6 30:6	8:19 8:24 9:2	
33:6 33:10 57:21		58:11			57:18 57:19	57:20	10:14 11:1 14:20	
bleeding [2]	28:9	umreful [4]	32:2 37:1		clear [2]	29:3 36:20	consulting [2]	8:12
41:12		umrotid [1]	7:25		clearly [2]	18:4 38:13	11:7	
blood [38]	14:9 21:22	carried [1]	44:8		Cleveland [3]	7:1	contact [1]	33:13
27:7 27:10 27:13		case [30]	4:19 4:19		7:5 19:7		contain [1]	60:12
27:15 27:18 27:21		6:2 10:19 11:16			clinical [1]	8:11	contained [1]	18:13
27:25 28:11 29:7		11:18 12:6 13:12			close [3]	43:6 55:6	containers [1]	52:1
29:12 33:6 33:13		14:21 15:3 16:1			55:12		contiguous [1]	32:7
40:14 45:22 47:2		16:4 16:6 16:19			closure [1]	43:12	contributed [1]	37:23
48:15 49:11 49:15		18:10 18:25 19:3			clotted [1]	52:10	control [3]	23:12 23:14
49:16 51:16 51:21		19:19 20:7 22:8			clutter [1]	59:7	49:22	
51:25 52:3 52:5		23:1 23:2 34:17			Clyde [1]	54:5	controlled [3]	38:18
52:8 52:9 52:10		35:25 38:7 38:19			coaching [1]	56:7	39:16 44:23	
52:12 52:22 52:23		39:8 45:20 48:10			cold [1]	7:7	controlling [2]	40:13
52:25 54:24 55:14		48:14			colon [1]	7:23	41:5	
55:23 56:1 56:1		cases [20]	8:25 9:2		Colville [1]	1:21	copy [1]	50:5
blunt [2]	57:10 57:18	9:3 9:4 9:6			combination [1]	14:3	coronary [1]	8:8
board [1]	15:16	10:11 10:14 11:1			combinations [2]	47:4	coroner's [2]	17:8
body [1]	35:5	11:11 13:10 13:24			47:9		28:23	
Bolesta [1]	17:2	14:19 14:23 14:24			coming [2]	7:1 54:7	correct [22]	4:17
bone [1]	53:18	15:7 21:6 21:19			commencing [1]	2:23	5:12 10:12 12:1	
Bonezzi [29]	2:8	22:9 22:25 23:15			comments [2]	28:3	14:6 14:10 14:18	
11:11 11:15 12:12		caused [9]	26:10 29:11		28:17		17:21 28:5 29:22	
17:22 19:18 20:4		29:12 29:19 30:5			Commission [1]	60:25	32:25 33:1 33:8	
37:4 37:12 37:19		32:4 53:3 56:12			common [4]	1:1	33:14 36:11 44:20	
37:21 38:1 38:4		causes [1]	17:24		2:25 32:9 36:20		44:25 46:1 48:21	
42:10 44:10 46:3		cavity [1]	23:10		commotion [1]	41:15	50:25 55:3 58:12	
48:24 49:6 49:24		cc [1]	51:25		compared [1]	53:18	corrected [1]	55:2
50:4 50:7 51:6		cc's [2]	52:12 52:19		competency [3]	19:15	counsel [1]	60:14
		Center [1]	6:19		54:14 54:18		counts [1]	27:13
					competent [1]	19:23	County [3]	1:2 2:20
							2:25	
							couple [2]	39:10 47:22

