IN THE COURT OF COMMON

STATE OF OHIO, COUNTY OF CUYAHOGA

JILL BOLTIN,

Plaintiff,

vs.

THE CLEVELAND CLINIC FOUNDATION; RONALD LESSER, M.D.; JOSEPH F. HAHN, M.D.,

Defendants.

No. 90787

DOC. 425

DEPOSITION OF ROBERT F. SPETZLER, M.D.

Phoenix, Arizona
November 26, 1986
2:10 **o'clock** p.m.

REPARED FOR:

OMMON PLEAS COURT

Original)

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I N D E X

E X H I B I T S

THE DEPOSITION OF ROBERT F. SPETZLER, M.D.,

taken at 2:10 o'clock p.m., on November 26, 1986, in the office of Robert F. Spetzler, M.D., 2910 North Third Street, Phoenix, Arizona, before MARK BARTUNEK, a Notary Public in and for the County of Maricopa, State of Arizona.

The plaintiff was represented by her attorney, Mr. Charles I. Kampinski.

The defendants were represented by their attorneys, Reminger and Reminger, Co., by Mr. Gary H. Goldwasser and Dr. John R. Irwin.

Phoenix, Arizona
November 26, 1986
2:10 o'clock p.m.

ROBERT F. SPETZLER, M.D.,

called as a witness herein, having been duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. KAMPINSKI:

Q. Doctor, my name is Charles Kampinski. I represent Jill Boltin. I want to ask you a number of questions this afternoon. If you don't understand any of them, please tell me. All right? I'll be happy to rephrase my questions. When you respond to them, if you would, do so verbally. He is going to be taking down everything we say and he can't take down a nod of your head. All right?

A. Will do.

Q. Someone is bringing your C.V. over?

A. correct.

Q. Until it gets here, why don't you --

(Interruption off the record.)

Doctor, it indicates, your C.V., that is, indicates that you went to medical school at Northwestern from 1966 to 1971; is that correct?

A. From 1967 to 1971.

Q. And then you did internship in Chicago and residency training in neurosurgery at the University of California for five years until 1977; is that correct, sir?

A. Right.

Q. You then Stayed at the University of California for one year as an instructor in the Department of Neurosurgery?

A. Right. That was the last year of the residency program, which is why the two years correlate with the previous dates.

Q. You then went to Cleveland. And you have listed here on your C.V. that you were assistant professor of neurosurgery from 1977 to 1981 and associate professor from '81 to '83.

A. Correct.

Q. Was that just teaching duties or were you also involved in treating patients there?

A. Treating patients.

Q. Okay, And your teaching duties, how much time would you say was spent at that as opposed to patient care?

A. Very hard to differentiate since the teaching and patient care were very often one and the

same.

Q. Did you have actual duties that were limited to didactic training only;'

A. Yes.

Q. But IC also consisted of training what, residents and interns in the hospital setting treating patients?

A. Right.

Q. Did you have a private? practice in Cleveland or was it Limited to your association with the university?

A. Limited to my association with the university.

Q. So that you saw only statt patients?

A. No. The university's main patient pool, in tact, are I think what you would reter to as private patients,

Q. How is it that you became associated with their care then7 Referrals?

A. Correct.

Q. But they would remain the patients of the referring physicians?

A. No. They would become our patients,

a. When you say "our," were you part of a group?

A. correct.

Q. What group?

A. University Associates. University Neurosurgical Associates.

Q. I haven't had a chance to go through your entire C.V. and I am not going to take the time to do so right now, but were you on any committees while you were in Cleveland of any groups with Doctor Hahn or any of his associates at the clinic?

A. Not to the best of my recollection.

Q. Were you on any committees of any organizations while you were in Cleveland?

A. Yes.

Q. What were they?

A. I was on the Scientific Program Committee of the Congress of Neurological Surgeons in 1981. I was on the registration committee of the same organization in 1980. I was on the Sergeant At Arms Committee in 1980 of the same organization. I was Chairman of the Special Courses Committee in 1982 of the same organization. I was an associate editor of Clinical Neurosurgery of that committee in 1982.

Q. You are reading from page 5 now?

A. That is correct,

Q. None of these committees had Doctor Hahn

as a member ot them; is tnat correct?

A. That's correct.

Q. How about any ot the organizations that you were a member ot?

A. He certainly was also a member ot many of: those organizations.

Q. Dad you know Doctor Hahn before coming to Arizona?

A. Before coming to Arizona?

Q. Yes.

A. Certainly.

Q. And what was your relationship with Doctor Wahn? Was it professional, social, both'.?

A. Professional.

Q. Did the two ot you collaborate on any papers ow reports ox studies?

A. No·

Q. What was the nature ot the professional association? Did you have any joint patients, tor example'.?

A. I don't believe so.

Q. Did you ever work with him?

A. You mean professionally?

Q. Yes.

A. No.

Q. What did you mean?

A. Maybe puttering around in the backyard. No.

Q. Why, were you neighbors?

A. No.

Q. I thought I asked you if you were friends or if you socialized with Doctor Hahn.

A. That's correct.

Q. Did you?

A. Yes.

Q. Did the two of you undergo any training together?

A. No.

Q. Was that the extent of your relationship then, a social one?

A. Neurosurgeons are a relatively small body of men and women, and I think those that are in teaching locations tend to know each other, almost everyone. And I knew Doctor Hahn being in the same city, particularly after he became chairman. And, therefore, I certainly knew him relatively well from that aspect.

Q. Was it Doctor Hahn that asked you to get involved in this particular case?

A. Yes.

Q. And when was that? And it you've got correspandence that will assist you, you can reter to it.

A. I don't recall. I would -- I just don't remember.

Q. You wrote a short, one paragraph, and I'll call rt a report tor lack ot anything better to call it, dated I think August 5th. Let me find it. Do you have it there handy?

A. August 26th.

Q. 26th. In relation to that report, when were you contacted by Doctor Hahn?

A. Before then.

Q. Well, a week, a month, a year?

A. I think probably several months.

Q. And how many discussions did you have with Doctor Hahn regarding this particular case?

A- That was the only discussion.

Q. What is it that he told you at that time?

A. That there was a case that he was being sued tor and whether I would be willing to review the case.

Q. And was that all or did he go into the details at: the case?

A. No details.
Q. Did you ever discuss the details with him at any time after that?
A. No.
Q. Any other doctors at the clinic?
A. No.
Q. What was your next contact in relation to becoming involved?
A. The next contact was from the attorneys.
Q. The firm of Reminger and Reminger?
A. Right.
Q. Who were you contacted by?
A. I believe it was Doctor John Irwin.
Q. Did you know Doctor Irwin before this?
A. No.
Q. Had you ever had any relationship with the firm of Reminger and Reminger before?
A. No.
Q. Have you ever testified as an expert in any case before?
A. I believe I've testified once.
Q. Where was that, sir?
A. Here in a deposition.

