SUPREME COURT OF THE STATE OF NEW YORK

COUNTY OF BRONX: TRIAL TERM PART IA-4

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BERNARD VERDON,

TESTIMONY
Dr. Aric Hauscknecht
Dr. Andrew Merola

Plaintiff,

- against -

PORT AUTHORITY OF THE CITY OF NEW YORK,

Defendant.

- - - - - - - - - - - - - - - - - - - -X

Index No. 309654/2009

Bronx Supreme Civil Court
851 Grand Concourse
Bronx, New York 10451
April 8, 2014

B E F O R E: HONORABLE HOWARD H. SHERMAN
Justice of the Supreme Court

A P P E A R A N C E S:

SACKS & SACKS, LLP
Attorneys for the Plaintiffs
150 Broadway
New York, NY 10038
BY: JAMES J. McCRORIE, ESQ.
DAVID H. MAYER, ESQ.

SEGAL, McCAMBRIDGE,SINGER & MAHONEY, LLP
Attorneys for the Defendants
850 Third Avenue, Suite 1100
New York, NY 10022
BY: CHRISTIAN H. GANNON, ESQ.
SIMON LEE, ESQ.

RENÉE SCOTT, RPR, CSR
Official Court Reporter

MR. McCRORIE: Your Honor, just as we did with the anatomy of the vertebral column, which went into evidence, Plaintiff's 28 is for ID. It's the anatomy of the nerves of the lumbar, not in any damaged condition, in the correct condition. So it's just the anatomy of the nerves. I was just going to put it into evidence after asking does it fairly and accurately depict the anatomy as it exists.

MR. GANNON: Your Honor, I think I had objected to the other -- I don't recall if I did or didn't, I may have -- to another illustration of the anatomy. I have a similar objection to this. This is just for demonstrative purposes. It's not a piece of evidence that should go into the jury deliberations.

THE COURT: Okay. Because I think there was also one where there was a question, an objection about and I think there was an objection for even using this for even demonstrative purposes.

MR. McCRORIE: That was for future that was kept out.

THE COURT: Right. So you're objecting to it going into evidence but you don't want it to go off in the jury room but you don't object to the doctor using it for demonstrative purposes on his testimony?

MR. GANNON: Correct.

THE COURT: So if that's your main purpose is to have the doctor point out things to the jury and he doesn't care if he shows it to the jury during the trial as an ID, do you need it in evidence?

MR. McCRORIE: I'd like it in evidence because the regular anatomy doesn't show the radicular nature of nerves that go from here to here. So it's just the anatomy of the nerves which aren't on the other illustration.

THE COURT: So in the interest of moving this along right now, we'll leave it for ID, show it and let the doctor testify and we'll talk about whether it goes in afterwards.

MR. GANNON: Thank you.

MR. McCRORIE: Sure. I won't do it in front of the jury.

THE COURT: No, no. He's not objecting to you're using it in front of the jury.

MR. McCRORIE: I understand that. I wouldn't move it into evidence. We'll talk about at the --

THE COURT: Right. I'm reserving decision on the in evidence for now but it can be used for the testimony.

MR. McCRORIE: Yes, Your Honor.

THE COURT: Okay.

COURT OFFICER: All rise. Jury entering.

(Jury enters courtroom; the following

occurred:)

THE COURT: Good morning.

THE JURORS: Good morning.

THE COURT: Have a seat. Welcome back. Hope you had a good weekend. You remember we didn't finish the last doctor but we're going to take another doctor and then finish the last doctor.

So your next witness is?

MR. McCRORIE: Plaintiff calls Aric Hausknech, MD.

(Witness approaches witness stand.)

THE COURT OFFICER: Stand here, raise your right hand.

D O C T O R A R I C H A U S K N E C H T, a witness called on behalf of the Plaintiff, having first been duly sworn/affirm, took the stand and testified as follows:

THE COURT OFFICER: Please have a seat. In a loud and clear voice, please state your name, title and business address.

THE WITNESS: My name is Aric Hausknecht, MD. My place of business is 2488 Grand Concourse, Bronx New York, 10458.

THE COURT REPORTER: Can you please spell your name?

THE WITNESS: Sure. H-a-u-s-k-n-e-c-h-t, first

name is A-r-i-c.

THE COURT: Good morning, Doctor, just please keep your voice up because it's hard to hear.

THE WITNESS: I'll try. I'm just getting over a cold so I'm having a hard time projecting.

THE COURT: The level you're at right now is great.

MR. McCRORIE: May I proceed, Your Honor?

THE COURT: Go ahead.

MR. McCRORIE: Thank you.

DIRECT EXAMINATION

BY MR. McCRORIE:

Q. Good morning, Dr. Hausknecht.

A. Good morning.

Q. Can you tell the jury when you became licensed to practice medicine in the State of New York?

A. Sure. I received my license to practice medicine and surgery in New York State in 1992.

Q. Starting with your educational background, can you tell them where you went to undergraduate and what your major was, what your degree was in?

A. I graduated from Duke University in 1987 majoring in physical anthropology then I graduated from Mount Sinai Medical School in 1991 with a medical degree.

Q. The jury has already heard the terms and been defined

"residency," "fellowship." Could you please tell the jury more about your background starting with your residency and any fellowships and positions you've held up until your current position?

A. I completed a year of medical internship at Beth Israel Medical Center in Manhattan in 1992. I completed my neurology residency training program at New York Hospital, Cornell Medical Center and Memorial Sloane Kettering Cancer Center in 1995 where I've been in private practice since 1995.

My private practice includes an office here in the Bronx as well Manhattan and Queens. I'm affiliated with several different hospitals including Beth Israel Medical Center and New York Hospital. And I'm currently board certified in neurology by the American Board of Psychiatry and Neurology and I'm also certified in pain management by the American Academy of Pain Management.

Q. Can you please tell the jury -- they heard from an orthopedic spine surgeon -- can you please tell them what a neurologist is?

A. A neurologist is a physician that specializes in the treatment of the disorders of the nervous system. The nervous system includes the brain, the spinal cord and the peripheral nerves. So there is a lot of crossover between an orthopedist I guess and a neurologist when it comes to the spine. Because the spine is made up of both bones as well nerves.

So as a neurologist and a pain management specialist, I deal with a lot of people that have neck and back pain. It's my job to figure out what's causing that pain. It's my job to figure what's the best type of treatment for that pain is such as physical therapy or medications or some type of injection or surgery.

Q. And can you please tell the jury, although the words might be self-explanatory, about the field of pain management, what that entails?

A. Pain management is the field of medicine that deals with the treatment and evaluation of pain and the consequences that that pain has on a person. So as a pain management specialist, it's my job to try and treat that pain by whatever means are available to improve the quality of that person's life, that is, to say to reduce that pain as much possible as and to increase their ability to perform daily activities to function on a day-to-day basis.

Q. Have you ever testified in court before?

A. Yes, I have.

Q. Can you tell the jury a little bit more about your practice and what it entails?

A. I have a neurology and pain management practice. Generally, I see adult patients. I don't see pediatrics. I see a lot of people with neck and back pain. Some of it is from accidents whether it's a car accidents or a construction

accident, some of it's from other causes such as wear and tear like arthritis or some other type of rheumatological disorder?

It's my job once again to try and figure out what's causing that person's pain. Oftentimes, different types of imagining studies are employed so I might send a patient for an Ms, CAT scans or x-rays different types of tests are done. We do nerve tests in the office and then I would monitor a patient's response to treatment. So, for example, I might send a patient for physical therapy, for chiropractic treatments or prescribe various medications and then have them come back in to see how they are responding to that treatment.

Q. You sort of answered in the last answer but can you tell the jury whether or not your practice accepts work-related accidents and all of the rules and procedures that go along with accepting such patients?

A. Yes. We don't discriminate. We take almost all types of patients. There are different rules that have to be followed in the office depending on what type of patient it is but we comply with those.

Q. Are you being paid for your time away from your practice?

A. I am. Normally, I would be in Manhattan this morning seeing patients. I had to cancel all of those patients. I'm being compensated for that. My fee for time away from the office is $500 per hour.

Q. And did we, myself and Mr. Mayar, did we meet with you approximately a week or so ago to go over your anticipated testimony, your file, the enlargements that Dr. Merola picked out?

A. Yes.

Q. And certainly certain medical illustrations?

A. Yes.

Q. Regarding MRI's and x-rays and CAT scans, can you tell the jury whether or not you view and interpret those on a recognize basis in your practice?

A. Yes. That's an important part of the diagnostic process in my office. So as a clinician, I'm sort of like a detective. I try to take all the different pieces of the puzzle: what a person is saying, what I find on examination, what a MRI or an x-ray or CAT scans shows, what a nerve test shows, put all those pieces of the puzzle together to get the big picture.

So imaging studies like MRI's CAT scans, x-rays are important in helping to establish the structural pathology, what it looks like. So part of my training, part of my board examination, part of what do on a daily basis is prescribing and reviewing different MRI's and x-rays and CAT scans, something I do everyday.

Q. And do you employ a radiologist to read those for you or do you read them yourself in your practice?

A. Well, I don't employ. A radiologist doesn't work for me put a radiologist generally owns the facility that does the MRI or the CAT scans. So when I'm seeing a patient, two pieces of information will be available. One would be the actual film which I look at; another would be the radiologist report and generally I rely on both and usually I'm in agreement with the radiologist

Q. Your file is deemed in evidence so you can read from any notes that you've personally made.

Is Brian Verdon a patient of yours?

A. Yes.

Q. When did you first -- withdrawn.

Have you reviewed your file in anticipation knowing that you were going to come here this morning to testify?

A. Yes.

Q. Can you tell us from your file when Brian Verdon first became a patient of yours?

A. It was in 2009, specifically November 17, 2009.

Q. And do you know or can you tell us from your note how it is Mr. Verdon became a patient of yours?

A. He had been referred by the spinal surgeon Dr. Merola.

Q. Is that common in the interplay between you said orthopedist and neurology that you would refer patients to an orthopedist or a orthopedist would refer patients to you?

A. That's pretty common.

Q. The jury already knows what a history is but could you please tell the jury, going through the history of the first visit, what was the history that Mr. Verdon gave to you, what had happened, what was going on since the accident?

A. Mr. Verdon came in the first time accompanied by his wife. She was helping to give some of the history. He also had some medical records with him but basically he had been injured on the job 8/11/09 when he had fallen off a scaffold and sustained a head injury. He was bleeding from his scalp, had been taken to Bellevue Hospital where he was found to have multiple fractures of the spinal column, by a burst fracture at T12 which was retropulsed meaning the bone fragments had moved into the spinal canal which required emergency surgery so he had undergone surgery in the hospital. He was in a hospital for a few days then he was transferred to a rehab facility and had been taken to rehabilitation.

When I saw him, he indicated that he was still having pain and stiffness, specifically in his neck, mid and lower back. At times, he had what he called a stinging pain which went down the back of his left leg. He was having numbness in his right thigh and calf and this seemed to be provoked by activity or use of the leg. Both of his arms had been filling weak. At that time, he denied any autonomic symptoms. Autonomic symptoms would refer to loss of bowel or bladder control or loss of sexual function. He was having problems with

his activities of daily living, specifically sitting, standing, bending, lifting and walking. He was in a back brace and he was using a cane.

He denied any prior history of spinal injury or spinal trauma or spinal problems. He had been taking Ibuprofen for pain because he was trying to avoid taking pain medications. He had been unable --

Q. Let me just stop you for one second. Did you actually indicate in your notes he wanted to avoid taking medication?

A. That's what he told me, yes.

Q. Okay, and it's indicated so in your note?

A. That's correct.

Q. Please continue.

A. I performed a physical examination. At that point, I found that was there some weakness in his arms and legs. There was a five minus weakness of the shoulder inductors. The shoulder inductors are the muscles that raise the arms up. Motor strength is rated on a scale of zero to five with five being full strength, five minus would be one grade below full strength. So he had lost some strength in his arms. He was far from paralyzed.

Q. What, if anything, was medically significant to you about that finding?

A. Loss of motor strength in the extremities can be an indication of neurological dysfunction or nerve damage. There

was a potential that he had sustained either a spinal cord injury or injury to one of the nerve roots coming from the spine to the arms.

There was motor weakness also in the left hand which I found to be four plus, in the right hip which I found to be four plus, in the left hip which I found to be five minus, in both knees which I found to be five minus and in the left ankle which was a five minus. There was also atrophy which is a shrinking of the muscle and decrease muscle tone in both of the legs. The reflexes I found to be brisk or hyperactive in the lower extremities at the knees and the ankles and the sensory exam I noted there was a loss of feeling in his lower back around the area of the surgery.

Q. What, if anything, was of medical significance about the atrophy and the weakness in the lower extremity?

A. Once again these are signs of potential nerve damage either a spinal cord injury or a peripheral nerve damage. In the case of brisk reflexes, it's usually a sign of upper motor neuron dysfunction and upper motor neuron we're typically referring to the spinal cord or to the brain itself. In this case, I was concerned that he had sustained a spinal cord injury and, in fact, he did have a T12 burst fracture that went into the spinal canal.

The mechanical exam when I examined his neck and back I found that there was a cervical paravertebral tenderness and

associated muscular spasm as well as throughout the lumbar paravertebral tenderness associated with muscle spasm.

Q. If you could tell the jury, Doctor, whether or not those findings of spasm in both the neck and the mid back, low back, whether they were objective or subjective and how you determined whether or not they was spasm present in these areas?

A. Sure. First, let me explain the cervical is the neck. Thoracic is the middle back. Lumbar is the lower back. Paravertebral would refer to the tissues around that area. It would be the skin, the subcutaneous tissue and the muscle. Spasm is the involuntary tightening of a muscle due to an underlying injury such as a disc or a pinched nerve or a broken bone.

In this case, when I was palpating the spine, when I was like physically examining him, I found that the muscles had gone into spasm. This is an objective finding as posed to a subjective complaint. So, for example, if a person comes in and says my neck and back feel very tight, that is subjective. That's what they're saying. I, as an outside observer, don't know whether or not their neck and back is actually tight or whether or not there's actual spasm. But if I now exam them and I find that the muscle are locked up, they are in spasm. If I find that his neck and back doesn't move the way that it should, that would be an objective finding, a sign that will confirm or corroborate his subjective complaint.

So he did complain of stiffness and when I examined him, I found that there was tenderness and spasm in the neck and back. The Spurling maneuver was positive on the right. the Spurling test is performed by taking a person's head in your hands, turning it, extending it and putting pressure down on top. If there's an area of the spine that's been compromised such as a slipped disc or a pinched nerve, this maneuver can put stress on that injured area and in this case it was positive on the right side.

The straight leg raise test was positive on the right side at 60 degrees and the left side at 45 degrees. The straight leg raised test was performed by slowly raising a person leg upwards. Normally a person could get to 80 or 90 degrees without any problem. In this case, at 45 degrees on the left, it caused a shooting down his left leg and 60 degrees on his right it caused a shooting pain down his right leg.

Once again this is a sign of pathology or damage to the lower back. So if there was a portion of the lower back that's been damaged, pinched nerve or the pressure on the spinal cord and when you perform this maneuver, it stresses that area and can reproduce the patient's symptoms in which it did in this case.

I checked the range of motion to his neck and back actively and passively using a tool known as a goniometer. Active range of motion depends on the activity of the patient.

Passive range of motion is performed manually by the examiner.

So, for example, if I say to a patient bend your neck to the left as far as it will go and I measure that angle that would be active left lateral flexion of the cervical spine. That depends on the activity of the patient.

If I take that person's head in my hands and I push it to the left until it doesn't any further that would be passive left lateral flexion of the cervical spine. It's objective. It's performed by the examiner. In this case, there was no discrepancy between the active and passive movements.

I asked Bernard to bend his head to the left. When I physically pushed his head to the left I got the same measurement. So we got a pretty good idea of the movement of his neck and back. This was measured using this tool and he had significant restrictions. In the neck, there was left lateral flexion or the ability to bend to the left. He had lost 40 percent of the movement; right lateral flexion, the ability to bend to the right, he had lost 30 percent of the movement; left rotation, the ability to turn his head to the left, he had lost about 28 percent; right rotation, he had lost about 18 percent; forward flexion, his ability to put his chin to his chest, was relatively maintained. He had almost full motion there and extension ability to bend backwards, he had lost about 18 percent. In his lower back, it is more significant restrictions. His ability to bend forward at the waist was

limited by almost 50 percent. His ability to bend backwards at the waist was limited by 60 percent. So he could only get to 10 degrees. Normal he would get to 25 degrees.

Left lateral flexion, the ability to bend to the left, right lateral flexion, the ability top bend to the right, left rotation, the ability to twist to the left, right rotation the ability to twist to the right, these are all limited by approximately 50 percent.

I noted that his gait was antalgic meaning he was limping. He had difficulty dressing and undressing. He had problems getting on and off of the examination table and he was relying on his cane at that point for walking.

Q. The difficulty with dressing and undressing that's something you observed. You're talking about during the examination?

A. During the exam, yes.

Q. Doctor, before we go further there, I just wanted to know if you did this. Did you ask him, seeing him for the first time, whether or not there was any past medical history?

A. I did.

Q. Could you tell the jury why that's significant when you first see a trauma patient and when you're eventually going to be determining the cause of something whether or not someone has past medical history?

A. Well, in order to determine what's causing a problem,

it's important to know if the person ever had that type of problem before. In this case, Mr. Verdon indicated that he never had a problem with his neck or back before, never treated with a doctor for his neck or back before, never missed work because of his neck or back before but it was until this accident that he started having neck and back pain.

Q. One other thing I failed to ask you. In accepting work-related accidents and you said construction accidents, have you, in fact, treated patients that have been Sacks and Sacks clients before?

A. I have. I'm one of the doctors.

Q. And have you testified, in fact, in court before on behalf of patient's of yours that were also clients of ours?

A. Yes.

Q. Okay. If you could just please continue. I'm sorry I didn't ask you that. Just going over, you talked about the functional examination. Did you have any testing results or what kind of tests, diagnostic testing knowledge did you have on the first visit?

A. On the first visit, I had the -- some of the hospital records, I had some of the CAT scan reports specifically of the head which showed some swelling in the scalp but really no injury to the brain itself. There were x-rays and CAT scans of the neck and back which showed a little bit of arthritis which was common for his age and occupation but most notably showed

multiple fractures in the -- throughout the lumbar spine.

Q. Is that arthritis what's known as degenerative changes?

MR. GANNON: Objection.

Q. Is there a --

THE COURT: Overruled.

A. Yeah. Osteoarthritis or degenerative joint disease is also what's known as wear and tear. So all adults throughout the course of their lifetime will develop osteoarthritis or wear and tear on the parts of the body that we use the most, our spine our hands, our knees, our shoulders. Over the course of time, these tend to wear out and what happens is you get bone spurs or osteophytes. All adults will have osteoarthritis. It's not to say that all adults will have symptoms. It may not bother you at all. You may not even know it but this is just something that happens to our body as we grow old.

Q. If you could tell the jury what the term -- they heard it the other day but "asymptomatic degenerative changes." What does that mean, those three words together?

A. Asymptomatic degenerative changes would mean that you have some arthritis in your body that you don't even know. You might have some degeneration through your neck and back but it doesn't affect you. You're still working. You don't have neck or back pain. You don't have to go for treatment. You're not missing work because of your neck or back. It's just something

that's there that you don't know it.

Q. Okay. Will you could continue please, Doctor?

A. So after reviewing the -- after taking the history and performing the physical exam, I reviewed some of the CAT scans, most specifically the CAT scan of the thoracic lumbar spine which showed multiple fractures affecting the spinous at T7, T8, T9, T10, T11; compression fracture of the body at T10, transverse fracture at L1 with a hard disc complex at T12-L1 and acute burst fracture of the T12. Vertebral body with retropulsion meaning that the bone was basically just pulverized and some of the fragments went back into the spinal canal.

Q. What was your impression, that's as you call it in your note or diagnosis, your first initial working diagnosis?

A. Initially, I was impressed that he had sustained a closed head trauma.

Q. Which is what?

A. Just that he hit his head but based upon the history and the examination that I took from him that took place as well subsequent days it didn't appear that he had sustained any significant sequella from the head trauma although clearly he did sustain a head trauma.

There was a cervical, thoracic and lumbar derangement with multiple fractures requiring surgical repair as well as exacerbation of previously asymptomatic underlying degenerative joint disease.

Q. Can you tell the jury what exacerbation means, medically?

A. It means basically it was activated. It was there before but it wasn't bothering him. This accident is what made it become symptomatic.

Q. What was your plan on that first visit?

A. That date I recommended that he attend physical therapy, that he take medications and I suggested that we do diagnostic testing, specifically some nerve testing and some MRI's.

Q. And just because your notes will be in evidence and are in evidence, if at all in your notes, it says in your note that you're requesting formal authorization for treatment or testing, is that required in the work accident system, a request in your notes?

MR. GANNON: Objection.

Q. Well, without telling us the entity you were requesting it from, did you in all cases put formal requests in your notes?

MR. GANNON: Objection.

MR. McCRORIE: Withdrawn.

Q. What testing did you request on the first date if any?

A. Nerve testing of the neck and back which is what's known as the SSEP and NCV-EMG study.

Q. Can you just tell the jury what that's an acronym for

why you were ordering those specific tests with the symptoms Mr. Verdon had?

A. SSEP stands for Somatosensory Evoked Potential. NCV-EMG stands for Nerve Conduction Velocity and EMG stands for Electromyography. These are computer generated tests that measure the function or the integrity of the nervous system.

The human nervous system functions by transmitting small electrode impulse. So, for example, if a person decides they want to make a fist in their right hand somewhere on the left side of the brain, one of the neurons, the nerve cells, fire off releases electricity and causes a chain reaction. That electricity is transmitted across the brain down the spinal cord into the nerve root that goes to the muscle causing one side of the muscles to contract and another set of muscles to relax. This all happens within about one to two tenths of a second. So the SSEP and the NCV portion of the test is performed by putting an electric shock on the nerve and then measuring how quickly that electricity either gets to the muscle or to the brain. The EMG portion is performed by placing needles into the muscles and measuring the electrical activity.

So, for example, in this courtroom, if there are 17 recessed lights and there are five switches back there that control, you turn on all five switches and four of the lights don't go on, it means there's either a problem with the switch, the brain; there's a problem with the wiring, the spinal cord or

the nerve root or there's a problem with the fixture or the bulb which would be the muscle or the neuromuscular junction. So this test determines objectively whether or not there's nerve damage, where that nerve damage is coming from, how severe it is, how long it's been there.

Q. And can you tell the jury further on your plan what your prognosis was and what you instructed Mr. Verdon, if anything, before the end of his exam?

A. The prognosis at that point was guarded meaning that this was a pretty serious injury. I was concerned about his ability to recovery, to recover. I was concerned about his need for further care and then I told him to restrict his activities.

Q. Was he wearing a brace when he first saw you?

A. Yes.

Q. Dr. Hausknecht, when did you next see Mr. Verdon?

A. He returned to the office on 12/22/09 at which time the nerve testing was performed and then he came back again on 2/2/10.

Q. Was authorization, in fact, given to you to do that exam?

MR. GANNON: Objection.

THE COURT: Sustained.

Q. Has all of your treatment to date been authorized?

MR. GANNON: Objection.

THE COURT: Sustained.

Q. Did you do the exams that you sought authorization for on the first exam?

MR. GANNON: Objection.

Q. Did you perform them?

THE COURT: Sustained. The exams did you do it?

THE WITNESS: Yes.

Q. Can you tell the jury the results of those exams?

A. The exams showed, in fact, that there was nerve damage that was coming from his back and going down his right leg.

Q. Go to the -- we're not going to go through every note. Some of your notes are typed, some of your notes are handwritten.

On all of your notes, are they signed by yourself whether typed or handwritten?

A. Yes.

Q. Just go to the next exam February 2nd, 2010. Can you just go through -- you don't have to go through the whole history. What, if any, complaints was Mr. Verdon making to in February of 2010.

A. His complaints were similar. He was still having neck and back pain. His right thigh was feeling numb. His arms and legs were feeling weak. He noticed in his left foot he was cramping up in the morning. Once again he denied any autonomic symptoms. He had been taking physical therapy and that seemed to be helping. He was seeing an orthopedist for his right

shoulder. He was taking Vicodin for pain which is a narcotic analgesic. He was having problems with his activities of day-to-day living as we discussed before, the sitting, the standing. He was using the back brace as well as the cane.

Q. Just going back to the first exam. What, if any -- I know you had recommended that he restrict his activities but what, if any, recommendations did you make regarding returning to work as a carpenter?

A. He could not return to work.

Q. Okay. So continue with the -- was he taking any medications in February?

A. He was taking Vicodin.

Q. Do you know who was writing the prescriptions for those Vicodin?

A. On that particular date, I'm not sure if -- he had gotten those prescriptions from my office on other occasions but I'm not sure if that came from my office or not.

Q. And when you said "from your office," you're the medical physician that prescribes them?

A. Yes.

Q. Okay. The physical examination in February of 2010 was there any difference from the prior examination, anything of medical significance?

A. It was not identical but similar. He still had weakness in the arms and legs, atrophy and deceased tone in the

legs, loss of mobility in the neck and back. I noted a exaggerated kyphosis of the thoracic spine. His gait was still antalgic. He was limping. He had problems dressing and undressing. He had problems getting on and off the exam table. He was using a back brace. He was using a cane.

Q. Can you tell the jury -- you told them what atrophy was in connection with the first exam -- can you tell them what the medical significance, if any, of atrophy is in the lower extremities?

A. Well, once again, this a sign of nerve damage. It's an indication that he sustained either trauma or damage to the spinal cord as well as to the nerve roots in the lumbar region.

Q. The exaggerated kyphosis of the thoracic spine, can you please tell the jury what that is?

A. Sure. There is a normal, normal curvature to the spine, a convexity. So normally the spine curves in a little bit like this and then curves forward. The kyphosis in this case was in the thoracic region where the fractures had occurred. The spine was starting to collapse so he was basically hunching forward.

Q. And the EMG, what is -- can you tell the jury what -- you said lower extremity nerve damage. Can you tell them what radiculopathy is and means?

