IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

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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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APPEARANCES

* * * * *

CHATTMAN, CAINES & STERN
By John V. Scharon, Jr., Esq.
For the Plaintiffs

JACOBSON, MAYNARD, TUSCHMAN & KALUR
By William D. Bonezzi, Esq.
For the Defendants
and
REMINGER C REMINGER
By James L. Mdlone, Esq.
For the Defendants
(Appearing Telephonically)

BE IT REHEMBERED that pursuant to notice the deposition of Howard Charles Pitluk, M.D., was taken at the offices of Howard C. Pitluk, M.D., Inc., 1925 West Orange Grove Road. Suite 100-101, in the City of Tucson, County of Pima, State of Arizona, before Lisa Erwin. a Notary Public in and for the State of Arizona. on the 14th day of April 1997, commencing at the hour of 12:29 p.m. on said day, in a certain cause now pending In the Court of Common Pleas, Cuyahoga County, Ohio.

DEPOSITION OF HOWARD CHARLES PITLUK, M.D

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EXHIBITS

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(No Exhibits Offered)

HOWARD CHARLES PITLUK, M.D.,
having been first duly sworn to state the truth, the whole truth, and nothing but the truth, testified on his oath as follows:

EXAMINATION

BY MR. SCHARON:

Q. Would you state your name for the record, please.

A. Howard Charles Pitluk.

Q. Your address, sir?

A. Office address?

Q. That's fine.

A. 1925 *West* Orange Grove, Tucson, Arizona.

Q. All right. That's where we are here today for your deposition?

A. Correct.

Q. Dr. Pitluk, you have been identified in this case, the case of Kostelnik versus Dr. Stephen Helper and others, as an expert for Defendant Dr. Helper, and we have been furnished with a report by you, and I'm here to take your deposition in preparation for trial to find out what you have to say and the reasons that you hold those opinions.

You have been through this before, I

presume. Am I right?

A. Depositions?

Q. Yes.

A. Yes.

Q. So I don't need to belabor the point about letting me know when you don't understand a question so I can try to rephrase it or, you know, waiting until I ask my complete question and making your responses out loud so the court reporter can get them. You understand all those ground rules, if you will?

A. Correct.

Q. Okay. I've been provided with your CV, Doctor, and I don't know whether that's the most recent version. Can you tell me whether it is?

A. When was this given to you?

Q. At the same time as your report, which was dated August 16th of last year.

A. I think there has been a slight update on this. My secretary will be more than happy to give it to you.

Q. Okay. I'd appreciate that. And maybe by looking at the last entries, you can tell me what needs to be added.

A. Basically just I think I gave one or two

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

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

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

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

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A. Yes, I do. I'm sorry.
Q. Okay. And how many firms besides Jacobson, Maynard have you done work with?
A. I would have to guess in the neighborhood of seven, eight.
Q. Okay. Would you say that the majority of your work is done with that firm, the majority of the legal, medical/legal work?
A. Of the defense work, yes.
Q. Okay. I take it, then, that you also consult with plaintiffs' attorneys on cases?
A. That's correct.
Q. Can you tell me how many plaintiffs' cases you've consulted on?
A. I would say in the neighborhood of 10.
Q. Ever testify in one?
A. Yes.
Q. When was the last time that you testified on behalf of a plaintiff in a malpractice case?
A. In court you mean?
Q. Or by deposition.
A. By deposition, there was -- it was this year. In court, it's been several years or many years.
Q. Okay. What percentage of the defense

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cases that you consulted on would you say have been with lawyers from Mr. Bonezzi's firm?
A. Of the defense work percentage-wise, I would say around 75 percent.
Q. And how would you break down the percent of your work between plaintiffs and defense consulting'?
A. Probably 60 percent defense and 40 percent plaintiffs.
Q. Okay. Have you worked on medical negligence cases with Mr. Bonezzi in particular before?
A. I think once.
THE WITNESS: Did I, Bill?
MR. BONEZZI: Yeah, one time.
Q. And was that case related in any way to the area of medicine in which you are testifying here in this case?
A. I don't believe so.
Q. Okay. Are you insured by physicians' insurance PIE?
A. No.
Q. Have you been in the past?
A. Yes.
Q. I assume back when you were in Ohio?