A. It was for the defendant.

Q. Did it involve a neurosurgeon within your group?

A. NO.

Q. Another neurosurgeon here in town:,

A. No.

Q. A neurosurgeon in Cleveland?

a. No.

Q. Where?

A. Neuroradiologist.

Q. Where?

A. In town.

Q. Have you, yourself, ever been involved in a Lawsuit?

A. I have been mentioned in two lawsuits, both of which were dropped.

Q. Were they here or in Cleveland?

A. They were in Cleveland,

Q. And who were you defended by?

A. I don't remember.

Q. Was it the same firm that: is involved in this case, Reminger and Reminger?

A. I really don't know.

Q. Was it Mr. Goldwasser?

A. No. Whoever was for the firm of --

Q. Arter and Hadden?

A. Yes.

Q. Both of them were dropped as to your involvement?

A. One was dropped as to my involvement and the other one was dropped altoyet·her.

Q. What were you provided with by the attorneys, Doctor? You were looking at some papers, Do you have a tolder pertaining to this file?

W

Dickinson.

Q. Well, were you. contacted by Mr. Irwin by correspondence or phone or what? Do *you* recall?

A. I believe it was by phone.

Q. AIL right. And was that tollowed up at all in terms of documentary material tor you to look at?

A. *Yes.*

Q. All right. First of all, were you apprised of any facts regarding the case by Mr. Irwin

in that conversation, in that phone conversation?

s about.

But to the best of my recollection, it was that Doctor Hahn was being sued in relation to a postoperative infection in a patient; who was suffering from seizures.

Q. Anything further in terms of:details of the operation?

A. Not to the best of my recollection.

Q. Is the folder you have, that you are holding onto right now, the correspondence between yourself and the law firm?

A. Yes.

Q. Could I see it, please?

A That's my personal folder.

Q. Well, whatever it is, if it relates to the case, I'd like to see it, sir.

Has anything been removed from this folder before today?

A. No.

Q. Doctor, there is a letter dated July

28th, which is trom Mr. Irwin, with respect to what it is he torwarded to you tor review; is that correct:,

A. Correct,

Q. In the last paragraph ot the letter, could you indicate tor the record what it is that he wanted trom you, what it was you were retained to assist in, sir? Why don't you just read the paragraph and then we will talk about it.

A. "Most ot the pertinent medical issues which torm the basis ot plaintitt's claims in this case are set torth in Doctor Dickinson's report Letter. Although this report letter should serve as the starting point tor review ot this case, please teel tree to expand your comments on any other topics, issues, or matters which you teel are pertinent in the defense of this litigation. Plaintiffs are, of course, not necessarily bound *to* only the issues raised by Doctor Dickinson and we, therefore, need to be prepared or retute any implications or insinuations which may derive from Doctor Dickinson's conclusions.

"Your willingness *to* assist in this case is greatly appreciated."

MR. KAMPINSKI: Wauld yaw hand that" to the court reporter, Doctor, Why don't you mark that as Spetzler Exhibit 1.

(Deposition Exhibit No. 1 was marked for identification.)

Q. BY MR. KAMPINSKI.: Doctor, did you understand this request by Mr. Irwin as contained in the last paragraph to be one where he wanted to have your assistance to, quote, "refute any implications or insinuations which may derive from Doctor Dickinson's conclusions," unquote, or to review the records for your own opinion?

A. To review the records and arrive at an opinion.

Q. So you didn't ascribe any significance to that language in that last paragraph?

A. No.

Q. You've got in front of you a stack of items. And correct me if I'm wrong, but are those the items referred to in Mr. Irwin's letter?

A. Yes.

Q. The Cleveland Clinic records, Good Samaritan Hospital records, Columbia Presbyterian; depositions of Doctor Hahn, Lesser; and Doctor Dickinson's medical report, and some x-rays?

A. Right.

Q. Have you received any records or x-rays or films since receiving these records?

A. Yes.

Q. What else have you got, sir?

A. I received some turther copies ut the x-rays.

Q. Not of the same ones?

A. Actually I think some of them are copies of the same ones.

Q. You received some additional ones also,

Q. Any additional documentatron, Doctor; depositions of Doctor Fromm or Doctor Dickinson?

A. No.

Q. Did you see the report of Doctor Fromm?

A. Only a verbal summary.

Q. What was told to you and *by* whom;,

A. By Doctor Irwin, and that was related to me today.

Q. What were *you* told?

A. That Doctor Fromm telt that the case should nave been handled in a ditterent manner, particularly to the removal ot bone at the time of the last operation at Cleveland Clinic. And the need to resect bone beyond the bone plate itself, and that the wire mesh should have been removed at that time, and he would have continued antibiotic treatment tor six weeks.

Q. Anything turther that you can recall?

A. I don't think so.

Q. ALL right. First ot all, Doctor, in your practice, have you had occasion to encounter postsurgica4 intections7

A. Yes.

Q. Were you told by Mr. Irwin or anyone else that neither Doctor Fromm nor Doctor Dickinson takes issue with the tact that an intection did occur? Were you told that at any time, sir?

A. Not specifically in those terms,

Q. Okay. Because your August 26th letter seems to imply that that was one ot the issues that you were addressing yourself to, And that is the original complication ot obtaining an intection. Were you told that that was an issue, Doctor?

A. No, I don't recall that that was

discussed as an issue of contention.

Q. Okay. All right. Specifically you indicate in your Auyust 26th Letter, "Certainly the patient as well as the parents were well informed of the risks of surgery." Is there a reason you put that BIZ? Did that have some significance to you in terms of the issues in this case?

A' I think the importance there is the fact that there was no doubt that the patient and the family indeed were aware of the risks of surgery, which obviously included a postoperative infection.

Q. Okay. Maybe we are talking cross purposes, but I don't know that anybody has disagreed with that, And I guess I'm asking you what the importance of that finding or that understanding is in relation tu what the issues are in this case.

A. If there is no disagreement, I don't understand the purpose of the question.

Q. The purpose of the question is to find out why you put it in your correspondence.

A. It doesn't seem to be inappropriate to state the fact since there was a complication after surgery to ascertain the fact that the family and the patient indeed were well aware of the risks of surgery.

Q. Is there a standard and recognized fashion in dealing with postsurgical complication of an infection when there is any foreign body in the area of the infection?

A. Can you repeat that question.

Q. Should you take out all foreign material in the presence of infection?

A. I think that depends very much on each individual case,

Q. Isn't that black Letter medicine, to remove all foreign material?

A. I have no idea what black letter medicine means.

Q. It means the place from which you start,

A. No, not at all, I think there are many instances in which you attempt to sterilize an infection in the presence of a foreign body.

