User Name: Jasen Abrahamsen

Date and Time: Friday, June 3, 2022 12:23:00 PM EDT

Job Number: 172462506

Document (1)

1. *EXAMINATION BEFORE TRIAL OF ANDREW MEROLA, M.D.; 1 Exp. Wit. 141301; 1 Exp. Wit. 190310; 1 Exp. Wit. 495051, 2013 Depo. Trans. LEXIS 5028*

Client/Matter: 000000.000000

Search Terms: andrew /2 merola

Search Type: Natural Language

Narrowed by:

Content Type	Narrowed by
Expert Witness Analysis	-None-

EXAMINATION BEFORE TRIAL OF ANDREW MEROLA, M.D.

UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF NEW YORK

DOCKET NO.: 13-CV 578

October 30, 2013

Reporter
2013 Depo. Trans. LEXIS 5028 *; 1 Exp. Wit. 141301; 1 Exp. Wit. 190310; 1 Exp. Wit. 495051

LEON BRYANT and CYNTHIA BRYANT, Plaintiffs, -against- CARLISLE CARRIER CORP. and CALVIN A. FRANCIS, Defendants.

Expert Name: Dr. Angelo Merola, M.D.ANDREW MICHAEL GEORGE DAVY, M.D.Nidia Rosa Carrero, M.D.

Disclaimer

Counsel

[*1] KOENIGSBERG & ASSOCIATES, P.C., Attorneys for Plaintiffs, Brooklyn, New York, BY: RICHARD WEISS, ESQ.

WILSON ELSER MOSKOWITZ EDELMAN & DICKER, LLP, Attorneys for Defendants, White Plains, New York, BY: JOHN HSU, ESQ., FILE NUMBER: 9492.112.

Proceedings

Page 138

INDEX

[7]

[8]

REQUESTED INFORMATION

DESCRIPTION:	PAGE:	LINE:
Intake form for Leon Bryant	33	14
Intake form for Cynthia Bryant	33	22
Copy of the bills for each patient	111	12

[14]

[15]

[16]

[17]

RULINGS

PAGE	LINE
(NONE)	

[*2]

[23]

[24]

[25]

Page 139

EXHIBIT INDEX

EX:	DESCRIPTION:	PAGE:	LINE:
A	One page medical record for Leon Bryant	4	18
B	18 page medical record for Cynthia Bryant	4	21

[8]

[9]

[10]

[11]

[12]

[13]

[14]

[15]

[16]

[17]

[18]

[19]

[20]

[21]

[22]

[23]

[24]

[25]

Page 1

44 Court Street

Brooklyn, New York

October 30, 2013

2:51 p.m.

EXAMINATION BEFORE TRIAL OF ANDREW MEROLA, M.D., a non-party witness in the above-entitled action, held at the above time and place, taken before Danielle McMahon, a Notary Public of the State of New York, pursuant to subpoena and stipulations between Counsel.

Page 3

[1]

[2]STIPULATIONS

[3]

[4]IT IS HEREBY STIPULATED AND AGREED, by and

[5]between the attorneys for the respective parties

[6]herein, that the sealing and filing of the within

[7]deposition be waived.

[8]

[9]IT IS FURTHER STIPULATED AND AGREED

[10]that this deposition may be signed and sworn to

[11]before any officer authorized to administer an

[12]oath with the same force and effect as if signed

[13]and sworn to before the officer before whom said

[14]deposition is taken.

[15]

[16]IT IS FURTHER STIPULATED AND AGREED

[17]that all objections, **[*3]** except as to form, are

[18]reserved to the time of trial.

[19]* * *

[20]

[21]

[22]

[23]

[24]

[25]
Page 4

[1]

[2]ANDREW MEROLA, M.D., a non-party

[3]witness, having first been duly sworn by a Notary

[4]Public, was examined and testified as follows:

[5]

[6]EXAMINATION BY

[7]MR. HSU:

[8]Q. Please state your name for the

[9]record.

[10]A. Dr. Andrew Merola.

[11]Q. Please state your address for the

[12]record.

[13]A. 567 First Street, Brooklyn, New

[14]York 11215.

[15]MR. HSU: Let's just mark these

[16]two sets of medical records that the doctor

[17]brought with him Defendants A and B.

[18](One page medical record for Leon

[19]Bryant was marked as Defendant's Exhibit A,

[20]for identification, October 30, 2013, D.M.)

[21](18 page medical record for

[22]Cynthia Bryant was marked as Defendants

[23]Exhibit B, for identification, October 30,

[24]2013, D.M.)

[25]Q. Dr. Merola, good afternoon.
Page 5

[1]

[2]A. Good afternoon.

[3]Q. My name is John Hsu. I'm an

[4]attorney with the law firm of Wilson Elser, and I

[5]represent Carlisle Carrier Corp. and Calvin

[6]Francis as a result of a motor vehicle accident

[7] **[*4]** and a lawsuit brought by Cynthia and Leon Bryant.

[8]I'm going to ask you some questions this afternoon

[9]pursuant to a federal subpoena which was served

[10]upon your office for your testimony here today.

[11]If there's any question that I ask you that

[12]you don't understand, which I'm sure that will not

[13]be the case, but be reverse, since we are talking

[14]about medical terminology, please let me know,

[15]okay?

[16]A. Yes.

[17]Q. The address that you gave, is that

[18]your business address or home address?

[19]A. Business.

[20]Q. What is your home address?

[21]A. The home address is the same.

[22]Q. Now, 567 First Street, that's your

[23]office?

[24]A. Correct.

[25]Q. And is that the only office that
Page 6

[1]

[2]you have?

[3]A. No, I also have an office in

[4]Manhattan, on 21st Street. That's 18 West 21st

[5]Street, and that is a satellite office or a

[6]secondary office.

[7]Q. And do you have any other offices

[8]in Brooklyn?

[9]A. No.

[10]Q. And the office at 567 First

[11]Street, is that your own practice or a practice

[12]you share with others?

[13]A. It's mine.

[14]Q. Do **[*5]** you have any other doctors that

[15]work with you at that practice?

[16]A. No.

[17]Q. Okay, and what about in the

[18]Manhattan office?

[19]A. No.

[20]Q. Do you share space at either of

[21]those offices with any other doctors?

[22]A. In Manhattan I sublease an office

[23]space with another physician.

[24]Q. Okay, and who's that?

[25]A. It's a pain management physician
Page 7

[1]

[2]named Dr. Kaisman.

[3]Q. Arden Kaisman?

[4]A. Yes.

[5]Q. Do you sublet any space at your

[6]Brooklyn location to any other doctors, whether it

[7]be pain management doctors or anything?

[8]A. No.

[9]Q. Now, you're here today pursuant to

[10]a subpoena and the $ 40 fee that was served upon

[11]your office, correct, Doctor?

[12]A. Yes.

[13]Q. Are you being paid by plaintiff's

[14]office for your testimony here today?

[15]A. No.

[16]Q. What is your usual and customary

[17]hourly charge for deposition testimony?

[18]A. It's usually $ 650 an hour away

[19]from the office.

[20]Q. What about for trial testimony, is

[21]It the same?

[22]A. Yes.

[23]Q. Now, I saw in a previous trial

[24]that you **[*6]** testified in that you had indicated your

[25]hourly right was 750 per hour?

Page 8

[1]

[2]A. Yeah, I think that might have been

[3]when I was working with University Orthopedics at

[4]the time.

[5]Q. And now you're out on your own,

[6]with your own practice?

[7]A. Correct.

[8]Q. Okay. So, your hourly rate is

[9]$ 650 per hour?

[10]A. Yes.

[11]Q. And does that include record

[12]review, as part of your hourly rate?

[13]A. Yes.

[14]Q. Now, did you have an opportunity

[15]to meet with Mr. Weiss before today?

[16]A. Yes -- well, today.

[17]Q. Today, okay.

[18]A. Yes.

[19]Q. Earlier today?

[20]A. Correct.

[21]Q. Was that at your office, somewhere

[22]else, in the car, on the train?

[23]A. At Mr. Weiss' office.

[24]Q. Okay. What time was that at?

[25]A. Probably about 20 minutes ago.

Page 9

[1]

[2]Q. And was that the first time you

[3]had met Mr. Weiss?

[4]A. Yes.

[5]Q. Had you ever worked with his

[6]office before, Koenigsberg and Associates?

[7]A. Have I ever worked --

[8]MR. WEISS: What do you mean

[9]worked with our office?

[10]MR. HSU: **[*7]** Let me rephrase the

[11]question.

[12]Q. Have you ever testified on behalf

[13]of Koenigsberg and Associates before?

[14]A. Yes, I believe I have.

[15]Q. Okay, and would that be at

[16]deposition, at trial, a combination?

[17]A. I think it was at trial.

[18]Q. Okay, and how many times have you

[19]testified at trial for them before?

[20]A. One that I can recall.

[21]Q. Do you remember when that was,

[22]approximately, within the last year, two years,

[23]three years?

[24]A. Maybe about a year or so ago.

[25]Q. Was that here in Brooklyn or
Page 10

[1]

[2]somewhere else?

[3]A. I think it was Brooklyn, but I'm

[4]not a hundred percent sure.

[5]Q. Okay. No problem. When you met

[6]with Mr. Weiss, in his office, what did you and he

[7]discuss?

[8]A. The purpose of today's deposition,

[9]because this is going to -- it is in federal

[10]court, I believe.

[11]Q. Correct.

[12]A. And to make sure that I had my

[13]treatment records with me.

[14]Q. Okay, and what did he tell you the

[15]purpose of today's deposition was?

[16]A. That the deposition -- so, when

[17]you go to federal court, they have **[*8]** a standard set

[18]of rules, and that one of those rules is that they

[19]-- I guess your firm can call for a deposition of

[20]the treating prior to court.

[21]Q. Okay, and did you discuss with him

[22]any questions that you might be asked?

[23]A. We didn't really have any time to

[24]discuss any of the questions or anything.

[25]Q. Okay. Did he discuss with you any

Page 11

[1]

[2]answers he wanted you to provide to any questions?

[3]A. No.

[4]Q. Okay. Did you discuss with him

[5]Leon's treatment by you?

[6]A. Just to say that this was my only

[7]office visit with Mr. Bryant, and that I had my

[8]treatment record with me.

[9]Q. Okay, but nothing specifically

[10]about what treatment you gave him, what your

[11]findings were, anything like that?

[12]A. Correct.

[13]Q. And then with respect to

[14]Ms. Bryant, did you discuss with him anything

[15]about your treatment of Ms. Bryant?

[16]A. No, other than to just make sure

[17]that I had my treatment notes and records here

[18]with me.

[19]Q. Okay, and did he go over each note

[20]and record that you had, by visit date?

[21]A. No.

[22]Q. Had you ever spoke **[*9]** to Mr. Weiss on

[23]the telephone before today?

[24]A. Just to tell him that I was on my

[25]way.

Page 12

[1]

[2]Q. Prior to today, had you ever spoke

[3]to him in anticipation of your testimony today,

[4]once we confirmed the date and time?

[5]A. No.

[6]Q. Had you ever spoke to anyone from

[7]his office about your testimony here today, prior

[8]to today?

[9]A. No, I have not.

[10]Q. Have you spoken to either

[11]Mr. Bryant or Ms. Bryant about your testimony here

[12]today?

[13]A. No.

[14]Q. Doctor, did you have an

[15]opportunity to review your records before today,

[16]before testifying here today?

[17]A. I did look at my office notes,

[18]yes.

[19]Q. Okay, and did you read them front

[20]to back for each patient?

[21]A. No.

[22]Q. Okay. Tell me how you reviewed

[23]them.

[24]A. I just looked at Leon and saw that

[25]it was July 16, 2012, which was the date that I
Page 13

[1]

[2]saw him on.

[3]Q. Okay.

[4]A. And then I looked at Cynthia's

[5]chart, and just made sure that I had copies of my

[6]notes of when I had seen her, up to my most

[7]recent.

[8]Q. Okay, and before **[*10]** looking at your

[9]notes for Leon Bryant, did you have an independent

[10]recollection of his visit with you and any

[11]treatment that you might have rendered?

[12]A. No.

[13]Q. And before looking at Ms. Bryant's

[14]records today, did you have an independent

[15]recollection of your treatment of her?

[16]A. No.

[17]Q. Did you review any other medical

[18]records for Leon Bryant, besides that one page

[19]initial evaluation that you have in front of you,

[20]in preparation for today?

[21]A. No.

[22]Q. Does your file consist of any

[23]other treatment records for Mr. Bryant relating to

[24]this accident, besides that one page in front of

[25]you?
Page 14

[1]

[2]A. No.

[3]Q. Okay, and the file for Cynthia

[4]Bryant, which I looked through before today, does

[5]it include any other medical records from any

[6]other doctors, providers that treated Ms. Bryant

[7]for this accident that we are here for today?

[8]A. I think there are some reports

[9]from some other treating physicians in the chart.

[10]I think Dr. Baum has a test that he had ordered

[11]that I have a copy of here.

[12]Q. Okay.

[13]A. But I don't have **[*11]** any other

[14]treatment records, per se, In the chart.

[15]Q. Okay, and by the test you're

[16]referring to, which test was that; would that be a

[17]CT exam or an MRI exam?

[18]A. There's an MRI that he had ordered

[19]of the lumbar spine of which I have the report in

[20]the chart.

[21]Q. Besides that MRI that he had

[22]ordered, do you have any other records from'

[23]Dr. Baum, or any other doctors, as part of your

[24]chart for Ms. Bryant?

[25]A. No.

Page 15

[1]

[2]Q. And have you ever seen any other

[3]records, either shown to you by plaintiff's

[4]counsel, or anyone else, or by the patient,

[5]related to any other injuries, any other

[6]accidents, any other treatment, besides what we

[7]have in front of you?

[8]'A. No.

[9]Q. Now, Doctor, can you just tell us

[10]a little bit about your educational background,

[11]where you went to medical school, residency, so

[12]on?

[13]A. Sure. So, I attended medical

[14]school at Howard University College of Medicine.

[15]I graduated medical school in 1990. After I

[16]finished medical school I came to the State

[17]University of New York, Health Science Center, in

[18]Brooklyn, which is **[*12]** Kings County Hospital

[19]Downstate, where I did my general surgery

[20]internship and my orthopedic residency.

[21]I finished my training in 1995, and then I

[22]went to the University of Colorado for a spinal

[23]reconstructive fellowship from 1995 till 1996. I

[24]came back to New York City in 1996, and then

[25]started practice at both SUNY Downstate Medical

Page 16

[1]

[2]Center and St. Vincent's Hospital, in Manhattan.

[3]Q. And you're licensed to practice

[4]medicine in the State of New York, correct,

[5]Doctor?

[6]A. Yes.

[7]Q. Okay. Has your license ever been

[8]suspended?

[9]A. No.

[10]Q. And are you board certified?

[11]A. Yes, I am.

[12]Q. In what area?

[13]A. Orthopedic surgery.

[14]Q. And have you had to renew your

[15]certification recently?

[16]A. Yes, I have.

[17]Q. Do you remember when?

[18]A. So, I was initially certified in

[19]1998, and it's good for 10 years. So, I renewed

[20]in the year 2008, and I will be due for my next

[21]renewal in 2018.

[22]Q. And the renewal test for your

[23]board certification in orthopedic surgery, is that

[24]a written exam, an oral exam, a combination? **[*13]**

[25]A. So, they've changed the rules a
Page 17

[1]

[2]little bit on how the renewal process works, and

[3]what happens now is -- it used to be your initial

[4]certificate was a written test, after you finished

[5]your residency, and after two years of practice it

[6]was an oral examination.

[7]For the renewal process, there's now that

[8]10 year period through which you do your renewal.