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

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

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Q. Fink. Is your relationship with Jacobson, Maynard strictly professional as opposed to being either a combination of professional and social?
A. No, strictly professional.
Q. Okay. So would I be correct in assuming you are not related to anybody in the firm?
A. Not that I'm aware of.
Q. Okay. Either by blood or marriage?
A. Correct.
Q. All right. And how are other people otherwise related?
A. We are not related. I have no relationship other than professional with them.
Q. So like none of their lawyers are your kids' godfathers or parents, and you are not theirs and all that?
A. That's correct.
Q. Have any of the cases in which you have consulted been, as you would consider it, similar to the case involving Mrs. Kostelnik?
A. You know, I do surgical consultation malpractice cases. So in that respect they are surgically related cases, but other than that, the similarity of a specific instance such as this

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occurring, no.
Q. Okay. And what would be similar to me would be a case involving a back surgery with a vascular complication and the sequelae.
A. No.
Q. None of those?
A. None of those cases I have done.
Q. Great. Have you ever had a license or hospital privilege suspended, denied, or revoked?
A. No,
Q. Have you ever been asked to leave a group practice?
A. A group practice?
Q. Yeah.
A. No.
Q. Let's see. I believe you are board certified in general surgery?
A. And recertified both.
Q. And did you pass on first attempt?
A. Yes.
Q. Do you teach medicine anywhere at this time?
A. No.
Q. Have you written anything in the medical literature that you consider to be pertinent to this

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case?
A. No.
Q. Okay. To be more specific now about this particular case, have you -- well, why don't you start by telling me what you have reviewed to enable you to express opinions in the case.
A. I have in front of me everything that I have reviewed. So if I could, could I just go through and list it?
Q. That's fine.
A. I have - this is in no particular order, by the way. I have my own particular letter that I wrote dated August 16, 1996. I have a letter, actually a summary, from Mr. Michael Michelson regarding our position, quote, unquote, in this matter that I have reviewed.
I have a letter from Dr. George Schoedinger, S-c-h-o-e-d-i-n-g-e-r, III, who I believe is an expert for your firm in this case. I have a letter from John S. Wilson, also an expert from California for your firm.
Then I have the depositions of Dr. Mark Grady, Dr. John Wilson, Nurse Jo Ann Mitchell, Dr. Eric Rothfusz, R-o-t-h-f-u-s-z, Dr. George Schoedinger, Nurse Joseph DeCaro, Nurse John Van

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Deventer, a deposition also of Dr. Stephen Helper and Dr. Michael Bolesta, Dr. George Anton, and the office records regarding Mrs. Kostelnik of Dr. Stephen Helper, and then the chart from Meridia Hillcrest Hospital dated 4-26-94 regarding Mrs. Kostelnik.
Q. Okay. Have you reviewed any of the coroner's office materials, photographs, or the autopsy report?
A. No.
Q. Okay.
A. Well, the autopsy report I said something about, and I didn't see any photographs or the actual report, per se.
Q. Okay. Do you plan to review any additional materials before testifying?
A. Unless they are provided to me.
Q. But you haven't asked that any be provided that you think might be necessary at this point?
A. That's correct.
MR. BONEZZI: I will make the same representation everybody has; that is, if he receives any further information and that causes an addition to his opinions or deletes them, I will

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notify you so you have the opportunity to ask him further questions.
MR. SCHARON: Okay.
Q. Clearly some of the materials which you've just listed for us you received after your report of August of 1996 because some of those depositions weren't taken until later. Did any of the additional information which came to you cause you to make or change any of the opinions that you hold in the case?
A. No, they did not.
Q. Okay. Did they cause you to formulate any additional opinions which are not contained in your report?
A. Not really.
Q. Okay. Well, kind of? I don't mean to be flip about that.
A. I understand.
Q. But that really suggests something.
A. Any additional opinions, no. My opinions are still the same. They haven't really changed. They have reinforced some of my opinions that were provided in this report.
Q. All right. Have you reviewed any medical literature in preparation for this case?