Q. And leave the foreign body?

A. Absolutely.

Q. Well, when you say there are many times when that would be done, why don't you tell me what they are,

A. In fact, patrents that have shunts, it is not uncommon at all to attempt to sterilize. The fact is when there is a CNS infection and there is a

catheter tram the ventricle to the outside, despite the presence ot an intection, that remains tor the purposes of instilling bodies or draining fluids.

Q. Any others?

is distant trom an intection, tor example, it you have an intection in the brain and you have a total hip, I prosthesis in place despite the tact that you have a generalized septicemia.

Q. Any others?

A. I think the list can go on.

Q. Well, we weren't dealing with a shunt or Doctor Wahn wasn't dealing with a shunt in the case ot Jill Boltin, was he?

A. No.

Q. fie wasn't dealing with a catheter, was he?

a. No.

Q. Nor was he dealing with a toreign body distant trom the site of intection, was he?

A. I think that becomes closer to the point. It depends which toreign body we are talking about.

a. Do you consider the bone flap toreign

body?

A. No.

Q. Is it a fact that bone flap in fact will become devitalized as various procedures are undertaken regarding that bone flap? Specifically she had a procedure in Montreal. She had two procedures at the clinic. Would that cause that bone flap to become devitalized to some degree after those procedures?

A. I'm not sure what you mean by the word "devitalized."

Q. Having less than a sufficient blood flow to the bone flap.

A. Implying if there isn't sufficient blood flow that --

Q. That it could be considered a, quote, "foreign body," unquote, that could harbor infection.

A. Any portion of your body can harbor infection. Bone flaps are removed on multiple occasions and multiple times. And I know of no one that would Leave the bone flap out because you have taken it out twice or three times or four times for that matter,

Q. That's not the point. The point is the infection has occurred in the meantime. And don't you

of the second surgery at the clinic?

A. I think it's very important to differentiate between devitalized and between infection. If devitalized means that it was separated from its surrounding tissues on two occasions, then that's certainly the case. It there is any intection, that is no reason not to put the bone flap back in.

Q. Isn't it? Isn't that a likely place tor the organism to simmer?

A. Bone is considered a tissue of the body, particularly when it comes out of that particular person. It is routine when there is an infection in the spine involving the bone to clear out that

infection as much as possible with instruments and then to take a, quote, "devitalized," piece of bone from the hip and place it in the setting of that infection with excellent results,

So, no, I don't think there is any reason to think that any piece of: Done that has been taken and separated trorn its attachment, whether rt be other bone or the layer, the tissues adjacent to the bone, and consider nt as a bed tor intection.

Q. Where did the intection recur in Jill Boltin? You've reviewed the records?

A. I don't know. I haven't seen the CT scans, but according to the records -- are we talking about the intection at the Cleveland Clinic?

Q. No. At Presbyterian a year and a half: later.

A. It appears that the intection was an intection in the epidural. space around the bone and in tnat frontal area of the craniotomy.

Q. In tne area of the bone flap; correct, sir?

A. It would be hard to have an intection in that area which would not be adjacent to bone.

Q. Do you know any reason why you weren't provided the CT scan since the attorneys here obtained

those specitically from Doctor Boltin a couple weeks ago?

MR. GOLDWASSER: The tact of: the matter is I forgot them inadvertently. He didn't know anything about them and I torgot to bring them. Do you have them wrth you?

MR. KAMPINSKI: I didn't get them. You got them.

MR. GOLDWASSER: Okay.

MR. KAMPINSKI: You asked for them specitically tor Doctor Spetzler to review.

MR. COLDWASSER: You are absolutely correct,

Q. BY MR. KAMPINSKI: Did you have an explanation, Doctor, as to why the intection recurred?

A. I thrnk that's one of the risks of any intracranial procedure, that there is a risk of late infection. I think when you are talking about a procedure which has now undergone three separate surgical explorations, the risk of intection is higher. And late intection is very small, but a definite risk,

Late **intection?** Is that your understanding, sir?

A. My brief report referred to the tact that the family appeared to have been intormed ot the risks ot surgery. And whether **this** included specifically late intection or not obviously was not **available to** me. But I **think** it was clear that. they had a sense ot the seriousness of the undertaking that they were about to proceed with.

Q. Is your answer no, Doctor, that. they were not intormed ot the risk ot **late** infection?

A. No, I think I just gave you my answer.

Q. I don't understand it to be yes or no,

a. You are correct, it is neither yes nor no.

Q. So you don't know **whether they** were intormed of that or not?

A. Correct.

Q. And your report **doesn't** address that issue at **all; would** that **be fair?**

A. That's correct.

Q. Knowing, though, **you** as a neurosurgeon, Doctor Hahn as a neurosurgeon, of this potential risk, is it theretore **more** important to analyze **the** toreign bodies that can in **tact** cause this **late** intection tu occur?

A. Can you make that a little clearer?

Q. I'll try. You will have to bear with me. I'm just a Lawyer. I'm not a doctor.

A. I am well aware of that,

Q. Knowing as you do, Doctor, that there is this potential of late infection, is it therefore more important for you as a neurosurgeon, speaking generally now, to analyze and assess the potential of in the site or near the site?

where there was any analysis made of the removal of the wire mesh and/or the bone flap?

A. No.

Q. And have you talked to Doctor Hahn or Mr. Irwin or Mr. Goldwasser about that failure to address that situation in the record? Has that been discussed, sir?

A. No. But I don't believe that any record will discuss every potential. complication, its management, et cetera. It would be voluminous in

nature and would still certainly in some case miss a salient feature in that particular case.

Q. Well, in this particular case, knowing that there were foreign bodies in or near the area -- and let's speak about the wire mesh. We may not be speaking about the bone flap at all depending upon how you analyze it. But would you do anything after the second surgery if it was your patient in terms of trying to determine where the mesh was or, you know, the likelihood of removing it? Would you do any follow-up x-rays, for example?

MR. IRWIN: The second operation or third operation?

MR. KAMPINSKI: The second operation at the clinic. There were only two at the clinic.

THE WITNESS: But it's the third operation in the patient's history.

Q. BY MR. KAMPINSKI: Right.

A. The question, if I may, pertains to whether I would do any further x-rays to ascertain the wire mesh?

Q. Sure.

A. No. I think the wire mesh has been very well localized on the x-rays. Considering how long it had been there, they are not going to move it.

Q. Is there a reason why you wouldn't take out the wire mesh, sir?

A. The records suggest tnat the wire mesh, which was present trom the procedure performed in Montreal. six years earlier, is relatively Far torward ot the procedure that Doctor Hahn carried out. And I think it thus can be assumed to be relatively remote. And I don't think I would proceed to remove them it they were out ot my surgical tield.