[9]You're required to do yearly continuing medical

[10]education credits, and then you're also required

[11]to take written examinations. You also are

[12]required to keep a case list of all the patients

[13]that you've operated on, and then you submit all

[14]of those credentials at the end of your renewal

[15]process, and then you have two options. One

[16]option is for an oral examination. The other

[17]option is for a written examination. So, It's a

[18]little more complicated a process for the renewal

[19]than it used to be in the past.

[20]Q. So, you have a choice?

[21]A. You have a choice of which one you

[22]are going to do, provided that you've provided all

[23]of your credentials up to that point in time.

[24]Q. Okay, and which one did you

[25]choose, **[*14]** Doctor, on the recertification?

Page 18

[1]

[2]A. On the initial recertification I

[3]did the written examination.

[4]Q. Okay, and did you have to take

[5]that on one occasion or more than one?

[6]A. So, for the initial

[7]recertification that I did in 2008, that was my

[8]first recert.

[9]Q. Right.

[10]A. The second recert will be in 2018.

[11]Q. Okay. So, the first recert, did

[12]you take that exam just one time or more than

[13]once?

[14]A. Once.

[15]Q. And did you submit with your

[16]credentials a list of the patients that you've

[17]operated on in that 10 year period?

[18]A. Correct, yes. Well, they actually

[19]ask for a list. It's for the period of time, I

[20]think it's between six to eight months before you

[21]take your examination. So, that's the period of

[22]what we call collections --

[23]Q. Okay.

[24]A. -- for your cases.

[25]Q. Okay, and how many individuals had
Page 19

[1]

[2]you operated on in that six to eight month period?

[3]A. So, in general, when I do spinal

[4]surgery during the week, it's both myself, and I

[5]usually operate with another spine surgeon. So,

[6]we **[*15]** share responsibilities, surgically.

[7]Q. Okay.

[8]A. So, on any given week, between

[9]myself and the other two colleagues that I operate

[10]with, we probably do somewhere in the neighborhood

[11]of four to six cases per week.

[12]Q. And the other two surgeons that

[13]you operate with, was that when the

[14]recertification process was ongoing, or is that

[15]now, or a combination?

[16]A. Yeah, it's been -- ever since I've

[17]come back into practice, spinal surgery is

[18]something that requires really four hands and two

[19]sets of eyes. I've always worked with another

[20]spine surgeon, and spine surgeons, in general,

[21]will work with another spine surgeon to increase

[22]the safety and efficiency of the procedures,

[23]themselves. So, that's pretty much been my

[24]standard practice, ever since I finished and came

[25]back to practice.

Page 20

[1]

[2]Q. Who are the spine surgeons that

[3]you work with now?

[4]A. So, there are two other surgeons

[5]that I work with, both at the hospital systems

[6]that I'm at, and they are in their own private

[7]practices. One is Dr. Franco Cerabona, and the

[8]other one is a Dr. Carl Paulino. **[*16]**

[9]Q. Did you work with either of those

[10]doctors for the surgery performed here on

[11]Ms. Bryant?

[12]A. That actually should be in my

[13]operative report. So, let me just check the

[14]operative report for you.

[15]Q. Sure.

[16]A. And so I operated on her at New

[17]York Methodist Hospital, and my assistant at that

[18]time Was Dr. Carl Paulino.

[19]Q. Okay, and when you work with

[20]another spinal surgeon, Is there a lead surgeon

[21]and then an assistant surgeon, or how does that

[22]work?

[23]A. Yeah, so it depends upon whose

[24]patient it is, per se, and so that would be what's

[25]known as the primary attending.

Page 21

[1]

[2]Q. Okay.

[3]A. And then the other spine surgeon

[4]is basically known as the assistant.

[5]Q. So, Ms. Bryant was your patient in

[6]this instance, correct?

[7]A. Correct, yes.

[8]Q. Now, Doctor, do you have any

[9]privileges at any hospitals?

[10]A. Yes, I do.

[11]Q. Okay. Tell me what your

[12]privileges are and at what hospitals?

[13]A. So, I have admitting and attending

[14]privileges at Mount Sinai Hospital, New York

[15]Hospital, SUNY Downstate Medical **[*17]** Center, and New

[16]York Methodist Hospital.

[17]Q. And which hospital was this

[18]surgery performed at?

[19]A. This operation was at the New York

[20]Methodist Hospital.

[21]Q. Have your privileges ever been

[22]suspended at any hospital since you've been

[23]practicing here in New York?

[24]A. No.

[25]Q. Are you a member or a shareholder
Page 22

[1]

[2]at any of these hospitals?

[3]A. No.

[4]Q. Do you have any lawsuits pending

[5]where you're a defendant?

[6]A. Yes.

[7]Q. Okay. Is that one or more than

[8]one?

[9]A. One.

[10]Q. And where is that pending?

[11]A. In Brooklyn.

[12]Q. And is that a medical malpractice

[13]lawsuit or something else?

[14]A. Med mal.

[15]Q. And who is the patient?

[16]A. I don't know if I'm allowed to --

[17]can I tell you that, is it a HIPAA issue or --

[18]MR. WEISS: Yeah, I think there

[19]are some HIPAA issues.

[20]MR. HSU: Not for the name of the

[21]patient. I'm not asking about medical

[22]treatment. The name of the patient is

[23]public.

[24]Q. I have a couple names I can throw

[25]out there, but --

Page 23

[1]

[2]A. Brown. **[*18]**

[3]Q. Brown is the last name of the

[4]patient?

[5]A. Correct.

[6]MR. WEISS: If it's no suit, it's

[7]not public. It's possible it may not be in

[8]suit yet.

[9]Q. Is that action in suit; has there

[10]been a lawsuit started?

[11]A. Yes.

[12]MR. HSU: Okay. So, it's public.

[13]Q. And what is the allegation in that

[14]lawsuit, Doctor?

[15]A. I don't know.

[16]Q. Was a summons and complaint

[17]served?

[18]A. Yes.

[19]Q. Did you read it?

[20]A. I guess I did, but it's a little

[21]difficult to kind of make heads or tails out of

[22]it.

[23]Q. Okay.

[24]A. Cause it kind of says a lot of

[25]stuff that I'm not really exactly sure what the
Page 24

[1]

[2]allegations are.

[3]Q. Okay. The allegation of medical

[4]malpractice, did it result from a surgery that you

[5]performed?

[6]A. Yes.

[7]Q. What type of surgery was it?

[8]A. It was a revision cervical

[9]surgery.

[10]Q. Who did the initial surgery?

[11]A. The patient had actually had

[12]multiple prior initial surgeries.

[13]Q. Okay. Any of them performed by

[14]you?

[15]A. I don't recall, because **[*19]** I was one

[16]of the initial -- I was one of the patient's

[17]previous treating physicians many years ago. So,

[18]I don't know.

[19]Q. Well, by virtue of revision, it

[20]means that --

[21]A. It was a redo.

[22]Q. It was a redo?

[23]A. Correct, and they had had prior

[24]surgery to their neck. I don't think I was the

[25]prior neck surgeon, no.

Page 25

[1]

[2]Q. And did you perform that surgery

[3]with another surgeon?

[4]A. Yes.

[5]Q. Okay. Do you know who that

[6]surgeon was?

[7]A. Dr. Paulino.

[8]Q. Is he also a defendant in that

[9]lawsuit?

[10]A. I believe so.

[11]Q. The hospital where the surgery was

[12]performed, are they also a defendant in that

[13]lawsuit?

[14]A. I believe so as well, yes.

[15]Q. Do you know which hospital that

[16]is?

[17]A. New York Methodist Hospital.

[18]Q. You indicated that was the only

[19]lawsuit pending, which I think you are correct

[20]about. I do see a lawsuit here once brought

[21]recently by Frank Vaccarino?

[22]A. Yes.

[23]Q. Okay. What did that entail?

[24]A. That was a personal lawsuit

[25]regarding the purchase of his practice. **[*20]**

Page 26

[1]

[2]Q. So, he is a doctor?

[3]A. Yes.

[4]Q. And did you purchase his practice

[5]when you went into private practice?

[6]A. No.

[7]Q. So, what practice are you

[8]referring to?

[9]A. Well, that was the dispute about

[10]the lawsuit.

[11]Q. He claimed that you purchased his

[12]practice?

[13]A. He claimed that he wanted me to

[14]purchase his practice.

[15]Q. Oh, you mean because you had a

[16]contract or something?

[17]A. No, actually, we never had a

[18]contract.

[19]Q. Okay.

[20]A. He was retiring, and he had asked

[21]me to -- when you retire from practice --

[22]Q. Right.

[23]A. -- you're kind of obligated to

[24]make sure that your patients have someone that

[25]they are going to follow with.

Page 27

[1]

[2]Q. Right.

[3]A. So, he had approached me to do

[4]that for him, and he also had some office space to

[5]rent. So, I started renting office space from

[6]him, and I told him that because he was retiring,

[7]I would be happy to follow those patients of his

[8]that continued to require treatment.

[9]Q. Okay. How did that lawsuit end?

[10]A. It **[*21]** was settled out of court.

[11]Q. I see another older lawsuit here

[12]from Regina Dasilva?

[13]A. Yes.

[14]Q. What happened in that case?

[15]A. That case was dropped against me.

[16]Q. Okay. Edward Castillo?

[17]A. That was also dropped against me.

[18]Q. Geri Passalacqua?

[19]A. G-E-R-R-I?

[20]Q. I have G-E-R-I, but --

[21]A. Yes.

[22]Q. What happened in that case?

[23]A. I went to court on that case, and

[24]I was found to be not --

[25]Q. Liable, not responsible?

Page 28

[1]

[2]A. Correct, yes.

[3]Q. After trial?

[4]A. Correct.

[5]Q. Samantha Dacres?

[6]A. That was dropped against me.

[7]Q. Linda Young.

[8]A. That was dropped against me.

[9]Q. Let's talk about Dr. Baum; do you

[10]know Dr. Baum?

[11]A. I do, yes.

[12]Q. Okay. Do you know where his

[13]practice is located?

[14]A. Yes.

[15]Q. Okay. Where is his practice

[16]located?

[17]A. I believe it's located in the Bay

[18]Ridge area.

[19]Q. Okay. Does he refer you patients?

[20]A. Yes.

[21]Q. For how long has he been referring

[22]you patients?

[23]A. I've known **[*22]** Dr. Baum since we were

[24]residents together at SUNY Downstate Medical

[25]Center.

Page 29

[1]

[2]Q. Okay. So, for some time he's been

[3]referring you patients?

[4]A. Yes.

[5]Q. Can you put a number on how many

[6]patients he refers you per month?

[7]A. No.

[8]Q. Per year?

[9]A. It would be tough for me to do

[10]that, but I have known him for at least -- I

[11]started my residency in 1990, so I've known

[12]Dr. Baum for 23 years, I guess.

[13]Q. In the last year how many patients

[14]would you say he's referred you?

[15]A. Enough so that I see his name

[16]on --

[17]Q. Frequently?

[18]A. Yes.

[19]Q. Would you say more than 20, less

[20]than 20?

[21]A. I don't know. I couldn't come up

[22]with a number.

[23]Q. What type of doctor is Dr. Baum?

[24]A. Dr. Baum is an orthopedic surgeon,

[25]who has subspecialty training in foot and ankle
Page 30

[1]

[2]surgery.

[3]Q. Does Dr. Baum do spinal surgery?

[4]A. He does not, no.

[5]Q. So, does he refer to you those

[6]patients that he treats that he thinks are

[7]candidates for spine surgery?

[8]A. Yes, I do see patients **[*23]** that he

[9]thinks may require spine surgery.

[10]Q. Dr. Davy, a pain management

[11]doctor, do you know who he is?

[12]A. Yes.

[13]Q. Have you ever seen any of his

[14]patients?

[15]A. Yes, I have.

[16]Q. Does he refer you patients, do you

[17]refer him patients, or a combination?

[18]A. A combination thereof.

[19]Q. For how long have you been

[20]referring patients to Dr. Davy?

[21]A. So, I've known Dr. Davy since I

[22]started my private practice, so at least --

[23]Q. What year was that again?

[24]A. 1996, so for at least that length

[25]of time. I know that we've been referring

Page 31

[1]

[2]patients back and forth to each other.

[3]Q. Did you know he's not board

[4]certified now?

[5]A. He's lost his board certification?

[6]Q. Yes, did you know that?

[7]A. No.

[8]Q. Did you speak to him, at all, in

[9]preparation for your testimony here today?

[10]A. No.

[11]Q. Did you speak to him, at all,

[12]since he gave a deposition in this case?

[13]A. No.

[14]Q. Are you aware that he treated

[15]either Leon, or Cynthia, or maybe both, in this

[16]particular case?

[17] **[*24]** A. Yes.

[18]Q. And Dr. Davy, did he refer you

[19]either of these patients?

[20]A. I don't recall.

[21]Q. Do you know who did refer you

[22]these patients?

[23]A. I just have to check my note.

[24]Q. Okay. Well, let's start with

[25]Leon; who referred you Leon Bryant?
Page 32

[1]

[2]A. I'm just going to check the

[3]dictation that I did. He was treating with

[4]Dr. Davy, according to my history section. I

[5]don't have the referral indicated in the note for

[6]Leon.

[7]Q. Okay. Doctor, while you look for

[8]that on Cynthia, besides that one page form that

[9]you have here, is there an intake form that you

[10]have the patients fill out?

[11]A. They do fill out an intake form,

[12]and then I synthesize the intake, along with

[13]whatever notes I may have taken, and then I

[14]dictate --

[15]Q. The initial evaluation?

[16]A. Correct, yes.

[17]Q. Do you retain the intake form in

[18]your file?

[19]A. Not usually, no. You know, in the

[20]past, we've made a switch over to an electronic

[21]medical record, within the last year or so. In

[22]the past, when it was a paper chart, we usually

[23]held onto the paper, **[*25]** but now we are trying to

[24]eliminate all of the paper. So, if I dictate it

[25]into the electronic file, so then generally we

Page 33

[1]

[2]just keep that dictated note.

[3]Q. So, you don't scan the intake form

[4]into the file or anything?

[5]A. I'm not sure we are scanning the

[6]intake sheets in anymore, if I'm dictating the

[7]note.

[8]Q. Just so we are clear, are you

[9]unsure if there's an intake form for Mr. Bryant or

[10]are you sure there is not one?

[11]A. I don't want to answer in the

[12]affirmative, if I'm not completely and entirely

[13]sure.

[14]Q. So, to the extent there is an

[15]intake form, after today, I'm going to ask if you

[16]can take a check, and if there is, if you can send

[17]it to us.

[18]A. Sure, certainly.

[19]Q. The address would be on the

[20]subpoena.

[21]A. Okay.

[22]Q. Same thing for Cynthia Bryant, do

[23]you know whether or not there was an intake form

[24]completed by her prior to your treatment?

[25]A. I'm not sure, but I'll check for
Page 34

[1]

[2]you, and if I have those forms, I will send them

[3]over to your office.

[4]Q. Okay.

[5]A. Okay.

[6] **[*26]** Q. These two exhibits that we've

[7]marked, A and B, which are your records for Leon

[8]and Cynthia, you printed these out today, off of

[9]an electronic system?

[10]A. Correct, yes.

[11]Q. So, you don't maintain paper files

[12]anymore?

[13]A. I have old charts, that are stored

[14]and filed, but everything within the last -- I

[15]think we scanned in everything from about five or

[16]six years ago.

[17]Q. Okay.

[18]A. Yeah, because you know, you

[19]accumulate so many patients over the course of

[20]time, and then you try to scan in whatever's

[21]active, and then for the inactive cases that are

[22]paper charts, those go to long term storage.

[23]Q. Dr. Davy, what type of doctor is

[24]he?

[25]A. Pain management.
Page 35

[1]

[2]Q. Approximately how many patients

[3]does Dr. Davy refer you each year?