course [3] 21:14 53:6	29:5	degree [3] 31:7 56:15	40:5	dispute [5] 43:2 43:7 43:8	43:13 43:18	<b>-E-</b>		
court [7] 1:1 5:9 9:12 10:20 10:23	2:24 9:14	delay [1] 23:2		disputed [2] 43:14	43:11	E [6] 1:22 2:1 3:3	2:1 3:9	
courtesy [2] 6:20	6:18	delicate [1] 58:22		disputing [1] 43:2		early [1] 38:22		
cover [1] 7:19		denied [1] 15:9		dissociation [2] 46:23		easily [2] 27:14	27:15	
covers [1] 7:20		department [2] 38:16		distance [1] 35:12		eastern [1] 7:5		
credentials [1] 31:24		department's [1] 38:10		distances [2] 32:10		easy [2] 53:15	53:16	
critical [7] 37:17 37:21 38:9 46:17 46:18	37:19 38:19	dependent [1] 24:19		distended [1] 43:16		effected [1] 48:5		
criticisms [1] 38:6		deposed [1] 48:13		distinction [1] 9:1		effects [1] 49:18		
crosses [1] 34:22		deposition [15] 1:14 2:17 3:1 4:16 4:22 10:21 10:22 17:1 26:21 42:18 42:20 57:8 59:19 60:4 60:13		doctor [3] 5:14 59:4	31:13	eight [1] 10:5		
crystalloid [2] 27:22	27:11	depositions [7] 5:2 9:6 16:22 18:7 25:16 42:5 47:24		doctors [1] 19:2		either [9] 9:19 14:3 14:9 44:13 51:22 53:17 60:15 60:17	13:1 60:15	
curve [1] 51:19		depth [1] 36:22		doesn't [4] 24:14 37:8 39:13	24:14	electrical [4] 46:19 46:23	26:11 47:5	
cut [3] 57:18	57:17	describe [2] 41:25	7:15	done [12] 10:3 15:7 38:11 40:2 40:3 45:22 53:7 53:12 58:24 58:25 59:11	10:7 40:2 53:7 58:25	electrolyte [5] 27:4 39:23 46:22	26:12 46:21	
cuts [1] 40:22		described [2] 56:13	42:17	double [1] 58:5		emergency [2] 41:20	20:6	
cutting [2] 30:11	57:10	description [2] 57:7	28:8	doubt [5] 29:6 29:10 29:17	29:9 29:18	employed [1] 12:2		
Cuyahoga [2] 2:25	1:2	descriptions [1] 42:1		down [12] 8:10 11:5 13:8 30:12 30:17 39:18 50:11 51:4 51:10 51:11 52:14	8:22 30:12 50:11 51:11	employee [1] 38:3		
CV [3] 5:13 6:11	6:3	designed [1] 48:17		Dr [54] 4:18 4:21 16:17 16:22 16:23 16:24 16:24 17:1 17:2 17:2 17:4 19:6 19:10 26:21 28:8 29:13 29:21 30:10 30:15 30:25 31:8 31:21 32:1 32:23 35:13 36:4 39:16 42:1 42:2 42:14 42:22 43:5 43:20 44:7 44:14 45:12 45:14 49:4 49:21 51:16 51:23 51:24 51:24 52:9 54:22 54:22 54:25 55:1 55:13 56:12 57:8 57:23 58:8		enable [1] 16:5		
<b>-D-</b>		despite [2] 48:16	49:18	determined [1] 4:18	4:19	enables [1] 31:14		
D [3] 3:3	1:7 2:8	deteriorating [1] 41:14		dies [2] 28:4	28:18	endarterectomy [1] 8:1		
daily [1] 51:14		Deventer [1] 17:1		dies [2] 39:22	48:7	ends [1] 35:5		
damage [1] 21:21 25:21 29:7 29:11 32:4 45:21 49:15 56:13 57:6	20:7 29:7 45:21 57:6	device [2] 56:25	57:11	difference [5] 42:1 44:19 45:1	35:6 45:1	entries [1] 5:23		
damaged [5] 33:6 34:17 58:8	20:18 56:2	die [1] 25:9		differ [1] 6:1		envelope [1] 57:16		
dated [3] 17:5	5:18 16:13	died [2] 28:4	28:18	differently [1] 46:12		ephedrine [2] 51:13	48:18	
deal [4] 53:23 53:25	21:2 23:21	direction [1] 60:11		difficult [4] 32:12 53:11 53:13	32:12 53:17	episode [1] 47:22		
dealing [5] 35:3 35:5	34:2 35:20	lirection [1] 60:11		directly [1] 12:2		Eric [1] 16:24		
death [10] 39:5 39:14 39:23 39:24 46:19 46:20	28:23 37:23 39:23 46:20	lirection [1] 60:11		lirector [1] 54:6		Erwin [3] 2:21 60:24	60:3	
debilitating [1] 42:2 42:2	24:17 42:17	lirector [1] 54:6		lirector [1] 54:6		especially [2] 57:17	38:19	
DeCaro [4] 42:2 42:2	16:25 42:17	lirector [1] 54:6		lirector [1] 54:6		Esq [3] 2:4 2:12	2:8	
decisions [1] 13:12		lirector [1] 54:6		lirector [1] 54:6		estimate [1] 9:5		
defect [1] 56:6		lirector [1] 54:6		lirector [1] 54:6		et [6] 1:5 26:2 31:25 55:22	1:7 55:22	
defendant [2] 12:6	4:20	lirector [1] 54:6		lirector [1] 54:6		etc [1] 1:5		
defendants [3] 2:9 2:13	1:7	lirector [1] 54:6		lirector [1] 54:6		evaluated [1] 55:17		
defended [1] 13:23		lirector [1] 54:6		lirector [1] 54:6		went [1] 60:16		
defense [5] 11:3 11:6	10:9 11:8	lirector [1] 54:6		lirector [1] 54:6		?vents [2] 26:25	39:6	
defer [2] 58:13	58:16	lirector [1] 54:6		lirector [1] 54:6		zventually [1] 47:2		
definition [1] 26:4		lirector [1] 54:6		lirector [1] 54:6		verybody [1] 17:23		
		lirector [1] 54:6		lirector [1] 54:6		evidence [3] 35:24 58:11	33:4	
		lirector [1] 54:6		lirector [1] 54:6		xactly [2] 47:6	57:2	
		lirector [1] 54:6		lirector [1] 54:6		EXAMINATION [2] 3:5 4:6		
		lirector [1] 54:6		lirector [1] 54:6		xcept [2] 8:3	27:16	
		lirector [1] 54:6		lirector [1] 54:6		xception [1] 19:9		
		lirector [1] 54:6		lirector [1] 54:6		xceptions [1] 47:23		
		lirector [1] 54:6		lirector [1] 54:6		xclusively [1] 41:22		
		lirector [1] 54:6		lirector [1] 54:6		xcuse [1] 37:3		