A. Radiculopathy refers to a pinched nerve. A radiculopathy can be a clinical syndrome meaning what the person

presents with to the doctor. So sciatic is a type of radiculopathy. If a patient comes in and they say I'm having a burning pain down my leg or a stinging type of electric pain and the doctor finds that there is loss of power, changes in the sensation, changes in the reflexes, positive straight leg raise test, these would all be signs and symptoms of a radiculopathy. Radiculopathy is also electric diagnostic findings. So in this case on the EMG, there was pathology abnormalities that were indicative of radiculopathy or nerve damage.

Q. I would like you to assume that in evidence and in Dr. Merola's notes and in his testimony the other day that on November 9, 2009 Mr. Verdon was referred to a Dr. Touliopoulos for appendicular injuries, one of them being the right shoulder.

Do you have any knowledge that Mr. -- what, if any, knowledge did you have of Mr. Verdon having right shoulder injury --

MR. GANNON: Objection.

Q. -- back in February of 2010?

MR. GANNON: Objection.

THE COURT: Overruled.

A. I was aware that he had a right shoulder injury. That was one of my diagnoses. I was aware that he was treating with the orthopedist Dr. Touliopoulos for the shoulder and this was a team approach. Dr. Touliopoulos was taking care of his shoulder. Dr. Merola and I had been taking care of his spine.

Q. Just in the impression, can you tell the jury what the word right shoulder arthropathy. Is that arthropathy?

A. Correct.

Q. Can you tell them what that means?

A. Arthropathy basically means dysfunction of the joint. So the shoulder -- the shoulder had been injured. It wasn't functioning properly.

Q. And your plan at that time in February of 2010.

A. 2010, my plan was conservative management. I wanted him to continue to restrict his activities, do the therapy and try and heal up from the fractures and the surgeries and to take the medications as needed to relieve his pain.

Q. Did there come a time when you yourself reviewed Mr. Verdon's MRI films in 2009 regarding his neck and back?

A. Yes.

Q. And over the course of your treatment, did there come a time when you reviewed the MRI films of the neck and back in 2011 as far as 2013 and the thoracic films in 2013?

A. Yes. Basically, he's had three sets of his films for his neck and back: 2009, 2011, 2013, that were either ordered by myself or Dr. Merola. So we had been able to monitor his condition and progress over the course of the past four years or so.

MR. McCRORIE: With the court's permission, I'm not going to go through the whole thing with Dr. Merola but

I would ask that Dr. Hausknecht be able to step down and I'll get the easel.

THE COURT: Go ahead.

MR. GANNON: Your Honor, I apologize. Before we start questioning, could we have a side bar?

THE COURT: Sure.

(Discussion off the record.)

Q. Dr. Hausknecht, if you could step down. The jury has already been given the anatomy, the basic anatomy of the spine and in Plaintiff's 16 they have the model -- I think the sticker fell off -- it's Plaintiff's 17. Can you use a new diagram in conjunction with it's Plaintiff's 28 for identification in discussing with the jury radiculopathy and how a radiculopathy occurs. So understanding that -- 16 doesn't have nerve roots coming out of it -- using the lower extremity and 28 is for identification.

First, before you even comment on it, does 28, Plaintiff's 28 fairly and accurately depict the normal anatomy of the spine and the exiting nerve roots as they go down in the lower extremity?

A. Yes.

Q. And is that a fair and accurate depiction of Plaintiff's 28 of the normal anatomy as related to the spine and the exiting nerve roots?

A. Yes.

Q. Okay. Please continue, Doctor.

A. This is a plastic model of a portion of the human spinal column. This would be the top, this is the bottom, this is the front, this is the back. Referring specifically to the lumbar spine or the lower spine, you can see that it attaches to the sacrum which is the tail bone which is attached to the pelvis.

The spinal column is divided up into three separate parts: the cervical, the thoracic and the lumbar region.

In the thoracic spine, there are 12 vertebrae numbered from T1 through T12. In the lumbar spine, there are five vertebrae and they're numbered L1 through L5. The disc sits between the bones and inside the spinal column there are a number of separate openings. Running from the top to the bottom is the spinal canal and the spinal cord itself is located right within that spinal canal.

And at each level, the neuroforamin that's the level of the neuroforamin, the nerve roots come out. So in the lower back, those nerve roots come out and they go down to the leg, the thigh, the calf and the foot and they provide information to the muscles either to contract or relax and they also provide information back to the spinal cord and the brain.

Q. I know you gave the jury the analogy of the light switch and you talked about EMG. Is the EMG test in anything that we see in Plaintiff's 28?

A. Yes. So the EMG tests these nerves as they come down the leg. So this nerve could be damaged either in the leg itself or it can be damaged within the spinal cord, the neuroforamen and this test could determine at what level that nerve damage has occurred. It shows within the spinal cord itself that those nerves were being damaged.

Q. Continue if you want to say anything else about the anatomy?

A. Well, I'm not sure --

Q. Well --

A. -- how much is going to be --

Q. -- let's do this just before we have you sit down.

You said that you actually interpreted and looked at the films of November 17, 2009, the lumbar?

A. Correct.

Q. If you could just tell the jury -- it's been marked up by someone else's red pen -- if you could tell the jury any significant medical findings?

A. This is the --

Q. And it's Plaintiff's 5A.

A. This is the lumbar MRI. This one is will be T1 sagittal view. We're looking at the spine from side to side. So if you can imagine that you take somebody's spine, turn it 90 degrees and then cut it from left to right. What you're looking at is one of the slices, the long way through the spine.

So here is the tail bone down here and each of these large squares is a vertebral body and each of these wedge shapes in between is the disc material. And what you see in looking at this MRI is one -- these spikes over here are actually the screws that are going into the bone. On the MRI, you don't see the metal but what you do see are the bones themselves and these are starting to swatch down as well as the discs which are starting to push it out. You see these disc is pushing out here and over here and this is where the spinal column and the nerve roots are.

Q. And what is the disc with the arrow, the two arrows? What is it pushing against in the back?

A. These would be the nerve roots coming down in what's known as the cauda equina, the horse's tail. So the spinal cord ends at approximately the level T12-L1 and from that point on all the nerve roots go down through the spinal column and exits at their respective level.

Q. What, if anything, is the disc material called?

A. It would be a disc protrusion either a bulge or herniation. These nerve roots are within the spinal column themselves. If there's anything in there that's not supposed to be in there such as disc material or bone fragments, it can put pressure and damage or irritation or inflammation on those nerves.

Q. I'm just going to skip over the 2011 and just go a

little quicker.

Looking at the 2013, lumbar film of the same area, I would like you to assume that Dr. Merola has testified that it progressed as a protrusion called herniation at that level where the arrow is the facet joint.

Do you agree or disagree with that interpretation?

A. It looks like it has gotten worse at these two levels.

Q. Can you explain to the jury the progressive nature of a protrusion or herniation? This is 10A.

A. Once the discs slips out of place, it can never go back to its normal healthy state. Sometimes it gets worse, sometimes it can dry out and get better but in this case because there's been stabilization so you see the screws here, the screws here, the screws here, that means that these bones, these joints don't move at all. They're basically fused together. So what happens is all the movement, all of the weight of gravity from standing up, it's transmitted to the levels above and below. Those levels become more susceptible to wearing out.

So in this case because these levels have been fused, the major stress that's on his spine from standing up, sitting down and walking is translated to the levels above and below the surgery. And as you can see, this is causing a progressive deterioration at those levels.

Q. Let me show you Plaintiff's 7A, which is October 9, 2011 cervical MRI being the sagittal view and I note it's been

circles in red by Dr. Merola. Can you tell the jury what is circled in red?

MR. GANNON: Objection, your Honor. May we approach?

THE COURT: Yes.

(Discussion off the record.)

Q. Doctor, can you just point out any findings of medical significance that you see on that exhibit?

A. Sure. So this is the cervical MRI. Once again it's the sagittal image. It's a different magnetic image called a T2 but each of these is a separate slice. So will this is the top, this is the bottom, this is the front, this is the back, this is actually the base of the brain with the brain stem and the cerebellum and this becomes the spinal cord. This is the spinal cord coming down. Each of these square ish shape with the vertebral body and the wedge shape between it is the disc. And you see at the level of C2, 4 that the disc material is pressed backwards. That's a disc herniation and it's putting pressure on the spinal cord itself. You can see how far the cord buckles around that disc herniation and you see it again in the image in front of it as well is not as clear as this one.

Q. So I'm going to put up 4B. This is the 2009 axial view of the cervical. Would you just point out to the jury any findings of medical significance?

A. Sure. Now, this is a different perspective. So if

you can now imagine that a person is laying flat on the table and you're taking short slices through the spine. Each one of these is the short slice. So this is the vertebral body with the transverse process to the left and right and the lamina process behind it. So the bone itself would look like that, like the vertebra. This opening here is as such is the spinal canal. The heart shape is the CSF or the cerebral spinal fluid and that central oblong shape is the spinal cord itself.

If you go up to the level of C3-4, you see how something is pressing backwards right there and that's the disc material that's putting pressure on the spinal cord and displacing the CSF. It's the same thing that we saw in that other picture. We're just looking at it from a different perspective.

Q. Okay. Thank you, Doctor. I'm going to have you sit down now.

(Continued on the next page ...)

Q From the time you first saw Mr. Verdon in 2009 until present, have you seen him on a regular basis?

A Yes.

Q Approximately how often?

A Initially, he was seen approximately every month, for the first year or two. Since then, he's been seen every other month, more or less.

Q And, regarding Mr. Verdon speaking from a neurological and pain management perspective, have his symptoms gotten better, worse, something else?

A His condition has deteriorated slowly. He's a very stoic individual. He doesn't like to complain. He doesn't like to take medication but over the course of time, his condition has deteriorated.

Q And despite Mr. Verdon being stoic, and have you in fact indicated whether or not he has complained of pain on each and every occasion, is that noted?

A He's always had pain, yes.

Q And have you always noted that he complained of pain?

A Yes.

Q To what areas of the body has he complained of pain to each and every visit he had with you?

A Every time, he's got pain in his mid or lower back. Most of the time he has neck pain as well, that's not been quite as severe as the pain in the mid and lower back.

Q You previously said, in reviewing the, your first note, that at that time you don't know if you were prescribing the medication, who prescribes his medication these days and for the past few years?

MR. GANNON: Objection.

Q Well, you said you prescribed medication to him?

A He's been prescribed medication in my office throughout this course of treatment. On that particular day, who prescribed that actual Vicodin, I can't say for sure, but I have been prescribing him medications each time he's been in the office, more or less.

Q And can you tell the Jury the difference between Vicodin and Norco?

A They're similar mediations, they are both narcotic analgesic, they contain a morphine derivative, known as Hydrocodone with a variable amount of Tylenol, but they are both very similar types of medicines.

Q And each time in your handwritten notes and your typewritten notes, there is a section that says Rx. So, the Jury can know, does that mean that on that occasion you prescribed whatever is in the box after Rx?

A No, the Rx on the note will indicate what medications he was taking, in the impression or attached to the note would be a prescription for what we are renewing or changing. Generally, in this case it was just renewing.

Q Did there come a time you noted in the first visit that I was in physical therapy, did there come a time when you had any knowledge as to whether or not physical therapy in the program had stopped with Mr. Verdon?

A Yes.

Q Can you tell the Jury what home physical therapy is?

A Well, in this case, I instructed him on certain exercises, stretching, strengthening, that he is to do on his own because he was no longer eligible for supervised physical therapy. Also prescribed for him what's known as a TENS Unit which is electrical stimulation unit, similar to the one that they would use in a physical therapy facility so that he could use it at home on his own.

Q Can you tell the Jury the purpose of physical therapy, as a board certified pain management physician in connection with spinal injuries or disks injuries?

A Physical therapy can have several different positive effects. One is symptomatic relief. So, doing physical therapy, heat, electrical stimulation, it can help alleviate some of the pain. It helps to, it helps injured parts of the body recover. For example, the nerves in the muscle have been damaged, exercising those limbs will help other muscle groups overcome those impairments and also helps to prevent any deterioration of the condition. So, in this case, there were several different purposes for doing physical therapy, as well

as the exercises afterwards.

Q And, you said you prescribed a TENS Unit. Did Mr. Verdon eventually get a TENS Unit to your knowledge?

A Eventually, he did, yes.

Q Can you tell the Jury the, tell them what it is, can you tell them in a little more detail what it is, what it looks like, how it works and you know, what purpose it serves?

A A TENS Unit looks almost like a little beeper and it's got some wires that come off it, with a small electrodes that transmit small electrical impulses to the skin and the superficial muscles. Nobody is really sure how it works. But the theory is that the small electrical impulses that are generated help to block some of the pain signals that are going to the spinal cord and to the brain and help the muscles and the nerves to reset themselves. It can be very effective. But generally, it's only temporary.

Q Does the TENS Unit itself, does it need to be replaced?

A Yes.

Q How often with a reasonable degree of medical certainty would the actual unit need to be replaced?

A The unit is variable. Depending upon how much you use it and the type, but probably every three to five years you need a new unit, the electrodes themselves probably have to be replaced every six months or something.

Q I'm going to skip to a note, June 25th, 2013, the rest

of your notes are in evidence. It's one of the typewritten notes. If you could just go over the findings during that visit?

A Sure.

Q Any ones that are medically significant?

A His complaints as well as the findings were similar. He was still having neck and back pain. The neck pain was going into his right arm. The back pain was going into both of his legs. Both of his hands were feeling tingly, both of his feet have been feeling numb when he was waking up in the morning. He had lost power in his arms. He was also experiencing some urinary incontinence, meaning he was having problems controlling his bladder as well as erectile dysfunction.

Q Can you tell the Jury the significance of the urinary incontinence and erectile dysfunction regarding spinal injuries?

A The ability to enjoy your bowel, and bladder, and to obtain and maintain erection are all depending upon the nerve roots within the lumbar region. So, in this case it was an indication he was having progressive deterioration of those nerves.

Q If you can continue?

A Sure. He was having problems with daily activities especially sitting, standing, bending, lifting and walking. He was still using a cane and the support but not all the time, but like he was initially. He was having problems sleeping and

indicated the pain would wake him up every forty-five minutes or so from sleep. He was doing some exercises at home. He was still seeing Doctor Touliopoulos and Doctor Merola. He was considering lower back surgery with Doctor Merola. He didn't really want it. The injections which we discussed previously, he was taking Norco for pain, which is like the Vicodin and indicated at times it made him feel drowsy, so he didn't like to take it.

Q And if you could just go back to handwritten note of a few notes before, January 18th, 2013. When it says N-S-A-I-D-S, ineffective, what does that mean?

A NSAID would be non-steroidal, anti-inflammatory. Motrin, Advil Aleve. These are all over the counter NSAIDS. He had tried those medications which are not as potent as a narcotic pain killer and they basically did nothing for him.

Q Okay. And what if any medications was he taking when he required it?

A I'm sorry.

Q Right above that, it says what he was taking?

A On 1/18/13, he was taking Norco which once again is that narcotic pain killer.

Q And just so we go into the bottom right. When it says, he declines ESIS, what is that?

A Epidural steroidal injections. This was a pain management procedure that I had discussed with him, that might

give him some temporary relief. Basically, it's an injection of steroid into the spinal canal to help reduce any inflammation or irritation that was occurring and affecting the nerve roots.

Q And typically when epidural steroid injections are given in the neck and back, are they done one or a series of them?

A Generally they are done in a series of three.

Q And when they are done on the neck, where the spinal cord is a full spinal cord as opposed to the back where the cauda equina is there, is there a different way the procedure is done when it's up by the spinal cord?

A It depends. It depends on the person doing the injections, but generally these are all done under X-ray guidance with sedation. So, the patient is placed on a special table, and in a special position and the needle is advanced using X-ray into the epidural space and then the solution is injected into that area.

Q Just your physical findings on that date in June, 2013, going back to that and right above it, you can tell them what medications he was taking and what if any effects that had on him?

A He was taking Norco, which is that narcotic pain killer but once again it made him feel drowsy. He tried to avoid taking it. On physical exam, there was some pain, limited weakness in the arms and legs. Approximately meaning of the

shoulders and the hips. There was weakness of the right ankle, reflex of his knees and ankles were diminished, there was loss of sensation in the right thigh. There was cervical and paravertebral tenderness and spasm, Spurling maneuver was positive on the right, straight leg test was positive bi-laterally. There was kyphoscoliosis of the spine, spine was now hunched and also twisted. His gait was antalgic, moving slowly. He was having problems dressing, undressing, getting on and off the exam table.

Q I'm going to have you go to the last typewritten note, I know there are other notes, handwritten after that, but the typewritten note of August 6th, 2013. Could you tell the Jury on that, in August 6th, 2013, what if any complaints Mr. Verdon had to you?

A Pretty much the same. He was having neck and back pain, with shooting pains down both his arms and down both his legs.

Q Is the shooting pains, is that what you described before, radiculopathy?

A Yes.

Q Okay. Had that condition of the shooting pains down Mr. Verdon's arms and specifically legs, had that condition gotten better, worse or stayed the same from the time he started seeing you in November of 2009 until August of 2013?

A In general, it had gotten worse and it deteriorated.

There were certainly some days he was better and some days that he was worse. His exam was not identical each time but over the course of the four years or so that I was monitoring his condition, he had deteriorated, he had gotten worse.

Q Okay. And in fact, moving up to his neck, singling it out from the back, was there ever any improvement to the neck pain?

A Sure. There were times where his neck pain was not as severe as his mid and lower back pain, that was a more consistent problem, his mid and lower back.

Q Okay, if you just continue with your findings on that date. I stopped you at the shooting pains?

A We, we had gone over some of the findings, pain, limited weakness in the shoulders and the ankles. I'm sorry, shoulders and hips. There was a five minus weakness of the right ankle. The reflexes in his legs were decreased down, there was loss of sensation, I'm sorry, sensation on that date was intact. There was cervical and lumbar spasm and tenderness. Spurling maneuver was positive. The straight leg raise testing was positive. His gait was antalgic, his movements were slow, he had problems dressing, undressing, getting on and off the exam table. There was a loss of mobility in the cervical and lumbar region.

Q Was he still experiencing the urinary urgency?

A On that date, he was having urinary urgency as well as

erectile dysfunction.

Q The activities of daily living, can you go over whether or not there were any complaints made regarding sitting, standing?

A Yes, he was still having problems sitting, standing, walking, bending, lifting, and he used the lumbar support and the cane at times, not always, but at times.

Q And the medications on that date, in addition to Norco, were there other medications and if so, what were they for?

A I prescribed other medications to him in an attempt to try to minimize some of the side effects he was having from the Norco. Medications I prescribed was Naprosyn, which is an anti-inflammatory, Flexoril which is a muscle relaxer and the Norco which is the narcotic analgesic. And what I explained to him was to try to take the Naprosyn if the pain was mild, especially during the day. Norco, if the pain was strong and he is to take the Flexoril, the muscle relaxer, tends to make people drowsy, especially at night, if he was having spasms and problems sleeping, I wanted to him to be on all three medications, in combination.

Q Go over the physical examination on that date, take us right through the range of motion and tell us whether or not that stayed the same, got worse or something different from the course of your treatment from the beginning?

A He had still some antalgic weakness in both upper and

lower extremities proximally, five minus weakness in the right ankle. Reflexes were diminished, essential sensory exam was intact and there was tenderness and spasm in the neck and back. Spurling maneuver was positive, straight leg raising testing was positive. Loss of motion in the neck and back. His gait was antalgic, he was having difficulty removing around, difficulty dressing and undressing, difficulty getting on and off the exam table.

Q And did you quantify the thoracolumbar spine?

A In terms of his ability to bend forward at the waist, normally a person can get to 90 degrees. In this case, he can only get to 30 degrees which would be a sixty-six percent loss of his ability to bend forward.

Q During the course of your treatment with of Mr. Verdon, did you in fact have the Bellevue Hospital record that's entered into evidence here as Plaintiff's 1? Did you in fact review that Bellevue medical record?

A Yes.

Q And have you in fact reviewed that record prior to coming here today in anticipation of rendering opinions?

A Yes.

Q To cut down on time going through the whole thing, from a neurological standpoint, what if anything was of medical significance in the Bellevue medical record?

A I'm not sure I understand the question.

Q Well, what is your understanding of Mr. Verdon's injuries as contained in the medical record of Bellevue?

A Well, he sustained significant trauma to his spine, as well as other parts of his body, but specifically the spine and multiple fractures. There was a T-12 vertebral fracture with retropulsion of the fragments, meaning this was an unstable fracture within the spinal canal, and this was a potential neurological emergency, for which they did emergency surgery and stabilized it.

Q Can you tell the Jury what a plural effusion is?

MR. GANNON: Objection, cumulative.

THE COURT: Didn't Doctor Merola go over that?

MR. MCCRORIE: Yes.

THE COURT: Sustained.

MR. MCRORIE: Your Honor, with the Court's permission, I would just like to, instead of going through the actual records to save time, just show the Doctor the October, 2009?

MR. GANNON: If I can just see that again.

MR. MCCRORIE: In Bellevue, and August 14th.

Q I'm just going to show you what is contained as part of the larger record in evidence, I'm just going to show you the October 16th, 2009 record as well as an August 14th, 2009 record, Plaintiff's Exhibit 1. Can you tell the Jury what if any findings of neurological significance are contained on those

records?

(Whereupon, the exhibit was handed to the Witness)

A On 8/14/09, there was basically a rehabilitation evaluation, physical therapy evaluation while he was in the hospital and indicates that he had the fall and undergone the surgery, that he was complaining of back pain that was graded as a 7 over 10 in severity. That, on examination, there was significant loss of strength, and in both the arms and legs, as well as loss of mobility and had difficulty getting around. And another page where they recommend different types of treatments to improve his symtomology.

Q And just looking at the other document from October 16th, just on the, any medical significance as from a neurological standpoint?

A October 16th, 2009, this is the clinic notes. So, he had gone back out to Bellevue Rehabilitation Clinic, and they examined him and they noted that he had been getting physical therapy at Kessler, that he was still wearing his back support, that he was walking with a cane, that he was still having mid and lower back pain which was graded as a five over ten. That he was taking various medications including Ibuprofen which is Motrin, the Flexeril, which is the muscle relaxer we discussed before, as well as oxycodone which is Percocet similar to the Vicodin and Norco. He had been experiencing numbness in his

right thigh that was most notable when he was walking or when he was sitting and also having some numbness in his left second toe, since the surgery. Otherwise was doing okay. And, on examination, they noted that he was wearing his back support. There was motor weakness throughout in both the arms and the legs. There was loss of sensation in the left second toe and that he was able to walk with a cane. They found that he was stable and recommended continued therapy.

Q Thank you, Doctor. Doctor, contained within your handwritten notes, when there is a section called overall pain level and you give a number out of 10. Can you explain to the Jury what that is on each of your notes?

A Basically, it's a pain scale that helps us to monitor the patient's level of pain from visit to visit. It's a self reporting scale. So, I'll say to a patient, on a scale of zero to 10, zero being no pain at all and 10 being the worst pain, generally over the course of the past month, with the treatment and the medications or injections, whatever type of treatment you've received, how would you grade your pain, and they would give a number. And it just helps us to monitor the patient's condition over time, to make sure that this treatments are effective.

Q And, on any of your notes where it indicates functional ADL, can you just tell them what ADL stands for since it will be in evidence?

A ADL refers to activities of daily living. So, one of our jobs as doctors, to try and make sure that things, activities that people do on a daily basis are being done without causing a great deal of pain and discomfort. So, generally, when I ask patients, what types of things are you having problems with, sitting, standing, bending, lifting, walking, we can try to focus our treatment on those particular activities, whether it be physical therapy or bracing or something to that effect.

Q And words contained within your assessments, cervicalgia and lumbago, can you please tell the Jury what those words mean?

A Cervicalgia is a fancy word for neck pain and lumbago, fancy word for lower back pain, general tightness.

Q And, progressive thoracic, kyphoscoliosis can you tell them what that means contained in the assessment?

A In this case, I was concerned, basically his spine is collapsing, getting progressively hunched over and twisted. The bones, the joints in the spine are breaking down.

Q When did you last see Mr. Verdon prior to your testimony here today?

A March 11th.

Q And what were the complaints at that time?

A Primarily mid and lower back pain, radiating pain down both legs, numbness in both of his feet in the morning. Both of

his legs were feeling weak. Having incontinence, his pain was 6 over 10. He was taking Naprosyn, Flexeril and Norco, physical findings were essentially unchanged. I recommended that he continue his home exercise program, continue using the TENS Unit, continue taking the medications, and to consider the spinal surgery.

Q Doctor, I'm going to be asking you a series of questions now and I would like you to assume the following as true?

MR. GANNON: Objection.

THE COURT: I'll sustain. You want him to assume certain facts in evidence.

MR. MCCRORIE: Yes.

THE COURT: Whether or not they are true.

MR. MCCRORIE: Assume the following, take the word true out of it.

THE COURT: Okay.

Q I'd like you to assume that on August 11th, 2009, Mr. Verdon had fallen from the height you see in the photograph, Plaintiff's Exhibit 14. That he landed on his back on the rebar below, the rebar below. I'd like you to assume that a witness testified here that he was unconscious, that he was bleeding from the back of his head. I'd like you to further assume that there were a number of staples put into the back of his head at Bellevue Hospital. I'd like you to further assume he was

admitted to Bellevue Hospital and all the findings that were in the record in Plaintiff's 1 that you have reviewed prior to testifying here today, most notably the T-12 and T-10 fractures as well as the spinous process fractures were sustained. I'd like you to further assume that Mr. Verdon underwent a cervical spinal, a lumbar thoracic spinal fusion on 8/12/09, at seven levels. They skipped the one level of the T-12. I'd like you to further assume that within weeks of being released from the hospital, Mr. Verdon was back at Bellevue, and that some of his complaints as you just read to the Jury were right thigh numbness and numbness into his toes, the lower extremities. I'd like you to further assume that all of the treatment you've done, that you can assume everything you've done when he came to you in November and made the complaints and all of the findings that you told the Jury about, the findings from the MRI, the CT's, EMGs, all of the findings as you discussed with the Jury today, and that are in your notes were found. That you don't have to assume. That's what you found.

Do you have an opinion within a reasonable degree of medical certainty as to the cause, first of the symptoms that Mr. Verdon has been complaining to you about, the radiating pain down the legs, the pain in the lower back, and the pain going into his arms?