[4]A. I can't give you an exact number,

[5]but I do know that over the course of the amount

[6]of time that I've know him, since I've been in

[7]practice, we have referred each other patients.

[8]Q. And what do you refer him patients

[9]for?

[10]A. Pain management.

[11]Q. But what sort of treatment; are

[12] **[*27]** these patients you refer him presurgery,

[13]postsurgery, a combination?

[14]A. It's a combination thereof,

[15]sometimes it's a presurgical patient, who I think

[16]requires perhaps chronic pain management --

[17]Q. Okay.

[18]A. -- or a patient that I don't think

[19]is necessarily is a surgical candidate, or a

[20]postop patient, that may have chronic pain, that

[21]requires treatment.

[22]Q. Do you know, from looking at your

[23]treatment records for either of these two

[24]patients, if they were treated by Dr. Davy before

[25]you began treating them?

Page 36

[1]

[2]A. Yes.

[3]Q. Okay, and they both were?

[4]A. Yes.

[5]Q. And do you know if Dr. Davy was

[6]the one that referred them to you?

[7]A. I'm not sure.

[8]Q. The date of the accident, which

[9]brought these two patients to you, what's the date

[10]of that accident, Doctor?

[11]A. I have May 19th, of 2012.

[12]Q. And do you have an opinion, within

[13]a reasonable degree of medical certainty, whether

[14]or not the injuries alleged by Mr. Bryant as a

[15]result of that accident were caused by that

[16]accident?

[17]A. So, from the history that **[*28]** I took

[18]of the patients, and from my treatment of those

[19]patients, within a reasonable degree of medical

[20]certainty, from what I know, they were caused by

[21]that accident.

[22]Q. And the same question for

[23]Ms. Bryant?

[24]A. Yes, correct.

[25]Q. So, you believe her injuries were

Page 37

[1]

[2]also caused by the subject accident?

[3]A. Based on the history and my

[4]treatment of those patients, yes.

[5]Q. And when you say based upon the

[6]history, Doctor, tell us what a history is, and

[7]why you take it, and what the importance of it is,

[8]please.

[9]A. Sure. So, the history, when a

[10]patient presents to the office, they generally

[11]have what's known as their presentation complaint

[12]or their chief complaint, and after they offer

[13]their chief complaint to you, you will generally

[14]take a history, and then find out a little bit

[15]more about what the problem is, and what precisely

[16]it is that bothers them, how long it's been

[17]bothering them, and then try to get some idea for

[18]what the root cause of that is, so that you can

[19]offer a treatment plan.

[20]Q. Okay, and as part of a history,

[21] **[*29]** Doctor, do you ask the patient whether or not they

[22]had any similar complaints as they present to you

[23]prior to the accident which they say caused their

[24]initial complaint?

[25]A. Yes.

Page 38

[1]

[2]Q. And in this particular case, let's

[3]talk about Leon first, did you take a history?

[4]A. Yes.

[5]Q. And what was Mr. Bryant's chief

[6]complaint?

[7]A. So, his chief complaints were

[8]progressive low back pain, with a description of

[9]pain radiating into the legs. He reported some

[10]difficulty with his ability to sleep. He

[11]indicates that it had gotten worse over time, and

[12]that he had failed conservative treatment, that is

[13]to say nonsurgical management.

[14]Q. And what was the date of that

[15]initial evaluation by you, Doctor?

[16]A. July 16, 2012.

[17]Q. And as part of the history, did

[18]Mr. Bryant indicate whether or not he had ever

[19]been involved in a prior accident with similar or

[20]the same injuries?

[21]A. He did indicate that there was a

[22]prior history, from what he could recall,

[23]approximately three or four years prior.

[24]Q. And which you indicate that he

[25]sustained **[*30]** no untoward sequelae, correct?

Page 39

[1]

[2]A. Yes.

[3]Q. Meaning what?

[4]A. So, I asked him if there was

[5]anything after that particular accident that was

[6]persistent or severe, or required, for example,

[7]surgery, and so the answers to those questions

[8]were negative.

[9]Q. Okay. Did you ask Mr. Bryant if

[10]he had ever undergone an MRI prior to treating

[11]with you?

[12]A. I don't know that I had

[13]specifically asked him for any older MRIs, no.

[14]Q. Okay. Did he indicate to you

[15]whether or not he had ever undergone any MRI

[16]tests, prior to treating with you?

[17]A. No, not that I'm aware of.

[18]Q. For this prior accident that he

[19]referenced, did you review any or request any

[20]medical records relating to that accident?

[21]A. No.

[22]Q. Your history says that he was

[23]pending a pain management evaluation, had he seen

[24]Dr. Davy at that point?

[25]A. I know that he was -- I think his

Page 40

[1]

[2]wife was treating with Dr. Davy, and I think he

[3]was either waiting for an appointment or had had

[4]an appointment with him.

[5]Q. Okay. Do you know if since your

[6] **[*31]** evaluation if he saw Dr. Davy or treated with

[7]Dr. Davy?

[8]A. I don't know.

[9]Q. Okay. Did you ever speak with

[10]Dr. Davy about his particular care of this

[11]patient, Leon Bryant?

[12]A. No.

[13]Q. Did you ever obtain any of

[14]Dr. Davy's records relating to his care of this

[15]patient?

[16]A. No.

[17]Q. Now, you indicate here that

[18]Mr. Bryant was working --

[19]A. Yes.

[20]Q. -- at the time of your initial

[21]exam?

[22]A. Correct.

[23]Q. Did he tell you what type of work

[24]that he did?

[25]A. I don't recall, no.

Page 41

[1]

[2]Q. Okay. Did he tell you if he had

[3]one job or more than one time job?

[4]A. I don't recall.

[5]Q. Did he tell you if his job

[6]required or involved any type of lifting?

[7]A. I'm not sure.

[8]Q. Any type of heavy lifting?

[9]A. I didn't go into any of the job

[10]specifics with him.

[11]Q. Now, it says here that he brought

[12]with him an MRI of the lumbar spine?

[13]A. Yes.

[14]Q. Dated 6/16/12; is that correct?

[15]A. Yes.

[16]Q. Is that part of your chart?

[17]A. I don't have a copy of that

[18]report, **[*32]** no.

[19]Q. Okay.

[20]A. But I read the film and then

[21]dictated it as part of my report.

[22]Q. Okay, and did he bring to you, at

[23]that time, the actual film, or did he bring the

[24]report, or both?

[25]A. He brought the actual film.
Page 42

[1]

[2]Q. And what was your determination of

[3]that film, Doctor?

[4]A. So, I looked at the MRI film, and

[5]I had written down in my report that the MRI

[6]demonstrates herniations in L4-L5 and L5-S1

[7]segments.

[8]Q. Were you able to make a

[9]determination, within a reasonable degree of

[10]medical certainty, whether or not those

[11]herniations, at those two levels, were cause by

[12]this accident?

[13]A. Based on his history, and his

[14]complaints, and his symptoms, and the physical

[15]examination that I was able to take, and then

[16]correlating those with the MRI films, reasonably

[17]given all of that, yes, I would say that they were

[18]causally related.

[19]Q. Now, Doctor, the accuracy of the

[20]history is very important, correct, the accuracy

[21]given to you by the patient?

[22]A. Sure.

[23]Q. The accuracy of the information

[24]that you're given is **[*33]** important?

[25]A. Yes.
Page 43

[1]

[2]Q. And it's important for you because

[3]with that information you come up with a diagnosis

[4]and prognosis, correct?

[5]A. Correct.

[6]Q. And with that information you also

[7]determine or you attempt to determine the cause?

[8]A. Yes.

[9]Q. And so were you ever told by

[10]Mr. Bryant that he had had a prior MRI to his

[11]lumbar spine, prior to this accident which he

[12]began treating with you for?

[13]A. No, as far as I recall, we didn't

[14]get into any previous MRI that he had had, no.

[15]Q. If Mr. Bryant had undergone an

[16]MRI, prior to treating with you for this accident,

[17]would that be something you would have wanted to

[18]have seen?

[19]A. You know, it wouldn't necessarily

[20]be pertinent to the treatment of Mr. Bryant,

[21]because my treatment would be based on his

[22]physical condition at the time I saw him.

[23]Q. Correct.

[24]A. But if he had had an MRI

[25]previously, rd be happy to take a look at it.

Page 44

[1]

[2]Q. Okay. Well, Doctor, you wouldn't

[3]need to see his prior MRI in order to treat the

[4]patient, because you're treating **[*34]** him for his

[5]current complaints?

[6]A. Yes, thank you, yes.

[7]Q. But if he had a prior MRI, for you

[8]to determine the cause, that would be something

[9]you'd want to look at, correct?

[10]A. The prior MRI could be helpful in

[11]terms of --

[12]Q. Determining the cause?

[13]A. A causation, yes.

[14]Q. A cause of his complaints?

[15]A. With respect to comparing it to

[16]the more recent MRI, it could give you an idea of

[17]what the anatomy was at the time of the initial

[18]MRI or the older MRI.

[19]Q. Correct.

[20]A. And then you can compare it to the

[21]more recent MRI, yes.

[22]Q. And you would compare it to see if

[23]anything's changed?

[24]A. And you can compare it to see if

[25]there was a change in the MRI or not, yes.

Page 45

[1]

[2]Q. If it got better, if it got worse?

[3]A. Yes.

[4]Q. If an MRI, prior to this accident

[5]of Mr. Bryant, an MRI of his lumbar spine had

[6]diagnosed him with a herniation at L4-5 and 15-S1,

[7]would that be something that could affect your

[8]causation opinion?

[9]A. So, it would actually depend on

[10]the film itself --

[11]Q. Okay. **[*35]**

[12]A. -- and in general, I don't rely on

[13]the radiologist reading of the film. So, you'd

[14]actually have to look at the previous MRI, and

[15]then compare that previous MRI to the MRI that he

[16]had. For example, the one that I looked at in

[17]June, of 2012, and then you'd have to make sure

[18]that it was similar technique on a similar magnet

[19]and that you were looking at similar sections, and

[20]then you could take, for example, measurements, or

[21]do a qualitative comparison of those disks.

[22]Q. So, Doctor, assuming that it was

[23]taken on a similar magnet with a similar

[24]technique, could that MRI, assuming that it shows

[25]herniations at those two levels, which was the

Page 46

[1]

[2]case in the MRI that you reviewed, could that

[3]affect your opinion as to the cause of those two

[4]herniations?

[5]A. Once again, yes, after reviewing

[6]the prior MRI film, and comparing it to the more

[7]recent MRI film, would be another piece of the

[8]puzzle in being able to determine causation more

[9]accurately.

[10]Q. Now, the MRI that you reviewed,

[11]that was brought to you by Mr. Bryant, which I

[12]believe you said was 6/16/12? **[*36]**

[13]A. Yes.

[14]Q. Besides demonstrating herniations

[15]at L4-5, L5-S1, was there any impingement, any

[16]nerve root impingement on those MRIs that you

[17]observed or that you noted?

[18]A. So, herniations, by definition,

[19]because they involve an asymmetrical protrusion of

[20]the disk beyond the vertebral borders or the

[21]vertebral boundaries, it encroaches into the canal

[22]on the area where the nerves are. So, by

[23]definition, if you do have a true herniation by

[24]those criteria, you do have to have some nerve

[25]root contact and/or impingement.

Page 47

[1]

[2]Q. So, then based upon the fact --

[3]just so I can interpret what you just said, based

[4]upon the fact that there was herniation at L4-5,

[5]L5-S1, there has to be some nerve root

[6]impingement, based on the fact that there is a

[7]herniation?

[8]A. Correct.

[9]MR. WEISS: Excuse me, I have to

[10]make a phone call. Can we take five?

[11]MR. HSU: Yeah, sure.

[12](Whereupon a discussion was held

[13]off the record.)

[14]Q. So, Doctor, with that

[15]understanding, the impingement that results from

[16]the herniation, is it that impingement that

[17] **[*37]** generally causes the pain?

[18]A. So, a couple of things are at play

[19]with a disk herniation. Pain in the distribution

[20]of the nerve roots, per se, or radiculopathy, is

[21]caused by a couple of different things. One, the

[22]disks leak, if you will, certain substances that

[23]produce inflammation, and so those particular

[24]substances can produce pain along the distribution

[25]of the nerve root by their inflammatory or their

Page 48

[1]

[2]ability to irritate. The second way is for the

[3]disk, itself, to also cause a direct pressure

[4]phenomenon on the roots, themselves. So, there

[5]may be usually more than one mechanism at play,

[6]where a disk herniation causes radicular or

[7]radiating leg pain.

[8]Q. But, Doctor, not every herniation

[9]will cause pain; is that correct?

[10]A. Correct.

[11]Q. There may be herniations which are

[12]asymptomatic?

[13]A. Yes.

[14]Q. And then there are those that are

[15]symptomatic?

[16]A. Yes.

[17]Q. Now, in your initial evaluation of

[18]Mr. Bryant, did you do a physical exam?

[19]A. Yes.

[20]Q. Can you just tell us about that?

[21]A. So, would you like me to give **[*38]** you

[22]the just --

[23]Q. Yeah, what you did and what your

[24]findings were?

[25]A. So, with respect to his gait
Page 49

[1]

[2]pattern or the way he walked, he had asymmetrical

[3]contractions of the paravertebral muscles in the

[4]neck and the back. He had a cervical spine which

[5]was extended or able to be extended to about five

[6]degrees, flexion of his cervical spine was at 30

[7]degrees, right lateral bending was to 20, and left

[8]lateral bending was to 25, with right lateral

[9]rotation of 15, and left lateral rotation of 20.

[10]Q. Doctor, let me just stop you

[11]there, I'm sorry to interrupt. Now, those are

[12]range of motion measurements, correct?

[13]A. Yes.

[14]Q. And those measurements are taken

[15]by you, with the patient?

[16]A. Yes.

[17]Q. And those measurements are taken

[18]by you asking the patient to make certain

[19]movements, correct?

[20]A. Well, they are actually -- you do

[21]them two ways.

[22]Q. Okay.

[23]A. So, one of them is what's called

[24]active range of motion.

[25]Q. Right, active or passive range of
Page 50

[1]

[2]motion?

[3]A. And then passive range of motion. **[*39]**

[4]Q. Active range of motion is when the

[5]patient does it itself?

[6]A. Yes.

[7]Q. And passive range of motion is

[8]when you move the body part, correct?

[9]A. Correct, yes.

[10]Q. So, were these done actively or

[11]passively?

[12]A. So, in general, when I do it, I'll

[13]use a combination of both. I'll ask the patient

[14]to, for example, extend their neck as far as they

[15]can, while I'm palpating their neck, and then I

[16]will also try to take them beyond that particular

[17]portion, in a passive way, to see whether or not

[18]they're able to extend further than that.

[19]Q. And when you say take them in a

[20]passive way to see if they are able to extend

[21]further, when the patient says they feel pain, you

[22]stop, correct?

[23]A. Generally, I'll stop when they --

[24]they all generally say that they feel pain, and

[25]then stop on their own.

Page 51

[1]

[2]Q. Okay, that's during the active

[3]range of motion test?

[4]A. Correct, yes, and during the

[5]passive portion of the range of motion, what I'll

[6]do is I'll have my hand on the back of their neck

[7]or on the side of their neck.

[8] **[*40]** Q. Okay.

[9]A. And then, as I'm taking them

[10]through that range of motion, I'll try to feel if

[11]the muscle is contracting, and if the muscle

[12]contracts or becomes spastic, then generally at

[13]that point I'll stop.

[14]Q. Okay. With the passive range of

[15]motion test, would that be objective or

[16]subjective?

[17]A. So, if you're palpating the

[18]muscles passively, pushing them to the range of

[19]motion to the point where you can feel their

[20]muscles contract, that'll be objective.