Q. How tar is relatively remote, relatively tar torward? When you say "relatively," why don't you give me a distance, Doctor,

A. I think distances are relative when it comes to the brain. If you are in a vital area ot the brain, a millimeter might be relative. If we are talking about a leg, maybe ten centimeters might be relative.

Q. Haw tar was it trom the surgical tield?

A. The surgical tield was obviously not available to me except in retrospect from the description,

Q. How about the x-rays?

A. The x-rays that I have are all preoperative x-rays.

Q. How about pictures? Were you provided

with pictures that were taken during the operation?

A. No, No. The description of the procedure and the location of the electrodes after the first Cleveland Clinic procedure suggests that it was in the temporal area of the brain and the wire mesh is in the frontal area,

Q. Are you saying that the x-rays were all preop, Doctor, that you were provided?

A. No.

Q. I thought that's what you said.

A. The x-rays were not after the second operation.

Q. Can't you tell from the first x-rays after the first operation'?

A. I just explained it.

Q. Can you tell from the x-rays, sir?

A. I can tell where the wire mesh was and I can tell where the electrodes were, which I just described.

Q. Why don't you just show me on the x-ray, Doctor.

A. This would do very nicely. Here is where the electrodes are and here is where the wire mesh is.

Q. Where was the bone flap, Doctor?

A. The bone flap tram the second operation -- f think that's probably the Done flap. We can see the lines through it.

Q. I'm sorry?

A. I think that's probably the bone flap, because one can see the lines through it.

Q. Does that encompass the area of the wire mesha

A. It comes *very* close to the wire mesh.

Q. Would it have been, in your opinion, difficult to remove the wire mesh during the second operation, sir?

A. It depends a little bit technically how the tlap was made, Because it it's deep and the bone is removed deep, then it may be more awkward to remove it. But it the question implies whether it can be removed, I think the answer is *yes.*

Q. And what is your understanding, sir, of the nature of serratia marcescens? What kind of infectran are we talking about here? That is the one she had, right?

A. That's the bug that was described. Bug referring to bacteria.

Q. Right.

A. I would say it's an organism that

infects the body and can certainly cause the symptoms that were described in this particular patient's case.

Q. Do you claim to have expertise in the nature ot the organism in terms of its likelihood of returning, how to treat it, or would you in encountering that particular bug seek guidance from, let's say, an infectious disease person?

A. I think it depends very much on the particular nature of *that* patient's infection. If it's a postoperative meningitis with serratia, which is sensitive to antibiotics, I think in the majority ot cases the neurosurgical team would treat that.

Q. And without getting any consult?

A. Correct.

Q. In treatrng it, I take it you have some idea ot the nature of the bug and its propensity to he indolent or return at same point in the future?

A. Correct.

Q. Would that militate tor removal ot toreign bodies within the surgical area, to try to at least minimize the risk of its returning at some point in the future?

A. I think that should certainly be considered.

Q. an terms of treating It medically, that

is, the infection, is there any particular medication, antibiotic, that you would have used in 1983, Doctor?

A. I think the antibiotics that were used in this particular case appear appropriate.

Q. By the way, you were in Cleveland in 1983 when Jill Boltin was being seen at the clinic?

A. What time of the year was that?

Q. You were there July to August -- I'm sorry, you were there until August of '83?

A. I left in August. I actually left in July.

Q. You didn't have anything to do with Jill Boltin's care?

A. No.

Q. You weren't called by Doctor Hahn or anybody else in terms of a consultation of her case?

A. No.

Q. How many cases of serratia marcescens have you seen postsurgically?

A. I don't know that I can put an exact number on it. But it certainly has been greater than ten.

Q. Pretty rare organism.

A. Pretty rare organism. Pretty rare in patients that have to have colonic drainage systems.

Q. Shunts?

A. Shunts, exactly. That's where I have seen a number of them.

Q. What's the incidence of recurrence of the bug in those ten that you've seen? I'm not holding you to a num

A. I didn't specifically say ten.

Q. I understand.

A. To the best of my recollection, after they have been sterilized, I have not seen any late recurrences.

Q. How long do you treat them in terms of follow-up? And I may have cut you off before when I asked you what antibiotic you would use to treat --

A. I would be guided by the sensitivities of the organism. I don't think -- I do like chloramphenicol, and the bug usually is. And I like it given IV.

Q. How long?

A. It again depends on the specific case. If it's a simple shunt infection and the shunt can be removed, a shorter time may be appropriate. And if it's a more difficult procedure with greater operative undertakings or second procedures that are necessary, I would keep it on longer.

Q. When you say "longer," how long? Let's talk about Jill Boltin.

A. In Jill Boltin, my own feeling would be to treat with two weeks of IV chloramphenicol and potentially followed with an oral case of appropriate antibiotic for another four weeks.

Q. Well, knowing that you were leaving a foreign body in the area, would your judgment be affected at all knowing that the wire mesh was staying in and perhaps devitalized?

A. This was for the specific case?

Q. Yes.

A. I think I would stick with the two weeks of IV and potentially four weeks of oral.

Q. Is it your opinion then that seven days of IV was not enough?

A. I think seven days of IV antibiotics is too short.

Q. And that increases, I take it, the likelihood of the bug recurring at some point in the future?

A. I would think in this particular case it increases the likelihood of serratia being indolent,

Q. Have you reviewed any literature in preparation for getting involved in this case?

A. No.

Q. Do you intend to?

A. No.

Q. I'm sorry?

A. Not unless there is a specific issue that comes up.

Q. Earlier, Doctor, you made some indication of the infection being epidural. Do you recall that?

A. Uh-huh.

Q. You made a point of saying that to me and I think you were referring to the subsequent infection?

A. Right. I believe you were specifically interested in the one at Columbia at the time.

Q. That's correct. Do you believe that it was limited to the epidural area or do you think that it was more extensive than that? And it's difficult. Obviously you didn't see it. You weren't there.

A. From the presentation and from the information that I've read, it makes sense that it was an epidural infection.

Q. Why is that?

A. Because the clinical presentation was one of swelling and tenderness without any suggestion

of meningitis ox encephalitis, the Latter being much more common with intections within the epidural space as opposed to autsI.de of the epidural. space.

Q. Is that significant. in relation to what effect this intection had on Jill Boltin? Is that where it derived its significance?

A. Definitely.

Q. What is your belief of the effect of that infection, the one that occurred at Columbia?

A. Well, I don't have any follow-up, so it is a little hard tor me to assess.

Q. Have you treated patients with epilepsy in the past, Doctor?

A. Yes.

Q. Or would that be something that a neurologist would do and you would only get involved in terms of some surgical. procedure?

A. I think we treat a number of patients that have seizures or epileptic attacks, although the vast majority receive neurological consultation or are seen primarily by the neurologist.