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A. No.
Q. Do you know any of the doctors, nurses, or experts in the case?
A. Yes.
Q Who?
A. I know Dr. Anton. I did practice at the Hillcrest Hospital before leaving Cleveland, so I professionally have known most of the people involved in this patient's care with the exception of Dr. Helper, who I never did meet that I'm aware of. But the nurses, the nurse anesthetist, the anesthesiologists, the vascular surgeon, I'm familiar with them all.
Q. Okay. Did you form any conclusions of your own concerning the competency of those folks that you worked with at Hillcrest?
A. When?
MR. BONEZZI: As it relates to this case?
MR. SCHARON: No, during the time he worked with them and as a result of having worked with them.
A. I thought they were all competent.
Q. Okay. Did you form any opinions as a result of your working with them at Hillcrest

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Hospital concerning their truthfulness or lack of truthfulness?
A. No.
MR. BONEZZI: Objection.
Q. Have you been called upon in your practice to respond to the emergency which occurred in this case, that being damage to an iliac artery and vein during a back surgery?
A. Not during a back surgery, but during other surgeries, yes.
Q. During what surgeries --
A. Usually --
Q. -- did your experience take place?
A. I'm sorry. Usually it would be gynecologic procedures when laparoscopic injuries occurred to these vessels. It's a similar type of an injury as the retroperitoneal structures being damaged. I believe, I think there might have been an orthopedic injury. That was not during a posterior approach but was an anterior approach, many years ago, but a similar kind of injury again.
Q. All right. How many times has that occurred in your practice or experience?
A. Maybe three times or something of that nature.

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Q. And were you called in at some point during the primary operation to deal with the complication that had arisen?
A. Yes.
Q. And do you recall what happened in those cases?
A. No, to be honest. I believe they all survived, but I really can't remember the specifics.
Q. Do you think any of them involved transection of the iliac artery and laceration of iliac vein?
A. Yes. I don't know. I don't know if it was complete transection of the artery or a major laceration of both the artery and, of course, the vein.
Q. You think, you said, the patient survived?
A. That's my recollection for all three cases, yes.
Q. Okay. Do you have any recollection about the timing of your intervention following the damage to those blood vessels?
A. Only in that, once it was recognized and there was a problem arising, I was called. So the time would be, peri-injury, 10 minutes, give or

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

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

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

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

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Mrs. Kostelnik's situation, age, physiologic condition, et cetera.
Q. All right. Do you have any opinion as to why -- I assume that by definition, then, she is in the 25 percent of people who don't survive?
A. Right.
Q. And do you have any opinion as to why she is in that 25 percent?
A. The only thing I can think of is that she physiologically sustained something that caused her heart to stop, whether there was electrical problems, whether there was fluid electrolyte problems during resuscitation. Those would be the answers I would come up with.
We had a woman who basically was hemodynamically pretty stable for the most part even during the time of her recognition of the injury, the brief minute or two when her pressure was at about 70, I believe, and then came back up. But more importantly, she had been salvaged, if you will, according to Dr. Anton's note in deposition, to the point where he was calling for someone to take a picture. Then all of a sudden her heart stopped.
That's the analytical type of events.