[21]Q. And does it indicate here on these

[22]range of motion measurements whether they were

[23]done actively or passively?

[24]A. So, I always do the range of

[25]motion, I'll start with their active, and I'll

Page 52

[1]

[2]take them to where they can go, to where they feel

[3]comfortable, and then I'll finish it with the

[4]passive range of motion, to give the maximum range

[5]of motion.

[6]Q. Okay. So, these range of motion

[7]measurements are done actively and passively, as

[8]you just stated?

[9]A. Yes, correct.

[10]Q. So, these measurements

[11]differentiate where the patient went activity and

[12]where they went passively, **[*41]** in terms of their range

[13]of motion?

[14]A. No, it will give you their maximum

[15]passive range of motion up to palpable spasm.

[16]Q. Okay. So, cervical extension to

[17]five degrees was the maximum passive range of

[18]motion?

[19]A. Correct

[20]Q. And what is normal?

[21]A. So, functionally, you should be

[22]able to -- if you're thinking about your cervical

[23]spine, you should be able to tilt your neck back

[24]to the point where you can get your eyes pretty

[25]much straight up into the sky, which is somewhere
Page 53

[1]

[2]in the neighborhood of about 75 to 80 degrees.

[3]Q. So, you're saying that his

[4]extension was five degrees, and the normal was 75

[5]to 80 degrees?

[6]A. It should be about 75 to 80

[7]degrees, yes, both actively and passively, without

[8]spasm or pain, correct.

[9]Q. So, you're telling me that

[10]Mr. Bryant's extension was severely, severely

[11]limited?

[12]A. At that time, yes.

[13]Q. And what is the normal range for

[14]flexion, in terms of degrees?

[15]A. So, flexion, you should be able to

[16]get your chin down onto your chest. So, you're

[17]looking at, once again, of **[*42]** being able to get down

[18]into the flex attitude of your neck --

[19]Q. Okay.

[20]A. -- at least to about 80 degrees or

[21]so.

[22]Q. So, again, that would be he's

[23]severely limited during flexion, correct?

[24]A. So, his flexion was to about 30

[25]degrees, so.

Page 54

[1]

[2]Q. It's not even halfway?

[3]A. Right, I would consider that a

[4]significant limitation of flexion.

[5]Q. What about lateral bending?

[6]A. So, lateral bendings, you should

[7]be able to get almost your ear down to where your

[8]shoulder is, so you're looking at about at least

[9]45 to 50 degrees worth of lateral bending, and so

[10]his right was 20 and his left was 25.

[11]Q. Is there any way to tell -- I

[12]don't want to beat a dead horse, Doctor, is there

[13]any way to tell, from your initial eval, as to

[14]what degree the patient was able to go to

[15]activity; is there any way to tell, from looking

[16]at this paper?

[17]A. No, because once again, I would

[18]take him to their active, as far as they could,

[19]and then palpate muscle spasm in order to get them

[20]to their maximum potential range of motion.

[21]Q. Right. So, **[*43]** looking at these

[22]measurements, since this is their maximum, we can

[23]assume that their active was something less than

[24]this range?

[25]MR. WEISS: Note my objection as
Page 55

[1]

[2]to what you can assume.

[3]Q. Is that accurate, based upon the

[4]way you perform the test?

[5]A. Sometimes their active and passive

[6]may be the same. So, it's a little --

[7]Q. Either the same or less?

[8]A. Could be, yeah, I mean, It

[9]depends, every circumstance is a little bit

[10]different.

[11]Q. Well, their active measurement is

[12]not going be more than their passive measurement,

[13]the way you conduct the test?

[14]A. That's correct, yes.

[15]Q. Just tell us what happened with

[16]your lumbar range of motion examination.

[17]A. So, for lumbar range of motion, I

[18]actually only took him to one range of motion, in

[19]order to look at what's known as a provocative

[20]sign, which is the Phalen's Maneuver in the lower

[21]back, and so the Phalen's Maneuver in the lower

[22]back is extension of the lower back up to the

[23]point where they splint or they have spasm in

[24]their lower back, whereby it reproduces symptoms

[25] **[*44]** going down into their legs.

Page 56

[1]

[2]So, In this case the lumbar spinal

[3]extension was restricted to zero degrees, which is

[4]neutral, which is upright posture.

[5]Q. So, is that normal, zero degrees?

[6]A. No. So, your lumbar spine should

[7]be able to extend qualitatively at least 60 to 70

[8]degrees, If you tilt yourself backward, at your

[9]waist, in your lower back.

[10]Q. When you said you have them do the

[11]Phalen's Maneuver until it produces symptoms, what

[12]symptoms are you referring to, pain symptoms?

[13]A. So, low back spasm with

[14]reproduction of pain going down into the legs.

[15]Q. And these symptoms are something

[16]that the patient tells you subjectively that they

[17]feel?

[18]A. So, you would be palpating for

[19]spasm in their lower back.

[20]Q. And that's an objective test?

[21]A. Yes.

[22]Q. And whether or not there was any

[23]pain radiating, that would be subjective, correct?

[24]A. If they told you they had

[25]radiating pain, yes, or if they had give way, then

Page 57

[1]

[2]you can palpate for that, as well.

[3]Q. And then we talked about the MRI

[4]film that **[*45]** you reviewed, right, Doctor, you said

[5]there were two herniations, L4-5, L5-51?

[6]A. Yes.

[7]Q. And can you just tell us what your

[8]impression and plan was for Mr. Bryant?

[9]A. So, my impression and plan was

[10]that he had some evidence of both cervical and

[11]lumbar radiculopathy, and I had recommended

[12]conservative treatment, including physical

[13]therapy, and pain management, and possibly to

[14]consider lumbar epidural steroid injections.

[15]Q. You determined that he had

[16]radiculopathy based upon the fact that he had two

[17]herniations that would have caused some

[18]radiculopathy or there was some other evidence of

[19]radiculopathy?

[20]A. No, the entire treatment of, you

[21]know, my impression from having done the history

[22]and the physical examination, and having looked at

[23]the films, and then correlating them with his

[24]complaints and symptoms.

[25]Q. And you didn't keep the films,

Page 58

[1]

[2]right; it says here you gave the films back to

[3]Mr. Bryant?

[4]A. Correct, yes.

[5]Q. Was that unusual that Mr. Bryant

[6]came to you with the actual film?

[7]A. No, it's part of my screening

[8] **[*46]** process. So, when I do see patients in the

[9]office, my office staff makes sure that when the

[10]patients come into the office, they bring their

[11]films, because I want to see the actual films for

[12]all patients.

[13]Q. So, when you say your screening

[14]process, you don't see the patient until they have

[15]the actual film?

[16]A. Correct, yes.

[17]Q. Does part of your screening

[18]process involve getting any prior films that they

[19]have, that they had taken for that same body part?

[20]A. No, not necessarily, once again,

[21]because treatment is based on where they are when

[22]you see them, and so --

[23]Q. Based on their present complaints?

[24]A. Present complaints and symptoms,

[25]and you would want their most recent, you know,
Page 59

[1]

[2]diagnostic study, of course, if they had previous

[3]ones --

[4]Q. Right, previous diagnostic tests

[5]wouldn't affect your treatment, but it may affect

[6]your opinion as to causation?

[7]A. Yes.

[8]Q. Did Mr. Bryant ever come back

[9]again to see you?

[10]A. I haven't seen him specifically

[11]back in the office for a surgical consultation,

[12]no.

[13] **[*47]** Q. Okay, and it's been about a year

[14]and a half, correct?

[15]A. Correct.

[16]Q. Did you refer him to Dr. Davy, at

[17]that point, for pain management?

[18]A. I think since he had mentioned

[19]Dr. Davy, I said he can just, you know --

[20]Q. To continue to treat with him?

[21]A. Yes, correct.

[22]Q. Do you know where the MRI was

[23]taken that Mr. Bryant brought to you?

[24]A. I don't have the name of the

[25]facility, no.

Page 60

[1]

[2]Q. Do you know a Dr. Robert Soloman

[3]from Complete Radiology?

[4]A. I have heard the name, yes.

[5]Q. Is that a doctor that frequently

[6]reviews films for patients that you treat?

[7]A. I have seen his name on radiology

[8]reports, yes.

[9]Q. How frequently, you're not sure?

[10]A. Correct.

[11]Q. Did you give Mr. Bryant any

[12]opinion as to whether or not he should work or not

[13]work, or recommendation?

[14]A. Let's see, I don't think I made a

[15]specific recommendation with respect to his work,

[16]other than just to tell him that in terms of

[17]treatment I made those conservative care

[18]recommendations.

[19]Q. Did you indicate to him or **[*48]** provide

[20]him with any recommendation about any lifting he

[21]should do in the future, any type of work that

[22]required lifting?

[23]A. So, in general, my -- it's my

[24]usual custom and practice for these types of

[25]patients, I tell them that they should let their

Page 61

[1]

[2]body be their guide. So, as part of their

[3]counseling for these issues, I usually tell them

[4]to try to do what they can do, if they felt

[5]comfortable doing it. If they feel they are doing

[6]something that is uncomfortable or reproductive of

[7]symptoms, that they should back off.

[8]Q. Okay. Did Mr. Bryant come in with

[9]his wife on the initial evaluation, who would be

[10]Cynthia Bryant, your other patient?

[11]A. I saw Leon on the 16th, it looks

[12]like I saw Cynthia on the 20th. That's a good

[13]question, I'm not sure.

[14]Q. Do you also have an initial

[15]evaluation for Cynthia Bryant?

[16]A. I do, yes.

[17]Q. And you said that was on the 20th?

[18]A. Yes.

[19]Q. And that's also the 20th of July?

[20]A. Yes.

[21]Q. Tell us what her initial

[22]complaints were when you took a history, Doctor.

[23]A. So, she had indicated **[*49]** a car

[24]accident of May 19, 2012. She told me that she

[25]had had a prior history of an injury in 2009. She
Page 62

[1]

[2]gave me her past medical surgical history as

[3]hypertension, diabetes, and kidney failure, for

[4]which she was on dialysis, and she was on some

[5]medications, Including clonidine and what I have

[6]listed as carvedilol, which I believe is one of

[7]her kidney medications or her dialysis meds. She

[8]was doing physical therapy, and came in pretty

[9]much with a pain in her neck, with radiating

[10]symptoms to the arms and hands.

[11]Q. Did she have any low back

[12]complaints, Doctor?

[13]A. Let's see, she indicated some low

[14]back complaints, with some radiation into the

[15]lower extremities, I think, I believe her neck and

[16]upper extremity symptoms were predominant.

[17]Q. Again, it doesn't indicate whether

[18]or not she had seen Dr. Davy yet or not, it just

[19]says she's pending an appointment?

[20]A. Correct.

[21]Q. After this initial visit, did you

[22]ever speak with Dr. Davy about his treatment of

[23]this patient?

[24]A. I don't recall. I'm just going to

[25]look in my notes to see if I did.

Page **[*50]** 63

[1]

[2]Q. If it's indicated anywhere in your

[3]notes, please let me know.

[4]A. Sure. I don't see any separate

[5]conversations that I had had with him, no.

[6]Q. Did you ever obtain Dr. Davy 's

[7]records?

[8]A. No.

[9]Q. Did Ms. Bryant bring in with her,

[10]that day, any medical records from any other

[11]doctors that had treated with relation to this May

[12]19th accident?

[13]A. So, I did see she did have an MRI

[14]of her cervical spine, that's the film of the

[15]cervical spine, and I would have also gotten from

[16]her that MRI of the lumbar spine that Dr. Baum had

[17]ordered, because I have a copy of that record in

[18]the chart.

[19]Q. It doesn't indicate on your

[20]initial evaluation that you saw that initially,

[21]correct?

[22]A. I probably didn't look at the

[23]film, so I didn't dictate it under the MRI review

[24]section.

[25]Q. Because you only had the report,

Page 64

[1]

[2]you mean?

[3]A. Correct.

[4]Q. And if you only had the report,

[5]then you wouldn't include it in your overall

[6]evaluation?

[7]A. I wouldn't put -- so under my

[8]dictation, when I --

[9] **[*51]** Q. Your protocol is just to look at

[10]the actual films?

[11]A. Correct, yes.

[12]Q. So, if you have the report, would

[13]you not use it as a reference, as a guide into

[14]determining diagnosis, prognosis, causation?

[15]A. Correct, if it's not the main

[16]focus of my treatment, I wouldn't specifically

[17]comment on it, and so my main focus for her was

[18]her cervical spine.

[19]Q. Okay.

[20]A. We had that MRI record, so I put

[21]it into her chart, but I didn't look at or read

[22]the films, and I didn't offer treatment, per se,

[23]of the lumbar spine.

[24]Q. What was your interpretation of

[25]her cervical MRI?

Page 65

[1]

[2]A. So, what I indicated in my note

[3]was that her cervical MRI was significant for disk

[4]herniations at C4-05 and at C5-C6.

[5]Q. And did Ms. Bryant ever indicate

[6]to you whether or not she had ever had a cervical

[7]MRI prior to the May 19, 2012, accident?

[8]A. Not that I'm aware of or that I

[9]recall.

[10]Q. And none that you ever reviewed,

[11]correct?

[12]A. Correct.

[13]Q. And did Ms. Bryant tell you any of

[14]the doctors that she treated with her for prior

[15]accident? **[*52]**

[16]A. No, not that I have recalled, no.

[17]Q. And do you have any medical

[18]records from any of the doctors or any diagnostic

[19]films that she might have taken for the prior

[20]accident?

[21]A. No.

[22]Q. Now, again, Doctor, the same

[23]reason would apply for you to look at the prior

[24]MRI, it may assist you in determining causation,

[25]correct?

Page 66

[1]

[2]A. It may be helpful in determining

[3]causation, yes.

[4]Q. It may be helpful in determining

[5]whether or not these herniations, which you

[6]reviewed on this particular film, which was July

[7]13, 2012, may have preexisted the accident,

[8]correct?

[9]A. Or were in some way, shape, or

[10]form different.

[11]Q. But by different, you mean what;

[12]how would they be different, in terms of their

[13]impingement, whether it was more severe or less

[14]severe?

[15]A. It could be a different anatomical

[16]appearance, but those would -- so, you'd really

[17]just be looking at the anatomy or just one part of

[18]the puzzle, if you will.

[19]Q. When you say one part of the

[20]puzzle, you're referring to the prior MRI scan?

[21]A. When I mean one **[*53]** part of the

[22]puzzle, I mean in terms of causation, here we have

[23]a history, and then I have my treatment, and then

[24]the diagnostic studies that I saw of her after

[25]that accident of May 19, 2012. So, in terms of

Page 67

[1]

[2]causation, as you said, it may be something that

[3]adds to your causation, if you have any of those

[4]other medical records available for review.

[5]Q. As part of your history, do you

[6]ask the patient if they had ever had any MRI scan

[7]to that particular body part prior to the accident

[8]which they come to you for treatment?

[9]A. Well, I would ask them if they had

[10]a significant problem with that particular body

[11]part prior to my treatment, and then whether or

[12]not that, for example, had they required surgery

[13]or something, and then in those cases I would be

[14]much more aggressive about tracking down that

[15]particular film.

[16]Q. So, to you, in your opinion,

[17]significant only means whether or not they had

[18]surgery before the accident?

[19]A. As a surgeon, I think one of the

[20]thresholds for significant is whether or not

[21]they've had prior surgery, certainly because it

[22]would **[*54]** influence the way you would plan a

[23]subsequent surgery.

[24]Q. When you ask the patient whether

[25]or not they've ever had any significant injury to
Page 68

[1]

[2]that same body part, you leave it to them to

[3]determine what significant is, besides surgical

[4]intervention?