Q. And can you determine patterns with respect to prognosis on those patients? In other words, if you follow them for, let's say, two, three years, have you pretty much determined what that

person's future course is likely to take?

A. That's a very broad question.

Q. Right, I am going to get specific after you answer it.

A. Because the source of the seizure focus is really critical in determining the natural history.

Q. When you say "the source," are you talking about the location or the etiology?

A. The etiology.

Q. There are studies that downplay the significance of the etiology in determining prognosis. You are aware of those, are you not, Doctor?

A. I would like to see those, I think --

Q. You are not aware of them?

A. I think that's an unclear and misstatement of the facts of seizures, The etiology of seizures is very critical. A very clear: example to demonstrate that is a patient who has a seizure secondary to a tumor. Obviously I don't think there would be anybody, including yourself, that would deny the etiology in that particular case plays a critical role in that patient's natural history.

Q. Being only a lawyer, I'd be in no position to either deny it or admit it.

A. I don't think it makes any difference

what sort of specialists we are. As tar as common sense is concerned.

Q. I agree with you, Doctor. If the etiology is unknown, is that a prognostic indicator in and of itself?

A. If the etiology of the seizure is unknown, does that in itself have prognostic significance?

Q. That's correct.

A. No.

Q. Do we know what the etiology is of Jill Boltin's seizure activity?

A. I believe that the records suggest tnat it may be related to a history of encephalitis. Possibly herpes encephalitis when the child was much younger or when she was a child.

Q. And does that have any prognostic significance?

A. I think in and of itself, the prognostic significance is derived from the emergence of the seizure pattern,

Q. I'm not sure I understand what you are saying.

A. The patient tnat has encephalitis and

has encephalitis and has one seizure, and is markedly different tram the patient who has encephalitis and then has one seizure and then in another year has two seizures, and the next year has multiple more seizures so that there is a progressive pattern to the seizure disorder.

Q. SO it's not the etiology we are talking about. It's the manifestation --

A. Correct.

Q. -- of the seizure pattern?

A. Correct.

Q. That you believe has some prognostic significance as the person gets older?

A. Right.

Q. What history were you given with respect to Jill Boltin's seizure history?

A. The records tnat you see in tront of me that we've already listed.

Q. So you knew that tor approximately a year and a half tollowing the Montreal surgery, she was seizure tree'?

A. *Yes.*

Q. I also take it that you were apprised or that you've been able to derive krom the records the purpose tor which she was at the clinic, and that was

to attempt to find a focus for the seizure activity and hopefully surgically remove it?

A. Correct.

Q. From your review of the records, were you able to determine whether or not absent the infection she would have been a likely candidate for this procedure?

A. I could not determine that from the records.

Q. Why not?

A. Because the message that was sent was that they were going to review all the data and see

A. From the records that I reviewed, I did not see a clear cut recommendation, as to whether or not they recommended.

Q. Do you have any feeling in terms of your

A. I don't think there is any way for me to tell.

Q. After th@ surgeries at the clinic and

the intection and she was sent home, were you provided any information of her seizure pattern during the interim period, that is, her discharge from the clinic and her subsequent admission to Presbyterian?

A. I saw the admission summaries from I think: it was Samaritan, Was it not Samaritan where again a mention was made of continued seizure activity?

Q. By the way, you were not provided with the depositions of either Jill Boltin or her father, Marry Boltin, were you?

A. That's correct.

Q. Were you provided with any summary of what they said?

A. No.

Q. Did you ask for any indication of what their testimony was with relation to her seizure pattern?

A. The only knowledge was that -- the only information that I was given was that: we don't have a follow-up of the seizure activity after Columbus.

Q. Columbia you mean?

A. Columbia.

Q. Wouldn't it be important for you to -- first of all, were you asked to give any opinion with

respect to what effect, it any, the recurrence of the infection had on Jill Boltin?

A. Have I been asked?

Q. Sure. Is that something that you've been asked to give an opinion on?

A. We discussed in general. terms. In fact, I believe I asked what the patient's clinical status was following the last surgical procedure at Columbia. And I was not given a clear cut answer because they, according to the attorneys, they didn't have follow-up of the patient's clinical seizure pattern.

Q. When you say "clinical seizure pattern," are you talking about in some type of institutional setting where she can be watched?

A. No, The clinical appearance of seizures.

Q. And the reason you asked tor that was what, Doctor?

A- To see whether the seizure pattern has changed any over this rime period.

Q. And why is that important?

A. I think the seizure pattern is important in relationship to whether it has continued to become worse.

Q. Would it nave been important tor you to

know that they had become more trequent and more debilitating and were related to physical activity and stress atter the Columbia-Presbyterian incident? Would that have been important tor you to know?

MR. GOLDWASSER: Objection, I am objecting for the record. You may answer.

THE WITNESS: My primary mission was to address what happened in Cleveland and the complications thereof. The seizure pattern *is* certainly an important part. And I in tact am interested in what the seizure pattern has been atter Columbia.

Q. BY MR. KAMPINSKI: Is the answer then *yes*, it was important, that is something that is important Lor you to know?

A. Yes.

Q. What does that mean to you in relation to analyzing this case, it anything? I'm trying to understand, Doctor, it your involvement is limited solely to that of the analysis at the Cleveland Clinic, and that is whether or not Doctor Wahn and/or Lesser and/or anybody else at the clinic deviated trom the standard of care required ot them trom their treatment of the infection, or whether you are also going ta be involved in an analysis of damages that-,

have stemmed from those actions. Bo you understand my question, sar?

A. No.

Q. What. are you going to testify to when you come to Cleveland'?

A. I am going to answer the questions.

Q. What have you responded in terms of what injury you believe has occurred trom the infection? What is your belief, sir?

A. Well, the initial intection at the Cleveland Clinic was treated quickly and appropriately.

Q. In your opinion?

A. As opposed to?

Q. As opposed to Doctor Fromm's opinion.

MR. IRWIN: I object.

THE WITNESS: Yes, it was treated quickly and appropriately with the appropriate laboratory values trom the spinal fluid specimans to suggest that the infection had been brought under quick control. And, theretore, I think it is relatively unlikely that that in itself would cause any brain damage.

The second intection in Columbia over a year later I believe --

Q. BY MR. KAMPINSKI: Correct.

A. -- was an infection that seemed to be limited to the epidural space. That's a very important differentiation because the dura separates the brain and its covering from the skull and the scalp, And if that's the case, it is very unlikely for epidural infections unless they have a significant mass effect. And that's why I was interested in seeing the CT scan. Unless a significant mass effect puts pressure onto the brain itself.

Q. What is a significant mass effect?

A. A significant mass effect would be one which produces a shift of the brain, compression of the brain, and, more importantly, if it produces clinical symptoms that are related to that pressure.