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And I have to assume, and this is again in reference to your question, that something happened during that resuscitation with the fluids, that the electrolyte situation probably changed.
Q Would you think that the fact that up until half past 3:00 of that afternoon she hadn't been given any whole blood products, that that was a factor in this, the imbalance, as you are referring to it?
A. I don't think it's the blood products more than it is the crystalloid that was being given. As I said, you can - I have patients who walk into my office with blood counts of six grams, five grams, which is easily less than half of their blood volume, easily less than half, and they walk in the office. They feel fine except a little tired.
So I don't think the blood products, per se, was the issue here, and that's my opinion as a surgeon.
Q If she had been receiving blood products, would she have been getting less of the crystalloid?
A. It's hard to say. It depends on what her pressure would be doing and how fast they get the blood products in. Not necessarily, no. Not necessarily.
Q. Am I right, then, in taking from your comments that you don't think that Mrs. Kostelnik died because of a volume problem?
A. Correct. I think her volume was probably pretty well up to snuff.
Q. Right. And we can take that from Dr. Anton's description of the vein after being repaired, bulging and bleeding?
A. Yeah.
Q. And her blood pressure and pulse returning to normal?
A. And the anesthesiologist's record indicated she had been given a large volume of fluid, and that's partially or probably the major reason her pressure and pulse revived.
Q. I take it, also, from your comments, then, that you would agree that Mrs. Kostelnik died because of the transection of the iliac artery and the laceration of the iliac vein?
A. As a result of?
Q. Yes, as a result of.
A. As the coroner's report would go, death probably secondary to cardiac arrest as a result of fluid instability as a result of transection of the vessels.

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Q. Right. Okay. I just wanted to be sure I was clear, that it does all come back to that, though, as the starting point.
A. Of course.
Q. Okay. Is there any doubt in your mind but that the damage to those blood vessels occurred during the disk removal surgery?
A. No doubt.
Q. Okay. Is there any doubt but that it occurred or was caused by that -- the damage to the blood vessels was caused by instruments in the hands of Dr. Helper?
A. Is that the plural?
Q. Or an instrument?
A. Yes.
Q. There is doubt in your mind?
A. No, no, there is no doubt it was an instrument that caused it.
Q. And an instrument in the hands of Dr. Helper?
A. Correct.
Q. Okay. Do you have an opinion as to what instrument it was?
A. Yes.

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

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

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

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

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just a little bit. Again, we are dealing with very small spaces here. We are dealing with centimeters, half an inch.
Q. Okay. I didn't mean to interrupt.
A. That's okay.
Q. Is it half an inch from the right side of the posterior longitudinal ligament lying over the disk space to the anterior longitudinal ligament on the left?
A. On the left?
Q. Uh-huh.
A. Probably more like an inch, I would imagine.
Q. And wasn't it?
A. It depends on the individual.
Q. Yeah. Weren't the vessels that were damaged in this case the left iliac artery and vein?
A. Yes.
Q. Okay.
A. But understand how they run.
Q. Well, tell me.
A. The left iliac vein crosses over from the right side. So it has to traverse all the way over to get there. The bifurcation of the aorta is really central and somewhat to the left where the

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disk spaces are.
But the distances involved are like millimeters, centimeters. We are not dealing with left and right. You think of left arm, right arm, opposite ends of the body. We are dealing with spaces, the difference between left and right are literally millimeters.
Q. Have you looked at any films of Mrs. Kostelnik?
A. No.
Q Okay. Do you have an opinion as to what the distance was from the location at which Dr. Helper made his star-shaped incision to the location of the iliac artery and vein?
A. My opinion is that it's probably going to be like most people's, nothing dramatic, not more than an inch or two maximum. It may be less, I don't know, in this particular individual. But anatoniically speaking, that's what we are normally dealing with.
Q. Okay. So assuming her to be within norm, somewhere between an inch and two inches?
A. Perhaps, yes.
Q. Okay. Have you seen any evidence in this case that Mrs. Kostelnik's anatomy was outside of

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norm?
A. No.
Q. Since you hold and have expressed opinions about Dr. Helper's disk surgery, I think I need to ask you some more questions about that particular surgery. Is it the goal of the surgeon while removing the disk material to stay within the disk space with his instruments?
A. The goal?
Q. Yes.
A. I would assume that's correct.
Q. Okay.
A. Actually the goal is to remove the herniated disk.
Q. Right.
A. And if the herniated disk is not in the disk space, then I would assume maybe you are not supposed to stay in the disk space. As I told you, I'm not an expert in this operation, but it's -- the common principles are pretty clear.
Q. Are you aware of whether or not there is a recommended depth of instrument incursion into the disk space while performing the surgery?
A. No.
Q. Do you think that the surgeon performing