A I do.

Q Can you please tell the Jury what your opinion is?

MR. GANNON: Objection.

THE COURT: Overruled.

A In my opinion, his neck and back pain, shooting pains, numbness, the weakness problems with his bladder, erectile dysfunction are all related to the spinal injuries that he sustained from the fall.

Q As I'm required to do, please tell the Jury the basis of the opinion that you just gave to them?

A Never had a problem with his neck and back before he fell. Sustained multiple acute fractures, clear, that there was trauma to the spine, and that the trauma to the spine that caused these problems.

Q Do you have an opinion, we talked about the symptoms, within a reasonable degree of medical certainty as to the cause of the protrusion that you pointed out to the Jury as exhibited on 5A and 10A in the lumbar spine?

A I do.

Q And can you please tell the Jury your opinion and the basis for same?

MR. GANNON: Objection.

Q Well, first tell them your opinion?

MR. GANNON: Objection, also cumulative.

THE COURT: Overruled.

A In my opinion, there was trauma from a fall that was substantial cause for that protrusion. Protrusions can occur

sometimes because of degenerative joint disease, but he never had any problems before and I think it was the accident that caused this problem.

Q Do you have an opinion with a reasonable degree of medical certainty as to the protrusion you pointed out on the cervical spinal cord on the axial view to the Jury?

A I do. Likewise, I think it was the fall that caused it. Once again, sometimes you can have an asymptomatic protrusion. In this, but in this case, it's not asymptomatic. In this case, protrusion is pretty significant, causing spinal cord impingement. I think it was the fall that was the substantial cause of his problem.

Q Can you tell the Jury whether or not, we told them, you told them that arthritis can be asymptomatic, can a herniation be asymptomatic? Or a protrusion of the disk, can that be asymptomatic?

A Osteoarthritis, degenerative, joint disease can be asymptomatic, meaning that you don't know if you have it. Sometimes along with that, osteoarthritis of the spine you can have a disk bulge or less likely, a disk herniation, and it is possible that that can be asymptomatic, meaning you don't know, but in this case it's not asymptomatic, is the cause of the problems and I think it's the accident that caused these problems.

Q And let's goes under the assumption that, let's assume

this to be true. That prior to the, there are no tests to show it, but prior to the accident date, Mr. Verdon as you said had pre-existing degenerative joint disease, as you said, we all do, but that he also had a pre-existing herniation that was asymptomatic, both in the neck and the back. Do you have an opinion with a reasonable degree of medical certainty as to whether or not a fall such as the one that Mr. Verdon sustained from the height depicted in the photograph I'm showing you, Plaintiff's 14, and the subsequent findings in the hospitalization in Plaintiff's Exhibit 1 in Bellevue, do you have an opinion as to whether or not such a fall could activate and or aggravate any pre-existing asymptomatic herniations?

MR. GANNON: Objection.

Q First just activate an asymptomatic previous herniation?

MR. GANNON: Objection, outside the scope of the disclosure.

MR. MCCRORIE: Within the BP.

MR. GANNON: Outside the scope of expert disclosure.

MR. MCCRORIE: I just wanted to bring it up.

THE COURT: Why don't we go in the back.

MR. MCCRORIE: I got it right here.

THE COURT: Why don't we go back here?

(The following occurred in the Judge's robing

room, on the record, among the Court and Counsel, but outside the presence of the Witness, the parties and the sworn Jury)

THE COURT: It's in the BP, not in the disclosure.

MR. MCCRORIE: Exacerbation of Plaintiff's asymptomatic underlying. The general Disclosure, BP, activation of previous asymptomatic states a claim. Activation degenerative, entirely asymptomatic before. Under the charge that we have to have, it has to be pled and proven. Their claim is its degenerative. I'm just giving the alternative hypothetically.

MR. GANNON: It's the wrong expert. This should be Doctor Merola who is coming back on the stand.

THE COURT: Dr. Merola, you didn't ask about that.

MR. MCCRORIE: I didn't do opinions with Dr. Merola.

THE COURT: Are you going to ask him about it also, apart from the fact he's objecting to everything because it's cumulative or become cumulative this afternoon.

MR. MCCRORIE: Under the neurological, I know Mr. Gannon certainly has the right, but my point would be, there is an orthopedic injury and a neurological injury.

Both of them have such a close interplay, it's my position that they could have hired a neurologist as well. I believe we have the right to put forth the opinion from a neurological standpoint and an orthopedic standpoint. I don't believe we're trying to sneak it in as double.

THE COURT: Okay, let me ask you, apart from the cumulative, with what he just pointed out is in the BP and the notice about activation exacerbation, other than the cumulative, are you objecting?

MR. GANNON: I'd have to look at the expert disclosure.

THE COURT: Let him look at it.

MR. MCCRORIE: I think it's in his notes.

MR. GANNON: That's my point.

THE COURT: I thought that was part of it.

MR. MCCRORIE: It's in the BP.

THE COURT: No, he's talking about the actual 3101.

MR. MCCRORIE: He is a treating authorization, given medical records, in addition to that, we pled it, we wouldn't even have to, because it's in the --

THE COURT: I actually lost sight of the fact he's his Doctor.

MR. GANNON: I only raised it that Mr. McCrorie pointed to it at the 3101.

THE COURT: To the extent it's the treating and in his notes.

MR. GANNON: Again, we've been down the road where Mr. McCrorie has gotten a double shot at the exact same testimony. I understand the close coordination of these two experts, but I think that question he asked him was clearly an orthopedic question. What the effect of that is, and the issue of degeneration, is really more proper for Doctor Merola.

MR. MCCRORIE: However, it's in Doctor Hausknecht's notes and his opinion.

THE COURT: I'm going to overrule the objection.

MR. GANNON: Objection, thank you, your Honor.

(Whereupon, the following occurred in open court)

THE COURT: The objection is overruled. You remember the question.

MR. MCCRORIE: I'll try to re-ask it, succinctly.

DIRECT EXAMINATION CONT'D

BY MR. MCCRORIE:

Q I'd like you to assume, although that's not the opinion, but I'd like you to assume that there was a pre-existing herniation in both Mr. Verdon's neck and back prior to the accident, but as you told the Jury, it was one of those asymptomatic herniations. Do you have an opinion, given the

same facts in the hypothetical, the first hypothetical, the same accident, the same findings in the hospital, the same findings on the MRI, do you have an opinion as to whether or not such an accident could have activated any, activated any latent or asymptomatic herniation to become symptomatic?

A Yes.

Q Can you please the tell the Jury under that hypothetical your opinion and the basis for same?

A Once again, I don't believe that these were there before the accident, but assuming that they were, it's possible that they could have been there and been asymptomatic, with the trauma, causing inflammation and irritation causing them to become larger and become activated and cause the symptoms and the problems that he has.

Q Can you tell the Jury what adjacent level breakdown is from a neurological standpoint?

A Adjacent level breakdown which would be what we referred to before, if you have a portion of the spine that's been fused together so it doesn't move, all the movement, all the stress of the spine gets translated to the level above and below, because there is increased stress at these levels, they are more susceptible to breakdown.

Q Do you have an opinion with a reasonable degree of medical certainty as to what you've told the Jury on the findings from 2009 to 2013 on the lumbar spine, the progressive

nature of that breakdown, do you have an opinion as to the cause of that?

A In my opinion, it was the trauma to the spine, with resultant fractures, requiring the stabilization, so there are now numerous portions of his spine that no longer move properly. They are starting to collapse, putting abnormal pressures on different parts of the spine and causing them to deteriorate.

Q Is that both in the neck and the back, Doctor?

A More so in the back but in the neck as well.

Q Have all your opinions today been with a reasonable degree of medical certainty so far?

A Yes.

Q Do you have an opinion with a reasonable degree of medical certainty as to whether or not it would be advisable for a man with Mr. Verdon's conditions to ever return to manual labor or any form of construction work?

A No, he cannot do that.

Q If it's the same, just say for the record, just give the basis?

A The spine is unstable, it would be potentially dangerous for him to do any type of manual labor, lifting, carrying, pulling, pushing, put himself at risk of falling and twisting and to potentially aggravate his condition and make it worse.

Q How about any position whatsoever that would require

standing, sitting, bending, lifting for any long period of time?

A Sitting and standing per se is not going to make him worse, but he can't tolerate. It causes him pain, he can't do it. Bending and lifting could make it worse.

Q With a reasonable degree of medical certainty, have the conditions that you've told this Jury that were caused by this accident permanent in both the neck and the back?

A Yes, they are.

Q With a reasonable degree of medical certainty, would you, as a board certified pain management physician and neurologist, expect a man with Mr. Verdon's progressive conditions to have pain in the future?

A Yes. He's going to have pain, he's going to have good days, he's going to have bad days, depending on his activity, whether or not he's taking treatment or medications, but this is going to be a chronic condition.

Q For the record, for what period of time?

A For the rest of his life.

Q With a reasonable degree of medical certainty, would you, do you have an opinion as to whether or not his condition that's progressed from the accident until today, whether or not it will continue to progress into the future, deteriorate in both the neck and the back?

A I don't have a crystal ball but based upon what's transpired in my office over the past couple of months, he's

getting worse and I would expect that he continues to get worse and I think that sooner or later he's going to need that stabilization surgery with Doctor Merola.

MR. GANNON: Objection, move to strike.

THE COURT: Stricken.

Q With a reasonable degree of medical certainty, can you give us the basis, not for the last part that you said, but just that it will continue to progress in your opinion?

A Yes.

MR. GANNON: Objection.

THE COURT: Overruled.

A Based upon my clinical evaluations, especially autonomic symptoms that he developed, serial imaging studies, MRIs, X-ray which shows progressive kyphoscoliosis, it's a progressive condition that it's going to require further intervention.

Q Has Mr. Verdon been offered something as an alternative to the epidurals and the all the medications?

A We've talked about another option, which is a spinal cord stimulator type of pain management procedure.

Q These are in for ID only, Plaintiff's 23 and 24, as a board certified pain management physician and neurologist, can you just tell the Jury how a spinal cord stimulator works and why that would avoid the need for medication if someone chose to do that route?

A I don't know if it would avoid the need for medication. Basically, a spinal cord stimulator is a type of interventional tool, similar to the TENS Unit. So, there is a small battery operated generator that emits small electrical impulses and the electrodes are inserted into the spinal column and placed upon different nerve roots, in the different parts of the spinal cord itself. And these electrical impulses basically override the pain impulses, so instead of feeling pain all the time, you feel a sort of buzzing of electric sensation which most people would prefer to pain. So, still not a pleasant feeling, but it's much better being in chronic pain.

Q And I just wanted to ask you, the pulse generator, it may not be clear on this, is that inside the body or implanted or outside the body?

MR. GANNON: Objection, cumulative.

THE COURT: Overruled.

A It's inside the body, sort of like a pacemaker. Where the pacemaker is the generator unit in the chest wall itself, and the electrodes and the leads are on the heart. It's the same type of thing but it's in the spine.

Q And just, the other image.

(Whereupon, that is displayed to the Jury)

A This would just be a depiction of the unit with the different electrodes up and down the spine, and once again, this goes to what's known as the voltage gated theory of pain, that

the spinal cord can only handle so many different sensory stimuli, so that if you overwhelm the pain pathways with this electrical stimulation, that you can help block some of that, those pain signals, from getting to the brain itself.

Q And finally, Doctor, we don't need the frequency, but I just want to ask, another Doctor will come later in the week, do you have an opinion with a reasonable degree of medical certainty as to whether or not Mr. Verdon will require pain medications into the future?

A Yes.

Q For what period of time?

A For the rest of his life.

Q Do you have an opinion with a reasonable degree of medical certainty as to whether or not Mr. Verdon, whether it's just you or a physician similar to you, should continue to see a board certified pain management physician and a neurologist?

MR. GANNON: Objection.

Q Or a neurologist, and or neurologist?

MR. GANNON: Objection.

THE COURT: Overruled.

A Yes.

Q And for what period of time, another doctor will handle that, but what period of time into the future?

A For the rest of his life, every two to three months, more or less, depending upon his condition, depending upon

what's going on.

Q And setting aside authorization or any requests for same, can you, do you have an opinion with a reasonable degree of medical certainty as to whether or not Mr. Verdon would benefit from physical therapy into the future to both his neck and his back?

A I believe he would.

Q One last thing. You talked about serial, I think you said serial diagnostic testing. That means over the period of time, multiple tests?

A Yes, for example, in the course of his treatment, he's had three sets of MRIs for neck and back, he's had three sets of EMGs for neck and back and would require this going forward and not quite as frequent, but similar.

Q So, with a reasonable degree of medical certainty, will he require diagnostic testing, either EMG, MRI, CT scans to both his neck and his back?

A Yes, he will.

MR. MCCRORIE: That's it.

THE COURT: We'll take a ten minute break and then prepare for the cross-examination. Don't discuss the case.

(Whereupon, a recess was taken in this matter,and after the recess, the following took place in open court, with the Court and all parties being present)

(Whereupon, the Jury entered the courtroom.

THE COURT: Have a seat.

CROSS EXAMINATION

BY MR. GANNON:

Q Dr. Hausknecht, how are you?

A Good afternoon, Counsel.

Q My name is Chris Gannon. We met briefly this morning before you took the stand. I represent the Defendants in the case, okay. We've never met before, correct?

A Not that I know of.

Q Okay. And you've testified on behalf of the Sacks law firm in the past?

A I have.

Q How many times have you done that?

A I've been in practice for twenty years, maybe a dozen times, more or less.

Q Have you ever testified on behalf of the defense counsel?

A On occasion, yes.

Q What percentage would you say you testified for plaintiffs versus defendants?

A Most of time that I testify, it's on behalf of the plaintiff, meaning that it's a patient that I've been treating in my office.

Q And but you've also testified on behalf of a

plaintiff's law firm for an individual that you had not been treating, correct?

A On occasion.

Q What's the percentage breakdown you would say for that?

A I would say ninety percent of the time that I've testified, it's on behalf of a patient that I've treated in the office, maybe ten percent is as an expert and most of the time it's on the plaintiff. Sometimes it's on the defendant.

Q Would you say seventy-five percent of the time you've testified on behalf of plaintiffs?

A More.

Q More?

A More.

Q What percentage of time you testified on behalf of plaintiffs?

A As I said, usually I'm testifying on behalf of a patient that I treated so it would be ninety percent.

Q The ninety percent, also, and I think you made reference to yourself, and I may have the phrase wrong, you are a union Doctor?

A Correct.

Q What does that mean?

A It's mean I'm in the plan for their health coverage.

Q So, that means if someone in a given union is injured, you are one of the doctors identified in the plan that they

could go see?

A Yes. Or even if they are not injured, if they have some type of neurologic condition, they can come see me.

Q Okay, you so know that Mr. Verdon is a carpenter?

A Yes.

Q And the plan that you are referring to is the union agreement. When you said plan, what did you mean?

A His health coverage.

Q His health coverage, which is provided through the union?

A Right.

Q Now, Dr. Hausknecht, you agree that you come in here to testify as an expert, obviously, you are here to tell the truth, correct?

A Correct.

Q You want to get access to as much information as you can, prior to testifying, so you can give the best testimony you are able to this Jury, correct?

A In general, yes.

Q Now, the records that you have reviewed for testifying today, you had your own office records, correct?

A Correct.

Q And, you have obviously more in that file than just your office records, correct?

A Correct.

Q And who supplied those records to you?

A Some of them were supplied by the patient, some of them were supplied by the doctors, some of them came from MRI facilities. I think some of them might have come from the lawyer's office, a combination. It's an accumulation.

Q Are you able to tell from looking at your file which records came from the lawyer's office?

A Only if there was a fax letterhead or something.

Q In there, do you have any type of correspondence from Plaintiff's Counsel?

A Just a subpoena.

Q Okay, that's a subpoena for you to come here today?

A No, I think it was a records subpoena.

Q Okay, to produce records. You are charging five hundred dollars an hour to testify today?

A That's correct.

Q So, do you also charge a rate for the full day, if you go past a certain time?

A It goes by the hour. But, if it was eight hours, it would be eight times five hundred.

Q And, what amount of your income do you have each year from testifying in court?

A I'm not sure exactly, less than five percent.

Q What's the number?

A The total dollar amount?

Q Yes?
A I testify approximately a dozen times a year. Figure the average testimony would be around three thousand dollars, something to that effect, maybe about forty thousand dollars a year.
Q That's for testifying in court, does that also include time you spend preparing to testify?
A That would include all of it.
Q What's the number again?
A About forty thousand.
Q How many times have you testified in 2013?
A I don't know exactly, but ten.
Q And how many times of those ten times, how many of those were for Sacks and Sacks?
A Zero, as I recollect.
Q None at all?
A No.
Q Now, Dr. Hausknecht, I want to get right into your records, if I could, okay. Could you pull out your, you said your initial evaluation of Mr. Verdon was November 17th, 2009?
A Correct.
Q How did Mr. Verdon come to see you, do you know that?
A He had been referred by his orthopedist, Doctor Merola.
Q Okay. And in your note, you mentioned that you reviewed all available records and diagnostic testing, that you

would review further records when they become available, correct?

A Correct.

Q Now, to move it along, you may know and I should have said from the beginning, to the extent you can answer a question yes or no, you can do that, if you need to expand beyond that, let me know.

A Sure.

Q Okay. You indicate in here that he's been attending physical therapy at Kessler in New Jersey?

A Correct.

Q Did you review any of the Kessler records?

A Yes.

Q What is in your file from Kessler, what dates does that cover?

A 9/2/09, and a few other dates but the first one is 9/2/09.

Q What are the other dates you have 3/23/11. 1/31/11.

A That looks like it.

Q So, you have three notes from Kessler?

A Yes.

Q You understand that Mr. Verdon was attending Kessler from approximately 2009, and you understand he finished in March of 2011?

A Yes.

Q You don't know the number of times he went to physical therapy?
A I do not.
Q And you didn't review any of the other records from physical therapy from Kessler other than the three that are in your file, correct?
A Not that I recall.
Q Did you request all of the records for Kessler Physical Therapy before you came here today to testify?
A Probably not.
Q Okay. You know that he complained of pain on his first visit to you, correct, November 17th, 2009?
A Correct.
Q And, he denied any headaches, any dizziness or any memory problems, correct?
A That's correct.
Q And the medication he was taking at that time was ibuprofen, correct?
A Correct.
Q What is ibuprofen?
A Anti-inflammatory like Motrin or Advil.
Q Is it a narcotic drug?
A No.
Q Is it an over the counter drug?
A No.

Q And what is the purpose of it, why would someone take that?

A In this particular case, it would be prescribed for pain, or taken for pain.

Q Okay. You did a general physical examination of him, correct?

A Yes.

Q His vital signs were within normal limits?

A Yes.

Q What do you mean by vital signs?

A Blood pressure, heart rate, respiratory rate.

Q You also did a pulmonary examination which was unremarkable, correct?

A Correct.

Q A cardiac examination which was unremarkable, correct?

A Correct.

Q A vascular and a gastrointestinal systems examination, both of which were unremarkable?

A Correct.

Q Unremarkable means what?

A I didn't see any gross abnormality of the structure.

Q His short term memory was intact?

A Yes.

Q Long term memory was intact?

A Yes.

Q What is receptive aphasia?
A It's the ability to understand what's being said to him.
Q He had no problems there, right?
A Right.
Q You had him spell backwards?
A Yes.
Q And that was normal. Within normal limits?
A Yes.
Q You did a mental status examination. Also that was normal?
A Yes.
Q You also did a cranial nerve, you have a section in here cranial nerves. No problems there, correct?
A Correct.
Q Now, what is that examination, what are you doing?
A Cranial nerves checks the function of basically the eyes, the ears, the nose, the throat, the face. And in this case he had sustained a head injury, so I was concerned about the sensory sequela, memory, speech injury, problems with hearing and speaking, no problems.
Q Your typewritten reports are broken down into various sections and you kind of use that as your guide when you meet with the patient each time, correct?
A More or less, yes.

Q Okay. And, we'll go through some of them, but you also have, you obviously got past family history, social history, general physical examination, cranial nerves which we just did, eventually you get to sensory mechanical range of motion, testing, and impression. Impression in your report is after all these examinations, impression is what you write down and you find to be significant, correct?

A More or less.

Q Okay. So, if we continue with that first report, under motor system you do note weaknesses in the shoulder, left hand, correct?

A Correct.

Q The remainder of the motor strength you note in the upper and lower extremities, other than what's identified is five out of five.

A Yes, but he didn't identify all the abnormalities but yes.

Q You did it with Mr. McCrorie, we can go through it. You saw some weakness in the shoulders, weakness in the left hand, why don't you tell us where you found weakness?

A There was weakness in both shoulders, the left hands, both hips, both knees, and the left ankle.

Q Other than that, the motor strength in the upper and lower extremities was a five out of five, correct?

A Yes.

Q And, myotomal groups, you tested all myotomal groups, what does that mean?

A The group of muscles innervated by the specific nerve roots, so C5/C6, L4/L5.

Q So, you did the muscle groups both arms and legs, upper and lower extremities, correct?

A Correct.

Q In other words, other than what we just identified, everything else was normal?

A Yes.

Q Now, under sensory, in that report, you noticed a patchy hypesthesia in the posterior thoracic, adjacent to the surgical scars, what does that mean?

A Hypesthesia would be loss of feeling; patchy meaning there were some areas that he had some area that he couldn't, feel, in his back around the scar he had lost feeling.

Q That's not abnormal for someone who underwent surgical intervention to have that type of effect around the scar area?

A I don't know what you mean by abnormal. Loss of feeling is always abnormal, but it's relatively common when you do a surgery, you are cutting nerves.

Q Okay, but the remainder of the testing there, so you did remainder of pain temperature, vibration and light touch perception, they were within the normal limit in the trunk, right, this is the thorax area and his arms and his legs?

A Correct.

Q You also mentioned that there is some testing you did, not your testing, I apologize, testing that you reviewed that's identified in your report, correct?

A Correct.

Q And these are the CT scans from 2009. You have, at this point, all the CTs that are done in 2009, correct?

A Correct.

Q And you reviewed those and the reports themselves, correct?

A I don't recall if I actually had the films or just the reports at that point in time. But, at some point I did review both.

(Continued on next page)

Q. And again following the first visit after the full examination with Mr. Verdon, your recommendation and the plan was that he continue his current course of outpatient physical therapy, correct?

A. Correct.

Q. That's what he's doing at Kessler?

A. Correct.

Q. And you recommended that he take Ibuprofen as needed for pain, correct?

A. Correct.

Q. So you didn't at this point prescribe any narcotic medication?

A. That's correct.

Q. And the impression are also in here as well, correct?

A. Correct.

Q. Let's go to your next report February 2nd, 2010. Are you there?

A. Yeah.

Q. Okay. Here again you are noting that the patient attends physical therapy, correct?

A. Correct.

Q. And the history in this part of the report is Mr. Verdon telling you, correct?

A. Yes.

Q. And Mr. Verdon indicates to you the physical therapy

has been helpful --

A. Correct.

Q. -- correct? And at this point, he's taking Vicodin as needed for pain --

A. Correct.

Q. -- correct? Do you indicate anywhere in here the amount he's taking?

A. No. I don't say how often or how much he's taking.

Q. At this point, you didn't prescribe this for him or did you?

A. Yes, I did prescribe it to him, the Vicodin.

Q. You did. Okay.

Doctor, not that it ever works out, but I have some monitors for the jury. All these are evidence. As I go through, the jury will be able to follow along.

If anyone has difficulty seeing, please just let me know.

So the February 2nd, 2010, you prescribed Vicodin as needed for pain?

A. Correct.

Q. Correct? In other words, in this situation, the Vicodin you're talking about, it's up to Mr. Verdon, if he feels pain to take it, if he doesn't feel pain, he doesn't need to take it?

A. Right.

Q. The physical examination that you do of Mr. Verdon on February 2nd, 2010, this is you essentially manipulating and looking at his body and making findings based on that, correct, generally?

A. More or less, yes.

Q. Okay. You have a notation in here that there is, a I think you said on your direct examination, you found an exaggerated kyphosis of the thoracic spine, correct?

A. Correct.

Q. And you did that based on what? A physical examination?

A. Yes.

Q. And you also said that based upon what you're seeing here, I think your quote was -- I wrote it down. I may be wrong -- that his spine was beginning to collapse, correct?

A. Correct.

Q. Okay. In the impression that we have, which you talked about just before the impression section of your report, is what you find to be significant in terms of recommending future treatment, correct?

A. Correct.

Q. You don't mention the exaggerated kyphosis in the thoracic spine, do you?

A. No, I do not mention that.

Q. You also don't mention that you believe his spine was

beginning to collapse, did you?

A. It doesn't say that, no.

Q. Okay. And, in fact, what you advise him in your plan for Mr. Verdon is to continue with his current course of rehabilitation, correct?

A. Correct.

Q. You don't make any recommendation that he should change his rehabilitation therapy in any way, correct?

A. Not at that point, no.

Q. And again you recommended that he take his medication as prescribed?

A. Yes.

Q. At that point, you're not telling Mr. Verdon you got to go get yourself into the hospital and get treatment immediately, are you?

A. Not on that date, no.

Q. Now, let's go -- I know some of your notes are handwritten. Those were handwritten by you?

A. Yes, either me or my physician assistant, yes.

Q. Okay. And when you have the HPI in your office visit, that's history of present illness?

A. Correct.

Q. It's what you find at that time during that visit?

A. It's what the patient says that has happened over the past six or five years.

Q. Now, you saw him February 2nd, 2010. You next see him on March 26,2010, correct?

A. Correct.

Q. He's taking Vicodin and Motrin?

A. Correct.

Q. Your notation under HPI: Vicodin, Motrin and what does that say?

A. PRN which means as needed.

Q. It says Vicodin, Motrin and then there's a word and then it says helps?

A. PRN.

Q. And helps means just as needed?

A. No. PRN means as needed.

Q. What does it help?

A. It helps when he takes it.

Q. He's noticing relief in pain from taking that?

A. When he takes the medication, yes.

Q. Okay. He's still in your physical therapy at this point, correct?

A. Correct.

Q. Now, when you see him again two months, almost close to two months later March 7, 2010 under HPI, what's the first word you have?