Q. Those clinical symptoms mean?

A. Those clinical symptoms would depend on where the pressure was being applied. If it's applied over an area of the brain, for example, that controls motor movements, and the motor movements would be affected, and so on.

Q. And if it was in the area of control of, Let's say, Learning, memory, speech, you would expect those to be affected clinically?

A. That's correct..

Q. Which is why, I take it, you asked what the follow-up was with respect to Jill Boltin:,

A. Correct.

Q. Just so I understand. When you say mass effect, are you saying there is some type of, in Layman's terms, lump in the area of infection that is pressing on the brain?

A. Where the actual volume of material is greater than would ordinarily be there and thus expands like a lump, an abscess.

Q. And that in fact could cause brain damage even if the infection was epidural is what you are telling me?

A. That is correct.

Q. I take it then you would be somewhat interested in knowing in addition to what I told you before, that is, the seizures are becoming more frequent, more debilitating; and related to physical activity and stress, that Jill's ability to concentrate, remember, speak effectively, recognize words, those things have all deteriorated since the operation at Columbia?

MR. IRWIN: Objection. You may answer, Doctor.

THE WITNESS: You see, I haven't seen

any records that have suggested to me that pattern.

Q. BY MR. KAMPINSKJ: And it you were told that's the tact?

A. I would have to see the actual studies as to the relationship of: the epidural infection to the Drain contents. The reason I would want that is because we have a young woman whose past history has clearly demonstrated a progressive unrelentless seizure worsening that has led to surgery back in Montreal, which was then controlled, and then again progressively became worse.

So that despite the tact of having already had part ot her temporal lobe resected, that her physicians felt that the additional risk ot throwing back on someone like that was justified because of her seizure problems. And, theretore, it's very important trom my *perspective* to ascertain whether the seizure pattern is one ot evolving severity and whether it is related or unrelated to the procedures that were pertormed.

Q. Just to clear up a couple things, Doctor. You made a couple assumptions in there that I want to know where you got them trom. And one ot them is that the seizures were progressive and that they were worsening, leading to both surgeries, that is,

the first surgery and the second one.

She obviously had an onset of seizures when this condition first came about and later went to Montreal where the initial resection was done. Where did you glean that they were getting worse, Doctor?

A. Actually I believe that you are the one that. told me about the seizure-free period after --

Q. The clinic?

A. The clinic?

Q. I'm sorry,

A. After Montreal?

Q. Right.

A. And then the progression of seizures.

Q. They recurred is what they did?

A. Well, seizures --

Q. Let me --

A. Seizures don't stop and then recur at a frequency which stays static. Seizures tend to be, particularly partial complex seizures, tend to have some sort of progression to them, although they may be static. But I think here we *have* a patient who was seizure free, who had an episode of encephalitis, and who then had seizures which required increasing amounts of medication to attempt to control.

I believe I am quite clear in recalling

the letter trom the neurologist in New York where there were multiple drugs in an attempt to control the seizures. And I think that at least to me suggests very strongly that this is a seizure problem which has been progressive in nature.

Q. That gust means it's not treatable with drugs. That's doesn't mean it's getting worse, does it, Doctor?

A. Xi: you require more drugs to control seizures one year ---

Q. They were not being controlled by druys at all, sir.

MR. IRWIN: Objection. Let him finish his answer.

MR. KAMPINSKI: His answer is assuming things I don't know to be a tact.

Q. BY MR. KAMPINSKI: You are assuming the drugs are controlling the seizures?

A. I said no such thing. I said that multiple drugs were utilized and that the seizures were not very well controlled, which is why the consideration for surgery was given.

Q. Right.

A. However, it the seizures were mild, nobody would consider surgery in the tirst place.

And, theretore, it is very important to ascertain the seizure history as started trom the beginning. The tact alone that tor 18 months there were no seizures and then the reemergence of: seizures I think is excellent evidence that it is in tact a progressive seizure problem.

Q. The absence ot seizures occurred atter the surgery. Do you attribute any significance to that in assisting in the cessation of: the seizures?

A. Yes. I think the tact is you've eradicated the seizure tocus to the point that you no longer had clinically evidence ot seizures. And that in the period atter that, a seizure tocus developed to the point where they obviously became clinically evident again.

Q. What does that mean? Whether they are progressive or not as opposed *to* what you believe couldn't happen, that's the recurrence?

A. I think we are talking in circles because --

Q. Maybe.

A. -- because a complete absence of: seizures and the initiation ot seizures to me is worsening.

Q. Okay.

A. And obviously it was tor the physicians and the patient and the family. Otherwise they wouldn't have agreed to further management.

Q. Is it important to you that between the discharge at the clinic and the time that she was admitted to Columbia, that the seizures were pretty constant and were constant in the sense that they were about the same as they had been before admissions to the clinic so that, in other words, for a period or time prior to the second infection at Columbia, the seizures were just about constant for a little over three years without any change in their frequency, duration, or nature?

MR. IRWIN: Objection.

THE WITNESS: You asked me whether that was important?

Q. BY MR. KAMPINSKI: Whether that was significant to you.

A. Well, I think it's important that they are the same, certainly.

Q. Would you attribute any significance to the fact that an event that we can in tact point to, that is, the infection at Columbia, intervened between a change in the nature of the seizures and, quite frankly, toe nature of when they come about, that is

related now to physical activity, whereas before she various sports teams?

MR. IRWIN: Objection.

Q. BY MR. KAMPINSKI: Is that significant to you, Doctor?

MR. IRWIN: Objection.

THE WITNESS: I think it would be significant if there was worsening of the seizures, certainly.

Q. BY MR. KAMPINSKI: The relationship of the seizures to physical activity, what significance does that have?

MR. IRWIN: Objection.

Q. BY MR. KAMPINSKI: If you know.

A. I don't know.

Q. Obviously it has some significance in terms of what she can and can't do. But in terms of medically, you just don't know why that might be?

MR. IRWIN: Objection.

THE WITNESS: Correct.

Q. BY MR. KAMPINSKI: Before when you made reference to mild seizures, I take it as to the patient there probably is no such thing as a mild seizure?

A. If a patient has severe seizures and mild seizures, I suspect it does make a difference.

Q. Was Doctor Hahn ever retained as an expert in any case that you were associated with, Doctor:'

A. No.

Q. Was anybody at the clinic ever retained as an expert in a case that you were involved in?

A. No.

Q. Are you the only member of the group of neurosurgeons from Cleveland or are there others?

A. No.

Q. Who else.?

A. Doctor Kekate, R-e-k-a-t-e.

Q. And has he been involved in litigation, do you know, Doctor?

A. I don't know. I don't think so. I mean nothing that would strike me. You are talking about being an expert witness? Being sued as a defendant?