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the disk surgery needs to be careful not to penetrate the anterior/posterior -- the anterior longitudinal ligament, excuse me?
MR. BONEZZI: Objection.
A. To be careful. It's prescribed in the operation, yes.
Q. Would you agree that, if the surgeon performing the discectomy doesn't go beyond the anterior longitudinal ligament, then, absent some anatomical abnormality, he will not compromise the paravertebral vessels?
MR. BONEZZI: Objection to form of the question.
A. The iliac vessels?
Q. Yes.
A. Yes.
Q. Okay. Are you critical of the other people involved in Ms. Kostelnik's care --
MR. BONEZZI: Critical --
Q. -- in any way?
MR. BONEZZI: Critical such as that somebody other than who has been sued plays a role or contributed to the death? Is that what you mean?
MR. SCHARON: Yeah. Well --

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

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

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

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

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

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

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

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

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

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

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

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Q. Yes.
A. No.
Q. That that was something about which Dr. Helper as the orthopedist should have been sensitive?
MR. BONEZZI: Objection.
A. Should have been sensitive?
Q. Yes.
A. He wasn't administering the anesthesia.
Q. I understand. But when it was reported to him the blood pressure had dropped, that's something that should have been important to him?
A. I'm sure it was.
Q. And would you agree that presumably, knowing that damage to the blood vessels is a possibility during this surgery, that when the blood pressure dropped below a hundred and stayed there despite the effects --
A. Stayed there for how long?
Q. Well, you tell me. I don't think it came back up until after Dr. Anton came on the scene and got control.
A. That's not my understanding.
MR. BONEZZI: That's incorrect.
A. My understanding is, it came back up to

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the 90-some level within five minutes. Well, we have the operative report. Do you have the anesthesia record there?
MR. BONEZZI: Uh-huh.
THE WITNESS: I don't think I have a copy of that, for some reason.
MR. BONEZZI: Here, then it goes up here.
A. So here she's running around a hundred, then she at -- let me get -- it's not good insofar as my eyesight is concerned. It drops down for about a period of 5 minutes, I can see here, 10 minutes, then it's back up to around 90, then it's back up to around 95.
Q. Tell me what time it's back up to 90. I want to make sure I'm looking at the right time.
A. I don't know if it's the same one you are looking at.
Q. This one?
A. Yes, back up there.
Q Quarter after?
A. Yes, that is quarter after.
Q Well, I'm looking at this time now.
A. 1500, so that would be 1515, that's correct.

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Q Okay. There's 30.
A. It's going up here at this point in time, so this is the only point. Here it's 90, now it's down here. As I said, this is the 59 or 60 they talk about.
MR. BONEZZI: 3:10?
THE WITNESS: Yeah.
A. That's the one we are missing right there. See that? So around 3:10 it's already way up, then down to 90 again. This little drop for five minutes is inconsequential, when she drops down that one time and she comes right back up with ephedrine, I imagine, and the fluid they gave her, we see that all the time, almost daily doing surgery, pressure fluctuations such as that. Dr. Helper should not have been worried about blood loss at this point. That should be one of the furthest things from his mind actually with that pressure curve.
Q. Have you reached any conclusion or tried to figure out how much blood loss Jackie Kostelnik sustained before the flow was stopped either by tamponade or ultimately by Dr. Anton?
A. By Dr. Anton, I think, right. Dr. Anton, I believe, records a 2,000 cc blood loss.