Exhibits [1]	3:11	firm [6]	9:18	10:7	group [2]	15:11	15:13	hour [10]	2:23	41:1
expecting [1]	30:24	11:2	14:7	16:19	Grove[12]	2:19	4:14	42:16	42:16	42:22
expeditious [1]	39:16	16:21			guess [3]	10:4	59:6	44:6	44:15	44:22
expeditiously [2]	38:23	firms [1]	10:2		gynecologic [1]		20:15	45:23	48:20	
55:25		first [5]	4:2	15:19				hours [1]	24:12	
experience [5]	12:5	31:6	40:22	60:9				Howard [7]		1:14
20:13	20:23	five [7]	9:11	9:15				2:17	2:18	3:1
23:16		27:14	40:19	48:19				4:1	4:10	60:8
expert [6]	4:20	50:1	51:11					human [1]	24:8	
16:20	31:20	flip [1]	18:17					hundred [4]		45:11
45:10		flow [1]	51:22					48:15	49:17	50:9
expertise [1]	53:23	fluctuations [1]		51:15				hypotension [3]		38:18
experts [2]	19:3	fluid [5]	26:12	28:15				41:6	55:21	
Expires [1]	60:25	28:25	48:9	51:13				hypotensive [4]		41:6
explain [3]	32:1	fluids [4]	27:3	46:24				41:7	41:8	41:9
48:8		47:7	47:15					hypovolemia [1]		39:13
explained [1]	39:5	folks [1]	19:15							
explains [1]	48:8	follow [1]	22:6							
explanation [1]	39:25	following [1]		21:21						
exposed [1]	39:1	follows [1]	4:4							
express [3]	16:6	foregoing [2]		60:4						
31:4		60:12								
expressed [1]	36:3	form [3]	19:14	19:24						
expressing [1]	23:1	37:12								
exsanguination [2]	23:9	formulate [1]		18:12						
41:11		forth [1]	6:8							
extreme [1]	24:12	found [1]	23:18							
extremities [1]	8:2	frame [1]	9:13							
eyesight [1]	50:11	front [1]	16:7							
		full [1]	60:12							
		function [1]		41:21						
		furnished [1]		4:21						
		furtherst [1]		51:18						

30:22	32:13	38:24	24:4	24:21	25:12	literally [1]	35:7	9:18	10:3	13:25
39:15	40:21	41:10	28:3	28:18	35:9	literature [3]	15:25	14:2		
43:17	43:17	45:13	38:6	38:21	39:3	18:25	25:17	mean [18]	9:4	9:21
insofar [1]	50:10		46:12	47:21	51:21	lived [1]	7:5	9:21	10:20	18:16
instability [2]		28:25	Kostelnik's [9]	23:19		localized [1]		22:17	31:3	34:4
38:21			25:21	26:1	35:25	located [1]	6:16	37:24	38:12	39:6
instance [2]		14:25	37:18	39:15	45:3	location [2]		42:12	42:14	47:7
24:13			48:14	54:23		35:14		52:1	53:21	53:22
instituted [1]		41:20	<b>-L-</b>			longer [1]	33:25	58:2		
instrument [10]		29:15	L [1]	2:12		longitudinal [11]	30:19	measured [1]		32:11
29:19	29:20	29:24	laceration [6]	21:10		32:25	33:10	measures [1]		38:25
36:22	56:12	57:9	21:14	22:11	28:20	33:16	34:7	mechanical [2]		46:23
57:10	57:18	57:21	30:6	57:19		37:3	37:9	47:5		
instruments [2]		29:12	lack [2]	20:1	58:11	57:19		mechanism [1]		30:4
36:8			lactate [1]	47:1		look [2]	7:3	medical [9]		6:4
insurance [1]		11:21	laparoscopic [1]	20:15		looked [2]	35:8	6:19	8:18	11:10
insured [1]	11:20		large [1]	28:14		looking [4]	5:23	15:24	18:24	31:8
insurer [1]	13:2		last [5]	5:18	5:23	50:18	50:23	40:6	41:19	
interested [1]		60:16	8:23	10:18	30:16	losing [1]	41:16	medical/legal [2]		8:16
interrupt [1]		34:4	lawsuits [3]	12:18		loss [7]	51:17	10:8		
intervention [2]		21:21	12:21	12:24		51:25	52:3	medications [1]		48:16
22:11			lawyers [3]	9:18		54:24	55:14	medicine [3]		8:11
intraoperative [1]		40:11	11:2	14:15		loud [1]	5:9	11:17	15:21	
involved [11]		7:17	layers [1]	57:15		loved [1]	7:10	meet [1]	19:10	
19:9	21:9	32:10	leaking [1]	52:7		Luke's [1]	54:5	mentioned [1]		42:4
33:18	35:2	37:18	least [1]	56:25		luxury [1]	24:18	Meridia [1]		17:4
38:7	38:15	53:14	leave [1]	15:11		lying [1]	34:7	met [1]	31:1	
53:17			leaving [2]	7:1	19:7	<b>-M-</b>				
involving [4]		14:21	led [2]	47:4	47:16	M.D [1]	1:7	16:14	17:2	
15:3	22:10	23:1	leeway [1]	23:13		2:17	2:18	Michelson [1]		16:14
irrelative [1]		53:20	left [8]	34:9	34:10	4:1	60:8	mics [1]	59:5	
issue [3]		41:25	34:17	34:22	34:25	maintain [3]		midline [3]		33:17
43:3			35:4	35:4	35:6	54:14	54:18	33:22	33:22	
itself [2]		33:11	legal [3]	6:23	8:13	major [4]	21:13	Midwest [1]		7:6
<b>-J-</b>			10:8			28:15	53:12	night [4]	12:24	17:19
Jackie [5]	45:3	47:21	less [6]	27:14	27:15	majority [2]		20:18	53:13	
48:14	51:21	54:23	27:22	35:17	45:4	10:7		millimeters [3]		32:12
Jacobson [5]		2:7	45:5			makes [2]	25:25	35:3	35:7	
9:18	10:3	13:25	letter [5]	16:12	16:13	Malone [5]		million [1]	45:10	
14:2			16:17	16:20	32:16	59:3	59:10	mind [5]	29:6	29:17
James [1]	2:12		letting [1]	5:6		59:16		39:5	39:25	51:18
Jim [1]	59:1		level [3]	48:1	48:2	malpractice [5]		minute [11]	26:18	
Jo [1]	16:23		50:1			10:19	12:6	minutes [24]		21:25
job [2]	38:11	40:10	levels [1]	47:4		14:23		22:3	22:12	23:3
John [4]	2:4	16:20	license [1]	15:8		manner [1]		40:19	42:15	42:16
16:23	16:25		lie [2]	25:7	32:6	Mark [1]	16:22	42:22	43:11	43:20
Joseph [1]	16:25		life [3]	7:5	54:10	marriage [1]		43:25	44:6	44:8
Jr [2]	1:5	2:4	54:11			Mary's [1]	6:18	44:15	44:22	44:22
<b>-K-</b>			ligament [11]	30:19		material [2]		44:23	46:4	46:5
Kalur [2]	2:7	13:25	32:25	33:11	33:12	56:23		48:19	50:1	50:12
keep [1]	47:23		33:16	34:7	34:8	materials [3]		50:13	51:11	
kids' [1]	14:16		37:3	37:9	40:23	17:16	18:4	Misdiagnoses [1]		13:16
kind [2]	18:16	20:21	40:24			matter [2]	12:25	misdiagnosis [1]		13:22
knife [1]	58:21		likely [2]	23:25	53:1	matters [4]		missed [1]	6:5	
knowing [1]		49:15	line [2]	44:16	57:22	8:13	8:19	missing [1]		51:8
known [2]	19:8	60:3	linear [1]	30:6		maximum [1]		misstate [1]		59:8
Kostelnik [19]		1:5	Lisa [4]	2:21	60:3	may [9]	6:4	mistaken [1]		33:19
4:19	14:21	17:3	60:24	60:24		33:20	33:21	Mitchell [1]		16:23
17:6	23:1	23:18	list [3]	6:22	6:24	38:1	41:3	mix [1]	56:21	
			16:9			58:6		mobilized [1]		33:20
			listed [1]	18:5		Maynard [5]		monitor [1]		38:17
								monitoring [2]		40:10
								40:13		