A. He's feeling better.

Q. All right. He's telling better, okay. And you also

in terms of your assessment you note that there is some clinical improvement for Mr. Verdon?

A. Yes.

Q. And what do you mean by that?

A. Primarily his neck had been improving.

Q. Does it say primarily his neck? It says Survalet and Provacado (ph), right? The next one says some clinical proof. That's for both?

A. I'm telling you based upon this note in my experience with him primarily his neck improved. You're looking at HPI. It says decreased neck pain.

Q. Right. The assessment you're talking about: Cervical pain, lumbar pain and you note some improvement?

A. Correct.

Q. That's in both.

A. It's not in both. That's what you're saying. You're taking bits and pieces. His neck was better. His back wasn't.

Q. Okay. You next see him June 18, 2010 and you note that his neck continues to improve, correct?

A. Correct.

Q. His overall pain on that visit is five out of ten and again he's taking Motrin and Vicodin, correct?

A. That's correct.

Q. Again, June -- and sorry July, 30, 2010, you note the Vicodin helps and is well tolerated?

A. Correct.

Q. Meaning by well tolerated he's having no adverse effect from taking the medication like getting sick or anything like that?

A. Right.

Q. On August -- I'm sorry -- September 24, 2010, you see Mr. Verdon again. In the HPI under the neck injury, could you read that to the jury what that says in your notes?

A. Neck pain resolving, four out of ten, radiating into right shoulder, no numbness, tingling, no weakness in arms.

Q. So that is based upon your examination of Mr. Verdon's history that he gave to you there?

A. No. That's his history that he's given. The HPI is basically what he's said.

Q. So the neck and the pain -- the neck pain is improving. He's now four out of ten in his complaints and right shoulder, what does that say right shoulder, no numbness?

A. Neck pain resolving, four out of ten radiating to right shoulder, no numbness, tingling, no weakness in the upper extremities.

Q. What's the next thing?

A. No headaches, no dizziness.

Q. And the next one?

A. Right shoulder pain was resolving status post surgery, still some difficulties reaching and dressing, improving back

pain radiating into right leg and numbness into groin down to legs and feet.

Q. Okay. You see him again two months later, see his pain as five out of ten. He's on Vicodin. You essentially tell him to continue physical therapy in each of these visits?

A. Yes.

Q. You're not recommending anything other than continuing physical therapy and the medications that you prescribed, correct?

A. The only things that he's accepting are the therapy and the medications. We discussed other options like the injections and the spinal cord stimulator.

Q. I'm sorry. We'll get there. At this point, you're basically telling him to continue conservative treatment, physical therapy?

A. Yes.

Q. You're not recommending anything else at this point?

A. Correct.

Q. You then see him in -- let's go to your notes I think it's August 11, 2011. And under HPI, could you read to the jury what that says under HPI?

A. What's the date?

Q. I'm sorry. August 11, 2011.

A. I'm not seeing that note.

Q. 8/11/11.

MR. McCRORIE: Maybe that's a three.

Q. It might be 3/11.

A. Yes, 3/11.

Q. Doctor, see I didn't make a comment about the doctor's handwriting.

A. I'm surprised I could read my own handwriting.

Q. So 3/11/11, could you read to the jury under HPI what that says?

A. It says right shoulder much better, 80 percent better, continue neck and back pain exaggerated by activity, taking Vicodin PRN with relief well tolerated, positive bilateral lower extremity radicular symptoms.

Q. And his overall pain level in this visit. Four out of ten?

A. It's four out of ten but it's ten out of ten with activity.

Q. And again you have at this point you recommend that he continue home exercises, correct?

A. Correct.

Q. Now, you're aware at this point that Mr. Verdon has finished Kessler rehabilitation therapy?

A. He's been discharged from there, yes.

Q. And he's never gone back since 2011 to Kesler for any physical therapy, correct?

A. Not as far as I know.

Q. Okay. Other than home exercises like stretching, that's what he's been doing since 2011 as far as you're aware of, correct?

A. Correct and the TENS unit that was prescribed.

Q. The TENS unit. June 3rd, 2011 again this is his overall pain level is four out of ten but a ten out of ten with activity?

A. Correct.

Q. Now, your note of October 13, 2011 this is your typed note if you can get that in front of you please. Are you with me?

A. Yes.

Q. Okay. When for the first time did Mr. Verdon complain to you of any type of a incontinence? Is this the first time of is there a --

A. Well, bladder symptoms would be October 13, 2011. He's complaining of urinary frequency or urgency rather.

Q. Urinary urgency. Is this the first time he made a complaint of any type of urinary urgency or incontinence?

A. As far as I can tell yes.

Q. Okay. How old is Mr. Verdon at this time in 2011.

A. He's about 62.

Q. What are the causes of urinary urgency or urinary incontinence?

A. It could be a problem with the bladder, it could be a

problem with the prostrate.

Q. Did you look to any of those other issues when you first learned that he had urinary urgency or urinary incontinence?

A. No.

Q. Did you provide or recommend any test to determine the source?

A. No.

Q. No?

A. No.

Q. And also you note that Mr. Verdon wants to defer surgery for the time being?

A. That's correct.

Q. You note again that he's completed a course of supervised physical therapy and he's been doing exercises at home on his own, right?

A. Correct.

Q. And he's taking Norco as needed for pain, correct?

A. Correct.

Q. And the Norco that he's taking at this time seems to be effective and it's well tolerated, correct?

A. Yes.

Q. You mention though again in the plan that you prescribed a TENS unit for home use as well and you'll renew his prescription?

A. Right.
Q. Did he ultimately obtained that TENS unit?
A. It took about two years but he did get it, yes.
Q. When did he first start using the TENS unit?
A. Some time in 2013 I believe. I'm not sure. I think it was some time after August 2000.
Q. And did you see him after he began using the TENS unit?
A. Yes.
Q. And did he say to you that the TENS unit provided him relief from his pain?
A. I'm sorry. Can you repeat that?
Q. When you saw Mr. Verdon after he began to use the TENS unit, did he indicate to you that that provided him relief?
A. Some.
Q. Okay. You first prescribed it at what date? Was this that --
A. 2000.
Q. Okay. Do you know the date exactly when he first began to use it?
A. I'm not sure. It was prescribed in 211. It was re-prescribed 6/25/13 or 8/6/13. I think it was some time after the 8/6/13 that he actually got -- started using it.
Q. Each of the times you prescribed the TENS unit, did you discuss with Mr. Verdon what a TENS unit is?

A. More or less.

Q. Is it your practice when you sit down with a patient to discuss the TENS unit? As an example, you describe to them what you believe the type of relief it could provide to the patient?

A. I'm not sure of the discussion being that detailed but basically would be to the effect that I'm going to prescribe a stimulation unit to use at home similar to what you're getting in physical therapy. If you feel like it helps, you should use it.

Q. He chose not to?

A. No. He's been using it.

Q. No. I mean from the first time that you did until 2013, despite you speaking with him, did he choose not to do it?

A. No. He couldn't get authorization to get the actual unit.

Q. Okay. But you have no information as to what that process was, correct, other than what Mr. Verdon told you? He said I couldn't get authorization to use it?

A. I prescribed it. It's a physical unit. He has to get the unit to use it. He did not get -- the company that supplies the unit could not get permission to give it to him until August 2013.

Q. I mean could you describe it -- and what does it cost? What does a TENS unit cost?

A. This particular unit that I prescribed I think costs about a thousand dollars.

Q. And how long does it last? How long do you have that?

A. Once again generally about three to five years although the electrodes needs to be replaced more commonly.

Q. Okay. And the reason he didn't use it as far as you understand it is because it wasn't authorized for him to use it?

A. Because he didn't have it, he couldn't use it.

Q. It wasn't authorized so he didn't get it?

A. Right.

Q. Did you write note on his behalf to the person authorizing it as saying you got to give him this TENS unit?

A. I didn't write a note. I didn't tell anyone they got to do anything. I just wrote the prescription with the medical justification as to why he needed it.

Q. And each time he came back and you asked him do you have a TENS unit and he said I don't have it, will you re-prescribe it or did you just sort of let it go at that?

A. No, I re-prescribed.

Q. Each time you re-prescribed it he didn't get it and didn't use it because it wasn't authorized?

A. He didn't use it until he got it and he didn't get it until 2013.

Q. And basically each time he came back for those visits from 2011 you essentially said, well, continue with your home

exercise therapy, correct?

A. More or less, yes.

Q. Let's go, if we can. I want to keep moving along. You see him other times but let me ask you a little bit about April 13, 2012. Do you see that?

A. Yes.

Q. And you noted here the current RX -- am I reading that correctly -- the current RX is effective?

A. That's correct.

Q. That's the prescription you were giving him that's effective for helping him with his pain?

A. Yes. On that particular day, it was Norco.

Q. Again you prescribed continue home exercises?

A. Correct.

Q. June 2012, you see him. You see him August 10, 2012. You then see him October 19, 2012. January 18, 2013 is the first time that you recommended epidural injections?

A. I'm not sure it's the first time that we recommended it but it's certainly the first time that he specifically said that he doesn't want to do it.

Q. Well, in any of your notes prior to January 18, 2013, did you prescribe epidural injections for Verdon?

A. Did I prescribe it to him? No. I never -- at no time did I actually prescribe it to him. It's a discussion that we had in terms of his alternatives for treatment.

Q. And can you show me the note prior to January 18, 2013 where you discuss epidural injections with Mr. Verdon?

A. Doesn't specifically say epidural injections. It just says other treatment options.

Q. It doesn't say epidural injections?

A. It does not specifically say that term.

Q. So assuming this is the first time that there is a discussion and Mr. Verdon's action was I'm not doing it, he declined it?

A. I wouldn't say that's exactly his reaction but, yes, the sum and substance of course he did decline.

Q. And what epidural injection are you recommending on January 8, 2013?

A. The cervical and lumbar.

Q. Okay. And you said to Mr. Verdon in my medical opinion if I give you epidural injections in your cervical area, in your lumbar area that will provide relief to you. That's the purpose of those, correct?

A. No. That's not exactly the conversation that occurred. So the conversation is there are risks, benefits and alternatives to all different types of medical treatments. The epidural injections can give you, in his case, some temporary symptomatic relief for his neck and back pain although I don't think it would be curative, it wouldn't fix his problem. I don't think it would eliminate the need for the eventual surgery

but, yes, there is a reasonable likelihood that that would give him some symptomatic relief.

Q. Okay. Again, the next time you have a discussion of epidural injections is May 10, 2013 and again he declined that, correct?

A. I can't say for sure that that's the only time we had these discussions. These had been ongoing discussions but, yes, he did decline.

Q. I guess we'll move along, Dr. Hausknecht.

Are you able to point to me other than these two notes where the issue of epidural steroid injections is mentioned in your notes when you first started to see him until today?

A. 8/6/13 it says he's been indicated for surgery and injection but it says he is hesitant to proceed. 6/25/13, at this point in time Mr. Verdon declines any further surgery or interventional pain management. So it doesn't necessarily say epidural injections but when I talk about injections or interventional pain management that's what I'm referring to.

Q. But each of the times that the issue of epidural injections is discussed, one of the purposes of epidural injection is to relieve pain whether temporary or a long-term basis, correct?

A. Correct.

Q. And each time he turned it down?

A. That's correct.

Q. And each time you discussed the possibility of surgery to possibly relieve pain for him he turned it down?

A. Correct.

Q. In June 25, 2013 again you note he's experiencing urinary incontinence in connection with the erectile dysfunction, correct?

A. Yes.

Q. You didn't look into any other sources after that potential complaint, correct?

A. I had a pretty good understanding of what was causing it. I did not look at any other sources.

Q. You assumed it was related to the lumbar spine and you accepted that?

A. Yes.

Q. Again you noted in June 25, 2013 the kyphoscoliosis. Again this is on physical examination?

A. I'm sorry. I didn't hear the question.

Q. Yes. In that June 25, 2013 note, you note kyphoscoliosis and that's upon physical examination, correct?

A. Correct.

Q. Okay. Your note for August 6, 2013 under your impression you note aggravation of osteoarthritis, correct?

A. Correct.

Q. What is osteoarthritis?

A. Degenerative joint disease, wear and tear.

Q. Okay. Did you look into any issues regarding to Mr. Verdon in terms of any bone density studies?

A. No.

Q. What is bone density?

A. Bone density refers to the mineralization content of the bone.

Q. And if you have a poor -- I'm not sure of the exact term -- a poor or compromised bone density, what's the affect on a person's skeletal system?

A. It causes a condition known as osteoporosis, a weakening of the bones and this generally happens in postmenopausal women. It really has no relation to osteoarthritis.

Q. And you're not aware of any findings or any films or studies that mention any issue with osteoarthritis, correct?

A. I don't understand the question. The initial CAT scans and the hospital showed that he had some arthritis. That was there before but not loss of bone density. That's osteoporosis. That's another thing.

Q. You mentioned before that you did some NCV-EMG reports, correct?

A. Correct.

Q. Now, how many did you do in total?

A. A total of three. The first one was 12/22/09 and then repeat studies were performed 10/13/11 and then again on 8/6/13.

Q. And when you're doing this NCV-EMG study, what are you testing? Are you testing upper and lower extremity?

A. Yes.

Q. And were your studies that was done on October -- I'm sorry -- December 22, 2009 based upon all of those studies, it revealed chronic L5-S1 right radiculopathy, correct?

A. Correct.

Q. You also did a SSEP study?

A. Correct.

Q. And that study found a normal DV nerve, SSEP study correct?

A. As well as tibial nerve, yes.

Q. Normal median nerve what are you referring to?

A. I'm sorry?

Q. Normal median nerve refers to what?

A. It's technical. It's the nerve that was tested from the arm to the brain. The tibial would be from the calf to the brain.

Q. And those were normal?

A. Yes.

Q. You did one on October 13, 2011 again? Again chronic right L5-S1 radiculopathy, correct?

A. Correct.

Q. And a mild diffused polyneuropathy of the upper and lower extremities?

A. Correct.
Q. What does that mean?
A. Neuropathy refers to mild dysfunction of the nerves and the arms and legs.
Q. Normal median nerve study on that date?
A. The SSEP's were normal, yes.
Q. And again your third one is on June 25, 2013 again chronic right L5-S1 radiculopathy, correct?
A. Correct.
Q. And a diffused polyneuropathy?
A. Correct.
Q. Otherwise all the other findings were normal?
A. More or less.
Q. Normal median nerve study, SSEP study?
A. The SSEP's were normal.
Q. Also you had a normal tibial nerve study, correct?
A. The SSEP's, yes.
Q. Okay.
MR. GANNON: Your Honor, if I could have one moment?
Q. Dr. Hausknecht, you mentioned when I first started questioning you it's significant for you to look at as many different medical records from as many different medical providers as you can find, correct?
A. In general, the more information you have the better

off.

Q. Would it be significant to you if Mr. Verdon went to see another doctor denied urinary issues or erectile issues?

A. It's possible.

Q. And if you saw records in which he denied this in 2013, that would have been a significant finding for you should you want to consider it in giving your opinion, correct?

A. Well, if it would be inconsistent, I would certainly question him about it, sure.

Q. Okay.

MR. GANNON: Dr. Hausknecht, thank you very much.

THE COURT: Any follow up?

MR. McCRORIE: Yes, Your Honor. I hope to be quick.

THE COURT: Go ahead. It's just about one. If it's a couple of minutes, we'll do it.

MR. McCRORIE: I think it's a couple of minutes.

THE COURT: Okay. Go ahead.

REDIRECT EXAMINATION

BY MR. McCRORIE:

Q. Dr. Hausknecht, if you did see such a note and that doctor had the history of the accident completely wrong, would you consider that as to whether or not giving the note any weight? He saw another doctor once or twice and that doctor had the history of the accident?

A. I'll consider a lot of things. Bernard and I have pretty personal things to talk about so I feel comfortable discussing it with him. I don't know. Maybe he didn't feel comfortable discussing it with that doctor. I really don't know. You would have to ask about him it.

Q. Okay. Just so we're clear. You said you take work accidents and you take union coverage. Are you aware that his union coverage had been long gone since he stopped working?

MR. GANNON: Objection.

MR. McCRORIE: Subject to connection.

THE COURT: Sustained.

Q. Were you seeing him under union coverage or work accident related benefits?

MR. GANNON: Objection.

THE COURT: Overruled. Do you know?

A. Do I know? Yes, I know.

THE COURT: Okay.

Q. Which one was it?

A. I was seeing him through the Workers' Compensation guidelines.

Q. Although it was pointed out -- I don't have the machine to do it -- but on your first note -- I'll just read it to you. Although it was pointed out that you didn't prescribe any medication, you did actually write that he's trying to avoid taking medications although he had complaints of pain to you; is

that correct?

A. That's correct.

Q. Okay. I just wanted to -- each time -- the notes are actually up for the jury though. I'll just pick one, say, on March 2010. It said each time all you did in your plan was to ask him to follow up with physical therapy and continue with the medication. You also on each time ask him to follow up with you in six weeks or thereabout, correct, in the plan?

A. Yes.

Q. You also said to follow up with Dr. Merola, the spine surgeon he was seeing, and Dr. Touliopoulos, the shoulder surgeon; is that right?

A. Correct.

Q. In the plan, each time?

A. That's correct.

Q. And was it -- you mentioned to the jury that you were aware that spinal surgeries was being considered and offered to Mr. Verdon; is that right?

A. Yes.

Q. You heard about a spinal surgery but did you understand it to take all the metal that is in this back out and add to it?

MR. GANNON: Objection.

THE COURT: Sustained.

Q. In any event, when you say to the jury that he was

hesitant to proceed with the surgeon and hesitant to proceed with the epidural injections, what did you mean "hesitant?" Why was he hesitant?

MR. GANNON: Objection.

THE COURT: Well, you said he followed up. Why was he hesitant? I'll sustain it. What did you mean when you wrote "hesitant?"

A. He was concerned about the potential risks associated with the injections and with the surgery and he was concerned about the potential that it wouldn't help.

Q. And, finally, despite any of the positive findings meaning that there was nothing from the calf to the brain, there was indeed, you told the jury, findings on EMG from the back through the thigh and the back down to the toes, correct, on the EMG?

A. The EMG showed that there was nerve damage coming from the lower back.

MR. McCRORIE: Nothing further.

MR. GANNON: Nothing, Your Honor.

THE COURT: Okay. That's it, Doctor. You could step down.

THE WITNESS: Thank you, your Honor.

THE COURT: It's 1:02. So with that, we'll break for lunch for one hour. Please be back in one hour and we're going to go back to the other one.

Don't discuss the case. I probably could tell you if I ever forget to say don't discuss the case, just make believe I said don't discuss the case.

COURT OFFICER: All rise. Jury exiting.

(Jury exits courtroom.)

THE COURT: The objection to 28 is sustained.

MR. McCRORIE: Understood.

THE COURT: Okay.

(A luncheon recess was taken.)

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A F T E R N O O N S E S S I O N

(The trial continued.)

COURT OFFICER: All rise. Jury entering.

(Jury enters courtroom; the following occurred:)

THE COURT: Have a seat. We're going to continue with Dr. Merola. That's the doctor who testified last week. I think we have a relatively short period of time to go on his direct exam and then we'll take a short break and defense counsel will begin his cross examination.

MR. McCRORIE: May I continue, Your Honor?

THE COURT: Go ahead.

DIRECT EXAMINATION (CONTINUED)

BY MR. McCRORIE:

Q. Good afternoon, Dr. Merola.

A. Good afternoon.

Q. Dr. Merola, just to orient you when we left, we had already done just one opinion regarding a future surgery, future surgery you told the jury about. I want to pick up with that opinion and get into other opinions.

Can you tell the jury with a reasonable degree, as it was the other day. We'd ask that all of your opinions be within a reasonable degree of medical certainty, if they can't, you'll tell us in case we forget to ask.

Can you tell the jury with a reasonable degree of medical certainty whether or not that future surgery you are suggesting Mr. Verdon have and you said it was inevitable the other day, other day whether or not that will take away his lower back pain?

A. So the rationale for the future surgery is to prevent continued and progressive collapse of the lower portion of the spine because of the condition of posttraumatic, that is, after fracture kyphosis. So posttraumatic kyphosis, the purpose of future surgery is actually to stabilize and balance the spine itself from a structural point of view. That's not something that addresses pain so much. It's a more of a structural reconstruction.

Q. So within a reasonable degree of medical certainty, can you tell the jury whether or not you have an opinion that a man with Mr. Verdon's condition whether or not he will continue

to have pain in the future after the date of this trial to his low back and neck or mid back?

A. So with this type of major injury to the spine with multiple noncontiguous fractures --

Q. Doctor, I'm just going to stop you just for the record the way it has to be done. First, do you have an opinion?

A. Yes.

Q. Can you tell us the opinion and the basis for it?

Thank you, Doctor. Sorry to interrupt you.

A. So I guess I do have an opinion and the basis for my opinion is based on what we know about the structural integrity of the patient's spine and what's going to happen to it over the course of time.

Q. What is the opinion whether or not he will have pain or not into the future, for what period of time?

A. So the opinion is that these types of injuries to the spine with multiple noncontiguous fractures, having required the reconstruction that it's already undergone is producing and will continue to produce a chronic pain syndrome or long lasting pain.

Q. We haven't done this and, again, it may be obvious but we are at trial for this and we need to do it.

Taking the facts, as you knew them to be, the fact that Mr. Verdon fell from a height on Plaintiff's 14 from a height of anywhere from 10 to 15 feet, whatever it would be at

least a story, landed on his back just with regard to the spine injuries, the kyphotic deformity of fractures of the back that he had those as diagnosed in Bellevue and as diagnosed by yourself when you showed the jury the fractures to the T12, the T10 and the spinous process fractures the other day, do you have an opinion with a reasonable degree of medical certainty just, because it has to be on the record, as to the cause of those fractures?

A. Yes, I do.

Q. And could you tell the jury what that opinion is and what the basis is?

A. The cause of those fractures is the fall from the height producing fractures to the spine.

Q. Do you have an opinion within a reasonable degree of medical certainty as to the cause of the lumbar herniations? I'm just the holding 10A. You pointed out herniations at three levels in the lumbar region. Do you have an opinion as to the cause of those?

A. Yes, I do.

Q. And can you tell the jury the opinion and the basis of same?

A. So the opinion regarding the lumbar spine is based on the progressive collapse of the lumbar spine and a response to the posttraumatic kyphotic deformity from the fractures.

Q. And only because I'm going fast, Doctor, I wanted to

first -- we have to breakdown -- as to the cause of the -- was that the cause of the herniation?

A. Yes.

Q. And that's in the lower back. Do you have an opinion within a reasonable degree of medical certainty as to the cause of the -- I'm now holding up Plaintiff's 7A, the cervical herniations that you pointed out and circled for the jury the other day?

A. Yes.

Q. And can you please tell the jury your opinion and the cause of it. Please do it with a reasonable degree of certainly?

A. So my opinion based on a reasonable degree of medical certainty is that the herniations and impingements and injury to the neck were caused by the fall as well.

Q. And I don't know if it came in the answer last time but as regards to both the neck and the back you told the jury the day of what's called the progression or progressive breakdown.

Do you have an opinion within a reasonable degree of medical certainty as to what caused the progression or progressive breakdown of the cervical and lumbar spine?

A. Yes, I do.

Q. Please tell the jury that opinion and the basis for same?

A. My opinion and the basis regarding that opinion, once again, is sagittal or spinal imbalance as a consequence of the multiple fractures that have been sustained to the spine producing posttraumatic kyphotic deformity.

Q. And just so the record is complete as far as the cervical and lumbar, do you have an opinion within a reasonable degree of medical certainty as to the only MRI film we had of the thoracic, which I'll hold up Plaintiff's 11A as to the cause of the herniation you've circle in 11A, the thoracic MRI taken on June 29, 2013, do you have an opinion as to the cause of that herniation?

A. Yes, I do.

Q. Could you please tell the jury what your opinion is within a reasonable degree of medical certainty and state the basis for same?

A. That herniation is a consequence of the burst fracture of the T12 segment and the significant amount of trauma that was sustained to the spine with that type of major injury is responsible for that herniation as well.

Q. Without getting into the specifics of what might be needed, do you have an opinion within a reasonable degree of medical certainty as to whether or not Mr. Verdon should continue into the future past the date of this trial seeing an orthopedic spine surgeon on any type of basis?

A. Yes, I do.

Q. And what is that opinion and your basis for same?

A. So my opinion is that he should continue to see an orthopedic spine surgeon because he will come to require a revision surgery to stabilize the lower portion of the spine and treat the posttraumatic kyphotic deformity and that's based on what we know of from his diagnostic imaging studies and the sagittal imbalance that he's suffering from because of the deformity.

Q. Do you have an opinion within a reasonable degree of medical certainty as to when -- for what period of time -- I'm sorry -- should he see a orthopedic surgeon with some regularity?

A. He should see that orthopedic surgeon with some regularly essentially for the rest of his life.

Q. And when Mr. Verdon sees an orthopedic surgeon, do you have an opinion with a reasonable degree of medical certainty as to whether or not he should have future diagnostic studies to monitor his spine such as x-ray, MRI, CT scan?

A. Yes, I do.

Q. What is that opinion?

A. My opinion is that diagnostic studies would be required and indicated as time goes on to monitor the spine and its balance as well its integrity.

Q. With a reasonable degree of medical certainty, first, can you tell the jury with spine injury such as the one that Mr.

Verdon sustained in this accident, can you tell the jury five years post injury approximately where we are? What would be the purpose of physical therapy to the areas of the spine that were injured?

MR. GANNON: Objection.

Q. From an orthopedic standpoint?

MR. GANNON: Objection.

THE COURT: Overruled.

A. So the purpose of physical therapy five years after an injury is what we would call palliative, that is, to maintain as much mobility and function as possible and to try to decrease some pain and symptoms.

Q. With a reasonable degree of medical certainty when Mr. Verdon has this inevitable surgery you say he needs, do you have an opinion whether or not he will require post surgical physical therapy?

A. Yes, he will.

Q. What would be the purpose of post surgical physical therapy after such an operation as you told the jury about the other day?