[5]A. Well, one of the things that I

[6]would offer to them as a significant issue is

[7]something that was persistent and/or progressive

[8]in terms of pain or symptoms.

[9]Q. And did you ask that of

[10]Ms. Bryant?

[11]A. Yes.

[12]Q. Okay, and what did she tell you?

[13]A. That she did not have any

[14]persistent or progressive previous symptoms with

[15]respect to the neck.

[16]Q. Did Ms. Bryant ever tell you that

[17]she had sought emergency room treatment at Kings

[18]County Hospital before this accident for neck

[19]pain?

[20]A. No.

[21]Q. Did she ever show you any of those

[22]records?

[23]A. No.

[24]Q. Did she ever show you any X-rays

[25]or any other diagnostic films that have been taken
Page 69

[1]

[2]of her cervical spine during that treatment?

[3]A. No.

[4]Q. Now, did you recommend a course of

[5]treatment **[*55]** for Ms. Bryant?

[6]A. Sure, so after the first visit of

[7]July 2012, one of the things that I suggested is

[8]for her to continue her conservative treatment,

[9]and then to come back to me if her condition was

[10]to the point where she could no longer tolerate it

[11]or if it got so bad that she was having more

[12]neurological symptoms.

[13]Q. Doctor, it's your understanding

[14]that she was undergoing conservative physical

[15]therapy before coming to see you?

[16]A. Yeah, part of the conservative

[17]treatment prior to this is what we consider

[18]activity modifications and restrictions, and

[19]things like physical therapy and/or pain

[20]management.

[21]Q. So, besides activity modification

[22]and restriction, what other prior treatment had

[23]Ms. Bryant had before coming to see you?

[24]A. So, as far as I know, she was

[25]doing physical therapy.

Page 70

[1]

[2]Q. Do you know where?

[3]A. I forgot the name -- I don't, off

[4]the top of my head, know the name of the treatment

[5]person.

[6]Q. Okay. Do you know the name of the

[7]facility?

[8]A. Not off the top of my head.

[9]Q. Did you ever obtain their **[*56]** records?

[10]A. No.

[11]Q. Did you ever speak to the doctor

[12]at that facility?

[13]A. No.

[14]Q. So, would you consider therapy for

[15]two months by Ms. Bryant to be conservative?

[16]A. Yes.

[17]Q. Now, Doctor, just going back to

[18]the physical exam, the second to last sentence you

[19]say "there's no significant evidence of peripheral

[20]nerve root compression;" Is that a good thing,

[21]Doctor?

[22]A. Yes.

[23]Q. And what does that mean?

[24]A. So, that would mean that there was

[25]no evidence of the nerve roots in the arms or
Page 71

[1]

[2]hands being -- when you say peripheral, you mean

[3]in the arm or hand, having localized irritation on

[4]them.

[5]Q. And would that irritation come

[6]from the neck?

[7]A. No, that would come from the arms

[8]or the hands.

[9]Q. It says that she had evidence of

[10]radiculopathy confirmed by Spurling's Maneuver and

[11]compression distraction maneuver?

[12]A. Yes.

[13]Q. Was that an objective test or

[14]subjective test?

[15]A. Objective.

[16]Q. The Spurling's test, is that done

[17]actively or passively?

[18]A. The Spurling's Maneuver **[*57]** is

[19]something that you would do, you put the patient

[20]into the provocative possession.

[21]Q. And then you would press down on

[22]their head, correct?

[23]A. Yes.

[24]Q. And upon pressing on their head,

[25]you would ask them whether or not they feel
Page 72

[1]

[2]discomfort, correct?

[3]A. Well, you would feel, for example,

[4]a withdrawal response or splinting when you put

[5]them into that stressed position.

[6]Q. And it's looking for, what did you

[7]say, Doctor, looking for what, when you put them

[8]in that position?

[9]A. A withdrawal response, or

[10]Involuntary contraction, or splinting.

[11]Q. Okay. Did you see that in this

[12]particular patient?

[13]A. Correct, yes.

[14]Q. As part of that test, when you

[15]press down on the patient's head, do you also ask

[16]them whether or not your pressing on their head

[17]results in any sort of pain to them?

[18]A. Yes.

[19]Q. And that would be subjective,

[20]correct?

[21]A. Yes.

[22]Q. And is that part of your

[23]determination, is that response from the patient

[24]also part of your determination whether or not the

[25]Spurling's test is **[*58]** negative or positive?

Page 73

[1]

[2]A. Yes.

[3]Q. Now, do you know whether or not

[4]Ms. Bryant was working at the time that she had

[5]her initial evaluation with you?

[6]A. I don't know.

[7]Q. Did you know whether or not she

[8]was on social security disability at that time?

[9]A. I don't know.

[10]Q. Now, she did suffer from renal

[11]failure, correct?

[12]A. Yes.

[13]Q. And she was undergoing dialysis

[14]for that?

[15]A. Yes.

[16]Q. Do you know the severity of her

[17]renal failure at the time that she came to see

[18]you?

[19]A. It was bad enough for her to be

[20]dialyzed.

[21]Q. Did you speak with her primary

[22]care physician either before or after your initial

[23]consult?

[24]A. After my initial consultation with

[25]her, as part of what's known as a clearance
Page 74

[1]

[2]process for surgery, yes, I would have

[3]communicated with the primary, In order to obtain

[4]what's known as a clearance.

[5]Q. But the clearance, according to

[6]your notes, didn't occur until after the second

[7]visit, correct?

[8]A. Yes.

[9]Q. So, between the first visit and

[10] **[*59]** the second visit, did you ever speak with her

[11]primary care physician?

[12]A. Not that I recall, no.

[13]Q. Okay. Do you know who her primary

[14]care physician is?

[15]A. I don't recall off of top of my

[16]head.

[17]Q. Did you ever obtain any records

[18]from the primary care physician?

[19]A. No.

[20]Q. Do you know if she had ever made

[21]any similar complaints to her neck to the primary

[22]care physician?

[23]A. I don't know.

[24]Q. Now, you indicated that she should

[25]restrict her activities of daily living?

Page 75

[1]

[2]A. Yes.

[3]Q. But you don't know if prior to

[4]treating with you her daily living had already

[5]been restricted; you don't have any idea, correct?

[6]A. I believe it was, and that's the

[7]reason that she was seeing me, because she was

[8]having pain, which was significant enough to

[9]interfere with her activities of daily living.

[10]Q. Okay. Let me rephrase the

[11]question. You don't know if prior to this

[12]accident if her activities of daily living were

[13]already restricted?

[14]A. Correct.

[15]Q. You didn't see her prior to this

[16]accident?

[17] **[*60]** A. Correct.

[18]Q. And you never reviewed any records

[19]from social security disability that were provided

[20]by Ms. Bryant to that agency?

[21]A. Correct.

[22]Q. And you don't know if she was on

[23]social security disability?

[24]A. Correct.

[25]Q. You know what social security
Page 76

[1]

[2]disability is given to someone for though, right,

[3]Doctor?

[4]A. Yes.

[5]Q. Okay. What's the reason that

[6]someone will receive social security disability?

[7]A. So, there could be multiple issues

[8]for them, In order to qualify for social security

[9]disability. So, they can be medical, they could

[10]be psychiatric, or they could be musculoskeletal,

[11]for example.

[12]Q. Okay.

[13]A. So, if a patient has a restriction

[14]whereby they are disabled, then they would qualify

[15]for social security disability.

[16]Q. And renal failure, that may

[17]qualify them for social security disability,

[18]correct?

[19]A. Yes.

[20]Q. If it prevents them from working,

[21]correct?

[22]A. Yes.

[23]Q. And if renal failure prevented the

[24]person from working, would it also prevent them

[25]from doing a lot **[*61]** of their normal daily activities?
Page 77

[1]

[2]A. Renal failure can interfere with

[3]their activities, yes.

[4]Q. Of daily living?

[5]A. Yes.

[6]Q. One of those activities of daily

[7]living would be working, correct?

[8]A. Yes.

[9]Q. You returned the film to

[10]Ms. Bryant that she brought in with you?

[11]A. Yes.

[12]Q. Do you know where that film was

[13]taken, the film that she brought in?

[14]A. Let's see if I have a copy of the

[15]report. I don't know if I have a copy of that

[16]report in the charts. I don't have the name of

[17]the facility listed.

[18]Q. I saw in your chart there's a

[19]Complete Radiology?

[20]A. I have Complete Radiology MRI

[21]lumbar spine June 16, 2012.

[22]Q. But you said your treatment wasn't

[23]of the lumbar spine?

[24]A. Yes, correct.

[25]Q. So, notwithstanding that, you have
Page 78

[1]

[2]the lumbar spine, but you don't have the MRI --

[3]A. Right, because I looked at the

[4]actual MRI film, itself.

[5]Q. Not the report?

[6]A. Right, recorded the date of the

[7]film, but I didn't record the facility name.

[8]Q. The lumbar **[*62]** MRI, that Ms. Bryant

[9]had taken, was the actual film brought to you or

[10]just the report?

[11]A. I believe it was just the report.

[12]Q. So, if the report was brought to

[13]you, it wasn't obtained by you, it was brought by

[14]the patient?

[15]A. Correct.

[16]Q. So, the report was scanned into

[17]your medical file of the patient?

[18]A. Yes.

[19]Q. And that's how you have it here

[20]today?

[21]A. Yes.

[22]Q. Now, if Ms. Bryant had had a prior

[23]cervical MRI that diagnosed her with a herniation

[24]or bulge at the same levels, again, we talked

[25]about that, that could affect your causation
Page 79

[1]

[2]opinion as it relates to this particular accident,

[3]correct, Doctor?

[4]A. Although herniations and bulges

[5]are different --

[6]Q. A little bit.

[7]A. -- anatomically. I would

[8]respectfully disagree, I think there are big

[9]differences between herniations and bulges.

[10]Q. Well, can a bulge at a certain

[11]level, can that turn into a herniation, Doctor?

[12]A. Well, anything can turn into a

[13]Herniation.

[14]Q. Okay. So, a bulge, after time,

[15]can turn into a herniation, **[*63]** over time?

[16]A. Yes, but in so much as a bulge

[17]could also be a normal finding. A normal disk can

[18]also turn into a herniation.

[19]Q. Okay. Can a herniation also be a

[20]normal finding?

[21]A. Yes, you can have patients that

[22]have what are known as asymptomatic herniations.

[23]I mean, not that it's a normal finding, because

[24]it's anatomically --

[25]Q. Abnormal?

Page 80

[1]

[2]A. Correct, but herniations can be

[3]asymptomatic, which means they don't have any

[4]symptoms.

[5]Q. Which means they don't produce

[6]pain --

[7]A. Correct.

[8]Q. -- in a particular individual?

[9]A. Yes.

[10]Q. And the same for a bulge, correct?

[11]A. Absolutely, yes, correct.

[12]Q. But a bulge can also produce pain

[13]similar in a fashion that a herniation produces

[14]pain?

[15]A. I would say that that is a bit

[16]controversial, because a bulge if I may?

[17]Q. Okay.

[18]A. It's a symmetrical protrusion of

[19]disk, outside of or adjacent to the vertebral

[20]boundaries and borders, and often times the

[21]bulges, themselves, can be what's known as

[22]constitutive, or physiological, or normal, **[*64]** and

[23]more often than not, when you're looking at

[24]bulges, they can just be part of the normal

[25]senescence process for that particular spine.

Page 81

[1]

[2]Q. Okay.

[3]A. Unless you see something else in

[4]that disk, for example annular tear or another

[5]anatomical abnormality that would lead you to

[6]believe that it's pathological.

[7]Q. And an annular tear is also

[8]something that you would see in a herniation,

[9]correct?

[10]A. You can, it depends. Annular

[11]tears may or may not be seen on the MRI, depending

[12]upon what's something known as the magic angle,

[13]which is the angle at which the MRI scanner

[14]interacts with the disk.

[15]Q. Whether or not the actual annular

[16]tear is seen, is it correct that generally there

[17]is a tear in the disk when there is a herniation?

[18]A. So, in general --

[19]Q. Whether it's showed on the actual

[20]scan, itself?

[21]A. So, in general, the disk is made

[22]of up two basic components, one is the inner

[23]nuclear jelly like portion of the disk.

[24]Q. Which they compare a disk to a

[25]jelly donut, right?

Page 82

[1]

[2]A. Correct, yes.

[3] **[*65]** Q. Okay.

[4]A. And then the outer portion of that

[5]disk has to have some defect in it in order for --

[6]Q. Nucleus pulposus to seep out,

[7]correct?

[8]A. Yes.

[9]Q. And it's that seeping that is the

[10]herniation of the disk?

[11]A. Yes.

[12]Q. And it's that seeping that causes

[13]the impingement on the nerves around the spine,

[14]which produces pain?

[15]A. Correct, In addition to the

[16]portion of the annulus that's also providing or

[17]sticking out beyond the --

[18]Q. Out of the disk?

[19]A. Yes.

[20]Q. So, Ms. Bryant never mentioned to

[21]you that she had had a prior MRI prior to the May

[22]2012 accident of the cervical spine, right?

[23]A. Not that I recall, no.

[24]Q. And you don't know whether or not

[25]that MRI showed that she had a disk herniation at
Page 83

[1]

[2]C5-6?

[3]A. No, I haven't seen it, so I don't

[4]know.

[5]Q. And you don't know at C4-5, again,

[6]cause you've never seen it?

[7]A. Yes, correct.

[8]Q. Can we just take a look at your

[9]next visit, Doctor, which I have here as October

[10]5th, is that correct, 2012?

[11]A. Yes.

[12] **[*66]** Q. It says "Ms. Bryant continued to

[13]remain symptomatic and was accompanied by her

[14]family members."

[15]A. Yes.

[16]Q. What family members would that be?

[17]A. I think that that was her husband

[18]who was with her.

[19]Q. Okay. So, he was there for moral

[20]support, not for actually treatment from you,

[21]correct?

[22]A. Yes.

[23]Q. Any other family members that you

[24]can recollect, as you sit here today?

[25]A. No.
Page 84

[1]

[2]Q. What complaints did she make at

[3]that time?

[4]A. Neck pain, with pain into the

[5]upper extremity arms and hands.

[6]Q. Had she seen Dr. Davy by this

[7]point for any sort of pain management treatment?

[8]A. I don't know. I don't have that

[9]listed as whether or not she did.

[10]Q. Do you know if whether or not

[11]Dr. Davy, by this time, had given her any

[12]interventional treatment, injections, anything?

[13]A. I don't know.

[14]Q. Would you have expected her to try

[15]interventional treatment prior to coming back to

[16]see you on October 5th?

[17]A. Depending upon what her overall

[18]medical condition was, and whether or not her

[19]renal **[*67]** failure and her other illnesses lent it to

[20]interventional pain management.

[21]Q. Would she have had to get

[22]clearance from her primary care doctor in order to

[23]get interventional pain management treatment?

[24]A. So, I'm not a pain management

[25]treating. I'm sure they all have different
Page 85

[1]

[2]protocols in terms of what they require for

[3]clearance. So, I would -- I mean, I haven't

[4]spoken to him about that.

[5]Q. When you say him, you mean

[6]Dr. Davy?

[7]A. Correct.

[8]Q. Okay. So, you don't know what, if

[9]any, Interventional treatment he provided to her

[10]prior to her seeing you on the 5th?

[11]A. Yeah, not that I have recorded and

[12]not that I have an independent recollection, no.

[13]Q. And then again, you did a physical

[14]exam?

[15]A. Yes.

[16]Q. And was her physical exam, as

[17]compared to the previous one, was it changed, in

[18]any way, was it different, In any way?