most [6] 5:14 19:8  
22:22 26:16 35:16  
47:22  
mostly [1] 25:6  
move [1] 7:14  
moving [1] 31:6  
Mrs [20] 14:21 17:3  
17:6 23:1 23:18  
23:19 24:4 24:21  
25:12 25:21 26:1  
28:3 28:18 35:9  
35:25 38:6 38:21  
39:3 39:15 46:12  
Ms [1] 37:18  
multiple [1] 42:4  
muscular [1] 57:15

-N-

N [3] 2:1 3:3  
60:1  
name [4] 4:8 6:8  
6:9 60:20  
Nash [1] 54:5  
nature [3] 7:15 13:15  
20:25  
necessarily [3] 27:25  
28:1 41:3  
necessary [1] 17:19  
neck [1] 7:21  
need [4] 5:5 36:5  
47:20 48:7  
needed [1] 38:22  
needle [1] 30:18  
needs [2] 5:24 37:1  
negatives [1] 58:5  
negligence [6] 8:19  
11:11 31:9 32:20  
32:20 47:16  
neighborhood [7] 8:24  
9:8 9:15 10:4  
10:15 52:4 52:12  
never [7] 13:3 13:5  
13:9 13:11 19:10  
32:17 56:20  
next [1] 13:7  
nicely [1] 23:5  
nne [1] 60:24  
nobody [1] 43:13  
none [3] 14:15 15:6  
nor [1] 60:14  
norm [2] 35:21 36:1  
normal [6] 28:12 39:17  
39:18 39:19 39:19  
47:2  
normally [1] 35:19  
Northwest [1] 6:16  
notable [1] 47:23  
Votary [3] 2:21 60:6  
60:24  
note [3] 26:21 42:17  
42:19

[noted] [1] 43:8  
notes [1] 60:13  
nothing [6] 4:3  
6:2 30:5 35:16  
53:5 57:11  
notice [1] 2:16  
notify [1] 18:1  
now [7] 2:24 16:3  
30:24 46:12 50:23  
51:3 59:11  
nucleus [1] 30:11  
number [1] 9:5  
nurse [5] 16:23 16:25  
16:25 19:11 42:2  
nurses [4] 19:2 19:11  
38:15 41:18

-O-

O [1] 60:1  
o'clock [3] 40:19 43:6  
55:10  
oath [2] 4:4 60:8  
Objection [10] 12:12  
20:4 37:4 37:12  
42:10 44:10 46:3  
48:24 49:6 54:1  
observed [1] 54:22  
obviously [2] 32:17  
42:20  
occasioned [1] 7:1  
occur [2] 32:15 32:19  
occurred [9] 12:15  
20:6 20:16 20:23  
29:7 29:11 30:22  
53:1 53:2  
occurring [1] 15:1  
off [1] 53:8  
Offered [1] 3:11  
office [7] 4:12 6:17  
17:3 17:8 27:13  
27:16 60:20  
offices [1] 2:18  
often [1] 54:13  
Ohio [3] 1:2 2:25  
11:25  
older [3] 7:7 24:14  
25:5  
ominous [2] 48:22  
48:25  
once [4] 11:13 21:23  
38:24 41:14  
one [19] 5:25 6:15  
7:11 10:16 11:15  
13:21 30:8 43:10  
45:8 45:10 45:11  
47:18 50:17 50:19  
51:8 51:12 51:17  
57:2 59:4  
open [1] 52:8  
opened [3] 30:19 44:22  
52:14  
operating [2] 31:23  
41:16