A. So after he has a reconstruction of the spine whereby the spine is then attached or fused to the pelvis, that starts with acute physical therapy in the hospital basically getting him up mobilized and then it proceeds to physical therapy whereby he can be taught how to function because of the

accommodations that we would have to make because of loss of mobility that he would have combined with decreasing symptoms and maintaining flexibility of his other -- his arms and his legs, etc.

Q. And, finally, one or two questions, Doctor. Do you have an opinion with a reasonable degree of medical certainty as to whether or not Mr. Verdon whether he has the future surgery or not will have pain upon sitting or standing for periods of time?

MR. GANNON: Objection.

A. Yes.

THE COURT: Overruled.

Q. If you could just tell the jury why?

A. Yes, and that part of the chronic pain syndrome stemming from the original fractures -- once again, I hate to be repetitive -- but the posttraumatic deformity and the progressive collapse and impingements in the lumbar spine.

Q. And have each of your opinions today and the other day been within a reasonable degree of medical certainty?

A. Yes.

MR. McCRORIE: I have nothing further, Judge.

THE COURT: Okay. We'll take a break a little sooner than normal but we'll get set up for cross examination. We'll be back in a few minutes. Please do not discuss the case.

COURT OFFICER: All rise. Jury exiting.

(Jury exits courtroom.)

(A recess was taken.)

(Defendant's Exhibit C, Lenox Hill Radiology records, were marked for identification.)

MR. GANNON: Your Honor, we took the break so I could mark this.

Your Honor, we took a break because my understanding when we first started this trial, we went over the subpoenaed records that were in court, my understanding is that as long as they were certified and in court neither side was going to raise the issue with regard to their admissibility subject to redaction.

The MRI films have gone into evidence. Dr. Merola testified about them. They were not taken by Dr. Merola. They were taken by another facility including Lenox Hill. I've now asked to mark and put into evidence the corresponding MRI reports themselves and put them in evidence so that I could obviously question Dr. Merola about those reports the same way he was questioned about the films and I understand that the plaintiff has an objection to that.

MR. McCRORIE: The objection is -- the understanding we had was -- the MRI films are in evidence under 45 -- under the notice, proper notice of intention

and in addition to the proper notice of intention, it's been changed that if the defense reviews the films they are in by operation of law. The films themselves, the reports under Wagman and all of the other cases -- I mean this wasn't discussed that the reports were going in. I specifically don't want them in and this is way.

There's -- it could be any number of five, six different reading radiologists and the court -- the defense has a radiologist that could look at all the films, put them up and give his interpretation. A radiologist that reads four or 500 films a day puts them up and doesn't know any history of the patient, any complaints. It's a little different. That's why we don't allow the reports in. The treating doctor who reviewed the report himself and the report is -- the film is in evidence. I'm not saying he can't say did you look at this report? Does it refresh -- did you see it? Did you rely on it? But the report itself doesn't go to the jury. I'm not saying he can't question Dr. Merola on it but the report is not in evidence, the films are by 4532a. The hospital films and the hospital records and reports are in under the hospital record exception. But so I'm not -- I don't know if we're talking about the same thing. I don't think they should go into evidence.

THE COURT: I think you're talking the same

thing, two different opinions so far but -- the films went in. You gave the notice. You didn't -- they didn't object and so on.

MR. McCRORIE: But other than that, by operation of law, it's changed if they review the films.

THE COURT: Right. So generally speaking reports under Wagman it says don't go in evidence unless other things have happened with reports.

MR. McCRORIE: Because we have a radiologist --

THE COURT: You said he can ask the doctor. How much can he ask a doctor? He could say take a look at this, don't read it out loud. Does that change your opinion. I don't think that's what he's getting at.

MR. McCRORIE: Judge, the orthopedic records and all the doctors from Comp can't go in. These are doctors that aren't here that we can't question what they knew about at the time. The films themselves -- we each hired -- well, we have a treating. They hired an expert -- this is what my interpretation is. He could even ask that person do you agree with the interpretation of the original radiologist but to have the film in front -- the report is -- it's never allowed and I don't -- I thought his doctors is going to come in and talk about what he says is degenerative.

THE COURT: I don't doubt that he will but I'm

assuming there's something in that report that he wants to get before the jury that's, I would guess, not favorable to plaintiff's position or we wouldn't be having this conversation.

MR. GANNON: Exactly.

THE COURT: So under what theory do you get the report in?

MR. GANNON: Well, Your Honor, obviously my first theory it would have been for Mr. McCrorie after we discussed all the subpoenaed records and we had an understanding, and my fault for not putting those records -- I trusted him obviously. These are subpoenaed, they are in court and are going into evidence. He didn't say -- and we went through Lenox Hill reports, Bellevue reports, every report that's in here. We compared it, we compared the list. Now, we're saying no I don't want to do that.

Now, I understand what the legal argument he's making but my intention is to ask Dr. Merola whether I can show the jury or not whether he was aware of the following findings in these reports.

THE COURT: Right. That's what I was asking when you say he could ask him about it. He's going to want to ask him about it in such a way that the jury may never get the report up in the jury room.

MR. McCRORIE: I just want to respond because I disagree with Mr. Gannon. He didn't say I want to put these reports -- everything he just said is in because we got it in advance by operation of law. He's not allowing -- we did subpoena the comp records. He doesn't want the comp records. He just said everything we subpoenaed. That's not true.

THE COURT: He didn't say the report of the hospital doctors.

MR. McCRORIE: Because they come in any way. They're in. He can't -- what could he object to them coming in? They are subpoenaed with a certification. The MRI's, the actual -- the actual x-ray films that comes in by operation of law. Maybe it could have been a little clearer but I'm certainly not trying to trick him.

MR. GANNON: I didn't say that.

MR. McCRORIE: No, no, I know but I'm not being disingenuous either. I don't think the MRI reports should go into evidence just like the reports on any other doctor that's not coming here to say this is what my report is. Doctors whose office notes are in that's one thing. They are here, they testify, they could be cross examined. You could put them up on a screen. If he calls in Dr. Milbauer or any of the other doctors I could say did you know this? Did you know that he fell? Did you know that he had other

MRI's?

THE COURT: Rather than the suspense since the jury is not here, what exactly is in the report that you want to bring out?

MR. GANNON: Your Honor, it's loaded with preexisting degenerative conditions and other issues with the plaintiff that are clearly the causal reason for his pain in certain parts of his body.

MR. McCRORIE: Can't he just ask Dr. Merola does this condition -- is this causing him pain and then his doctor will go here it is. Here's the condition. Same thing whatever is in the report, here's the condition and this is what's causing him the pain and then it's up to the jury between the two experts that know all the information.

MR. GANNON: Your Honor --

MR. McCRORIE: I'm sorry.

MR. GANNON: I'll be very frank. What I'm going to ask Dr. Merola is are you aware of this finding in this report? No, I'm not. I never reviewed it. If I can't show it to the jury, that's what I intend to do. I intend to go through each finding and each MRI report asking him if he's aware of it. He's going to obviously probably say no and then he never -- then mark the report for identification and then get him to admit that he's never even looked at it. If it can't go to the jury at that

point, I understand the argument. I agree it's based upon our conversation but that's what I intend to do with this witness.

MR. McCRORIE: I think what all the doctor said, both of them so far, they said we reviewed our own MRI. I'm sure he looked at the report too but he said this is my interpretation.

THE COURT: Okay. So --

MR. McCRORIE: Going into evidence, the report, that's the issue I have, not using it to cross examine him somehow.

THE COURT: Well, I think at this point I think he sort of just said or hinted that's what he wanted to do. There's a disagreement as to what the agreement was and that's nobody's fault necessarily. It's something that's understandable considering what we're talking about. I think and here's what I'm -- either someone is dropping the end of their sentence or I'm not paying attention. So he seems to think it's okay. Let me ask him about this. I understand it won't go into evidence even if I don't agree and you're saying go ahead ask him about it as long as it doesn't go into evidence.

MR. McCRORIE: Yeah. It's not going to be up on the board.

THE COURT: What he's going to ask him exactly --

I'm going to avoid objections in the middle. So if he raises the question are you aware that the radiologist that took these pictures indicated that he has arthritis at this level for 20 years or whatever and he's going to say -- either he's going to say, yeah, I read it, I don't agree with it or he's going to say I didn't even read the report. You're okay with that as long as the jury doesn't get the report?

MR. McCRORIE: I'd rather not read from it and I'd rather it not go up on -- because it won't be in evidence but I think it could be simply there's an impression one, two, three, four, look at this date. Do you agree with the impression number two? Do you agree with that or do you agree that there's a Schmorl's node or whatever it is. I mean they've already said there's degeneration. He's going to agree I believe that there's degeneration. Just the report is going in.

THE COURT: Okay. It's sort of an interesting question. I think you're right on the evidentiary part of it in terms of the report under Wagman and a hundred thousand other cases since then. However, under these circumstances, having thought mistakenly for whatever reason that everything was going in, I'm going to split the baby. I'm not going to put it into evidence. I'm not going to let him put it on the screen because that's as

good as putting it in evidence because I'm going to let you ask the questions the way you phrased them.

MR. GANNON: Thank you, your Honor.

THE COURT: And I understand that's sort of letting the jury hear something but under these circumstances, I'll allow it.

MR. McCRORIE: Understood.

MR. GANNON: Bellevue is in though?

MR. McCRORIE: Bellevue is the hospital and anything that was part of it.

MR. GANNON: Thank you.

THE COURT: Okay. We can get him and the jury.

(Continued on the next page ...)

(Whereupon the sworn Jury entered the courtroom)

THE COURT: Okay, have a seat. Whenever you are ready.

MR. GANNON: Thank you.

CROSS EXAMINATION

BY MR. GANNON:

Q Doctor Merola, how are you, good to see you again?

A Good, thank you.

Q I'm going to try to make sure I get you done here. I know you accommodated us to come back again?

A Thank you.

Q You've been licensed as a doctor in New York since 1992 you said, correct?

A Yes.

Q I failed to do this again, please answer my questions yes or no, unless you are unable to and you will let me know that, okay?

A Yes.

Q You've been licensed as a doctor since 1992?

A Yes.

Q And did I hear you right, you perform two hundred to two hundred and thirty-five spinal surgeries a year?

A Yeah, depending upon the year, yes.

Q What did you perform in 2013?

A 2013 is probably in the neighborhood of two hundred

twenty-five or two hundred thirty.

Q How many working days are there in a year, do you know?

A Three hundred and sixty-five.

Q Working days, no Saturdays, no Sundays, no holidays, no religious holidays, 261, right?

A Yeah, but I work on holidays and weekends.

Q Now, you've been doing that, two hundred to two hundred thirty-five surgeries a year since, did you say 1996?

A That's when I started my private practice, yes.

Q How many is that altogether, up to today, how many surgeries have you done since 1996?

A So, I guess if you average two hundred and twenty-five times, since '96, perhaps somewhere in the neighborhood of about three thousand surgeries or so.

Q And what does a, say single level or, say two level spinal fusion surgery cost?

A A two-level, are we talking about a lumbar or cervical?

Q Let's say cervical?

A A two-level cervical surgery depending upon the types of implants that you use and depending upon the length of stay in the hospital, it could range somewhere in the neighborhood of total cost, hospital, everything, included?

Q Yes?

A Probably somewhere in the neighborhood of fifty, seventy-five thousand.

Q What about thoracic?

A Thoracics are usually more than one level. So, let's say you were only doing a two-level thoracic, anterior or posterior, because it makes a little bit of a difference.

Q Posterior?

A Posterior two-level thoracic, somewhere in the neighborhood of about a hundred thousand or so.

Q And how about lumbar?

A A two-level lumbar posterior with implants and the hospital stay, somewhere in the neighborhood of about a hundred.

Q Now, let's add additional levels of fusion. Is there a multiplier you would apply in terms of the costs, going up from a two-level fusion and higher, is there a multiplier for each level of fusion to the overall cost for the surgery?

A Yeah, in general, it depends upon what the implants are that you are using and how much more time is involved and whether or not you are using cages or not.

Q So, what's the multiplier, what's the range of the multiplier for the cost?

A For each additional level you can probably look at somewhere in the neighborhood about, reasonably speaking for the entire cost including the hospitalization and the implants, maybe somewhere in the neighborhood of about twenty thousand dollars or so.

Q Added on?

A Per level.
Q Per level?
A Depending upon the amount of implants and cages that you use and that kind of stuff.
Q Can you tell the Jury what your income last year was from doing surgeries?
A My income from surgery?
MR. MCCRORIE: Objection.
A From last year.
MR. MCCRORIE: Objection.
THE COURT: Overruled.
A I don't have that exact number with me.
Q You don't know?
A No.
Q You don't know what you made last year in terms of a range?
A No, my wife usually handles all the finances, she's the office manager. I need more time to worry about taking care of patients.
Q I appreciate that. It's never come up once in 2013 how much you made?
MR. MCCRORIE: From surgeries.
Q From surgeries?
A I make enough to send my kids to school and night clubs.

Q Dr. Merola, did you file tax returns?
A Yes, I did.
Q Did you sign the tax returns?
A Yes I did.
Q What was the number on that tax return?
A I don't know the exact number.
Q You signed it but you don't know?
A Yes.
MR. MCCRORIE: Objection.
Q How many cases have you testified in court on behalf of Sacks and Sacks since you started practicing?
A I don't know the exact number on that.
Q Would it surprise you if I told you that currently you are treating or examining at least fifty individuals on behalf of Sacks and Sacks law firm.
A I'd say that after all the years I've been in practice, I wouldn't be surprised by that number, no.
Q Probably higher, right?
A I don't know.
Q Maybe a hundred that you are currently treating?
A I don't know. I wouldn't, I would be lying if I told you an exact number.
Q Not less than fifty?
A Once again, I don't want to be pinned down to a number. I don't have the statistics.

Q It's not five?

A Once again, if I gave you a number, I'd be giving you statistics.

Q So, you are telling me if I asked you that you only, to agree with the statement that you only treated five Sacks and Sacks clients in the history of your practice, and I asked you to agree to that, that would be a lie, right, because it's more than that, obviously?

MR. MCCRORIE: Objection.

THE COURT: Overruled.

A If you asked me to agree to a specific number, yeah, it would be difficult for me to agree with a specific number, but I would say I have treated Sacks and Sacks patients.

Q I asked you, I think you agreed at least fifty that you are currently treating that are clients of the Sacks and Sacks law firm, would you agree to at least fifty, correct?

A I wouldn't be surprised by that number, if that is the number.

Q And it could be higher, you just don't know?

A Whatever the number is. If you know it, I'm happy to know it.

Q I'm telling you now, you are currently treating fifty people --

MR. MCCRORIE: Objection. How does he know?

MR. GANNON: I didn't finish.

THE COURT: I think the way you started it.

MR. GANNON: Fair enough.

Q Do you keep records of all the individuals that you are seeing?

A I have treatment records for all of my patients, yes.

Q And, who maintains your files in your offices?

A They are maintained in the office, we have an electronic record, so they are part of our electronic medical record.

Q How many times have you been to the Sacks and Sacks office?

A I've been to that office, that I can recall, probably about, I want to say maybe four or five times.

Q What was the purpose of going there. You are not providing treatment obviously to individuals in their law office, right?

MR. MCCRORIE: Objection.

A I've been asked to come in for some trial preparation.

THE COURT: You objected.

MR. MCCRORIE: That's fine, the answer he said trial prep.

Q All the time you came in was for trial prep?

A I'm sorry?

Q All the times that you've gone to the Sacks and Sacks office is for trial prep?

A Yes.
Q Doctor Merola, you are aware, aren't you, that as a licensed Doctor in New York, and I think you said you are on staff at Mount Sinai?
A Yes.
Q You have an obligation to reveal whether or not you have any financial interests in a company that manufactures or supplies devices that will be used for, in your surgery, correct?
A Yes.
Q And what's, is that the Sunshine Act?
A I think, yes, the Sunshine Act is part of where you have to disclose your relationship with medical device companies.
Q And obviously, the hospitals are doing that so there is no conflict of interest of you as a surgeon recommending certain pieces of hardware, screws, plates or rods that would impact your judgment in doing the surgery, correct?
A Correct.
Q Now, you've made such a disclosure, haven't you?
A Yes.
Q And do you have any financial interest in any company that manufactures any of the equipment you use in your spinal surgeries?
A I don't have any relationships with any of the

companies that manufacture equipment that I use, no.

Q Do you have any financial interests in any company that manufactures any equipment used, whether by you or another Doctor in spinal surgery?

MR. MCCRORIE: Objection.

THE COURT: Overruled.

A At one time I did have a financial interest in a company that had just started up called Alpha Tech and I advised my financial advisors to divest from Alpha Tech when the Sunshine rule came into effect.

Q What percentage of interest did you have invested in Alpha Tech?

A Extremely small.

Q Can you put a number on it. I know you can't do how much you made, can you put a number on that, what percentage?

MR. MCCRORIE: Objection.

THE COURT: Overruled.

A Extremely small because I don't have a lot of money to make for investments, with three kids at home and school.

Q I know you mentioned that about your kids already. But are you able to tell me the percentage of interests you had in Alpha Tech at the time you divested?

A Very, very small. I could jut tell you it was insignificant small, to the point I don't think they really cared about me.

Q What is insignificant?
A A minimum amount of money.
Q What is a minimum amount? Doctor, you can say it. Is it five percent, six percent?
A Much less than that, perhaps a point of a percentage.
Q And how long did you have an interest in Alpha Tech?
A I would say like a year or two, perhaps.
Q When did it start and when did it end?
A I don't know.
Q Well, when the Sunshine Act came out recently, do you know what year it came out?
A I don't recall the year.
Q Did you have an interest in Alpha Tech when you joined Mount Sinai?
A No.
Q Did you have an interest in Alpha Tech when you were with St. Francis hospital?
A St. Francis.
Q The hospital that closed down?
MR. MCCRORIE: St. Vincent's.
A St. Vincent's Hospital. I've been at St. Vincent's Hospital for a long time.
Q During the entire time that you had an affiliation with St. Vincent's Hospital, during any of that time did you have a financial interest in Alpha Tech?

A I may have because I was at St. Vincent's from when I finished school.

Q Did you disclose that to St. Vincent's when you were there?

A I don't know if St. Vincent's asked, if they did I would have.

Q Do you disclose to St. Vincent's --

A I don't recall if they asked, I don't recall when the Sunshine Act came in.

Q I appreciate that. Whether or not they asked, did you go to St. Vincent's, you were on staff at St. Vincent's?

A Up until they closed, yes.

Q Did you ever go to St. Vincent's when you were on staff, whether they asked or not, and say by the way, just so you know, I have a financial interest in Alpha Tech?

MR. MCCRORIE: Objection, asked and answered.

THE COURT: Overruled.

Q Did you ever do that?

A I honestly don't recall because it was such a long time ago. If they did, I would have told them, yes.

Q You don't know if you did or didn't?

A No.

Q What did Alpha Tech make?

A Alpha Tech made rods, screws, anterior implants.

Q And the Alpha Tech implants and rods and screws, were

those used at St. Vincent's Hospital by any surgeon at St. Vincent's Hospital?

A Not that I'm aware of, no.

Q Did you ever use them?

A No.

Q Did you ever, try to find the right phrase, were you ever a consultant to any company that manufactured equipment or medical devices used in spinal surgery?

MR. MCCRORIE: Objection.

THE COURT: Overruled.

A Yes, I had consulted in the past.

Q And who did you consult with?

A I consulted with, I was a consultant, I believe Sofamor Danek bought out by a company called Medtronics. And another company called Depuy, bought out by Johnson and Johnson.

Q And when you say you consulted, what did you do?

A Well, because I'm, because I teach and I do research in spinal surgery, as a consultant, what we did, myself and the other physicians that were involved with implants, we would test implants, review implants for the companies and make recommendations on making those implants better for patients.

Q Was any of that consulting and recommendation done before any of the implants went out to the market?

A Was there consulting done before implants went to market? Most of the consulting was done on post marketed FDA

approved implants.

Q So, when you say most, are you saying that you did consult on some occasions for medical devices used in spinal surgery before they went on the market?

MR. MCCRORIE: Objection.

THE COURT: Overruled.

A It's hard to say, because when you are doing research, you test a wide variety of implants so you don't always know whether or not a particular implants is pre or post market but the research that we did was always done on cadavers and something called an MTS machine which is a machine that tests metal fatigue on implants. So, we never tested any of the implants on patients, or did we implant them as part of any of the research.

Q Well, you wouldn't test it on a patient, obviously it's done on a cadaver?

A Correct.

Q You want to see if it will work or not?

A There are a lot of different things you look for when you are testing.

Q What did you receive in terms of payment for your consulting?

A I never received any payment directly. All of the, anything that was either given to myself or my staff or my team was just in terms of providing the implants and covering the

cost of the actual testing itself. I never received a salary or anything.

Q I understand that, but there was a certain amount of money paid by some of these companies to, was it university orthopedics at the time?

A No.

Q Was it paid to you?

A No.

Q Who was it paid to?

A Either St. Vincent's Hospital, or I was doing the research through Downstate, Downstate Medical Center or what have you.

Q I understand. You testified earlier that you are board certified in orthopedic surgery, correct?

A Yes.

Q And you have a subspecialty in spinal reconstruction, correct?

A Yes.

Q You are not board certified in radiology?

A Correct.

Q And you are not board certified in neuroradiology?

A Correct.

Q How long have you been at Mount Sinai?

A I went to Mount Sinai when St. Vincent's closed, so right after St. Vincent's closed, I acquired privileges there.

Q I'm sorry, Doctor, when was that, that you joined Mount Sinai, was it 2009?

A May have been 2009. I want to say I've been at Mount Sinai for about three or four years now.

Q And you understand having been at Mount Sinai for three or four years now, they have a fairly extensive radiology department, don't they?

A Yes.

Q And in fact, the way medicine is developed these days, many doctors in certain fields, there is usually a companion radiology field, correct? Do you know what I mean by that?

A No.

Q In other words, within Mount Sinai, you are aware that there is a radiology specialist in chest and cardiovascular imaging?

A Okay, yes.

Q That's what I'm getting at?

A Yes.

Q There is also a department of CT dash MRI, of the body?

A Yes.

Q There is even a radiology department for gastrointestinal issues, correct?

A Yes.

Q There is a radiology department for head and neck, correct?

A Yes.
Q They have at Mount Sinai a radiology department for musculo-skeletal as well, correct?
A Yes.
Q There is also, obviously a neuroradiology department, correct?
A Yes.
Q There is a nuclear medicine slash PET Scan department, correct?
A Yes.
Q Pediatric radiology, correct?
A Yes.
Q Vascular interventional radiology, correct?
A Yes.
Q Ultrasound, correct?
A Yes.
Q And radiology informatics, right?
A Yes.
Q And within each of these departments there are doctors who are board certified as radiologists and perhaps with a subspecialty, say in neuroradiology, correct?
A Yes.
Q And you testified that when you do your surgeries, multi-level fusions, you never have a radiologist in the operating room with you, correct?

A Correct.
Q And in fact you don't even consult with radiologists when you are examining, say someone like Mr. Verdon, correct?
A Correct.
Q You said, I read all my own films?
A Yes.
Q Right. So, it's not, is it important to you to go out and seek a second opinion from another radiologist, from a radiologist who may have a subspecialty in the area that you practice in?
A No.
Q It's not important to you at all?
A No.
Q It's only your opinion that you rely upon?
A Well, I read the film myself, yes. And, when I'm comfortable with my decision, I proceed with what I think is best for the patient.
Q So, your testimony is that when you are suggesting this traumatic surgery for Mr. Verdon, it's based upon only your reading of the MRI and CAT scan and X-rays. You didn't go to anyone else and say, I'm finding this, do you agree with me. You not do that, did you?
A No.
Q And you don't plan on doing that, do you?
A Correct.

Q In fact, when Mr. Verdon first came to you, you did look at the MRIs and X-rays that had been taken before, correct?
A Yes.
Q You looked at them from Bellevue Hospital, where he had an operation done, correct?
A Yes.
Q And you also looked at them for Lenox Hill, correct?
A Lenox Hill radiology.
Q Lenox Hill radiology?
A Yes.
Q Okay. Now, Doctor, I just want to switch gears for one second. And I want to talk, just generally, because I knew you did it already in front of the Jury, generally the anatomy of a spine. Now, you did it already, I'm not going to cover things that you did before, but, and we have a model here. And obviously, it really is, this is a full scale model of a spine, correct?
A Yes.
Q So, when you, if I could ask you to hold this, if you don't mind?
A Sure.
MR. GANNON: And this is Plaintiff's Exhibit 17. I'm going to hand it up to you.
(Whereupon, that exhibit is handed to the witness)

Q So, when Mr. Verdon was operated on and they did the fusion on August 11th, 2009, can you point out for the Jury which vertebrae were fused?

A Sure. So, if we count up from the lumbar spine, I'll go up to L3. L3 is the last vertebrae that was fused, that was the bottom portion of the construct and then they went up to T-8. So, T-8 is this vertebra where my index finger is. And then the bottom one is where my other index finger is.

Q I'm going to try not have you hold that the whole time. That's okay, I'll take it back from you. Thank you. But the spine, Doctor, let me ask you, you mentioned during your direct that the typical human spine has a cervical lordosis?

A Yes.

Q Correct, which then moves into a thoracic kyphosis?

A Correct.

Q Correct and then a lumbar lordosis?

A Yes.

Q So, and you talked about this being the gentle S?

A Yes.

Q And you mentioned how the spine in the human body is essentially, depending upon what's going on in the spine, sort of readjusting in order for the head to stay above the hips, so we can be balanced correct?

A Yes.

Q And you mentioned that's what kind of distinguishes us

from other animals because we can stand up and stay balanced, correct?

A Yes.

Q So, if I were to give you an example of an individual who came to you and already had an exaggerated cervical lordosis, right, that means it's, it's more pronounced than normal, typically what the spine would then do is eventually adjust itself in a way that the head stayed above the hips, correct?

A Yes.

Q It's compensated for itself. So, if someone had a pre-existing cervical lordosis, it would not surprise you to see some other changes in the spine to account for that cervical lordosis, correct?

A Yes.

Q And same if there is a lumbar lordosis and it's an exaggerated lordosis, there is a change kyphotically in the thoracic region and probably cervical, correct?

A Yes.