[19]A. No, it demonstrated, essentially,

[20]a persistent disfunction in two nerve root

[21]distributions, C5 and C6, with some weakness in

[22]those nerve roots, as well, and I think if we

[23]compare the July 16, 2012, visit **[*68]** to October -- I'm

[24]sorry, July 20, 2012, she also had weakness. So,

[25]she had, essentially, the same type of disfunction
Page 86

[1]

[2]in the fifth and sixth roots.

[3]Q. And in the fifth and sixth roots

[4]of her cervical spine, the MRI scan revealed to

[5]you that she had a herniation at that level,

[6]correct?

[7]A. So, the fifth roots are adjacent

[8]to the C4-05 disk, and the sixth roots are

[9]adjacent to the C5-C6 disk.

[10]Q. So, she had a herniation at both

[11]those levels --

[12]A. Yes.

[13]Q. -- based upon your review at the

[14]prior visit of the MRI scan?

[15]A. Correct.

[16]Q. Did she bring with you her scan

[17]again --

[18]A. Yes.

[19]Q. -- at that visit?

[20]A. Yes.

[21]Q. And this is the same scan that you

[22]had already reviewed?

[23]A. Yes.

[24]Q. Did you review it again?

[25]A. Yes.

Page 87

[1]

[2]Q. What was the purpose of that?

[3]A. To make sure that I was

[4]correlating the MRI films with her physical

findings from that day.

Q. Just because you had no -- without

seeing the film, you would have no independent

recollection **[*69]** of what you reviewed the last time,

or did you have your note in front of you?

A. No, my notes in front of me, but

just to get a second look at it, particularly on

this visit, because of her persistent symptoms,

one of the issues here was whether or not we would

contemplate doing something surgically.

Q. Okay, and did you discuss surgery

with her on this visit?

A. Yes.

Q. And was that something brought up

by you, or something brought up by her, or someone

else?

A. Well, I think the purpose of the

follow-up visit was to consider surgery, if she

hadn't gotten any better or if she had gotten

worse. So, in general, when I tell patients to

follow-up with me, the purpose for their follow-up

Page 88

would be if they remain symptomatic with

persistent and/or progressive symptoms, with

correlations demonstrating an anatomical lesions

that are amenable to surgery --

Q. Which being an MRI scan?

A. Correct.

Q. Okay.

[9]A. Then she would be considered

[10]what's known as a surgical candidate. So, the

[11]purpose of that follow-up visit would **[*70]** be to sit

[12]down and review her symptoms and her exam.

[13]Q. Were her symptoms progressive or

[14]persistent?

[15]A. I think both, in terms of

[16]symptoms.

[17]Q. Well, the range of motion was

[18]essentially the same, correct?

[19]A. But the symptoms, which would be

[20]her complaints and symptoms, were severe pain in

[21]her neck, with pain shooting into her upper

[22]extremity arms and hands.

[23]Q. These were her subjective

[24]complaints?

[25]A. Correct, yes.

Page 89

[1]

[2]Q. But her subjective complaints, as

[3]compared do this visit and the previous visit,

[4]were essentially the same, no?

[5]A. So, in that --

[6]Q. Did she complain of radiating pain

[7]in the previous visit?

[8]A. Yes.

[9]Q. And in the initial visit she

[10]complained of radiating pain in her upper

[11]extremities, arms and hands?

[12]A. Yes.

[13]Q. And she continued to complain of

[14]that in the follow-up?

[15]A. Correct.

[16]Q. So, her complaints were

[17]essentially, her subjective complaints, were

[18]essentially unchanged?

[19]A. Correct, or persistent.

[20]Q. Or persistent?

[21]A. Yes.

[22] **[*71]** Q. Was there any progressive findings

[23]by you, any objective progressive findings,

[24]neurologically that is?

[25]A. Neurologically, when we compare

Page 90

[1]

[2]the exams, it appears that she continued to have

[3]essentially a stable disfunction of the fifth and

[4]sixth roots.

[5]Q. So, there was no progression,

[6]there was nothing progressive from the initial

[7]visit?

[8]A. There was as of yet no

[9]neurological progression, yes.

[10]Q. You had indicated on your initial

[11]exam that neurological progression would require

[12]surgical intervention?

[13]A. Of course, yes.

[14]Q. Would persistent complaints, was

[15]that also something that you'd look for in

[16]determining whether or not she's a surgical

[17]candidate?

[18]A. Yes.

[19]Q. And you discussed surgery with

[20]her, what type of surgery did you discuss with her

[21]at that time?

[22]A. So, the surgery we discussed is

[23]known as an anterior cervical discectomy and

[24]spinal fusion.

[25]Q. And by anterior, that means that
Page 91

[1]

[2]you're going from the front, not the back?

[3]A. Correct.

[4]Q. When I say front, in the area **[*72]** of

[5]the region of their throat?

[6]A. Yes.

[7]Q. And that was to C4-5 and C5-6,

[8]those segments?

[9]A. Yes.

[10]Q. And did you recommend surgery to

[11]her on that visit?

[12]A. Yes.

[13]Q. And did you discuss with her the

[14]pros and cons of surgery?

[15]A. Yes.

[16]Q. Okay, and what were those pros and

[17]cons?

[18]A. So, the advantages and the

[19]disadvantages of surgery?

[20]Q. Correct.

[21]A. The advantage of surgery is to,

[22]number one, try to prevent these nerve roots from

[23]continuing to get worse, because dysfunction to

[24]the roots could certainly lead to progressive

[25]dysfunction.

Page 92

[1]

[2]Q. They could become more

[3]debilitated?

[4]A. Yes.

[5]Q. Okay.

[6]A. So, that's the primary indication

[7]for surgery. The secondary indication for surgery

[8]is try to decrease the radiating component of the

[9]pain.

[10]Q. Her subjective complaints?

[11]A. Correct.

[12]Q. Okay.

[13]A. And to stabilize that portion of

[14]the neck, whereby the disks are not functioning

[15]properly, basically to prevent further damage to

[16]that area.

[17] **[*73]** Q. Did she ask you or request whether

[18]or not the surgery would alleviate her pain?

[19]A. Weil, that's one of the things we

[20]talked about in terms of discussing that radiating

[21]component of the pain, yes.

[22]Q. Let me rephrase it. Was there a

[23]determination of what percentage of success she

[24]would accomplish in terms of her subjective

[25]complaints through surgery?
Page 93

[1]

[2]A. So, in terms of those subjective

[3]complaints, yes. Part of that discussion involves

[4]the fact that within a reasonable degree of

[5]medical certainty, we can decrease some of the

[6]symptoms, but not completely and entirely

[7]alleviate or ameliorate all of them.

[8]Q. Okay, and did she elect to go for

[9]surgery on that visit, Doctor, or did she say

[10]she'd get back to you after discussing it over

[11]with her family?

[12]A. From what I have down in my note,

[13]I think she elected to proceed at that time.

[14]Q. Did she seek a second opinion at

[15]all?

[16]A. I don't know.

[17]Q. It doesn't indicate here that she

[18]did?

[19]A. No.

[20]Q. You said you spoke with her

[21]primary care physician, it says here you'll **[*74]** ask

[22]here primary care physician for clearance?

[23]A. Correct.

[24]Q. Do you know who you spoke to, when

[25]you spoke to them?
Page 94

[1]

[2]A. No.

[3]Q. Do you have an independent

[4]recollection of that conversation?

[5]A. No, I do not.

[6]Q. Okay. So, you're just going to

[7]tell us what clearance is generally?

[8]A. Yes, and also specifically for

[9]Ms. Bryant.

[10]Q. For this patient?

[11]A. Yeah.

[12]Q. What did clearance involve for

[13]this particular patient, who suffered from end

[14]stage renal failure?

[15]A. Excellent question. So, for this

[16]particular patient, number one, whether or not, in

[17]his opinion, she would be able to tolerate a

[18]general anaesthetic --

[19]Q. Okay.

[20]A. -- with this type of a procedure,

[21]to safely undergo that surgery.

[22]Q. And what was that doctor's

[23]opinion?

[24]A. I believe he gave us a medical

[25]clearance, and so that we were able to proceed

Page 95

[1]

[2]forward.

[3]Q. I saw in the surgical report there

[4]was an intraoperative neurophysiology report?

[5]A. Yes.

[6]Q. Is that something that's normally

[7] **[*75]** used during this type of surgery?

[8]A. Yes.

[9]Q. Okay, and what's the purpose of

[10]that?

[11]A. Particularly when you're operating

[12]on the spine, spinal cord, or nerve roots, what

[13]we'll do is we will have the patient monitored.

[14]So, we monitor what are known as SSEPs, or

[15]somatosensory evoked potentials. We also monitor

[16]what are known as motor evoked potentials, and in

[17]some cases we will also monitor EMGs, that is

[18]we'll test the nerves in their arms and their

[19]hands. So, we wire them up to a computer --

[20]Q. To insure there's no damage as a

[21]result of the surgery, or no injury as a result of

[22]the surgery to those nerves?

[23]A. Yeah, that's the primary reason to

[24]do it. We also want to know that while we're

[25]operating on the spinal cord and/or nerves, that

Page 96

[1]

[2]the cord and the nerves continue to remain well

[3]perfused, because sometimes an anesthetic can

[4]interfere with nerve function or spinal cord

[5]function, and if there are any changes during the

[6]procedure, it allows us to alter what we are

[7]doing, so that we don't do any harm.

[8]Q. Were there any abnormal findings, **[*76]**

[9]intraoperatively, during that test?

[10]A. So, as far as I know there were no

[11]significant intraoperative abnormalities.

[12]Q. Can we just take a look at your

[13]operative report, briefly?

[14]A. Sure.

[15]Q. Now, under indications, you say

[16]that "she has cervical disk herniations which are

[17]producing spinal cord and nerve root compression?"

[18]A. Yes.

[19]Q. "With severe progressive upper

[20]extremity C5-C6 nerve root dysfunction?"

[21]A. Yes.

[22]Q. And that's based upon her

[23]subjective complaints or objective tests, as well?

[24]A. A combination thereof.

[25]Q. Now, how did you test her loss of
Page 97

[1]

[2]sensation to know she had loss of sensation?

[3]A. So, sensory testing, you test the

[4]dermatome. So, a dermatome is that area of your

[5]skin that's innovated by a particular nerve root.

[6]Q. Right.

[7]A. In general, the dermatomes run

[8]down your arms and legs like stripes, and they are

[9]adjacent to each other, and so you'll test

[10]sensation in the dermatomes by comparing in the

[11]same extremity one dermatome to the next, and by

[12]comparing one extremity to the **[*77]** other.

[13]Q. And where did you perform that

[14]test?

[15]A. So, those tests were performed in

[16]the office and in the hospital prior to surgery.

[17]Q. Do you have any records indicating

[18]when these tests were performed or the results of

[19]those tests?

[20]A. They are in the office notes and

[21]in the operative --

[22]Q. When you say the office notes,

[23]you're referring to the first two visits?

[24]A. Yes.

[25]Q. Which notes in the first two
Page 98

[1]

[2]visits of Ms. Bryant indicate that she had loss of

[3]sensation?

[4]A. So, I believe the first visit,

[5]whereby we tested her dermatomes.

[6]Q. With pinprick?

[7]A. Correct, and tactile, so pinprick

[8]and tactile sensation.

[9]Q. And is that an objective or

[10]subjective test?

[11]A. Objective, when you're comparing

[12]dermatome to dermatome and limb to limb.

[13]Q. Now, I just want to direct your

[14]attention to the procedure section.

[15]A. Yes.

[16]Q. Starting with the sentence "next,

[17]with the assistance of loupe magnification."

[18]A. Yes, I see that.

[19]Q. Can you just read what is says

[20]there, those **[*78]** next three sentences?

[21]A. Sure, do you want me to start with

[22]next?

[23]Q. Yes.

[24]A. So, "next, with the assistance of

[25]loupe magnification disk dissection was
Page 99

[1]

[2]undertaken, this was done at each successive

[3]level, including C4-05 and C5-C6 segments."

[4]Q. Can you keep going?

[5]A. Sure. "This dissection was

[6]carried out down to the level of the posterior

[7]annulus."

[8]Q. I'm sorry, keep going.

[9]A. "The annulus was visualized and

[10]found to contain a tear beyond which herniation

[11]was found in the canal through some cord

[12]compression and nerve root compression."

[13]Q. Okay. The tear in the annulus is

[14]what allows for the nucleus pulposus to exude out,

[15]correct?

[16]A. Yes, correct.

[17]Q. And you observed that during the

[18]surgery, correct?

[19]A. Yes.

[20]Q. And it was your belief that it was

[21]that herniation which was producing cord

[22]compression and nerve root compression?

[23]A. Yes.

[24]Q. And you had the same finding at

[25]C5-6, right?
Page 100

[1]

[2]A. Yes, correct.

[3]Q. It says that the disk material was

[4]removed **[*79]** and sent for pathological evaluation, was

[5]that ever done?

[6]A. Yes.

[7]Q. Do you have the surgical pathology

[8]report in your medical records?

[9]A. I believe so, yes.

[10]Q. The diagnosis for the first

[11]specimen, which was the disk material C4-5 disk,

[12]what was the pathology findings?

[13]A. So, there are two, there's a gross

[14]description and then there's a diagnosis.

[15]Q. Okay. The diagnosis, what was the

[16]diagnosis?

[17]A. So, the diagnosis for specimen A,

[18]which was C4-05 disk, says "anterior cervical

[19]laminectomy and spinal fusion, degenerated

[20]fibrocartilaginous tissue, consistent with disk

[21]material."

[22]Q. What's the significance of that,

[23]degenerative fibrocartilaginous tissue?

[24]A. Degenerative fibrocartilaginous

[25]refers to the histological appearance of the disk
Page 101

[1]

[2]material that was removed.

[3]Q. Meaning that it was degenerative

[4]In nature, that the material was degenerative in

[5]nature, the disk material that was removed?

[6]A. Correct.

[7]Q. And this was the same material

[8]that was removed because it was causing nerve root

[9] **[*80]** compression?

[10]A. Yes.

[11]Q. So, the fact that the material was

[12]degenerative, what does that mean; what does

[13]degenerative mean?

[14]A. So, degenerative refers to the

[15]process that happens to all of us as we age. So,

[16]there's a process of generation between the ages

[17]of birth, up through your adolescence, when you're

[18]musculoskeletal system reaches maturity,

[19]musculoskeletal maturity.

[20]Q. Right.

[21]A. Thereafter, there is a process of

[22]degeneration, whereby your musculoskeletal tissues

[23]undergo --

[24]Q. An aging process?

[25]A. Yeah, we like to refer to it as
Page 102

[1]

[2]the normal senescence process.

[3]Q. Right.

[4]A. Because it happens to all of us,

[5]so it's normal, but it is degenerative and not --

[6]Q. Traumatically induced?

[7]A. And not generative.

[8]Q. Well, by degenerative,

[9]degenerative versus traumatic, traumatic would be

[10]something that's acute, correct?

[11]A. Well, traumatic means there's a

[12]consequence of trauma.

[13]Q. Right, that finding would be

[14]caused by a particular isolated incident?

[15]A. Trauma generally refers **[*81]** to a --

[16]I'm trying to think of a good definition of

[17]trauma. Trauma generally refers to, yes, an

[18]incident whereby there has been some force

[19]transferred to the musculoskeletal system in an

[20]unanticipated or unexpected way. Sometimes in an

[21]expected way, but sometimes in an unanticipated or

[22]unexpected way.

[23]Q. So, the fact that the disk

[24]material was degenerative, did that, at all,

[25]affect your opinion as to the cause of these
Page 103

[1]

[2]herniations?

[3]A. No.

[4]Q. Why not?

[5]A. Because degenerative histological

[6]description of the disk material is consistent

[7]with a woman of Ms. Bryant's age of 46 years.

[8]Q. Okay. Would it be consistent with

[9]a prior cervical MRI that also showed herniations

[10]at that level?