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Q. Yeah. You mean in the containers?
A. Yeah, yeah. Then there were sponges and stuff like that, so I would assume the blood loss would be in the neighborhood -- there shouldn't be a whole lot of blood in the belly at all because the retroperitoneum, per se, is not in the abdomen, it's retroperitoneal. You would have leaking but wouldn't have blood until you open.
And Dr. Anton, the blood he sucks out, scrapes out that is clotted and the blood that's in the drapes, ail added together, I would say probably in the neighborhood of 25, 26, 2700 cc's of blood.
Q. I thought he indicated that, after he opened the peritoneum, he was pawing down through a lot of hematoma.
A. He got through the retroperitoneum. That's the only way he could.
Q. You think that amount was 2600 or 2700 CC'S?
A. In addition.
Q. Because in addition --
A. Because a lot of that blood is in the sucker, too. A lot of that blood is in the sucker, also.
Q. Does that volume of blood loss tell you

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anything about when it likely occurred?
A. No. I know when it occurred.
Q. If you are right about what it was caused by.
A. I see nothing that tells me I'm wrong. Of course, if I'm right. I assume I'm right.
Q. I've already done a lot of these. I'm just checking them off.
A. That's okay.
Q. Your report refers to disk removal surgery as a difficult procedure. What makes it so?
A. It's a major procedure being done by an orthopedic surgeon. "Difficult" might be the wrong word. It's an involved procedure.
Q. How about easy?
A. No. "Easy" is not the right word, either. Involved, complicated, complex. Difficult when compared to things like setting a bone, like an orthopedic surgeon does.
Q. Well, irrelative of what word you chose to put in the report, what did you mean?
A. I mean complicated, complex, requiring a great deal of expertise.
Q. Okay. Would you think that it also requires a great deal of practice?

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MR. BONEZZI: Objection.
A. My feeling on this is that, if you have gone through a residency program specifically in orthopedic surgery, it's accredited, as his was at Luke's Hospital, Clyde Nash I believe was the program director, who is an outstanding back surgeon, my feeling is that anybody coming out of that program doing that operation is more than qualified.
Q. For the rest of their life?
A. For the rest of their life as long as they are doing it.
Q. How often do they have to do it to maintain their competency?
A. I have no opinion on that.
Q Do you think really that doing this surgery or doing disk surgery three times a year is enough to maintain competency at this complicated procedure?
A. No opinion.
Q. So is it your opinion, then, that until Dr. Anton -- or I'msorry, until Dr. Helper observed and palpated Jackie Kostelnik's abdomen, there was no reason for him to have suspected blood loss?
A. Dr. Helper?

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

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

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

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

MR. BONEZZI: Jim, do you have any questions?
MR. MALONE: I've got to be honest, this has been hard to hear. I think the doctor has one of those mics that picks up when you start talking. So no, I guess I don't. I guess I heard enough of it that I won't clutter up the record because I don't want to misstate.
MR. BONEZZI: That would be good.
MR. MALONE: Bill, give me a ring. Are you done now?
MR. BONEZZI: Yeah.
MR. MALONE: Bill, when you're back, give me a ring.
MR. BONEZZI: Okay.
MR. MALONE: And we'll talk about transcript, all that stuff.

(The deposition was concluded at 1:38. Signature was waived.)

CERTIFICATION

* * * * *

BE IT KNOWN that I, Lisa Erwin, took the foregoing deposition at the time and place stated in the caption hereto; that I was then and there a Notary Public in and for the State of Arizona; that by virtue thereof I was authorized to administer an oath; that the witness, Howard Charles Pitluk, **M.D.,** before testifying was first duly sworn to state the truth; that the testimony of said witness was reduced to writing under my direction; and that the foregoing 59 pages contain a full, true and accurate transcription of my notes of said deposition.

I FURTHER CERTIFY that I am not of counsel nor attorney for either or any of the parties to said cause or otherwise interested in the event thereof; and that I am not related to either or any of the parties to said action

IN WITNESS WHEREOF, I have hereunto subscribed my name and affixed my seal of office this 24th day of April 1997.

.....

LISA ~ W E N,ne, LISA ERWIN, NOTARY PUBLIC
My Commission Expires: 6/15/98

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