operation [8] 21:2  
30:9 31:20 31:20  
31:22 36:19 37:6  
54:8  
operations [2] 39:12  
58:22  
operative [4] 30:13  
30:15 32:23 50:2  
opinion [14] 22:25  
26:3 26:7 27:19  
29:23 30:1 31:4  
35:11 35:15 44:14  
47:18 54:15 54:20  
54:21  
opinions [11] 4:24  
16:6 17:25 18:9  
18:13 18:20 18:20  
18:22 19:24 30:25  
36:4  
opportunity [2] 7:9  
18:1  
opposed [1] 14:2  
opposite [1] 35:5  
optimum [1] 24:21  
Orange [2] 2:19 4:14  
order [5] 16:11 33:5  
44:7 44:8 44:12  
organism [3] 24:7  
24:7 24:8  
organized [1] 41:19  
orthopedic [9] 8:5  
20:19 31:2 31:15  
32:3 53:13 53:19  
54:4 58:14  
orthopedist [1] 49:4  
otherwise [2] 14:12  
60:16  
outcome [2] 44:19  
45:18  
outside [1] 35:25  
outstanding [1] 54:6  
own [4] 16:12 19:15  
23:16 45:10

-P-

P [2] 2:1 2:1  
p.m. [1] 2:23  
page [3] 3:6 30:15  
31:6  
pages [1] 60:12  
palpated [2] 54:23  
55:9  
paragraph [1] 30:16  
parameters [1] 24:10  
parathyroid [1] 7:22  
paravertebral [1] 37:11  
parents [1] 14:16  
part [1] 26:16  
partially [1] 28:15  
particular [8] 11:11  
16:4 16:11 16:12  
22:20 35:18 36:6  
48:10

parties [2] 60:15 60:18  
pass [2] 15:19 31:24  
past [4] 8:20 11:23  
23:25 27:6  
patient [13] 8:15  
12:24 13:1 21:16  
23:11 23:14 23:25  
31:9 38:10 38:21  
39:22 40:10 48:4  
patient's [5] 13:12  
19:9 38:17 39:1  
40:17  
patients [4] 6:14  
6:20 25:20 27:12  
pawing [1] 52:14  
pending [1] 2:24  
penetrate [2] 33:9  
37:2  
penetrated [1] 40:23  
penetrating [1] 55:19  
penfield [1] 56:18  
people [10] 14:11 19:8  
25:4 25:6 25:8  
25:13 26:5 37:18  
38:7 48:13  
people's [1] 35:16  
per [4] 17:14 27:19  
52:6 57:1  
percent [12] 8:15  
8:16 11:4 11:5  
11:8 11:9 25:20  
26:5 26:8 33:20  
45:9 45:11  
percentage [1] 10:25  
percentage-wise [1] 11:3  
perfectly [2] 47:21  
48:4  
perforated [1] 55:18  
perform [1] 31:8  
performance [2] 30:25  
31:10  
performed [1] 58:14  
performing [3] 36:23  
36:25 37:8  
perhaps [4] 25:20  
35:23 40:1 42:12  
peri-injury [1] 21:25  
period [2] 41:13 50:12  
periods [2] 24:11 25:4  
perioperatively [1] 40:11  
peritoneal [1] 23:9  
peritoneum [1] 52:14  
peritonitis [1] 55:21  
person [1] 24:3  
pertinent [2] 6:2  
15:25  
photographs [2] 17:8  
17:13  
physicians' [1] 11:20  
physiologic [3] 24:10  
24:15 26:1  
physiologically [2] 25:14