[11]A. I would have to look at the MRI

[12]film, but in so much as it's part of the normal

[13]senescence and/or aging process, I would say

[14]degenerative is a normal finding for disk material

[15]that you've removed, unless you're removing disk

[16]material from an adolescent or someone that's

[17]still growing.

[18]Q. And the diagnosis for the disk

[19]material, well this **[*82]** says C4-5 again. So, the only

[20]disk material that was tested, was that C4-5?

[21]A. No, it should have been both

[22]disks.

[23]Q. So, that's supposed to be C5-6,

[24]correct?

[25]A. Yes, because there were two

Page 104

[1]

[2]separate specimens.

[3]Q. Right, one from each disk?

[4]A. Yes.

[5]Q. Is that something you dictated or

[6]something that the hospital --

[7]A. No, this is a pathology report

[8]that is generated by a pathologist who is in the

[9]hospital, and I think we have the pathologist's

[10]name.

[11]Q. Is that Yin?

[12]A. Yeah, it's Yong --

[13]Q. Yongmei Yin?

[14]A. It looks like attending

[15]pathologist Yongmei Diana Yin.

[16]Q. So, that must be a typographical

[17]error or her part, correct?

[18]A. Yes, correct.

[19]Q. It's not something that you were

[20]involved in generating?

[21]A. No.

[22]Q. Now, did Ms. Bryant come to see

[23]you postsurgery?

[24]A. Yes.

[25]Q. What was the date of your surgery?
Page 105

[1]

[2]A. So, the surgical date was October

[3]25th, of 2012.

[4]Q. Okay, and when was the first time

[5]that she came to see you? **[*83]**

[6]A. Postop?

[7]Q. Yes, postop.

[8]A. So, first postop visit was on

[9]November 2nd, of 2012.

[10]Q. Were her symptoms different, at

[11]all, as compared to presurgical?

[12]A. So, at the time it's a little

[13]different to assess symptoms.

[14]Q. Because she's still healing?

[15]A. She's still on the acute phase of

[16]the healing process.

[17]Q. Which takes generally how long

[18]after surgery, lasts how long after surgery?

[19]A. It depends. I can tell you that

[20]my first postoperative visit is generally one

[21]about seven to ten days after discharge, and the

[22]reason that I want to see them on that first

[23]postoperative visit is to make sure they haven't

[24]had any complications from the surgery.

[25]Q. Okay.

Page 106

[1]

[2]A. So, that assessment is really

[3]geared towards assessing their physical status to

[4]make sure that they are on the mend or that the

[5]healing process is --

[6]Q. Make sure there's no infection?

[7]A. Correct, yes.

[8]Q. So, during that visit, you don't

[9]really perform any type of physical, not physical

[10]exam, but you don't perform any range of **[*84]** motion

[11]test or any test of that nature?

[12]A. Correct, yes.

[13]Q. Did she make any complaints of

[14]pain, at that point, unrelated to the surgery, but

[15]to her original symptoms?

[16]A. Not that I recall, no.

[17]Q. Would that be something that you

[18]would have documented, had she made those

[19]complaints?

[20]A. If it was unusual, if she was

[21]complaining of some type of unusual pain that she

[22]hadn't had previously, or it was something that we

[23]were concerned about having a postoperative

[24]complication from, yes.

[25]Q. Would you have expected for the
Page 107

[1]

[2]patient to have any reduction in her pain at the

[3]time that this visit took place, which would have

[4]been seven to ten days after?

[5]A. I would have expected her to have

[6]some reduction of pain, but I guess I wasn't all

[7]too impressed with either increased pain or

[8]decreased pain. Essentially this visit says she

[9]was status quo.

[10]Q. Okay. So, she remained the same?

[11]A. She remained stable after surgery,

[12]without any evidence of any complications.

[13]Q. But you didn't note here that she

[14]had any reduced pain **[*85]** symptoms?

[15]A. Correct, we didn't get into that,

[16]no.

[17]Q. Doctor, this particular surgery,

[18]do you know what you billed it, what the cost of

[19]this surgery was?

[20]A. I don't know, it depends on --

[21]Q. I'm not talking about what you're

[22]reimbursed from a no-fault fee schedule or from

[23]worker's comp; what do you bill out for this

[24]surgery?

[25]A. So, my billing actually depends on
Page 108

[1]

[2]what the insurance plan is.

[3]Q. Okay, let's say no-fault, what do

[4]you bill for this surgery?

[5]A. Yeah, there's a no-fault rate,

[6]which I don't know what the exact number is for

[7]the no-fault rate, but it would be sent in at

[8]whatever. It's a rate that's mandated by whatever

[9]the no-fault regulations are.

[10]Q. Right, that's the rate that

[11]they'll pay for the surgery?

[12]A. But that's the rate you have to

[13]bill them at, as well, as far as I know.

[14]Q. You also bill at the no-fault

[15]rate?

[16]A. Yes.

[17]Q. You don't bill at a higher rate?

[18]A. Correct.

[19]Q. And then have them reduce it to

[20]whatever their rate is?

[21]A. No, I bill it at whatever **[*86]** the

[22]no-fault rate is, because even if lets say you

[23]made up some numbers, and you bill it at whatever

[24]you wanted to bill it at, they are still going to

[25]pay you whatever the no-fault rate is.

Page 109

[1]

[2]Q. Okay. So, you just bill it at

[3]that rate?

[4]A. Correct.

[5]Q. So, do you have any idea what that

[6]rate is, approximately?

[7]A. I don't know off the top of my

[8]head, no.

[9]Q. Okay. Is it more than 5,000 or

[10]less than 5,000?

[11]A. God, there is multiple procedures

[12]that you do during the surgery. Each one of those

[13]procedures has what's known as a CPT code, or a

[14]procedural code.

[15]Q. Right.

[16]A. And so each one of those

[17]procedures has it's own --

[18]Q. Billing code?

[19]A. Exactly, correct.

[20]Q. So, for this procedure, in a

[21]whole --

[22]A. Yes.

[23]Q. -- for every different procedure

[24]within this discectomy procedure, right, it's a

[25]discectomy?

Page 110

[1]

[2]A. Cervical discectomy and spinal

[3]fusion, correct.

[4]Q. For this procedure, as a whole,

[5]what's the approximate cost or billing?

[6]A. Good question. **[*87]**

[7]Q. Do you do your own billing?

[8]A. No, I don't.

[9]Q. You have someone that does billing

[10]for you?

[11]A. Yes.

[12]Q. Do you see the bills before they

[13]go out?

[14]A. No.

[15]Q. You have no idea what this surgery

[16]cost or what you bill this surgery at, generally?

[17]A. Yeah, in general, I leave that up

[18]to --

[19]Q. Give me a ballpark figure.

[20]A. Honestly, I leave it up to my

[21]office manager, and then let them send in the

[22]bills with the billing department.

[23]Q. Do you have billing records

[24]related to your treatment of Ms. Bryant?

[25]A. I don't, as part of the chart,
Page 111

[1]

[2]because it's outsourced. So, it's outsourced to a

[3]billing company.

[4]Q. If we wanted to obtain the billing

[5]records, you would have access to those records?

[6]A. Yeah, what we would do is we'd

[7]contact the billing company and then say could you

[8]give us a copy of the bills that we sent.

[9]Q. For this particular patient?

[10]A. Yeah, to whoever the insurance

[11]carrier was.

[12]Q. Okay. We are just going to

[13]request a copy of the bills for each patient. **[*88]**

[14]A. Sure.

[15]Q. And we'll follow-up in writing to

[16]your office after this.

[17]A. Sure.

[18]Q. Is there anyone we should direct

[19]that correspondence to?

[20]A. If you direct it to the office

[21]manager, her name is Chris, then she'd be able to

[22]get in contact with the billing company for you.

[23]Q. Okay. Terrific. Now, the next

[24]visit with Ms. Bryant was December 7, 2012?

[25]A. Yes.

Page 112

[1]

[2]Q. And by this time she's about a

[3]month and two weeks postop?

[4]A. Yeah, so we did it in October, let

[5]me just check.

[6]Q. October 25th.

[7]A. So, just about two years ago, no a

[8]year ago.

[9]Q. No, I'm saying at the time of this

[10]visit.

[11]A. No, I'm thinking from now, sorry.

[12]Q. From now, okay, but at the time of

[13]this visit she's about a month and two weeks out

[14]from her surgical intervention?

[15]A. Correct, yes.

[16]Q. At this visit, do you expect to

[17]see a reduction in pain?

[18]A. Once again, I didn't assess her

[19]for that at this time. Primarily I'm just

[20]assessing her neurological status to see whether

[21]or not she's stable, deteriorated, **[*89]** or improved

[22]neurologically.

[23]Q. Okay.

[24]A. And once again, and just checking

[25]for any postop complications that can happen
Page 113

[1]

[2]within that first several months.

[3]Q. Okay. So, neurologically, was she

[4]better, worse, or the same?

[5]A. Stable.

[6]Q. So, meaning she was the same?

[7]A. Meaning, correct, that she was --

[8]Q. By stable, what's your

[9]interpretation of stable?

[10]A. I didn't do anything to make her

[11]any worse.

[12]Q. She wasn't any worse, but she

[13]wasn't any better?

[14]A. No, she wasn't any worse.

[15]Q. Okay.

[16]A. So, subjectively, I didn't take

[17]down any of her subjective symptoms at that time,

[18]but she was certainly no worse with surgery.

[19]Q. Now, it says here that range of

[20]motion was tested?

[21]A. Yes.

[22]Q. Okay, what range of motion tests

[23]were done?

[24]A. So, I did a qualitative spinal

[25]range of motion, just to see how much motion we

Page 114

[1]

[2]can get in her neck and her back.

[3]Q. Okay.

[4]A. And I qualitatively recorded it at

[5]about 30 percent of normal motion.

[6]Q. Do **[*90]** you know what particular test

[7]you did when you do that test?

[8]A. So, I would take them basically

[9]through all the major ranges of motion, which are

[10]flexion, extension, lateral bending, and rotation.

[11]Q. Given that these tests are

[12]postsurgery, are these done just activity, based

[13]upon the patients subjective complaints of where

[14]they can go with the bending, or do you do it

[15]passively, as well, given it's postop?

[16]A. I recorded it as both, actively

[17]and passively.

[18]Q. Does it say that here in the

[19]record?

[20]A. Yes, yes.

[21]Q. Where does it say that?

[22]A. It's the last sentence of the

[23]physical exam section.

[24]Q. Okay. Both activity and

[25]passively.

Page 115

[1]

[2]A. Yes.

[3]Q. Now, you say she remained a

[4]hundred percent totally disabled from all work and

[5]duties, correct?

[6]A. Yes.

[7]Q. And again, you don't know if prior

[8]to this accident she was already a hundred percent

[9]totally disabled from work, correct?

[10]A. Right, the reason I put that into

[11]this particular note is she's in the acute

[12]postoperative period. So, at this **[*91]** point in time

[13]I'm actively telling her, you really shouldn't be

[14]doing anything right now, except just being home

[15]and doing what you can do as comfortably as you

[16]can do it.

[17]Q. But as compared to prior, you

[18]don't know if that was also her --

[19]A. I didn't make a comparison, no.

[20]Q. And you don't know what her

[21]physical abilities were prior to this accident,

[22]you don't know what her physical state was prior

[23]to this accident, besides the history you took?

[24]A. Correct.

[25]Q. You don't know if she was working,
Page 116

[1]

[2]not working, what type of work she did, you don't

[3]know any of that?

[4]A. Right.

[5]Q. And then you saw her again about a

[6]month later, a little bit after a month later?

[7]A. Yes, in January.

[8]Q. Okay, and do you know Dr. Nidia

[9]Carrero?

[10]A. I listed that she was treating

[11]with that particular physician, so.

[12]Q. Is that a physician that you're

[13]familiar with?

[14]A. Not off the top of my head, unless

[15]I misspelled the name.

[16]Q. Is that a physician that refers

[17]you patients?

[18]A. Once again, I don't know. **[*92]** I

[19]dictated it as Nidia Carrero.

[20]Q. Right, it's not a physician that

[21]rings a bell to you?

[22]A. Not off the top of my head, no.

[23]Q. Now, did you take any subjective

[24]complaints from Ms. Bryant on this visit?

[25]A. So, lets see. I have listed that

Page 117

[1]

[2]surgery did prevent further severe shooting pain

[3]into the arms and hands.

[4]Q. Meaning she didn't get any worse

[5]based upon the surgery?

[6]A. And to some extent may have even

[7]gotten better, in terms of the radiating shooting

[8]symptoms that she had into her arms and hands.

[9]Q. Where does it indicate that she

[10]may have gotten better?

[11]A. "Surgical intervention has thus

[12]far been successful in preventing further

[13]neurological deterioration into the upper

[14]extremities, arms and hands, and further

[15]significant and severe shooting pain into the

[16]upper extremities, arms and hands."

[17]Q. Right, but where does it say that

[18]the symptoms that she had when she first came to

[19]you have been better?

[20]A. That's it.

[21]Q. That's what that means?

[22]A. Yes, that's what that means.

[23]Q. I read **[*93]** that to mean that it hasn't

[24]gotten any worse.

[25]A. Oh.

Page 118

[1]

[2]Q. But nothing about being any

[3]better.

[4]A. It says "successful in preventing

[5]severe shooting pain into the upper extremities,

[6]arms and hands."

[7]Q. Which would be any worse, any

[8]worse shooting pain?

[9]A. No.

[10]Q. She already had shooting pain when

[11]she came to see you?

[12]A. The shooting pain that she had is

[13]better.

[14]Q. Okay. That's what that means?

[15]A. Yes.

[16]Q. Does it say whether or not she had

[17]any reduction in her complaints, her subjective

[18]complaints of pain?

[19]A. It says that she continues to have

[20]mechanical axial pain in her neck primarily.

[21]Q. Meaning what?

[22]A. 'That's pain in the neck with range

[23]of motion.

[24]Q. With all range of motion?

[25]A. Correct.

Page 119

[1]

[2]Q. Did you test what her restriction

[3]was, specifically, in the neck?

[4]A. Yes.

[5]Q. Okay, and what was it for the

[6]cervical spine?

[7]A. The ranges of motion in her neck

[8]were cervical extension of zero degrees, flexion

[9]of 30, right lateral **[*94]** bending 20, left lateral

[10]bending 25, right lateral rotation 15, and left

[11]lateral rotation 10.

[12]Q. And how did that compare to her

[13]initial exam?

[14]A. So, initially, let's see, the left

[15]lateral bending actually got somewhat better from

[16]15 degrees to 25. Let's see, her right lateral

[17]rotation went from 10 to 15. And her left lateral

[18]rotation stayed at about 10.

[19]Q. Her extension stayed the same,

[20]correct?

[21]A. Yes.

[22]Q. Flexion stayed the same?

[23]A. Yes.

[24]Q. And were these measurements done

[25]actively, or passively, or a combination?

Page 120

[1]

[2]A. Combination.

[3]Q. And that same combination is the

[4]way you generally do it in your practice?

[5]A. Yes.

[6]Q. And that was what you discussed

[7]with us earlier?

[8]A. Yes.

[9]Q. Did she have a repeat diagnostic

[10]scan done at this time?

[11]A. I actually sent her at some point

[12]in time for a CT scan of her neck.

[13]Q. And was that due to her continued

[14]subjective complaints of pain?

[15]A. She had -- I just want to check,

[16]hang on one second. So, that scan was done May

[17]14th, **[*95]** of 2013. One of the things that she had

[18]complained about, which it was pain in the

[19]anterior portion of her throat. So, she was

[20]having some anterior throat pain, which struck me

[21]as being a little unusual. So, that's why I

[22]ordered a CT of the cervical spine.