Q And that can happen, someone could have a cervical thoracic or lumbar changes for degenerative reasons, correct?

A You can change your lordosis or your kyphosis for degenerative issues, yes.

Q For example, if a person presented to you and they had, I mean, you said skeletal development for a male sort of peeks

at sixteen years old, right?

A More or less, yes.

Q Maturity wise, no, but by skeleton, yes, and women, it's younger, thirteen, fourteen?

A Yes.

Q So, really from that date forward, if there is any type of degenerative change in the cervix, the cervical region, there would also then be ultimately corresponding changes in the thoracic region and the lumbar region to maintain that balance?

A Yes, there can be.

Q There can be, okay. And you are aware that Mr. Verdon, I think in August is going to be sixty-five, right, do you know that?

A Yes.

Q And at the time of his injury he was one week away from turning sixty, correct?

A Yes.

Q And, you are aware, are you not, that Mr. Verdon has worked as a carpenter since 1965, did you know that?

A Yes.

Q And where did you learn that information from?

A Having spoken to him for amount of time that I had seen him.

Q And I know he'll probably testify himself, but Mr. McCrorie mentioned that he was a carpenter in Ireland in 1965,

came to the United States in 1985, you are aware of that?

A Yes.

Q So, that's twenty years of being a carpenter and it would not surprise you given that type of activity, that there could be degenerative changes even just because you are a carpenter for twenty years, correct?

A You can have degenerative changes from twenty years worth of work, yes.

Q And you can also have degenerative changes just because you are no longer sixteen, but you are fifty, correct?

A Yes.

Q In fact, if I'm fifty-two, I wouldn't be surprised if you look at my back, and I had degenerative changes somewhere in my spine, correct?

A Unfortunately I think we both do, yes.

Q I can feel it. And probably changes in my disk space, yes?

A Yes.

Q Probably changes in my disks themselves?

A Yes.

Q Drying out, right?

A Yes.

Q Okay. Now, in terms of the different regions, we mentioned the cervical region where there is obviously a certain amount of flexibility and mobility, correct?

A Yes.
Q Naturally there is that, and also in the lumbar region there is flexibility as well?
A Yes.
Q I don't know if you agree with the phrase, there is much less flexibility in the thoracic region of a person's spine, correct?
A Yes.
Q And the reason is, you are not really bending over from the mid region, you bend from your back or you bend from your neck?
A And your hips.
Q And your hips. And when you do testing of Mr. Verdon on his thoracic spine, the test is the movement in his hips you are talking about, not the movement per se in his spine, thoracic, in thoracic region, correct?
A Well, when you are measuring spinal motion, you are looking at basically, the pelvis is kept level, so you are not looking for that motion, you are looking at actual spinal motion. You are looking at the way the spine moves as a whole.
Q Right, but my point is, when you are measuring someone's mobility and whether it's positive or negative or changed, naturally, people have much more mobility in their neck. When you function on a daily basis, it's really your neck lumbar, hips, it's not so much your thoracic region, correct,

that's relatively stable?
A In terms of its overall range of motion, thoracic region has the most limited range of motion, yes.
Q Now, Doctor, you have your file with you?
A Yes.
Q Do you have in your file, the Bellevue records or any records from Bellevue?
A I do, yes.
Q I'm going to ask you, I have to show, you are aware when Mr. Verdon was admitted into the hospital, he reported that he hit his head and he hit his mid back, correct?
A Let's see, instead of my going through the entire record, is it possible to show it to me.
Q Sure. We'll find it. If I could approach. Patient reports he hit his head and mid back on the scaffolding below, correct?
A Yes.
Q He reports mid back pain and head pain, correct?
A Yes.
Q He denies any numbness or tingling of his extremities, correct?
A Yes.
Q He denies inability in moving his extremities, correct?
A Yes.
Q And he denies incontinence of bowel or bladder?

A Yes.
Q And they ask about the bowel and bladder, that can ultimately impact the spinal cord?
A Yes.
MR. MCCRORIE: Just because the record is two weeks.
MR. GANNON: Admission date August 11th, 2009.
MR. MCCRORIE: Is that the date of the record as well.
MR. GANNON: Yes. Yes. Handwritten.
MR. MCCRORIE: Thank you.
Q And Doctor Merola, you had an exhibit here where you did your Metivisual of the impact. So, we have in as Plaintiff's Exhibit 19 and you took the Jury through this?
MR. GANNON: I apologize.
Q What is this part of the spine again?
A The spinous process.
Q And you mentioned that you noticed some impact in the thoracic region, based upon the films that you reviewed, correct?
A Yes.
Q There was no impact that you noted in the cervical region?
A There were no fractures in the cervical spine.
Q And there were no fractures in the lumbar region,

correct?

A Correct.

Q And also in the hospital, they don't report any bruising to the cervical region, correct?

A As far as I know.

Q And no bruising to the lumbar region, correct?

A Yes.

Q Now, when he entered the hospital, you testified that they appropriately took X-rays, CAT scans, MRIs, during his admission, correct?

A Yes.

Q And if we could put up the reports of the head CAT scan from August 11th, 2009.

(Whereupon, that was displayed on the monitor)

Q Doctor, do you have that report in your file?

A Let me see.

Q Doctor, if you don't have it, I'll come forward?

A I have non-contrast head CT.

Q Head CT and the date and time of that is 7:49?

A Let's see. August 11, August, 2009.

Q Yes and the time is 0749, you see that, right next to the date?

A Yes.

Q So, that's the time that this was taken in the hospital, correct?

A Yes.
Q And it's a head CAT scan, you see that?
A Yes.
Q And you see that the findings there and we have it up for the Jury so they can see it as well, no intracranial mass effect, contusions or hemorrhage is demonstrated correct?
A Yes.
Q The gray white matter differentiation is normal, correct?
A Yes.
Q No abnormal extra axial collection is visualized, correct?
A Yes.
Q The orbits of his eyes are normal, you see that?
A Yes.
Q There is mild soft tissue swelling at the posterior vertex, correct?
A Yes.
Q There is no evidence of intracranial hemorrhage or parenchymal contusion correct?
A Yes.
Q There is mention though of a right basal ganglia, age indeterminate, lacunar infarct, what is that?
A Lacunar infarcts, versus dilated perivascular space.
Q What is that?

A Lacunar are a portion of the brain located deep within the mid brain area, and it's a section of your brain where some of your motor fibers are located, a sub-anatomical structure of the brain.

Q That' an abnormal finding?

A Non-specific eight millimeter ovoid hypodensity.

Q Yes?

A They, don't they don't read it. They give it two differentials as a lacunar infarct and dilated perivascular space.

Q But they can't determine how long it's been there?

A Correct.

Q When you say give two different differentials, is it common practice for a doctor, when a patient presents to them with a complaint, not to take the answer of the Plaintiff but to look for differential issues, do a differential diagnosis?

A Generally you do a differential diagnosis in your head and then you come up with the diagnosis based upon, for lack of a better term, a preponderance of the evidence in front of you, for that particular patient. If you, if you are between the horns of a dilemma in terms of what the actual diagnosis is, then you may say, these are possibilities.

Q So, you could list the possibilities with the differential diagnosis or seek another opinion, correct?

A Well, actually, those are not mutually exclusive. I

mean, if you can come up with a diagnosis, you give a diagnosis. Before you come up with any diagnosis though, you run through differentials in your head.

Q Right?

A If you are unsure of what the actual diagnosis itself is, then you would give several possibilities and just list the differential.

Q I see, so if you as a doctor have several different possibilities for a condition that a plaintiff, that a patient presents to you, you would typically list the different differential diagnoses that you are considering, correct?

A Well, I think a good example is what they are doing here because they can't call it based on what they are seeing, they are saying these are two possibilities of what I'm looking at.

Q Let's put this one aside. Any complaint where someone comes in to you as a treating Doctor and you have differential diagnoses, meaning it could be caused by different things, you typically would list those different things in your report?

A If you can't make the, if you are unsure about what the diagnosis is, then you would say, one possibility is this, and another possibility is this other thing.

Q I think we agree with each other but what I'm saying is, if do you that, if a doctor in the future is going to look at your record, you want to have in there, the different

possibilities that are the basis of the differential diagnosis, correct, if you haven't decided yourself at that point?

A After you've listed the two potential diagnoses, the differential list is generally, I mean it's generally pretty standard, you know what I mean. So, the other Doctor, you don't have to put the differential in, for the other Doctor to look at it, because hopefully they went to medical school and they know what the differential is for your diagnosis.

Q Now, the next, I want to ask you to look at is the lumbar spine X-ray. It's also August 11th, 2009. This is taken at 8:41 that same morning of the incident.

A Let's see. I have the thoracic. I have the lumbar.

Q You have the lumbar?

A Yes. 8:41. 11 August, 2009.

Q Again, this is another X-ray taken at Bellevue Hospital upon his admission?

A Yes.

Q Before surgery?

A Correct.

Q And the findings there are the, for the lumbar spine, the vertebral alignment is normal, correct?

A Yes.

Q There is a moderate wedged compression fracture of the T-12 vertebral body, correct?

A Yes.

Q The remainder of the visualized thoracic and lumbar vertebral bodies are preserved, correct?
A Yes.
Q That means that they are in place, correct?
A Yes.
Q No damage to them?
A They are not fractured, correct.
Q And then it notes mild multi-level degenerative changes of the thoracic and lumbar spine are seen with osteophyte formation, you see that?
A Yes.
Q Osteophyte is a degenerative condition, correct?
A Yes.
Q So here, they are noting degenerative changes in the thoracic region, correct, where there is injury, and in the lumbar spine, they see that, correct?
A Yes.
Q The impression is a moderate T-12 vertebral wedge compression deformity, mild degenerative changes, correct?
A Yes.
Q Let's now go, Doctor, to the cervical spine, is a CAT scan, August 11th, 2009. 1936. Do you have that?
A Yes, I do.
Q So that is 7:36 p.m., correct?
A Yes.

Q So, this again is before his surgery was performed?
A Yes.
Q Correct. And again, the findings, now this is the cervical spine CT, and it indicates there is an exaggeration of normal cervical lordosis, do you see that?
A Yes.
Q Indicating that upon admission, they were able to find an existing cervical lordosis, exaggerated, in that part of his body, correct?
A Yes.
Q It indicates against the cervical spine, there is no, and I may butcher this word, prevertebral soft tissue swelling, did I get that right?
A Yes.
Q What is that?
A That means that there is no, prevertebral soft tissue is the soft tissue in the front of the vertebral bodies in the cervical spine, and it means that those soft tissues are not swollen, so there is no evidence of any swelling within those tissues that would typically occur, if you were to have a cervical fracture.
Q Or would he have that as well if there is any kind of impact to the front of his throat, something showing there?
A No, because not, if you had an impact to the front of the throat, you wouldn't, but if you had a fracture in the

cervical body, you would.

Q And what is paraspinal?

A Paraspinal means adjacent to the spine.

Q And again, that says the evaluation of the paraspinal soft tissues is normal?

A Yes.

Q What is the paraspinal soft tissues?

A Those are the muscles and the tissues that attach themselves to the cervical spine.

Q So, also an indication of no trauma, correct?

A Let's see. What line is that?

Q It's under findings, it's the last sentence of the second paragraph. Evaluation of the paraspinal soft tissues is normal?

A Evaluation, yes.

Q Again, notes minimal degenerative changes at C2/C3. Correct?

A Yes.

Q And they are also noting at this time, posterior end plate scleroses and minimal right neuroforaminal narrowing at this level. Correct?

A Yes.

Q That's an indication of the pre-existing condition in this part of the spine, correct?

MR. MCCRORIE: Objection.

THE COURT: Overruled.

A At C2/C3, yes.

Q Okay. Doctor, would you take a look at thoracic spine CT, August 11, 2009, this one is at 1440, the time, do you have that?

A Yes.

Q This also, this actually is not the report, but this is one of the films you put up before the Jury that was Plaintiff's 2A, and C. That series of CT's, correct?

A Yes.

Q And you commented on those films for the Jury, correct?

A Yes.

Q And you note, Doctor, in this report, they have an indication of there is diffuse mild osteopenia, correct?

A Yes.

Q What is osteopenia?

A Osteopenia, it's an adjective to describe the appearance of the density of the vertebral bodies. So, it's a descriptive term regarding the appearance of the vertebral bodies on CT scan.

Q But an osteopenia is not a normal finding, correct?

A Osteopenia means that relative, relative to the quote unquote normal density that you would see on a bone, it appears as though it has less, a less intense signal on the CAT scan.

Q Less dense, right?

A Yes.
Q That means, that's also a product of aging, isn't it?
A Yes, it can be.
Q Okay. And it also means, paracentral disc ridge complex at T12-L1. That's also a definitive condition?
A The ridge portion of it can be degenerative. The ridge portion of it would be a osteophyte.
Q Calcification is noted. I'll skip that one, Doctor. Now, when it said diffuse mild osteopenia, diffuse means throughout, right?
A Yes.
Q So, this means on this thoracic film or CAT scan, when they say diffuse mild osteopenia means Mr. Verdon on August 11, 2009, already had diffuse osteopenia throughout his thoracic spine, correct?
A It means that what the description that the radiologist is giving us regarding what he sees on those bones, yes.
Q Let's go to the lumbar CAT scan, August 11, 2009. This one is at 1936.
MR. MCCRORIE: Lumbar, Chris.
MR. GANNON: Lumbar spine, yes, CT.
Q Taken at 1936? 7:36. Do you have that?
A Yes, I do.
Q This one, they mentioned the diverse fracture. They talk about posterior mild retropulsion, correct?

A Yes.
Q There is no additional fractures in the lumbar spine, correct?
A Yes.
Q They do note however that there is mild to moderate multi-level degenerative discogenic disease of the lumbar spine?
MR. MCCRORIE: There is no additional fractures seen, not that there's none, in the other one.
MR. GANNON: Did I misread that?
MR. MCCRORIE: It says none seen because you just said there were none, because here they were all noted.
MR. GANNON: You are right.
Q It said no additional fractures are seen, correct?
A Yes.
Q Okay. But they do have a mild to moderate multi-level degenerative discogenic disease of the lumbar spine, that's noted correct?
A Yes.
Q Also, with osteophytes, correct?
A Yes.
Q They've got multi-level degenerative end plate changes?
A Yes.
Q Multi-level circumferential disc bulges in the lumbar spine, correct?
A Yes.

Q Again, this is degenerative in nature, so it's taking place over time, so at this point, he has disc bulges correct?

A It's hard to say what's happening with the disc bulges.

Q Let me stop you. It says, circumferential disc bulge, that is a bulge, what does that mean, circumferential?

A Circumferential means it's going around the entire disc.

Q Right and they note this at L1/L2, L2/L3, L3/L4, correct?

A Yes.

Q And there is anterior disc ridge complex at L3/L4?

A Yes.

Q There is no significant canal or neuroforaminal stenosis, correct?

A Yes.

Q The lumbar spine CAT scan continues. And, one impression is T-12 burst fracture, correct?

A Yes.

Q With no additional fractures, and mild to moderate degenerative discogenic disease to the lumbar spine, correct?

A Yes.

Q Now, his surgery was on what date, Doctor Merola?

A Let's see. Soon after his admission. After these studies were done.

Q The 12th, Mr. McCrorie just told me August 12?

A Yes.
Q They do a thoracic spine CAT scan on August 13, after the surgery, do you have that in front of you?
A Yes.
Q 1610. They note he's post surgery correct?
A Yes.
Q They do this because they are trying to check out the surgery, in terms of, and what's in place in the spine, correct?
A Yes.
Q The hardware is intact, correct?
A Yes.
Q And, there is an issue, they talk about the left transpedicular, screw, minimally approaches on the left lateral recess without contacting the cord, correct?
A Yes.
Q The post reduction alignment is anatomic. Which means, when they sort of corrected his spine, they put in the rods that the alignment is anatomically correct?
A Yes.
Q There is mild to central canal stenosis, at T-12?
A Yes.
Q There is stenosis at T-12/L1, correct?
A Yes.
Q And again, though they make mention now of the disc ridge complex which is unchanged, correct?

A Yes.
Q And, they are now noting or they note here, mild central canal stenosis of L4/L5 secondary to the disc bulge we talked about, correct?
A Yes.
Q And there is no evidence of any type of post-operative complication, correct?
A Correct.
Q Meaning based upon this study, the reading of this is that the surgery was successful, he's anatomically correct, the hardware is in place and there were no issues at that time, correct?
A But he does have a pleural effusion. They didn't bring that up as a complication, but that's a consequence of the surgery.
Q Which resolved?
A Correct.
Q His foot, there is also an X-ray of his foot taken on September 1st, 2009. Do you have that?
A I do, yes. September 1, 2009, left foot.
Q Taken 11:53, again post surgery, X-ray of the foot?
A Yes.
Q And they obviously take an X-ray, he had a fall, they want to see if there are any complications there, correct?
A Yes, there was a complaint about the foot, and they

wanted to look at it.

Q And in this X-ray of his foot they also note degenerative changes at the Hallux and sesamoid complex, correct?

A Yes.

Q Suspected hammer toe deformities, correct?

A Yes.

Q That's also a condition that develops over time?

A Hammer toes are kind of a strange thing, you can actually have congenital hammer toes as well.

Q You can have congenital hammer toes?

A Yes.

Q And there is a notation of some joint arthrosis in the left foot, correct?

A Yes.

Q What's arthrosis?

A Arthrosis refers to, it's descriptive term referring to a joint displaying some degenerative changes.

Q Displaying some?

A Degenerative change.

Q So, Mr. Verdon at this time is also having degenerative changes in his foot?

A Yes.

Q Now, Doctor, if you could pull out the operative report, the operation of August 12th, 2009.

A I can't find the operative report.
Q Are you able to find it.
MR. GANNON: Can I approach, your Honor, if I can?
THE COURT: Go ahead.
Q This is part of Plaintiff's exhibit 1, this is part of the operative report. Can you tell the Jury who the physician is who did this surgery?
A Sure. The attending surgeon is Doctor Anthony Frampong.
Q You've never spoken to Doctor Frampong about Mr. Verdon?
A No.
Q You never consulted with Dr. Frampong about the surgery that you are suggesting to him?
A No.
Q You never spoke to Doctor Frampong about the actual surgery itself, correct?
A Correct.
Q In fact, the Metivisual where you had a diagram of the surgery was based upon your reading of the operative report?
A Yes.
Q And your understanding of how these surgeries are done?
A Correct.
Q It notes in the operative report that upon admission to

the emergency room, he was neurologically intact, correct?

A Yes.

Q They also note from this view, of the T-12 vertebral body, appeared to be intact, correct?

A Yeah, that's, it's hard to know what he means there, there is a little contradiction there.

Q Fair enough. You understand that an operative report, this is actually a report done, maybe dictated contemporaneously with the surgery, correct?

A It was, yes.

Q And the findings in this report are exactly what Doctor Frampong was actually seeing when he was doing this, correct?

A Yes, this was actually dictated by another physician, Doctor Moshell, but this is a report of the operation that was done, yes.

Q So, Mr. Doctor Moshell would be --

A A resident.

Q A resident dictating what he's observing and Doctor Frampong is observing when he performed the surgery?

A Yes.

Q Upon observation, the T-12 vertebral body appeared to be intact, correct?

A Yes.

Q And there was no retropulsed bone?

A Yes.

Q Correct. But there was were fractures to it, meaning the T-12, correct?
A Yes.
Q Which were well aligned, right?
A Yes.
Q Dr. Merola, after the surgery, the T-12 burst fracture resolved, correct?
A After the surgery, T-12 burst fracture was stabilized.
Q Let me do it another way. The purpose of the surgery is to stabilize that part of the thoracic spine?
A Correct.
Q And then stabilize the burst fracture?
A Yes.
Q So, there is no further treatment to the T-12 burst fracture per se after the surgery, correct?
A Yes.
Q Meaning, that there are no elements of the bone that are impacting the spinal canal or any other part of Mr. Verdon to cause him pain, correct?
A To cause neurological compression.
Q Right, which would lead to pain?
A Which can lead to neurological pain, depending upon the amount of compression.
Q But the point is that they looked at this, they did the surgery, they stabilized it, there is no more incident or issue

or T-12 burst fracture itself, correct?
A Right.
Q It's stabilized?
A Correct.
Q Now, I'll come forward with it also, mentions the epidural bleeding that you talked about, correct?
A Yes.
Q And there, it was from underneath the alignment of the fractures, correct?
A Yes.
Q And that was easily stopped by the surgeon, correct?
A Yes.
Q Yes?
A Yes.
Q All the screws went in smoothly?
A Yes.
Q Correct. The screw positions were verified with fluoroscope, did I say that, right, close?
A Correct.
Q Then the custom shaped rod was placed into the screw heads which were then secured. You mentioned that with the Jury before, correct?
A Yes.
Q And it says, the patient's kyphotic deformity was corrected by compressing to the rod posteriorly and locking the

rod in place, correct?

A Yes.

MR. GANNON: Your Honor, we could break if you want to. Just because I'm going to go into another area.

THE COURT: Let's take five quick minutes, just to stretch, get a drink and then we'll finish up.

(Whereupon, a recess was taken in this matter, and after the recess, the following took place in open court, with the Court and all parties being present)

(Continued next page)

COURT OFFICER: All rise. Jury entering.

(Jury enters courtroom; the following occurred:)

THE COURT: Have a seat.

Q. Dr. Merola, Mr. McCrorie questioned you about some additional CAT scans or films that were done by Lenox Hill Radiology. Do you recall that?

A. Yes.

Q. We've marked it as Plaintiff's Exhibit 5A, an MRI of the lumbar spine, which you testified about. You told and you said that you found compression at L3-L4, L4-L5, correct?

A. Yes.

Q. Are you aware of Lenox Hill Radiology in reading that -- are you aware of an impression of that x-ray of mild to moderate ventral lateral spondylosis T10, T11 through L2-L3?

A. Which? I'm sorry.

MR. McCRORIE: Objection.

THE COURT: Overruled.

Q. The film will be marked as Plaintiff's exhibit 5A. Did you review the reports of those films?

MR. McCRORIE: Just tell him the date of that.

Q. So you need a date?

A. Yes.

Q. I apologize. November 17, 2005.

A. MRI of the lumbar spine?

Q. Yes.
A. Yes.
Q. Do you have that report in your file?
A. I do, yes.
Q. And you're aware in that report there's a mild to moderate ventral lateral spondylosis T10 to T11 through L2-L3?
A. Yes.
Q. What does spondylosis mean?
A. Spondylosis?
Q. Yes.
A. It's a descriptive term regarding the appearance of nerve bodies and usually it has something to do with the degenerative changes.
Q. They're finding a degenerative change at this location, correct?
A. Yes.
Q. It means it's been there before? It's been there already?
A. Yes.
Q. It's been a there a while?
A. Yes.
Q. You didn't mention that though when you testified earlier the other day. You didn't mention that spondylosis, did you?
MR. McCRORIE: Objection.

THE COURT: Overruled.

A. No, because it's not of any clinical significance.

Q. The fact that he has degenerative changes in that area is not of any clinical significance?

A. Correct.

Q. Okay. Also there's a mildly degenerative -- you're aware of the impression from that report as well of a mildly degenerative disc bulge at L1-L2, L2-L3, L4-L5?

A. Yes.

Q. And also that there is a mild to moderate facet joint arthropathy diffusedly. That's in the report as well? You're aware of that?

A. Yes.

Q. Mild multi-level neural foraminal stenosis. Do you see that?

A. Yes.

Q. And that's at L4-L5 --

A. Yes.

Q. -- correct? And it goes on. Without any existing nerve root compression, correct?

A. Exiting.

Q. I'm sorry. Exiting nerve root compression. There's a stenosis. That's the narrowing at that point in the spine, correct?

A. Yes.

Q. Do you have in your file -- did you look at the MRI of the cervical spine of from November 17, 2009.

A. Yes.

MR. McCRORIE: Report you mean?

MR. GANNON: Report, right.

Q. You have that in your file, Doctor?

A. Yes, I do.

Q. And again the impression here is mild spondylosis. Again that's a degenerative finding, correct?

A. Yes.

Q. And disc budging C2-C3 through C5,6, correct?

A. Correct.

Q. And again you didn't talk about that because you didn't find clinically that's of any significance, correct?

A. In terms of -- I'm sorry -- the spondylosis or the degenerative changes?

Q. The spondylosis and the disc bulging at C2-C3 through C5-C6?

A. Correct.

Q. You did not talk about that in your direct examination, correct?

A. Yes.

Q. And again because you don't find it to be clinically significant?

A. It's just part of a description of the film and some

constitutive changes, yes.

Q. Do you disagree with that finding?

A. No.

Q. C3-C4 level there's -- let me skip to that part -- more stenosis again at C3-C4, C4-C5 and mid left C4-C5, correct?

A. Yes.

Q. And there's also a disc herniation, correct?

A. Yes.

Q. At T2-T3?

A. Yes.

Q. Oak. The MRI of the cervical spine October 9, 2011 there is a C3-C4 posterior disc budging and accompanying osteophytes. Again that's a degenerative change?

A. Yes.

Q. Doctor, on the MRI of the lumbosacral spine October 9, 2011, they note disc bulging, correct?

A. Yes.

Q. They note stenosis at L3-L4?

A. Yes.

Q. Narrowing at L4?

A. Yes.

Q. And, Doctor, on the exam date of June 29, 2013, there were x-rays taken at Lenox Hill. Do you have that report in your file?

A. June 2013.

Q. June 29, 2013?

A. I don't have that.

Q. Plaintiff's Exhibit 12A was the x-rays that you looked at. Do you recall this is the thoracic spine and lumbar spine radiographs?

A. Yes.

Q. Are you aware of the reports from Lenox Hill Radiology that the findings of the metallic fusion hardware appeared to be in place?

A. Yes.

Q. And that there was no evidence of metallic fracture or loosening, correct?

A. Yes.

Q. So this is almost four years post surgery, correct?

A. Yes.

Q. And the finding by this Lenox Hill Radiology x-ray is that the hardware he has in his back is in place with no problems?