26:10		55:16		39:19		removal [2]	29:8
physiology [1]	25:10	pretty [4]	26:16	reached [1]	51:20	53:10	
picks [1]	59:5	36:20	57:16	read [1]	42:6	remove [1]	36:13
picture [3]	26:23	primary [1]	21:2	real [1]	55:5	removing [1]	36:7
48:6		principals [1]	38:3	really [15]	12:9	rendered [1]	38:6
PIE [2]	11:21	principles [1]	36:20	18:19	18:21	repair [2]	45:17
Pima [1]	2:20	privilege [1]	15:9	22:22	23:13	repaired [1]	28:9
Pitluk [8]	1:14	privileges [1]	6:18	39:8	39:9	rephrase [3]	5:7
2:18	3:1	probability [3]	31:8	47:21	54:16	58:4	58:7
4:10	4:18	40:6	56:16	57:20		report [16]	4:21
place [6]	20:13	problem [5]	21:24	reason [10]	25:9	17:9	17:12
23:10	39:6	28:4	46:21	31:5	39:12	18:6	18:14
60:4		55:17	55:15	50:6	54:24	28:23	30:13
placed [1]	24:9	problems [3]	24:17	55:6	55:18	31:5	32:24
plaintiff [1]		26:12	26:13	reasonable [3]	31:7	53:10	53:21
plaintiffs [4]	1:5	procedure [5]	53:11	40:5	56:15	reported [1]	49:10
2:5	11:6	53:12	53:14	reasonably [1]	23:11	reporter [1]	5:9
plaintiffs' [2]	10:11	58:15	54:19	reasons [3]	4:24	representation [1]	17:23
10:13		procedures [4]	7:19	24:16	55:20	required [1]	32:3
plan [2]	17:15	7:20	8:6	received [2]	18:5	requires [1]	53:25
plays [1]	37:22	20:15		44:15		requiring [1]	53:22
Pleas [2]	1:1	products [6]	27:7	receives [1]	17:24	requisitely [1]	32:2
plural [1]	29:14	27:10	27:18	receiving [1]	27:21	reserve [3]	24:5
point [13]	5:5	27:25	47:3	recent [2]	5:15	24:15	24:6
21:1	23:25	professional [4]	14:2	recertified [1]	15:18	reserves [1]	24:14
26:22	29:4	14:3	14:5	recognition [6]	22:4	residency [1]	54:3
51:3	51:17	professionally [1]	19:8	22:5	22:6	resilient [1]	24:8
55:12	58:13	program [3]	54:3	22:19	26:17	respect [1]	14:23
pointed [3]	32:14	54:6	54:8	recognize [2]	38:22	respond [2]	20:6
40:20		proper [1]	40:10	46:5		46:5	
pointing [1]	47:23	properly [1]	39:3	recognized [5]	21:23	responded [1]	44:16
points [2]	30:8	provide [1]	6:12	38:24	43:15	response [2]	25:11
position [5]	6:4	provided [4]	5:13	45:25	45:13	44:21	
6:6	16:15	17:17	17:19	recollection [3]	21:18	responses [2]	5:9
25:12	24:22	Public [3]	2:21	21:20	22:21	24:15	
possess [1]	31:14	60:24	60:6	recommended [1]	36:22	responsibility [3]	38:14
possibility [1]	49:16	pulmonary [2]	24:6	record [4]	4:8	38:16	39:2
possible [3]	22:19	24:15		50:3	59:7	rest [ti]	54:10
40:16	46:22	pulposus [1]	30:12	records [4]	17:3	result [11]	12:17
post [2]	42:19	pulse [3]	28:11	51:25	56:13	19:21	19:25
posterior [7]	20:20	39:18	28:16	reduced [1]	60:11	23:4	28:21
30:19	32:25	pursuant [1]	2:16	reference [1]	27:1	28:24	28:25
33:16	34:7	put [2]	6:10	referring [2]	9:25	28:24	28:25
40:22				27:8		resulted [1]	12:11
potassium [1]	46:21	-Q-		refers [1]	53:10	resuscitated [3]	39:4
practice [16]	6:7	qualified [1]	54:9	reflected [1]	6:3	46:14	46:15
6:8	6:9	qualifies [1]	31:14	regarding [3]	16:15	resuscitating [1]	40:1
6:15	7:10	quarter [3]	45:17	17:3	17:5	resuscitation [7]	26:13
7:17	8:11	50:21	50:22	reinforced [1]	18:22	27:3	39:2
15:12	15:13	questions [3]	18:2	related [6]	11:16	46:17	46:25
20:6	20:23	36:5	59:2	14:12	14:13	retract [1]	56:23
preparation [2]	4:23	quick [1]	55:5	60:17		retractor [4]	30:7
18:25		quickly [1]	43:6	relates [1]	19:18	56:19	56:20
prescribed [1]	37:5	quote [1]	16:15	relationship [2]	14:1	56:19	56:20
pressure [14]	26:18			14:14		retroperitoneal [3]	20:17
27:24	28:11	-R-		relatively [2]	24:23	23:8	52:7
38:17	39:10	R [3]	1:5	39:18		retroperitoneum [4]	40:17
40:14	47:24	60:1	2:1	relocate [1]	7:9	40:17	41:10
49:11	49:17	R-o-t-h-f-u-s-z [1]	16:24	remember [1]	21:8	52:16	
51:19		raised [1]	7:4	REMEMBERED [1]		returning [1]	28:12
pressures [1]	40:12	range [2]	7:20	2:16		review [2]	17:15
presumably [1]	49:14	rate [3]	39:18	IREMINDER [2]	2:11	reviewed [5]	16:5
presume [1]	5:1			2:11		16:8	16:16
presumed [2]	55:14					18:24	17:7