Q. Yes. As a matter of fact, represented by the same firm that's here today, Reminger and Reminger and Mr. Goldwasser.

A. I'd rather ask them. Can we ask them?

Q. Do you know?

A. I don't know.

A. Yeah.

Q. What was that?

A. A research publication,

Q. What was the subject: matter?

A. Cerebral ischemia.

Q. How was it that you were involved in a research paper with him? I mean was --

A. Because we were both interested in the same drug and he used it in one particular instance and we used it in another and we collaborated our

data.

Q. This was while you were in Cleveland?

A. Yes.

Q. Why don't we take just a couple minute break and I'll look over my notes and I should be able to finish up fairly quickly.

Was there any downside risk to removing the wire mesh that you could see from the record, Doctor? In other words, it didn't serve any function other than cosmetic; would that be a fair statement?

A. That's a fair statement.

Q. And I guess I jumped the gun. Was there any downside risk to the removal of the wire mesh?

A. The downside risk is only in further surgery in a field that is infected and requires further tissue dissection in finding the wire which by this time I'm sure is completely embedded in soft tissue.

Q. But I assume had the need been felt to be present to remove it, the downside risk that you've just indicated would not be overwhelming in terms of preventing its being done especially in the hands of a surgeon such as Doctor Hahn?

MR. IRWIN: Objection.

THE WITNESS: Correct.

Q. BY MR. KWMPINSKI: The finding in the operative note that subgaleal fluid was cloudy, was that important to you in terms of your review?

A. I'm not sure what that question means. I mean was it important? Important in what sense?

Q. Well, it was later confirmed by the findings, the laboratory findings, in terms of this being meningitis, correct?

A. Right.

Q. That was important to you?

A. Right.

Q. And it implies, of course, that the organism, the bug, is into *the* spinal fluid?

A. Correct.

Q. And is it more likely to have disseminated throughout the area contained within the skull if it's found to be a meningitis than if it were not?

MR. IRWIN: Objection.

THE WITNESS: Meningitis means that the spinal fluid which runs around the brain and within the cavities of the brain and down into the spine is infected and not limited to one area.

Q. BY MR. KAMPINSKI: Right. So that's a pretty important finding, isn't it, Doctor?

A. The meningitis was really established through the spinal fluid at that point.

Q. Okay. But it contirmed the finding of cloudy subgaleal fluid; that was an indication that was the fact?

MR. IRWIN: Objection.

Q. BY MR. KAMPINSKI: Correct?

A. Subgaleal fluid is a different space than the spinal fluid. And they are connected through the operation and, thus, there is a continuity.

Q. Okay.

A. And I would have been surprised it it had been otherwise rather than being surprised had it been there.

Q. Okay. I'm not interring that you should have been surprised- I mean one contirmed the other?

A. Right.

Q. It was, theretore, known that the entire brain area was attected, not just the limited area pernaps of the operative site?

MR. IRWIN: Objection.

THE WITNESS: No.

Q. BY MR. KAMPINSKI: If it was not known, could one highly suspect that?

MR. IRWIN: Objection.

THE WITNESS: No, your question was quite different.

MR. KAMPINSKI: Okay.

THE WITNESS: Can you read back his question.

(Whereupon, the record was read by the court reporter as requested.)

THE WITNESS: We are talking about two entirely different things. One is spinal fluid and one is brain.. There was no evidence that the brain itself was infected, but rather that the spinal fluid was infected.

Q. BY MR. KAMPINSKI: The spinal fluid as you indicated circulates throughout the brain; would that be correct?

A. Circulates around the brain and in the ventricles which are within the brain, but not throughout the brain.

Q. Is that a potential means of this bug or an infection, especially an indolent infection, becoming contained within the capsule of the skull?

MR. IRWIN: Objection.

THE WITNESS: No.

Q. BY MR. KAMPINSKI: How did this bug get from the operative site to wherever it festered for a

year and a half before it reemerged? And I'll ask you to assume it's the same bug.

A* I think the -- although we don't know that it's the same bug.

Q. I'll ask you to assume that.

A. I have no problems with that assumption because at makes sense. Where that bug hid tor a year is hard to say, but it may well have been in an area that has relatively poor blood supply.

Q. Bone tlap?

A. Bone tlap.

MR. IRWIN: Objection.

Q. BY MR. KAMPINSKI: Or a foreign body?

A. Foreign body.

Q. Those would be tine two most likely places'?

A. Those would be two likely places.

a. You indicated that you had been told that Doctor Fromm opined that not only should the bone flap be removed, but also that part ot the bone surrounding it as well, Do you differ with that opinion?

A. Yes,

Q. Why as that?

A. Every action that is taken carries with

it a risk and everything is a judgment. I personally know of: no one that would remove the bone tlap and then the additional bone around the edge ot the craniotomy, I see no reason tor it, I only *see* additional risk and I would strongly disagree with that course ot action.

Q. There is a risk of nonremoval of bone flap, isn't there?

A. I believe I just said any action; whether it's leaving it behind or taking it out carries with it a calculated risk.

Q. It you were going to remove it, do you

bone tlap should also be excised to ensure the eradication ot the bug;'

A. That's what I was answering.

Q. Okay. The infection at the clinic -- you may have answered this in different terms and let ne ask it in these terms -.- did it. involve both the epidural and subdural space?

Q. Does the tact that Jill Boltin's tather was a radiologist have any intluence in your analysis of this case?

A. Yes.

Q. What is that, Doctor?

A. I have the feeling that throughout the records, he took a very active role in the decision-making process. And particularly toward the time ot discharge, it was obvious that the patient very much wanted to yo home, and that the tather as a physician felt very contident in continuing the treatment,

Q. Is that it? So it makes a difference as tu who the fattier ot the patient is to you in terms of whether or not you discharge yours patient whose had an intection such as that; is that your testimony, Doctor?

A. Very much so. Very much so.

Q. In other words, it he was a Lawyer, you wouldn't do it, but it he is a radiologist, you would do it?

A. ane has to be circumspect in that particular question, But I think it I have a patient whose parents are very reliable, it plays a definite role in my discharge, whether it would be a day or two earlier than any situation in which there is an unreliable set ot parents.

Q. So it wasn't the tact that he was a doctor, but rather that he was reliable?

MR. IRWIN: Objection.

Q. BY MR. KAMPINSKI: Or both?

A. It was both. In this case, the tact that he was a physician was important in that according to the chart, he was going to manage treatment atter discharge.

Q. I didn't think doctors could manage their own family.

MR. IRWIN: Objection.

Q. BY MR. KAMPINSKI: Or is that just surgery?

A. I think that's not true at all..

Q. Is that just surgery?

A. Not even in surgery is that true.

Q. What's the reason that doctors normally won't operate or handle the ailments of: their own family?

MR. IRWIN: Objection.