A. Without any fracture or --

Q. I'm sorry.

A. Without any implant failure, correct.

Q. Okay. Now, Doctor, did you look at an x-ray taken February 12, 2014 at Lenox Hill Radiology Associates?

A. Yes.

Q. You did look at that?

A. Yes.

Q. And you're aware of the finding in there there's a L5 fragment appears partly sacralized?

A. Yes.

Q. Do you have that report?

A. No.

Q. And sacralized means what?

A. It just means that the L5, the lower most segment, appears to form a portion of the sacrum which is just an anatomical variant that occurs between 70 percent of the population.

Q. Is that a genetic finding? Do you have that at birth?

A. Most likely, yes.

Q. And again there are small osteophytes projecting from the vertebral margins there?

A. Yes.

Q. And the fact that the L5 -- I'll strike that.

And again this is now February 2014. They talk about that the hardware again is in place in tact, correct?

A. Yes.

Q. That there is a osteophytic encroachment upon the canal, an osteophyte as a degenerative change?

A. .

Q. And that there is minimal spondylosis in the ventral mark, correct?

A. Yes.

Q. Now, Dr. Merola, you first saw Mr. Verdon November 9, 2009, correct?

A. Yes.

Q. And in your first report, do you have that in front of you?

A. Yes.

Q. Did you make any recommendation in this report other than sending him to your colleague Dr. Touliopoulos?

A. Yes.

Q. What was your recommendation?

A. MRI's.

Q. Anything else?

A. Neurological consultation.

Q. Which is consultation with Dr. Hausknecht?

A. Yes.

Q. And other than that, did you make any other recommendations?

A. Diagnostic imagining studies, neurology consultation and then I had referred him to Dr. Touliopoulos for the shoulder yes.

Q. Okay. You then saw him again December 7th, correct?

A. Yes.

Q. You saw him January 18, 2010?

A. Yes.

Q. And January 18, 2010, you base your recommendation was to continue with present care, treatment and management and return visit in four to six weeks, correct?

A. Yes.

Q. March 1st, 2010, you are making a request for surgery, correct?

A. Yes.

Q. It wasn't done at that time, correct?

A. Correct.

Q. Other than that you recommended that he come back to you again in four-to-six-weeks time?

A. Yes.

Q. You see him April 19, 2010?

A. Yes.

Q. Same thing. You recommend lumbar surgery but other than that you're asking for four-to-six-weeks time, correct?

A. Yes.

Q. See him May 24, 2010, July 12, 2010, September 13, 2010, December 6, 2010, correct?

A. Yes.

Q. You see him twice in 2011 on April 4th, 2011 and October 24, 2011, correct?

A. Yes.

Q. You don't see Mr. Verdon at all in 2012, do you?

A. Correct.

Q. You don't see him at all in 2013 either, do you?
A. Correct.
Q. And the first time you saw him again was February 3rd, 2014 prior to this trial commencing this March, correct?
A. Yes.
MR. GANNON: Your Honor, if I could just have a moment?
Q. Dr. Merola, you've made a recommendation for future surgery for Mr. Verdon which he says he does not want to do, correct?
A. At this time?
Q. At this time. And that first recommendation came from you how many years ago?
A. I guess a couple of years ago, 2010.
Q. So for the past four years you've been recommending surgery for Mr. Verdon and he's turned -- he's declined do it?
A. Yes.
Q. And he's given you reasons for that but he's declined?
A. Yes.
Q. And we heard from Dr. Hausknecht earlier that he recommended certain procedures as well like injections or a TENS unit. Mr. Verdon also turned that down. Did you know that?
MR. McCRORIE: Objection to turning down. It wasn't authorized.
THE COURT: Sustained. I think the testimony was

turned down the shots.

Q. TENS is not authorized but he turned down the shots. Are you aware of that?

A. Yes.

Q. And, Dr. Merola, in deciding to do this surgery for Mr. Verdon, have you ever gone back to his original surgeon who did the fusion on the spine and ask for his input?

A. No.

Q. And that's not your practice?

A. I think Anthony did a great job of fixing his spine traumatically. Now, we're dealing with posttraumatic deformity which is more of my specialty.

Q. And those posttraumatic deformities that you're talking about are in the areas of the cervical spine, correct? Yes?

A. Well, it's the entire spine.

Q. Right but let's go one at a time. You say in the cervical spine there are what you call deformities, correct?

A. Well, he has a spinal deformity and it involves his entire spine.

Q. All right. But I want to go through that.

A. Okay.

Q. You said he's got an issue with his cervical spine, correct?

A. Yes.

Q. And he had issues already before this incident in 2011, correct?

A. He had constitutive degenerative changes prior to the accident.

Q. Right, and then you said he has issues now in the lumbar spine, correct?

A. Yes.

Q. He also had issues before in the lumbar spine, correct?

A. He had asymptomatic constitutive degenerative changes.

Q. Meaning -- asymptomatic means he wasn't complaining of pain?

A. And he was working full time, full duty until he fell off of a height and blew apart his spine, yes.

Q. But you mentioned he also wasn't complaining of pain?

A. Correct.

Q. And you also mentioned he's a stoic guy?

A. Yes.

Q. And he doesn't really complain of pain that often, does he?

A. Pain, no.

MR. GANNON: Thank you, Doctor.

REDIRECT EXAMINATION

BY MR. McCRORIE:

Q. Dr. Merola, you have Dr. Hauscknecht's notes as part

of your file, correct?

A. Yes.

Q. And were you aware that the times Mr. Verdon wasn't seeing you in 2012 and 2013 every six weeks he was under the care of a board certified pain management specialist Dr. Hausknecht?

A. Yes.

Q. Whenever you did see Mr. Verdon did he tell you about the medications he was on?

A. Yes.

Q. And you told us yesterday and Dr. Hausknecht told us today that although he does not choose to do this epidural injection -- well, the epidural injection that both yourself and Dr. Hausknecht have talked to him over time about the spinal cord stimulator, if he ever wants to choose that to have that inserted in his body, correct?

A. Yes.

Q. You were asked whether or not you sought Dr. Frempong?

A. Anthony Frempong.

THE COURT REPORTER: I'm sorry. Can you spell that?

THE WITNESS: F-r-a-m-p-a-o-n-g - B-a-d-h-u. That's a phonetic spelling.

Q. I'm just going to hold up Plaintiff's 21 in evidence. You were asked whether or not you called Dr. Frampaong on the

phone to see in preparation of the MediVisuals. When you look at the CT scan that's on here on the MediVisuals is that a fair and accurate depiction of what is in the actual x-ray -- of the CT?

A. Yes.

Q. And when we come down here to the sagittal view of the CT and where the arrows are, is that a fair and accurate depiction of the MediVisuals that was made?

A. Yes.

Q. In terms of the surgery that Dr. Frampaong did -- I will just hold up Plaintiff's 20 and we actually have x-rays to compare it to but looking at the CT scan done on 8/13/09, approximately a month -- one day after the surgery, does this Metavisual fairly and accurately depict a board certified spinal reconstruction surgeon who does two to 300 surgeries a year, the surgery that Dr. Frampaong did?

A. Yes.

Q. I don't know if -- I'm just going to put the official Bellevue record up here although your file may contain some of the reports that Mr. Gannon went over.

It was pointed out that you're not a board certified radiologist and you're not a board certified neuroradiologist. Do you still standby your contention that as a board certified spinal surgeon that you don't need a board certified radiologist to interpret the films of Mr. Verdon or any other patient?

A. Correct.

Q. And, in fact, when a radiologist, whether they do it in a hospital or whether they do it in an office, reads films that come before them, they don't even know anything about the history of the patient; is that correct?

MR. GANNON: Objection.

THE COURT: Sustained.

Q. Well, the patient doesn't meet with the radiologist; is that correct?

MR. GANNON: Objection.

Q. The technician takes the film?

MR. GANNON: Objection.

Q. Okay. Are you familiar with how MRI's are taken in the tristate area in New York?

A. Yes.

Q. Okay. Does a technician take the MRI or does a radiologist physically take the MRI?

A. The technician does the MRI.

Q. Okay. And in your practice, did the radiologist, whether it be in a hospital or in an MRI facility, ever meet the patient -- withdrawn.

Do they typically meet the patient?

MR. GANNON: Objection.

THE COURT: Sustained.

Q. And on the 200 to approximately 300 surgeries you do spinal surgeries, you interpret the films yourself for all of

those patients for all these years; is that correct?

A. And for all patients that I don't operate on that I see in my office as well, yes.

Q. I want to go back to some of the findings in the emergency room but you have no reason to doubt that Mr. Verdon as a witness came in and told the jury and it's reported right in the emergency room that he fell a certain height and landed on the rebar depicted in those photographs?

MR. GANNON: Objection.

THE COURT: Sustained.

Q. Well, it was pointed out that there was no bruising on his back at least in the record. Is bruising a prerequisite to having a burst fracture at the T12 or a wedge fracture at T10?

A. No.

Q. If you could find where radiological reports starting on August 11, 2009, the one that Mr. Gannon was going over with you. I want to go over some of the things that weren't pointed out on the reports with you.

And if we could just step back one moment to Mr. Gannon read to you that Mr. Verdon had denied any tingling or had denied certain things on the date of the accident in the emergency room?

A. Yes.

Q. And do you have any knowledge, and I'm going to point it out to you in a moment, as to whether or not Mr. Verdon's

head was actually split open and required staples to close that day?

MR. GANNON: Objection, outside the scope, Your Honor.

MR. McCRORIE: He was asking about the head --

Q. Why don't we do this? Go to the CT scan of August 9, 2009, 1936, the very one that Mr. Gannon read to you?

MR. GANNON: Of the cervical?

MR. McCRORIE: This is the CT of the cervical spine.

A. Yes.

Q. Okay. The findings before it talks about what he read to you, the exaggerated cervical lordosis. This is taken at 7:36, it says scalp staple project posterior ossifice of the scalp?

A. Yes.

Q. What does that mean? Tell the jury what that means?

MR. GANNON: Objection, beyond the scope.

MR. McCRORIE: He asked about the head CT.

MR. GANNON: Objection.

MR. McCRORIE: And he asked him about the brain CT.

THE COURT: I'll allow that. Go ahead.

A. That means that there are surgical staples in the skin of the scalp Mr. Verdon's head.

Q. Okay. We're not going to go too far into it but if I tell you it's part of the certified record that knowing he had T12 burst fracture and a T10 wedge fracture and a head injury that required staples to close his head, knowing it was a head injury and a fall from a scaffold, did you see also that the EMS record says he had no head, neck or back pain?

MR. GANNON: Objection, your Honor.

THE COURT: Sustained.

Q. If I tell you that it's in the record as part of the evidence do some times people with head injuries report strange things in emergency rooms --

MR. GANNON: Objection.

Q. -- or fail to report them?

THE COURT: Sustained.

MR. GANNON: Objection.

Q. Okay. So sticking with that same report, you were asked a lot questions about that one, so right under the part that says the staples are projecting over the posterior ossifice. Can you tell the jury what that means what the posterior ossifice is?

A. It's the back part of your head.

Q. It's a ridiculous question because it's not mentioned anywhere else in this Bellevue record at all. The jury may see some photos later but --

MR. GANNON: Objection, your Honor.

Q. Were the staples --

THE COURT: Sustained.

Q. Will you tell the jury whether or not the staples are preexisting if they're not mentioned anywhere else but this --

MR. GANNON: Objection.

Q. But this CT --

MR. GANNON: Your Honor, I'll object and I'll stipulate he didn't have staples in his head before.

THE COURT: With that outside the knowledge that he didn't go to work that day with staples.

MR. McCRORIE: I understand, Judge. My point was not mentioned anywhere --

MR. GANNON: Objection, your Honor.

THE COURT: Okay.

Q. And the C shape -- I'm going to hold up 4A from the 2009 film, two weeks after the accident -- the C shape on the MRI film, Plaintiff's 4A, you told the jury the other day, Friday, that this was an exaggerated lordosis, a C shape; is that correct?

A. Yes.

MR. GANNON: Objection to the -- can we approach, Your Honor?

(Discussion off the record.)

Q. Going back to -- Your Honor, may I continue?

THE COURT: Yes.

Q. Going back, Doctor, to 7:36 p.m., the night of the accident, the exaggeration of the normal cervical lordosis, that Mr. Gannon read to you, can you tell the jury your opinion how Mr. Verdon's cervical lordosis became exaggerated?

A. So, one of things he had thoracic multiple noncontiguous thoracic compression fractures also being mobilized and being put into a position whereby he wouldn't further cause any damage to his spine puts him into a position in addition to the fractures whereby he has an excess of cervical lordosis.

Q. And right after that we just used the word with regard to the lumbar spine, right after that it says the vertebral alignment is otherwise normal without spondylolisthesis. That's the word -- is that what that says there?

A. Yes.

Q. And it says the vertebral body height and disc spaces are maintained?

A. Yes.

Q. What does that indicate to you in connection with the exaggerated cervical lordosis?

A. So what that means is that, first of all, there are no fractures or disc locations in the cervical spine. In fact, the body height and the disc spaces are maintained means that there are minimal types of degenerative changes.

Q. And when a radiologist, this radiologist, specific

speaking about this film says there are minimal degenerative changes in this 59 almost 60-year-old gentleman. What does minimal mean in front of the word "degenerative?"

MR. GANNON: Your Honor, objection. That is not a quote from the record.

MR. McCRORIE: I'm reading it, Judge. There are minimal degenerative changes at C2-C3.

MR. GANNON: It doesn't make any reference to Mr. Verdon, his age. If Mr. McCrorie wants to read from a record, read it accurately. Don't interject what's not there.

THE COURT: I'm going to overrule the objection but I'll allow you to follow up.

Q. Okay. At the top, does it have Mr. Verdon's date of birth and it actually has his age as 63. You're correct. You see that up there?

A. Yes.

Q. Okay. So thinking he was a 63-year-old, the radiologist wrote those words, correct?

A. Yes.

Q. What does minimal mean in front of the word "degenerative?"

A. Minimal means very limited and not significant.

Q. And on the lumbar x-ray of that same date when it talks about mild multi-level degeneration or degenerative, what

does mild mean as opposed to minimal?

A. Once again mild and minimal are adjectives that describe very little, very little degenerative changes, minimal degenerative changes, not significant degenerative changes.

Q. And in the operative report and in the x-rays when they talk about the kyphosis that needed to be straightened out, can you tell the jury whether or not the thoracic kyphosis in your opinion was preexisting or caused by something else?

A. The thoracic kyphosis was caused by the burst fracture at T12.

Q. And in front of the word or in the middle, it said diffuse mild osteopenia, could you tell the jury what that means regarding the osteopenia that the radiologist in the hospital was noting in the T spot?

A. So osteopenia is that term that means not as dense as and diffuse means for all the vertebral bodies and mild means not very significant or minimal or not very much.

Q. Sure. Okay. Whether or not -- I'm going to hold up 2C from that study -- whether or not Mr. Verdon has diffuse mild osteopenia, do you have an opinion as to whether or not the osteopenia had anything to do with the T12 fracture, T10 fracture or the facet fracture that occurred on August 11th?

MR. GANNON: Objection.

THE COURT: Overruled.

A. So all of those bones when you look at them are well

minimalized to the point where osteopenia would not be contributory to that type of major spinal trauma with multiple noncontiguous fractures.

Q. And it was read to you that on at least when Dr. Frempong did the surgery that he did not see any retropulsion at least at that point in the surgery?

A. Yes.

Q. I would like you to go to the August 13th, two days later, 2009 CT scan of the thoracic spine. I just want to -- when it talks about mild central canal stenosis seen at the superior endplate of T12 secondary to minimal residual retropulsion, what does that mean?

A. That means there is a piece of bone in the canal narrowing down.

Q. And that's two days after the surgery?

A. Yes.

Q. And regardless of the spine and vertebral bodies were anatomic after the surgery, can you tell the jury, using what you showed them the other day on several of the x-rays, whether or not Mr. Verdon's spine stayed anatomically correct over the last four and a half years?

MR. GANNON: Objection, Your Honor. This was covered on direct.

THE COURT: I'm sorry.

MR. McCRORIE: He said it was covered on direct.

MR. GANNON: Outside the scope.

THE COURT: Sustained.

MR. McCRORIE: Well, it was brought out that the surgery --

MR. GANNON: Your Honor, could we not have this in front of the jury if he has a point to make?

THE COURT: The question you asked him was brought out probably much more than he has on cross.

Q. Is Mr. Verdon's spine anatomically correct today?

MR. GANNON: Objection.

THE COURT: I'll allow it. Go ahead.

A. No.

Q. Tell the jury why? In what way is it not anatomically, correct?

A. So he's out of spinal alignment of the progressive kyphosis in the thoracic region particularly above the level of the instrumentation with progressive hyperlordosis to the lower portion of his back throwing him into a condition of posttraumatic kyphosis.

Q. And it was read to you in the hospital records regarding the lumbar CT's that there were circumferential disc bulges. Do you remember that?

A. Yes.

Q. Can you tell the jury whether or not a fall from the height that we know Mr. Verdon fell can that cause a disc bulge?

MR. GANNON: Objection.

THE COURT: Well --

MR. GANNON: This is the third time we've done this on the record. We've done it again on redirect.

MR. McCRORIE: We went over herniation. He's talking about a disc bulge and I'm just --

MR. GANNON: Objection.

MR. McCRORIE: He brought it up.

THE COURT: Last time. Can that cause a disc bulge?

THE WITNESS: Yes.

Q. And when a disc bulge occurs from trauma, can that progress to the level of what you showed the jury over time a herniation?

MR. GANNON: Objection.

THE COURT: Overruled.

A. Yes.

Q. Mr. Gannon asked you about separate findings in both the neck and the back and then asked you whether or not they could be asymptomatic just as he ended.

Assume that Mr. Verdon had asymptomatic conditions of his lower back that were either circumferential bulges and the rest of the findings that are degenerative as listed in the radiological report at the hospital, okay?

A. Yes.

Q. And as well as the degenerative findings in Mr. Verdon's back that were present in the lumbar spine in Lenox Hill, okay?

A. Yes.

Q. Assume that to be true that he had those degenerative findings, that they were asymptomatic and that there was, in fact, a circumferential disc bulge in the lumbar region in those three areas.

Assume then that he had the same accident, he had the same treatment in hospital, he had the same traumatic thoracic fractures, he had the same fusion at all of the levels, that he had here the same kyphosis of the thoracic spine, the same reversible of the cervical lordosis, do you have an opinion with a reasonable degree of medical certainty as to whether or not the accident aggravated and activated previously asymptomatic conditions of his lumbar spine?

MR. GANNON: Objection, asked and answered on direct.

THE COURT: Sustained. You asked that on direct.

MR. McCRORIE: Not of this doctor and then he asked it on cross. I only did it with Dr. Hausknecht.

MR. GANNON: Your Honor, Mr. McCrorie doesn't get a second shot to give an opinion out of the same witness.

MR. McCRORIE: It's not the same witness, Judge.

THE COURT: Sustained.

MR. McCRORIE: Can I approach just because that's the last area?

THE COURT: Objection sustained.

Q. It was just pointed out it might be obvious that there were no fractures of the neck and no fractures of the back. Can you tell the jury so they're clear where the fractures that were traumatically induced in this accident occurred?

A. Fractures were at the T10 vertebral body, the T12 of the vertebral body and then what is known as the spinous process behind those vertebral bodies in the area spanning that T10 segment down that T12 segment.

MR. McCRORIE: I have nothing further.

MR. GANNON: Very brief.

RECROSS EXAMINATION

BY MR. GANNON:

Q. Dr. Merola, you just testified when Mr. McCrorie asked you that the surgery was done to correct the kyphotic deformity in his thoracic region, correct?

A. The kyphotic deformity as caused by the fracture, yes.

Q. As caused by the fracture. The fracture we're talking about is the T12 burst fracture, correct?

A. Yes, and the T10 fracture. That's way the hardware had to be as high as it did.

Q. Right, but the hardware went up to what level?

A. T8.

Q. And it down to what level?
A. L3.
Q. The doctor who did the surgery, he fitted the rod to fit a kyphotic deformity that he found, correct?
A. The rod was contoured --
Q. Right.
A. -- in order to accommodate the thoracic kyphosis and then placed into the screw heads with compression to reduce the fracture, correct.
Q. Where is the T12 burst fracture on this model Plaintiff's Exhibit 17?
A. Right here, right here. I'm sorry.
Q. This is T12.
A. Yes.
Q. And you said T10 also had what?
A. Had a fracture in it.
Q. So in the vertebral body?
A. Correct, so this one as well.
Q. Okay and everything else was fractured back here to what?
A. The spinous process and the facet joints.
Q. Okay. So the rod was placed in and it went to what levels of the spine?
A. The rod went up to T8 and then down to L3.
Q. So he's talking about correcting a kyphotic deformity

in his operative report, is he not?

A. Yes.

Q. The T12 fracture is in one location?

A. Yes.

Q. And there's a fracture of the vertebral body above, correct?

A. Eleven. One adjacent to the one above.

Q. Adjacent, and yet in his operative report he talks about adjusting a rod to fix a kyphotic deformity in the thoracic region, correct?

A. Yes.

Q. Above where the burst fracture was?

A. For the entire length of where the rod was.

Q. Right. In order to -- actually the doctors do it. He sees a spine and he places the rods so it matches the curve of a person's --

A. And also take into consideration the fracture itself so that he can get reduction of the fracture.

Q. Right, but your testimony is that the entire kyphosis from T8 -- you said that's kyphosis from T8 all the way down to what?

A. Well, which kyphosis are we talking about?

Q. Thoracic, thoracic, the thoracic kyphosis you're talking about. You're saying goes from T8 to where?

A. There's a couple of types of kyphosis. One is the

posttraumatic kyphosis that happened because of the spinal imbalance.

Q. And the other is a natural kyphosis that can occur because of aging, correct?

A. And then there's a natural thoracic kyphosis and then there's the actual kyphosis at the fracture site.

Q. Correct.

A. So the operative report is talking about reducing the kyphosis at the fracture site.

Q. Right, but it's not talking about a preexisting kyphosis which is there that he finds in Mr. Verdon's spine correct? That's what --

MR. McCRORIE: Objection to preexisting kyphosis.

THE COURT: Overruled.

A. No. It's not so much that he -- he's adjusting to the rod in order to accommodate the natural contour of the --

Q. Accommodate the kyphotic deformity that he finds in his spine?

A. But that the deformity is the fracture.

Q. Right.

A. Yes.

Q. Right. And he had cervical lordosis exaggerated preexisting. So it was there already.

MR. McCRORIE: Objection. He said it wasn't preexisting.

THE COURT: To the extent it's cross, I'll let him ask the question. The doctor can answer.

Q. Doctor, we saw an x-ray film, can't remember where was but there is a preexisting exaggerated cervical lordosis, correct?

MR. McCRORIE: Objection.

THE COURT: Overruled. Did you look at this film?

A. Right. I looked at that film and he had cervical lordosis. He had cervical lordosis. He had cervical hyperlordosis on the film, yes.

Q. So your testimony is that Dr. Frampaong put in a rod from T8 to-

A. -- L3.

Q. L3 because of a T12 burst fracture in that one location?

A. Well, it was as a result of the T10 fracture. That's why he went to T8.

Q. He had to basically bend the rod to fit a kyphotic condition above the burst fracture?

A. No.

Q. No?

A. No. That's not what he did, no.

Q. He just put the rod in one place?

A. Correct. The rod went from T8 down to L3 then he

contoured that rod to accommodate the thoracic spine area.

Q. Right, and to basically mold it into place with what the spine appeared to -- upon surgery when he opened him up, correct?

A. Right.

Q. Thank you, Doctor.

RE-REDIRECT EXAMINATION

BY MR. McCRORIE:

Q. I just want to make one thing clear. The cervical hyperlordosis that you showed the jury before was that preexisting in your opinion or did it come from the fall?

A. The hyperlordosis that he has is from the -- is from the fractures that he suffered in his thoracic spine because there are T10 with multiple posterior spinous process fractures, facet fractures and the T12 burst.

Q. And this 2/12/2004, there was also a hyper -- or this was a kyphotic condition?

A. This is a kyphotic condition --

Q. 13B.

A. -- of particularly above the level of the HB implants, right? So above T8, what you can see is the spine is actually bending itself away from where the implants are. So he's turning his thoracic spine into a big C and the areas that are not fused in the thoracic spine are continuing to kyphos forward. That's where the posttraumatic kyphotic deformity is

and then the accommodation is the lumbar spine going into more lordosis.

MR. McCRORIE: Thank you.

MR. GANNON: Thank you.

THE COURT: Thank you, Doctor. Thank you. You may step down.

THE WITNESS: Thank you.

THE COURT: With that, we are done for today. You got nervous. We'll resume tomorrow morning at 10:00 a.m. with another witness. Have a good night and please don't discuss the case.

COURT OFFICER: All rise. Jury exiting.

(Jury exits courtroom.)

* * * * *

(This matter was adjourned to April 9, 2014 at 10:00 a.m.)