revived [1] 28:16	sense [2] 25:23	25:25	St [1] 6:18	54:7
revoked [1] 15:9	sensitive [2] 49:5		stable [7] 23:11 26:16	surgeons [3] 8:9
right [33] 4:15 5:1	49:7		39:7 39:17 41:12	32:3 58:14
9:1 14:11 18:24	sequelae [1] 15:4		47:21 48:4	surgeries [3] 7:22
20:22 22:20 26:3	services' [1] 40:8		standard [1] 31:15	20:10 20:11
26:6 28:2 28:7	setting [1] 53:18		standards [4] 31:1	surgery [34] 7:18
29:2 30:23 32:6	settlement [1] 13:11		31:22 47:11 47:13	7:21 7:22 7:23
33:16 33:21 33:24	settlements [1] 13:5		star-shape [1] 33:25	7:23 7:24 7:24
34:6 34:23 35:4	seven [2] 10:5 22:23		star-shaped [4] 30:20	7:24 7:25 8:1
35:4 35:6 36:15	several [1] 10:23		33:15 35:13 58:10	8:2 8:3 8:5
42:25 50:16 51:8	sharing [1] 32:9		start [2] 16:5 59:5	8:5 15:3 15:17
51:12 51:24 53:3	sharp [3] 32:14 57:9		started [2] 7:12 41:14	20:8 20:9 29:8
53:6 53:6 53:16	57:21		starting [1] 29:4	31:1 31:11 31:16
right-sided [1] 33:19	shock [1] 55:21		state [7] 2:20 2:22	31:17 36:4 36:6
ring [2] 59:10 59:14	shot [1] 25:7		4:2 4:8 31:7	36:23 37:1 49:16
ringer [1] 47:1	side [4] 33:17 33:24		60:6 60:9	51:15 53:11 54:4
road [2] 2:19 13:8	34:6 34:23		statement [1] 25:19	54:17 54:17 58:3
role [2] 37:22 40:1	sighing [1] 56:9		statistic [2] 25:22	surgical [1] 14:22
rongeur [2] 30:8	sign [1] 48:22		25:24	surgically [1] 14:24
55:20	Signature [1] 59:20		statistics [1] 46:13	surmised [1] 43:17
rongeurs [1] 56:2	significant [1] 41:12		stay [4] 8:4 36:7	surrounding [1] 57:15
room [1] 41:16	similar [4] 14:20 15:2		36:18 41:12	survival [1] 45:3
Rothfus [1] 16:24	20:16 20:21		stayed [3] 48:15 49:17	survive [6] 24:1 24:11
rules [1] 5:10	similarity [1] 14:25		49:19	24:22 25:13 25:21
run [1] 34:20	situation [9] 23:17 25:21		Stephen [4] 1:7 17:4	26:5
running [4] 39:2 41:18 48:2 50:9	23:20 24:12 25:21		4:19 17:1	survived [4] 21:8
	26:1 27:4 32:4		STERN [1] 2:3	21:17 40:4 46:7
	41:23 45:20		stick [1] 56:18	suspected [1] 54:24
	six [5] 9:9 9:11 27:13		still [1] 18:21	suspended [1] 15:9
	9:16 22:23		stop [1] 26:11	sustain [2] 25:8 25:9
	slight [1] 5:19		stopped [2] 51:22 26:24	sustained [4] 23:12
	small [1] 34:2		strain [1] 24:9	25:1 26:10 51:22
	snuff [1] 28:6		strictly [2] 14:2 14:5	SWEN [1] 60:24
	social [1] 14:4		strong [1] 57:16	sworn [2] 4:2 60:9
	Soldiers [1] 25:6		structure [1] 57:14	
	someone [1] 26:22		structures [1] 20:17	-T-
	sometime [1] 22:6		stuff [2] 52:3 59:17	T [3] 3:9 60:1
	somewhat [3] 12:9		subscribed [1] 60:19	taking [3] 23:10 28:2
	34:25 38:9		succumb [1] 24:18	44:12
	somewhere [3] 13:8		such [10] 7:22 14:25	talks [1] 6:1
	22:16 35:22		24:3 24:16 31:21	tamponade [1] 51:23
	soon [1] 43:14		32:13 37:21 38:21	tamponading [2] 23:10
	sooner [1] 24:19		51:15 55:21	41:11
	sorry [5] 9:20 9:24 54:22		sucker [2] 52:23 52:23	teach [1] 15:21
	10:1 20:14		sucks [1] 52:9	Telephonically [1] 2:14
	space [9] 30:17 32:7		sudden [3] 26:23 39:22	telling [1] 16:5
	33:11 34:8 36:8		48:6	tells [1] 53:5
	36:17 36:18 36:23		sued [13] 12:7 37:22	terribly [2] 39:9
	56:24		38:3	47:25
	spaces [3] 34:2 35:1		suggests [1] 18:19	testified [3] 4:3
	35:6		Suite [1] 2:19	9:3 10:18
	speaking [2] 23:16		suits [1] 12:11	testify [1] 10:16
	35:19		summary [1] 16:14	testifying [3] 11:17
	specific [1] 14:25 16:3		supposed [1] 36:18	17:16 60:9
	specifically [2] 38:16		supposedly [2] 33:18	testimony [3] 43:13
	54:3			56:11 60:10
	specifics [1] 21:8			theirs [1] 14:16
	spend [1] 8:11		surgeon [14] 8:7	theory [1] 33:7
	spinal [1] 30:18		19:12 27:20 31:2	therefore [1] 43:16
	sponges [1] 52:2		31:15 36:6 36:25	thereof [2] 60:7 60:16
	square [2] 22:24 23:5		37:7 45:15 45:16	thinking [1] 55:8
			46:6 53:13 53:19	