[23]Q. Is that a complication in this

[24]type of surgery?

[25]A. Anterior throat pain?

Page 121

[1]

[2]Q. Yes.

[3]A. It's an unusual complaint, because

[4]it's difficult to really understand why you would

[5]be having anterior throat region pain, but you

[6]want to make sure that it's not something related

[7]to the surgery.

[8]Q. Related to the hardware, or

[9]something like that?

[10]A. Related the hardware, correct, the

[11]implants and/or the procedure, itself, that may

[12]have caused, let's say, a deviation of some of the

[13]structures, or some abnormal swelling, or

[14]something like that.

[15]Q. And was there any evidence in the

[16]CT scan to substantiate her throat complaints?

[17]A. Nothing significant, no.

[18]Q. So, there was nothing objectively

[19]to substantiate her complaint?

[20]A. Of anterior throat area pain, no,

[21]intermittent **[*96]** throat area pain, no.

[22]Q. Did you prescribe her any pain

[23]medication after the surgery; I don't see that

[24]anywhere listed in your --

[25]A. Yeah, that's correct, because I
Page 122

[1]

[2]generally don't prescribe pain medications, and

[3]particularly not with patients that have other

[4]medical comorbidities and/or renal failure, as in

[5]this case.

[6]Q. Do you know if Dr. Davy ever

[7]prescribed her any pain medication after your

[8]surgery?

[9]A. I don't know.

[10]Q. Do you know if her primary care

[11]ever prescribed her any pain medication?

[12]A. I don't know.

[13]Q. If she was taking pain medication

[14]prescribed to her by her primary care physician,

[15]who was also treating her for end stage renal

[16]failure, would you have asked her about that in

[17]the follow-up?

[18]A. If it was unusual, because of her

[19]axial symptoms, I wouldn't find it unusual for her

[20]to be taking pain medications, if she needed them.

[21]Q. Okay, but would that be indicated

[22]in your notes, at all, anywhere?

[23]A. No, once again, only if it was

[24]something that was unusual or out of the ordinary.

[25]Q. **[*97]** Okay. The last time that she saw
Page 123

[1]

[2]you was when, May 10th?

[3]A. May, of 2013, correct.

[4]Q. And have you seen her since then?

[5]A. No, I haven't.

[6]Q. Was she supposed to come back in

[7]to your office after that date, for a follow-up?

[8]A. So, in general, at this point in

[9]time, I saw her in spring, and she would be due as

[10]a postop patient to be coming in hopefully by the

[11]end of the year.

[12]Q. What were your physical findings

[13]on the last visit?

[14]A. So, last visit, let's see, and a

[15]lot of that last visit involved some of that

[16]throat area pain that she had mentioned.

[17]Q. Right.

[18]A. For what I ordered the CT scan.

[19]She had good formation, that meant that her vocal

[20]cords and her throat were working. Her swallowing

[21]mechanisms was intact by palpation, that means

[22]that she retained the ability to swallow, and

[23]there wasn't any abnormality there. The area,

[24]itself, was healing, without what's known as

[25]crepitus or any difficulty with the healing
Page 124

[1]

[2]process.

[3]Q. Right.

[4]A. There was some spasm and

[5]tenderness in her **[*98]** neck, which was pretty much

[6]persistent.

[7]Q. And that was tested how?

[8]A. By palpation of her neck.

[9]Q. By you?

[10]A. Correct.

[11]Q. Okay.

[12]A. Neurologically, she remained

[13]completely stable. So, from a physical

[14]examination point of view, she remained,

[15]essentially, stable postoperatively.

[16]Q. Did she have any other complaints

[17]to her cervical spine, besides intermittent throat

[18]pain?

[19]A. The axial pain that she had, which

[20]we kind of know that she had had that previously.

[21]Q. Did she have the axial complaint

[22]again on this visit?

[23]A. Yes, and the only new complaint

[24]that she made on this particular visit was that

[25]anterior throat area pain.

Page 125

[1]

[2]Q. Was there any measurement of her

[3]range of motion on this visit?

[4]A. No, I did not.

[5]Q. And why didn't you measure that on

[6]this visit?

[7]A. Well, she was neurologically

[8]stable. She had persistent spasm in her neck. I

[9]was going to get a CT scan anyway to take a look

[10]at the implants and the surgical site. So, I

[11]didn't think that the range of motion would add

[12] **[*99]** anything to the treatment plan, at all.

[13]Q. Did she remain a hundred percent

[14]disabled at this point?

[15]A. So, at this point in time I didn't

[16]Indicate any disability status to her.

[17]Q. Which means what?

[18]A. Which means I would have given her

[19]the advice that she can basically do the

[20]activities that she felt comfortable doing.

[21]Q. That her body allowed her to do?

[22]A. Yes, correct.

[23]Q. Until she felt pain, and then you

[24]would advise her to stop those activities?

[25]A. Yes.
Page 126

[1]

[2]Q. And you don't have any other -- I

[3]know we've covered this, but you don't have any

[4]records from her primary care physician, right?

[5]A. Correct.

[6]Q. Doctor, just bear with me one

[7]second, I'm just about done. Doctor, have you

[8]ever testified in federal court before?

[9]A. I have, yes.

[10]Q. For who?

[11]A. The United States of America, as

[12]in my capacity as -- I do function as the district

[13]medical advisor for the United States.

[14]Q. Okay.

[15]A. And I have had occasion to testify

[16]in federal court in defense of the United States.

[17] **[*100]** Q. Okay.

[18]A. I have also testified in federal

[19]court on behalf of a patient.

[20]Q. When you say in defense --

[21]A. Yes.

[22]Q. -- are you talking about in a

[23]personal injury context?

[24]A. It was -- this was a while back,

[25]yes, I believe it was.

Page 127

[1]A. Merola, M.D.

[2]Q. Somebody alleging an injury?

[3]A. Yes.

[4]Q. So, you did that on the defense

[5]side?

[6]A. Yes.

[7]Q. Since then, have you done any

[8]other work on the defense side or were you --

[9]A. Well, I do review cases for the

[10]United States.

[11]Q. You still do that activity?

[12]A. I do, yes.

[13]Q. Okay.

[14]A. And then the other time I was in

[15]federal court was for one of my patients.

[16]Q. Okay, who had a personal injury

[17]lawsuit?

[18]A. Yes.

[19]Q. Do you remember when that was,

[20]what year; was that within the last five years?

[21]A. That's a good question. It's been

[22]a while, because the federal courthouses are

[23]different. They are big fancy schmancy modem

[24]buildings, and I honestly don't recall the last

[25]time I was in a federal courthouse, but I do **[*101]** know

Page 128

[1]

[2]at least those two occasions.

[3]Q. Okay. Do you do any defendants'

[4]IME examinations?

[5]A. No, not generally, I've done --

[6]Q. Besides for the United States?

[7]A. Yeah, I've done them in the past.

[8]Q. When you say the United States,

[9]you're talking about for the US Attorney's Office?

[10]A. Yeah, it's also for what's known

[11]as the Office of Workman's Compensation Programs

[12]for the United States.

[13]Q. Okay.

[14]A. So, I review their cases, and I've

[15]also done defense work, I guess it's the Attorney

[16]General, because it was the Southern District of

[17]New York.

[18]Q. So, the Attorney General's Office,

[19]in the Southern District?

[20]A. That's correct, yes.

[21]Q. Besides doing that, you don't do

[22]any other defendant's IMEs, for your own

[23]individual practice?

[24]A. I don't think I've done IMEs in

[25]quite some time, no, but I have in the past, but I
Page 129

[1]

[2]haven't really done any IMEs, per se, for at long

[3]time. I do perform what are known as impartial

[4]examinations for the Long Shore Division of the

[5]Office of Workman's Compensation **[*102]** Programs for the

[6]United States.

[7]Q. Okay.

[8]A. So, I do that, but I guess those

[9]are strictly -- I don't know, they call them

[10]impartials.

[11]Q. Okay.

[12]A. I don't think they're under the

[13]same rules and regulations as an IME is.

[14]Q. And that's on your CV?

[15]A. Is it in there, it should be?

[16]Q. I don't know, I'm asking you.

[17]A. I don't know if it is, it should

[18]be. If it's not, I have to tell my

[19]transcriptionist to put it in there.

[20]Q. You've testified many times for

[21]Sacks and Sacks, right?

[22]A. I have testified on behalf of

[23]patients that have been represented by Sacks and

[24]Sacks in the past, yes.

[25]Q. And you've testified many times on
Page 130

[1]

[2]behalf of patients that have been represented by

[3]Block and O'Toole, right?

[4]A. I don't think a lot. I mean, I

[5]have testified in the past on patients that have

[6]been represented by Block & O'Toole, yes, that

[7]name also sounds familiar.

[8]Q. Okay, I don't have any other

[9]questions, Doctor. Thank you.

[10]A. My pleasure.

[11]MR. WEISS: I have a couple of

[12]follow-up questions. **[*103]**

[13]THE WITNESS: Sure.

[14]

[15]EXAMINATION BY

[16]MR. WEISS:

[17]

[18]Q. Dr. Merola, when you were

[19]discussing the mechanism by which herniated disk

[20]causes symptoms, you mentioned that there's a

[21]substance that leaks that produces inflammation;

[22]Is that correct?

[23]A. Yes, correct.

[24]Q. With a bulging disk, does that

[25]also leak that same substance?

Page 131

[1]

[2]A. That's why when I was talking

[3]about a bulging disk, and we were talking about

[4]bulging disks, per se, anatomically a bulging

[5]disk, if it appears to be only a bulge, and that's

[6]why you have to really read the actual MRI film

[7]yourself, to see what's going on, if the bulging

[8]disk has a deficit in the annulus, then those

[9]inflammatory chemicals can leak out of the disk

[10]and produce inflammation and/or irritation.

[11]Q. Now, what is that substance that

[12]leaks out?

[13]A. They are what are known

[14]proinflammatory cytokines. Off the record.

[15](Whereupon a discussion was held

[16]off the record.)

[17]Q. When you were discussing the

[18]Spurling's test, are were talking about putting

[19]the patient in a provocative **[*104]** maneuver and looking

[20]for splinting or withdrawal response?

[21]A. Yes.

[22]Q. What is splinting?

[23]A. So, splinting is, if a body part

[24]is injured, your body has less tendency to move

[25]that particular part. So, in other words, you're
Page 132

[1]

[2]holding that part in such a way that it does not

[3]continue to reproduce inflammation or pain. So,

[4]you're splinting that body part.

[5]If you injured your shoulder, you'd be

[6]holding your arm and your shoulder up against your

[7]body, irrespective of whether or not you had a

[8]splint, but it might look like you had a splint,

[9]because you were holding it up against you. For

[10]the neck and the back the same thing is also true.

[11]So, if you have a nerve root that's being

[12]Irritated within one of the exit structures,

[13]called the neural foramen, and you do anything to

[14]decrease the size of the neural foramen, like a

[15]compression, or a Spurling's, or a Phalen's, your

[16]body is not going to want to be put into that

[17]position. So, it's going to splint itself and

[18]resist motion in that particular position. So,

[19]you'll feel the muscle contracting, and in some

[20] **[*105]** cases you'll feel spasm, as well.

[21]Q. And what's a withdrawal response?

[22]A. A withdrawal response is if a part

[23]is painful, that part of your body will try to get

[24]itself away from what's provoking the pain. So,

[25]for example, if you take a patient, and extend
Page 133

[1]

[2]their lumbar spine, and it's reproductive of pain,

[3]you'll actually feel them not only contract their

[4]low back muscles, but they are going to want to

[5]come forward, almost involuntarily, like a reflex,

[6]because they don't want those openings where the

[7]nerves are to be putting any more pressure on the

[8]nerves. So, they are withdrawing the body part

[9]from what's producing pain.

[10]Q. When Ms. Bryant had the cervical

[11]surgery, she was under anesthesia; is that

[12]correct?

[13]A. Yes.

[14]Q. Was it general anesthesia?

[15]A. Correct.

[16]Q. Endotracheal anesthesia?

[17]A. Yes.

[18]Q. There was tube inserted into her

[19]trachea?

[20]A. Yes.

[21]Q. Can that endotracheal intubation

[22]cause throat pain?

[23]A. Yes.

[24]MR. WEISS: No further questions.

[25]MR. HSU: I just have one
Page 134

[1]

[2] **[*106]** follow-up, Doctor.

[3]

[4]EXAMINATION BY

[5]MR. HSU:

[6]

[7]Q. If there's a radiological finding

[8]that says there's a bulge creating an ventral

[9]extradural defect, what does that mean; Is that

[10]the defect that you were talking about around the

[11]annulus?

[12]A. No, it's actually not. So, if we

[13]parse the verbiage of the radiologist, when he

[14]says ventral, he means on the front side.

[15]Q. Okay.

[16]A. Extradural means outside the dura.

[17]So, what he's saying is that the bulge is making

[18]the -- the dura is moving away from the bulge.

[19]The anterior portion of the dura is moving away

[20]from the bulge.

[21]Q. But that's an abnormal finding?

[22]A. It may or may not be an abnormal

[23]finding, depending on what the rest of the spinal

[24]anatomy looks like, because when you look at an

[25]MRI, you will often times see portions where the
Page 135

[1]

[2]thecal sac appears to be draped over where the

[3]disks are.

[4]Q. Well, if at the other cervical

[5]levels there was no stenosis or no impingement,

[6]would that finding be an abnormal finding, if at

[7]the other levels there were normal findings? **[*107]**

[8]A. Not necessarily, because --

[9]Q. Could be, though?

[10]A. Anything could be, but stenosis,

[11]specifically that term stenosis, refers to a

[12]narrowing of an opening.

[13]Q. Right.

[14]A. So, that means whatever opening

[15]they happen to be talking about has to be narrowed

[16]in some way, then the other one you said was?

[17]Q. Well, I said, what my question

[18]was, If at the other levels there was no central

[19]stenosis and no impingement at the other cervical

[20]levels, but at that level there was the ventral

[21]extradural defect, would that defect, based upon

[22]those other findings, be abnormal?

[23]A. No necessarily, it just means that

[24]that segment did not have the same appearance as

[25]the other segments.

Page 136

[1]

[2]Q. And that difference in appearance

[3]could be an abnormal finding?

[4]A. Anything could be, but it really

[5]depends on what the film looked like, and because

[6]they didn't use the term impingement or stenosis,

[7]it may not be pathological.

[8]Q. Okay. I don't have any other

[9]questions. Thank you, Doctor.

[10]A. My pleasure.

[11](Continued on page 137 **[*108]** to include

[12]jurat.)

[13]

[14]

[15]

[16]

[17]

[18]

[19]

[20]

[21]

[22]

[23]

[24]

[25]

Page 137

[1]

[2](Whereupon the proceedings were

[3]concluded at 5:00 p.m.)

[4]

[5]

[6]

[7]

[8]

[9]

[10]

[11]Andrew Merola, M.D.

[12]

[13]

[14]

[15]

[16]

[17]

[18]Subscribed and sworn to

[19]before me this day

[20]of , 2013

[21]

[22]

[23]Notary Public

[24]

[25]
Page 140

[1]

[2]CERTIFICATION

[3]

[4]I, DANIELLE MCMAHON, hereby certify that

[5]the within was held before me on the 30th day of

[6]October, 2013.

[7]That the testimony was taken

[8]stenographically by myself.

[9]That the within transcript is a true and

[10]accurate record.

[11]That I am not connected by blood or

[12]marriage with any of the parties. I am not

[13]interested directly or indirectly in the matter in

[14]controversy.

[15]IN WITNESS WHEREOF, I have hereunto set my

[16]hand this 20th day of November, 2013.

[17]

[18]

[19]

[20]DANIELLE MCMAHON

[21]

[22]

[23]

[24]

[25]

End of Document