THE WITNESS: I think that's a personal choice. But the reason tor doing it is because you are emotionally involved.

a. Were there some assumptions made from what you could see in the record by Doctor Hahn or Lesser as to the ability of -- maybe you've just answered this -- of Doctor Boltin to further attend to the needs of his daughter?

A. I'm obviously limited by what I read. But I recall one note specifically by Doctor Lesser which discussed the continuation of.

Q. Continuation of what?

A. IV antibiotics and the father's -- and the father feeling comfortable to do that.

Q. She was discharged on oral, wasn't she?

MR. IRWIN: Objection.

THE WITNESS: The perusal of the notes

not on IV, but rather on oral?

MR. IRWIN: Objection.

THE WITNESS: I woubd disagree with the IV discontinuation.

Q. BY MR. KAMPINSKI: The subsequent admission at Good Samaritan shortly after the

Cleveland Clinic discharge, was that significant to you at all in terms of your analysis of this case? Obviously it wouldn't make a difference as to whether or not Doctor Hann did or didn't do the right thing. But as far as any other analysis in this case.:

A. I think I'd prefer a more specific /question,

Q. For example, do you have any criticism of anything that was or wasn't done at Good Samaritan shortly after her discharge from the Cleveland Clinic? For example, would you have anticipated that *they* would have gone back in and removed the wire mesh at that point?

A. I think at that point there would have been no reason to take out the wire mesh.

Q. All right. And they could have, I take it, relied to some degree on Doctor Hahn having been there, seen what he saw, them not having the Cleveland

THE WITNESS: Correct.

Q. BY MR. KAMPINSKI: Are you familiar with the procedure that was undertaken by Doctor Lesser and Doctor Hahn, that is, the testing by the placement of

this plate with electrodes under the scalp to tind the seizure tocus and then attempt to eliminate it?

A. *Yes.*

Q. Have you actually been involved in that pracedure?

A. No.

Q. Was it being done at University Hospital, tor example! When you were there is what I mean.

A. I wasn't involved with any ot it. And it it was done, it was done very intrequcntly.

Q. Was it a tairly accepted method of dealing with an epileptic problem?

A. Yes.

Q. But I take it it was only done at some tew institutions?

A. Correct.

Q. The purpose ot that is to try to see it there is a tocus outside of the speech area that can an tact be eliminated without hopetully too much tunctional deficit occurring?

A. Correct.

Q. And there is, of course, as we knaw and agree the risk of infection in any surgical procedure and especially this one, the second procedure, that

is, the movement ot the plate to try to turther determine where the tocus of: the seizure activity was; have you ever seen that done anywhere, Doctor?

A. No.

Q. Have you ever heard of it being done anywhere?

A. Advancing an electrode?

Q. Right, Well, actually removing I guess the plate, re-forming it, cutting parts of it off, and placing it back in the scalp,

MR. IRWIN: Objection.

Q. BY MR. KAMPINSKI: Have you ever heard ot that being done, sir?

A- Not specifically in that context,

Q. ALL right. Apparently you are thinking of something that's similar or --

A. It's not infrequent that adjustments have to be made in something tnat is placed inside the head. For example, a catheter that's not in tar enough or in too tar. And one would have to readjust it.

Q. Would that entail sterilization of: the catheter atter its removal or putting a new one in?

A. It depends on the specific circumstance. Certainly you are nut going to put in something that

Depends what they used tor cleaning it, But conceptually, it certainly is not unreasonable as long as the additional risk is recognized.

Q. BY MR. KAMPINSKI: Do you have any other opinions that we haven't discussed with respect to the care and treatment ot Jill Boltin, Doctor?

MR. IRWIN: Objection.

THE; WITNESS: None that come specifically to mind.

Q. BY MR. KAMPLNSKI: Well, you know, I'm here to try to determine it there are any. And it you need a minute to think about them -- I spent this long. I'll wait a tew more minutes. aut I don't want to have us meet again in January, which we'll do, and tind that you've harbored additional opinions that we haven't explored here today.

a. Mot to the best ot my knowledge.

Q. Given Jill Boltin's history of surgery, she has now undergone tour procedures, do you have any opinion as to the likelihood of her being a candidate tor any additional surgeries?

A. I don't think that tour procedures eliminate any reasonable chance for operating again. I don't see any reason why,

Q. Do you believe that she is at any increased risk for recurrence of the iritection if in tact there was ever any additional procedure done on her?

A. I think multiple operations carry a higher risk in infections than single operations, But there are many patients who have many more operations than tour who have no problems with intections. I think it the infection is eradicated, the risk is no higher in her than it is with somebody else that has had multiple operations.

Q. Do you think that any additional surgeries at this point would be advisable an terms of trying to tind either the tocus or surgical area treated? Do you think she would be an appropriate candidate tor additional testing to tind tne tocus?

A. I don't think I really feel qualified to make that determination.

Q. That's because you don't get *in* that procedure?

A. Because I haven't seen the patient and evaluated the seizure status. Complicated process. Not one to be given a glib answer.

Q. Did you indicate that you *did* or did not know Doctor Lesser? I think I asked you about Doctor Kahn.

A. I know Doctor Lesser on a very, very limited basis.

Q. What basis?

a. He gave a presentation at a course and I was part ot the faculty. And as *a* faculty group, we had dinner together.

Q. This was while you were at the university?

a. No. This was in Phoenix.

Q. He gave a paper here?

A. Correct.

Q. What was it on, do you recall?

a. It was on managing patients with seizures.

Q. Did you discuss this case at all with him?

a. No.

Q. Was that before or after your involvement in reviewing this case?

A. This was before.

MR. KAMPINSKI: That's all the questions I have. Thank you, Doctor.

(Whereupon, the deposition was concluded at 3:55 o'clock p.m.)

ROBERT F. SPETZLER, M.D.

STATE OF ARIZONA)
) ss.
COUNTY OF MARICOPA)

This instrument was ackowledged before me, _____, this _____ day of _____, 1986 at Phoenix, Arizona.

In witness whereof, I hereunto set my hand and official seal.

Notary Public

My commission expires:

STATE OF ARIZONA)
) ss.
COUNTY OF MARICOPA)

BE IT KNOWN that the toregoing deposition was taken betore me, MARK BARTUNEK, a Notary Public in and for the County of Maricopa, State of: Arizona; that the witness before testifying was duly sworn by me to testify to the whole truth; that the questions propounded to the witness and the answers of the witness thereto were taken down by me in shorthand and thereafter reduced to typewriting under my direction; that the deposition was submitted to the witness to read and sign: that tha toregoing 71 pages are a true and correct transcript of all proceedings had upon the taking of said deposition, all done to the best of my skill and ability.

I FURTHER CERTIFY that I am in no way related to any of the parties hereto nor am I in any way interested in the outcome hereof.

DATED at Phoenix, Arizona, this 9th day of December, 1986.

My commission expires
January 28, 1987

Notary Public