<b>third</b> [1] 13:21	<b>two</b> [9] 5:25 13:21	45:22 49:15 55:23	<b>younger</b> [4] 24:23
<b>thought</b> [4] 13:19	26:18 35:17 35:22	56:1 56:2 57:6	25:5 25:6 57:17
19:23 41:17 52:13	42:8 42:9 43:11	57:23 58:9	
<b>three</b> [10] 7:12 12:16	58:6	<b>virtue</b> [3] 31:17 31:23	
12:17 13:9 13:14	<b>two-thirds</b> [1] 30:16	60:7	
13:19 20:24 21:18	<b>type</b> [4] 8:6 20:16	<b>vis-a-vis</b> [1] 25:13	
54:17 58:6	26:25 39:24	<b>volume</b> [5] 27:15 28:4	
<b>through</b> [9] 4:25		28:5 28:14 52:25	
16:9 31:24 33:10	<b>-U-</b>	<b>VS</b> [1] 1:6	
33:11 33:11 52:14	<b>ultimately</b> [1] 51:23		
52:16 54:3	<b>unacceptable</b> [1] 44:1	<b>-W-</b>	
<b>throughout</b> [1] 47:22	<b>under</b> [3] 23:12 24:9	<b>wait</b> [4] 43:20 43:25	
<b>thyroid</b> [1] 7:22	60:11	44:2 44:6	
<b>times</b> [6] 12:15 20:22	<b>understand</b> [15] 5:6	<b>waiting</b> [1] 5:8	
20:24 39:10 47:8	5:10 12:22 18:18	<b>waived</b> [1] 59:20	
54:17	22:5 24:20 32:13	<b>walk</b> [2] 27:13 27:15	
<b>timing</b> [1] 21:21	34:20 38:4 44:13	<b>wall</b> [2] 32:10 56:6	
<b>tired</b> [1] 27:17	47:6 47:14 48:7	<b>wantonly</b> [1] 32:21	
<b>tissue</b> [2] 57:16 57:16	49:10 55:11	<b>weather</b> [2] 7:4	
<b>today</b> [1] 4:16	<b>unfortunate</b> [1] 32:17	7:7	
<b>together</b> [1] 52:11	<b>unless</b> [2] 17:17 57:20	<b>wedging</b> [1] 56:25	
<b>too</b> [6] 39:12 46:21	<b>unquote</b> [1] 16:15	<b>West</b> [2] 2:19 4:14	
46:21 46:22 52:23	<b>unstable</b> [2] 39:9	<b>WHEREOF</b> [1] 60:19	
58:5	47:25	<b>whole</b> [5] 4:3 7:5	
<b>took</b> [7] 22:11 39:6	<b>up</b> [25] 26:14 26:19	27:7 48:2 52:5	
40:21 43:11 46:4	27:5 28:6 32:6		
56:5 60:3	39:19 47:10 47:12	<b>wide</b> [1] 7:20	
<b>top</b> [1] 6:9	48:1 48:1 48:17	<b>wife</b> [1] 7:6	
<b>total</b> [3] 8:25 9:4	49:21 49:25 50:7	<b>William</b> [1] 2:8	
9:14	50:13 50:14 50:15	<b>Wilson</b> [2] 16:20 16:23	
<b>touching</b> [2] 32:7	50:20 51:2 51:10	<b>window</b> [1] 7:3	
32:8	51:12 55:5 55:13	<b>within</b> [7] 22:2 31:7	
<b>tough</b> [1] 57:14	59:5 59:7	35:21 36:7 40:5	
<b>transcript</b> [1] 59:17	<b>update</b> [1] 5:19	50:1 56:15	
<b>transcription</b> [1] 60:13	<b>used</b> [5] 32:24 33:2	<b>witness</b> [7] 11:14 50:5	
<b>transection</b> [7] 21:10	56:12 56:25 57:10	51:7 56:8 60:8	
21:13 22:10 28:19	<b>using</b> [6] 30:10 30:18	60:10 60:19	
28:25 30:6 55:22	32:2 38:18 57:24	<b>woman</b> [3] 26:15 41:17	
<b>traverse</b> [1] 34:23	58:9	57:17	
<b>treated</b> [1] 38:23	<b>usually</b> [3] 8:7 20:12	<b>word</b> [3] 53:14 53:16	
<b>treating</b> [1] 31:9	20:14	53:20	
<b>tremendous</b> [4] 24:5	<b>-V-</b>	<b>words</b> [2] 12:24 41:5	
24:5 24:9 41:15	<b>V</b> [1] 2:4	<b>worked</b> [4] 11:10 19:16	
<b>tremendously</b> [1] 24:8	<b>Van</b> [1] 16:25	19:21 19:21	
<b>trial</b> [2] 4:23 13:18	<b>vascular</b> [11] 7:18	<b>worried</b> [1] 51:16	
<b>tried</b> [1] 51:20	7:25 8:6 15:4	<b>writing</b> [1] 60:11	
<b>true</b> [4] 23:17 23:19	19:12 41:10 42:3	<b>written</b> [2] 15:24 42:19	
43:4 60:12	42:15 45:15 45:16	<b>wrong</b> [2] 53:5 53:13	
<b>truth</b> [4] 4:2 4:3	46:6	<b>wrote</b> [1] 16:13	
4:3 60:10	<b>vascular-type</b> [1] 43:17		
<b>truthfulness</b> [2] 20:1	<b>vein</b> [13] 8:2 20:8	<b>-X-</b>	
20:2	21:11 21:15 22:11	<b>X</b> [2] 3:3 3:9	
<b>try</b> [2] 5:7 58:7	28:8 28:20 32:5		
<b>trying</b> [2] 25:2 47:14	32:9 34:17 34:22	<b>-Y-</b>	
<b>Tucson</b> [7] 1:16 1:23	35:14 57:19	<b>year</b> [6] 5:18 7:13	
2:20 4:14 6:17	<b>venous</b> [1] 48:5	9:7 9:8 10:23	
6:19 7:16	<b>version</b> [1] 5:15	54:17	
<b>turn</b> [4] 43:7 43:12	<b>versus</b> [3] 4:19 8:12	<b>years</b> [8] 7:12 8:23	
55:7 55:13	9:2	9:15 10:23 10:24	
<b>turned</b> [1] 43:14	<b>vessels</b> [19] 20:16 21:22	20:21 22:23 31:18	
<b>Tuschman</b> [2] 2:7	29:1 29:7 29:12	<b>young</b> [3] 24:3 24:7	
13:25	32:6 33:6 33:13	41:16	
	34:16 37:11 37:14		