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$500 (1)
130:25

A

ability (17)
129:16;138:16,17,19,21,23,25;139:1,4,5,6,7;145:11;162:16;168:10,13;196:2
able (10)
150:21;151:1;171:7;190:18;191:6;201:15;216:10;251:21;274:7;283:2
abnormal (6)
182:6;198:17,19,20;269:11;270:5
abnormalities (2)
149:8;197:16
abnormality (1)
195:21
above (14)
155:17,21;163:19;164:19;181:20;261:22;262:8;311:16;316:5,7,12;318:20;319:20,21
Academy (1)
128:15
accepted (1)
217:13
accepting (3)
130:15;140:7;207:10
accepts (1)
130:13
access (1)
190:16
accident (25)
130:1;133:4;140:6;143:4,14;176:2,23;177:2;180:24;181:2,4,10;183:7,21;221:22,25;222:13;232:1;299:4;303:21;306:16;307:2;313:9,15;314:7
accidents (6)
129:25,25;130:14;140:8,8;222:7
accommodate (4)
315:7;317:16,17;319:1
accommodated (1)
243:10
accommodation (1)
320:1
accommodations (1)
233:1
accompanied (1)
133:5
accompanying (1)
292:12
account (1)
262:13
accumulation (1)
191:5
accurate (3)
151:22;301:3,6
accurately (4)
124:7;151:18;301:13;308:10
acquired (1)
256:25
acronym (1)
143:25
across (1)
144:12
Act (4)
250:11,12;252:10;253:9
action (1)
215:8
activate (2)
177:11,14
activated (5)
143:3;181:4,4,13;313:15
activation (3)
178:8,9;179:8
Active (3)
137:25;138:4,10
actively (1)
137:24
activities (11)
129:16;134:1;145:12;147:2,6;150:10;162:22;167:2;172:1,3,8
activity (9)
133:22;137:25;138:5;144:20;183:14;208:10,16;209:7;264:4
actual (16)
132:4;136:21;159:9;161:20;169:17;179:17;212:15;238:13,13;256:1;265:19;270:21;271:5;283:17;301:3;317:6
actually (23)
134:8;136:20;153:13;154:4;156:13;179:22;199:11;211:23;214:24;222:24;223:4;226:19;270:25;276:7;282:10;284:8,12,13;301:10;304:1;308:15;316:14;319:21
acute (3)
142:9;175:10;232:23
add (2)
223:22;245:11
Added (1)
245:25
addition (4)
167:8;179:20;235:1;307:9
additional (7)
245:11,20;278:2,7,13;279:19;288:6
address (1)
126:19
addresses (1)
226:21
adjacent (6)
181:15,17;198:12;275:3;316:7,8
adjective (1)
276:17
adjectives (1)
309:2
adjourned (1)
320:15
adjust (1)
262:8
adjusting (2)
316:9;317:15
ADL (3)
171:24,24;172:1
admissibility (1)
234:13
Admission (6)
267:7;268:10;272:16;274:7;279:23;283:25
admit (1)
239:24
admitted (2)
174:1;266:10
adult (1)
129:23
adults (3)
141:8,13,14
advance (1)
238:4
advanced (1)
164:15
adverse (1)
206:2
Advil (2)
163:13;194:21
advisable (1)
182:14
advise (1)
203:3
advised (1)
251:8
advisors (1)
251:9
affect (2)
141:23;218:8
affecting (2)
142:6;164:3
affiliated (1)
128:11
affiliation (1)
252:23
afternoon (4)
178:22;188:6;225:25;226:1
afterwards (2)
125:12;161:1
again (71)
130:3;135:16;137:17;145:17;146:23;148:10;156:9,20;163:20;164:23;169:19;176:8;180:3;181:9;185:24;192:9;200:1,19;203:10;204:21;205:22,24;206:7;207:3;208:17;209:5;210:14,23;213:4;214:13;216:3,4;217:4,15,16;218:25;219:21,21;220:7,7;227:21;230:2;233:15;243:7,10,15;247:24;248:2;267:16;272:15;274:1,3;275:4,16;279:1;280:24;281:21;291:8,9,13,23;292:5,13;294:14,18,19;295:22;296:11;297:3;309:2;312:4
against (2)
154:12;274:11
age (4)
140:25;269:22;308:9,15
aggravate (2)
177:12;182:23
aggravated (1)
313:15
aggravation (1)
217:22
aging (2)
277:2;317:4
ago (4)
131:2;253:20;297:13,14
agree (18)
155:6;190:12;236:20;240:1,20;241:5,13,13,14,16;248:5,7,11,12,16;259:21;265:5;271:23
agreed (1)
248:14
agreement (3)
132:6;190:7;240:14
ahead (9)
127:9;151:3;221:15,18;225:22;240:21;283:5;304:23;311:11
Aleve (1)
163:13
aligned (1)
285:4
alignment (6)
272:21;280:16,18;286:8;307:13;311:15
alleviate (1)
160:19
allow (5)
235:13;242:6;304:23;308:13;311:11
allowed (1)
236:22
allowing (1)
238:5
almost (7)
130:16;138:22;139:1;161:8;204:21;293:14;308:2
along (7)
125:10;130:14;176:19;193:4;201:15;214:3;216:9
Alpha (12)
251:8,9,12,22;252:6,13,16,25;253:15,23,24,25
alternative (2)
178:12;184:17
alternatives (2)
214:25;215:21
although (10)
129:7;142:20;180:21;213:5;215:23;222:21,23,25;300:12;301:18
altogether (1)
244:10
always (6)
158:18,19;167:7;198:20;255:8,10
American (2)
128:14,15
among (1)
178:1
amount (12)
159:16;191:21,25;201:7;230:17;246:3;252:2,3;256:3;263:22;264:25;285:23
analgesic (3)

147:2;159:15;
167:14
analogy (1)
152:23
anatomic (2)
280:16;310:18
anatomical (1)
294:10
anatomically (5)
280:18;281:10;
310:20;311:9,14
anatomy (13)
124:2,3,5,7,11;
125:6,7;151:9,9,18,
23;153:8;260:13
angle (1)
138:3
animals (1)
262:1
ankle (5)
135:7;165:1;
166:16;168:2;197:22
ankles (3)
135:11;165:2;
166:14
answered (3)
130:12;253:16;
313:17
antalgic (6)
139:9;148:3;165:7;
166:20;167:25;168:6
anterior (3)
245:3;253:24;
279:11
Anthony (3)
283:9;298:10;
300:19
anthropology (1)
127:23
anticipated (1)
131:2
anticipation (2)
132:13;168:20
anti-inflammatory (3)
163:12;167:13;
194:21
apart (3)
178:20;179:6;
299:14
aphasia (1)
196:1
apologize (4)
151:4;199:3;
267:15;288:24
appear (1)
142:19
appearance (3)
276:18,19;289:11
appeared (4)
284:4,21;293:8;
319:3
appears (3)
276:23;294:3,9
appendicular (1)
149:13
apply (1)
245:12
appreciate (2)
246:20;253:10
approach (6)
149:24;156:4;
266:14;283:3;
306:21;314:1
approaches (2)
126:11;280:13
appropriately (1)
268:9
approved (1)
255:1
approximately (11)
131:2;139:8;
154:15;158:4,5;
164:25;192:2;
193:23;232:2;
301:12;302:24
April (4)
214:5;296:13,21;
320:15
area (20)
135:13;136:9;
137:6,8,20;155:2;
164:17;198:15,18,25;
215:16,17;259:9;
270:2;287:4;290:3;
302:13;314:2,10;
319:1
areas (7)
136:6;158:21;
198:15;232:3;
298:14;313:8;319:23
argument (2)
237:18;240:1
Aric (2)
126:9,20
A-r-i-c (1)
127:1
arm (2)
162:8;219:17
arms (19)
133:22;134:15,17,
20;135:3;146:21;
147:25;162:11;
164:25;165:16,22;
170:9;171:5;174:23;
198:5,25;206:10;
220:4;233:3
around (9)
135:12;136:9;
156:20;168:6;
170:10;192:3;
198:16,18;279:6
arrow (2)
154:11;155:5
arrows (2)
154:11;301:6
arthritis (7)
130:2;140:24;
141:2,21;176:14;
218:17;241:3
arthropathy (4)
150:2,2,5;290:11
arthrosis (3)
282:13,16,17
aside (2)
187:2;271:16
assessment (3)
172:16;205:1,12
assessments (1)
172:10
assistant (1)
203:19
associated (3)
136:1,2;224:8
Associates (1)
293:23
assume (20)
149:10;155:3;
173:8,11,15,18,21,23,
25;174:5,8,12,13,18;
176:25;180:21,22;
312:21;313:5,9
assumed (1)
217:12
assuming (3)
181:10;215:7;
237:1
assumption (1)
176:25
asymptomatic (26)
141:18,20;142:24;
176:8,9,14,15,16,18,
21,22;177:5,12,14;
178:7,8,9;180:25;
181:5,11;299:10,11;
312:20,21;313:6,15
atrophy (5)
135:8,15;147:25;
148:6,8
attach (1)
275:8
attached (3)
152:6;159:23;
232:22
attaches (1)
152:5
attempt (1)
167:10
attend (1)
143:7
attending (3)
193:9,22;283:9
attends (1)
200:20
attention (1)
240:18
August (32)
165:12,13,24;
169:20,23;173:18;
206:6;207:20,23;
211:6;212:22;
214:15;217:21;
261:2;263:12;267:7;
268:13,20,20;272:10,
14;273:22;276:4;
277:13,18;279:25;
280:2;282:25;
303:16;304:6;
309:22;310:8
authorization (7)
143:13;145:19;
146:1;179:19;187:2;
212:15,19
authorized (6)
145:23;213:7,9,21;
297:24;298:2
authorizing (1)
213:12
autonomic (4)
133:23,24;146:23;
184:13
available (4)
129:14;132:4;
192:25;193:1
average (2)
192:3;244:12
avoid (7)
134:6,9;164:23;
184:24;185:1;
222:24;241:1
aware (27)
149:21,22;208:20;
209:2;218:14;222:7;
223:17;237:20;
239:18,22;241:2;
250:2;254:3;257:13;
263:11,18;264:1;
266:9;288:13,14;
289:5;290:7,12;
293:7;294:2;298:3;
300:3
away (5)
130:20,24;226:13;
263:15;319:22
axial (3)
156:22;176:6;
269:11

B

baby (1)
241:24
back (137)
126:4;129:2,24;
130:10;133:19,20;
134:2;135:12,24;
136:4,5,8,8,18,20,23;
137:3,18,18,23;
138:14,24;140:3,4,5,
6,24;141:22,24,25;
142:11;143:23;
144:22;145:17;
146:9,21;147:4,5;
148:1,5;149:18;
150:14,17,20;152:4,
19,22;154:12;
155:11;156:12;
158:23,25;162:7,8;
163:4,9;164:5,9,19;
165:15;166:6,9,10;
168:3,5;170:7,17,19,
21;171:4;172:14,24;
173:20,23,24;174:9,
22;175:3,9;177:5,22,
24;178:14;180:23;
182:8,9;183:7,23;
187:6,12,13,17;
198:16;205:17;
206:25;208:10,23;
213:16,24;215:23;
223:21;224:13,14,17,
24,25;226:14;227:2,
2;228:1,2;229:4,17;
233:24;243:10;
261:10;264:13;
265:10;266:11,15,18;
293:17;296:10;
298:6;303:4,12,19;
305:6,21;306:24;
307:1;311:18;
312:19,22;313:2;
314:5;315:19
background (2)
127:19;128:2
backwards (5)
138:23;139:1;
156:18;157:10;196:6
bad (1)
183:14
B-a-d-h-u (1)
300:22
balance (3)
226:19;231:23;
263:9
balanced (2)
261:23;262:1
ball (1)
183:24
bar (1)
151:5
basal (1)
269:22
base (2)
156:13;296:1
based (20)
142:17;183:24;
184:12;202:3,10,13;
205:9;206:11;219:5;
227:11;228:22;
229:13;231:5;240:1;
259:19;267:19;
270:18;271:13;
281:9;283:21
basic (1)
151:9
basically (23)

133:7;142:10;
143:3;148:20;150:5,
19;155:15;163:15;
164:1;170:4;171:13;
172:17;185:2,7;
196:17;206:14;
207:14;212:7;
213:24;232:23;
265:18;318:19;319:2
basis (22)
129:17;131:10,21;
158:2;172:3;175:7,
19;181:8;182:19;
184:7;216:22;227:8,
10;228:11,20;
229:24;230:1,15,24;
231:1;265:24;272:1
battery (1)
185:3
became (4)
127:15;132:17,20;
307:4
become (7)
143:5;155:18;
178:21;181:5,13,13;
193:1
becomes (1)
156:14
beeper (1)
161:8
began (3)
211:7,13,20
begin (1)
225:20
beginning (4)
167:24;193:5;
202:15;203:1
behalf (13)
126:15;140:13;
188:11,17,22,25;
189:6,10,14,16;
213:11;247:10,14
behind (2)
157:5;314:10
Bellevue (21)
133:10;168:15,17,
24;169:2,20;170:17;
173:25;174:1,9;
177:10;228:3;
237:14;242:8,9;
260:4;266:6,7;
272:15;301:18;
305:23
below (7)
134:19;155:18,21;
173:21,21;181:21;
266:15
bend (14)
138:2,11,16,18,23,
25;139:1,4,5;168:10,
13;265:10,10;318:19
bending (8)
134:2;162:23;
167:6;172:6;183:1,4;
265:9;319:22
benefit (1)
187:5
benefits (2)
215:20;222:13
Bernard (2)
138:11;222:1
best (3)
129:4;190:17;
259:17
Beth (2)
128:5,12
better (13)
155:12;158:10;
165:23;166:1;
185:11;204:24,25;
205:17;208:9,9;
220:25;254:21;
270:19
beyond (2)
193:6;304:18
bi- (1)
165:5
big (2)
131:17;319:23
bilateral (1)
208:11
birth (2)
294:12;308:15
bit (5)
129:20;140:24;
148:17;214:4;245:4
bits (1)
205:17
bladder (8)
133:24;162:13,16;
175:4;209:16,25;
266:25;267:2
bleeding (3)
133:9;173:22;
286:6
blew (1)
299:14
block (2)
161:13;186:3
Blood (1)
195:11
board (18)
128:13,14;131:20;
160:15;183:10;
184:22;186:16;
240:24;256:13,19,21;
258:20;300:5;
301:13,20,21,22,23
bodies (8)
273:2;274:17;
276:18,20;289:12;
309:16;310:17;
314:10
body (30)
141:10,16,21;
142:7,9;154:2;
156:16;157:3;
158:21;160:21;
169:4;185:13,14,17;
202:3;239:8;257:19;
261:20;272:24;
274:9;275:1;284:4,
21;300:16;307:16,
23;314:8,9;315:17;
316:5
bone (19)
133:12;136:13;
141:12;142:10;
152:6;154:1,5,22;
157:5;218:2,4,5,6,8,
18;276:23;284:24;
285:17;310:13
bones (8)
128:25;152:13;
154:6;155:14;
172:19;218:11;
277:17;309:25
both (41)
128:25;132:6;
133:22;135:6,9;
136:4;159:14,16;
162:8,9,9;165:16,16;
167:25;170:9;171:5;
172:25,25,25;177:5;
179:1;180:23;182:8;
183:7,23;187:5,16;
195:18;197:21,22,22;
198:5;199:13;205:8,
15,16;229:17;240:5;
264:15;300:13;
312:18
bother (1)
141:15
bothering (1)
143:4
bottom (6)
152:3,14;156:12;
163:22;261:6,8
bought (2)
254:14,15
bowel (4)
133:24;162:16;
266:25;267:2
box (1)
159:21
BP (5)
177:18;178:4,7;
179:7,16
brace (4)
134:2;145:13;
147:4;148:5
bracing (1)
172:8
brain (20)
128:22;135:20;
140:23;144:10,12,18,
25;152:22;156:13,
13;161:14;186:4;
219:17,18;224:12;
270:1,2,2,4;304:21
break (7)
187:20;224:23;
225:19;233:22;
234:6,8;287:3
breakdown (8)
181:15,17,22;
182:1;189:4;229:1,
19,22
breaking (1)
172:19
Brian (2)
132:10,16
brief (1)
314:13
briefly (1)
188:7
bring (3)
177:21;239:4;
281:13
brisk (2)
135:10,18
broken (2)
136:12;196:22
Bronx (2)
126:21;128:11
brought (3)
311:3,8;312:8
bruising (4)
268:4,6;303:11,12
buckles (1)
156:19
budging (2)
291:11;292:12
bulb (1)
145:1
bulge (11)
154:19;176:20;
279:4,5;281:3;290:8;
311:25;312:6,10,12;
313:7
bulges (5)
278:23;279:2,3;
311:22;312:22
bulging (2)
291:17;292:16
burning (1)
149:3
burst (19)
133:11;135:22;
142:9;230:16;
279:17;285:6,8,12,
14;286:1;303:13;
305:3;309:9;314:21;
315:10;316:12;
318:15,20;319:15
business (2)
126:18,21
butcher (1)
274:12
buzzing (1)
185:9

C

C2 (1)
156:17
C2/C3 (2)
275:16;276:2
C2-C3 (3)
291:11,17;308:7
C3-4 (1)
157:9
C3-C4 (3)
292:4,5,12
C4-C5 (2)
292:5,5
C5,6 (1)
291:11
C5/C6 (1)
198:4
C5-C6 (1)
291:18
cadaver (1)
255:16
cadavers (1)
255:10
cages (2)
245:17;246:3
Calcification (1)
277:8
calf (4)
133:21;152:20;
219:17;224:12
call (4)
142:12;232:10;
271:13;298:18
called (12)
126:15;133:19;
154:18;155:4;
156:10;171:10;
229:18;251:8;
254:14,15;255:11;
300:25
calls (2)
126:9;238:23
came (20)
133:5;145:17;
147:17;174:13;
191:3,7;194:9;
213:16,24;229:16;
249:22;251:10;
252:10,11;253:9;
260:1;262:5;264:1;
297:12;303:6
can (153)
125:21;126:23;
127:15,19;128:17,18;
129:7,20;130:12;
131:8;132:8,16,19;
134:24;137:7,21;
143:1,25;145:6;
146:7,16;148:6,7,13,
21,22,25;150:1,4;
151:11;152:5;153:3,

23;154:22;155:8,10,
12,22;156:1,7,19;
157:1;159:12,20;
160:6,14,17,19;
161:5,5,15;162:14,
21;164:19;167:2;
168:11,11;169:10,19,
24;171:11,24;172:7,
11,15;174:13,25;
175:18,25;176:8,13,
14,14,15,17,19,21;
181:7,15;184:6,22;
186:1,3;187:3;190:3,
17,17;193:5,6;
197:18;209:10,20;
211:12;214:3;215:1,
22;220:24;226:6,10,
24;227:8;228:20;
229:10;231:25;
232:1,25;236:10,11;
237:19;242:12;
245:20;246:5;
249:12;251:14,15;
252:3;261:2,23;
262:1,20,22;263:10,
11;264:7,9,16;267:2;
269:5;271:1;277:3,6;
282:9,11;283:3,4,7;
285:22;300:20;
305:19;306:21;
307:3;309:7;310:18;
311:24,25;312:9,12;
314:1,5;316:18;
317:3;318:2;319:21

canal (15)
133:13;135:23;
142:11;152:15,16;
157:7;164:2;169:7;
279:13;280:20;
281:3;285:18;
294:22;310:10,13

cancel (1)
130:23

Cancer (1)
128:8

cane (8)
134:3;139:12;
147:4;148:5;162:24;
167:7;170:20;171:7

car (1)
129:25

cardiac (1)
195:15

cardiovascular (1)
257:14

care (7)
125:3;145:12;
149:24,25;246:18;
296:2;300:5

cared (1)
251:25

carpenter (6)
147:8;190:4;
263:19,25;264:3,6

carrying (1)
182:22

case (32)
135:18,21;136:14;
137:8,14,22;138:9;
140:2;148:18;149:8;
155:12,19;159:25;
160:7,24;162:18;
168:11;172:17;
176:9,10,22;187:22;
188:9;195:3;196:19;
215:22;225:1,2,3;
226:9;233:25;320:11

cases (4)
143:18;235:4;
241:21;247:10

CAT (22)
130:6;131:8,15,18,
22;132:3;140:21,23;
142:4,5;218:16;
259:20;268:9,12;
269:2;273:21;
276:24;277:12,18;
279:16;280:2;288:6

cauda (2)
154:14;164:10

causal (1)
239:7

cause (23)
139:23;174:20;
175:14,25;176:12,22;
181:13;182:1;228:7,
12,15,18;229:1,2,5,
11;230:8,10;285:19,
20;307:8;311:25;
312:9

caused (14)
137:15,16;175:12;
176:3,7,23;183:6;
229:15,21;271:18;
309:8,9;314:19,20

causes (5)
130:1;144:11;
183:3;209:23;218:10

causing (13)
129:3;130:4;
139:25;144:13;
155:22;172:4;
176:10;181:12,12;
182:7;217:10;
239:10,13

cells (1)
144:10

Center (5)
128:6,8,9,12;
256:11

central (4)
157:8;280:20;
281:3;310:10

cerebellum (1)
156:14

cerebral (1)
157:7

certain (12)
131:6;160:7;
173:12;191:18;
239:8;250:16;256:3;
257:10;264:24;
297:21;303:7,21

certainly (7)
131:6;166:1;
178:24;214:19;
221:8;229:12;238:15

certainty (34)
161:19;174:20;
175:14;176:5;177:6;
181:24;182:11,14;
183:5,9,19;184:6;
186:8,14;187:4,15;
226:8,11,23;228:6,
15;229:5,14,21;
230:7,14,22;231:10,
16,24;232:13;233:6,
19;313:14

certification (1)
238:12

certified (18)
128:13,15;160:15;
183:10;184:22;
186:16;234:11;
256:14,19,21;258:20;
300:5;301:13,20,21,
22,23;305:2

cervical (63)
135:25;136:7;
138:4,8;142:22;
152:9;155:25;156:9,
23;165:3;166:18,22;
174:5;176:6;205:12;
215:14,16;229:6,22;
230:6;244:17,18,19;
261:12;262:5,12,13,
18,20;263:7;264:24;
267:22,24;268:4;
273:21;274:4,5,8,11,
18,21;275:1,9;291:2;
292:11;298:14,18,23;
304:8,9,13;307:2,4,
10,20,22;313:13;
317:22;318:4,9,10,
10;319:9

cervicalgia (2)
172:11,13

cervix (1)
263:7

chain (1)
144:11

change (9)
203:8;236:12;
262:17,22;263:7;
282:20;289:14;
292:13;294:22

changed (3)
235:2;236:5;
265:23

changes (34)
141:3,18,20;149:4,
5;262:13,21;263:8;
264:5,7,9,13,16,19;
273:8,14,19;275:16;
278:21;282:3,18,22;
289:13;290:3;
291:16;292:1;299:3,
10;307:24;308:2,7;
309:3,4,4

changing (1)
159:24

charge (2)
178:10;191:17

charging (1)
191:14

check (1)
280:7

checked (1)
137:23

checks (1)
196:17

chest (3)
138:21;185:18;
257:14

chin (1)
138:21

chiropractic (1)
130:9

choose (3)
212:14;300:12,15

chose (2)
184:24;212:11

Chris (2)
188:7;277:20

chronic (7)
183:16;185:11;
219:6,21;220:8;
227:19;233:14

circle (1)
230:9

circled (2)
156:2;229:7

circles (1)
156:1

circumferential (7)
278:23;279:4,5,6;
311:21;312:22;313:7

circumstances (2)
241:22;242:6

claim (2)
178:8,11

clear (7)
126:18;156:21;
175:10;185:13;
222:6;314:6;319:9

clearer (1)
238:15

clearly (3)
142:20;180:7;
239:7

clients (4)
140:10,13;248:6,
15

clinic (2)
170:16,17

clinical (6)
148:25;184:12;
205:1,7;290:2,4

clinically (2)
291:14,23

clinician (1)
131:12

close (6)
179:1;180:5;
204:21;286:18;
304:1;305:4

closed (5)
142:15;252:19;
253:12;256:24,25

clubs (1)
246:25

cold (1)
127:5

collapse (7)
148:19;182:6;
202:15;203:1;
226:16;228:23;
233:17

collapsing (1)
172:18

colleague (1)
295:9

collection (1)
269:11

column (9)
124:2;133:11;
152:3,8,13;154:9,16,
20;185:5

combination (2)
167:20;191:5

combined (1)
233:2

comfortable (3)
222:2,4;259:16

coming (11)
135:2;145:4;146:9;
151:15;154:13;
156:15;168:20;
178:14;224:16;
238:12,20

commencing (1)
297:4

comment (2)
151:17;208:4

commented (1)
276:11

common (5)
132:22,25;140:25;
198:20;270:14

commonly (1)
213:5

Comp (3)
236:15;238:5,6

companies (4)
250:14;251:1;

254:20;256:4
companion (1)
257:10
company (8)
212:21;250:7,22;
251:2,8;254:7,14,15
compare (1)
301:11
compared (2)
237:15,16
compensated (2)
130:24;262:11
Compensation (1)
222:19
complain (4)
137:1;158:12;
209:13;299:19
complained (4)
158:16,19,21;
194:11
complaining (5)
170:7;174:21;
209:17;299:11,15
complaint (7)
136:17,25;209:19;
217:9;270:15;
271:16;281:25
complaints (11)
146:18,20;162:6;
165:13;167:3;
172:23;174:10,14;
206:16;222:25;
235:12
complete (1)
230:5
completed (3)
128:5,6;210:14
completely (1)
221:22
complex (5)
142:8;277:5;
279:11;280:25;282:3
complication (2)
281:7,14
complications (1)
281:24
comply (1)
130:19
compressing (1)
286:25
compression (10)
142:7;272:23;
273:19;285:20,23;
288:11;290:20,22;
307:6;315:8
compromised (2)
137:6;218:8
computer (1)
144:5
concerned (7)
135:21;145:10,11;
172:17;196:19;
224:8,9
Concourse (1)
126:21
condition (31)
124:4,5;150:22;
158:11,13;160:24;
165:21,22;166:4;
171:21;182:23;
183:16,20;184:15;
186:25;190:3;
218:10;226:17,25;
239:10,11,12;271:9;
273:12;275:23;
277:5;282:8;311:18;
318:20;319:17,18
conditions (6)
182:15;183:6,12;
239:6;312:21;313:16
Conduction (1)
144:4
confirm (1)
136:24
conflict (1)
250:16
congenital (2)
282:10,11
conjunction (1)
151:12
connection (5)
148:7;160:15;
217:5;222:10;307:19
consequence (3)
230:2,16;281:14
consequences (1)
129:11
conservative (2)
150:9;207:14
consider (4)
173:5;221:7,23;
222:1
consideration (1)
316:17
considered (1)
223:17
considering (3)
163:4;240:16;
271:11
consistent (1)
166:10
constitutive (3)
292:1;299:3,10
construct (1)
261:6
construction (3)
129:25;140:8;
182:16
consult (3)
254:12;255:3;
259:2
consultant (3)
254:7,13,18
consultation (3)
295:14,15,19
consulted (4)
254:11,13,16;
283:14
consulting (4)
254:22,24,25;
255:22
contacting (1)
280:14
contain (2)
159:15;301:18
contained (6)
169:2,21,25;171:9;
172:10,16
CONT'D (1)
180:19
contemporaneously (1)
284:8
content (1)
218:5
contention (1)
301:22
continue (33)
134:13;140:15;
142:2;147:10;
150:10;152:1;153:7;
162:21;166:11;
173:4,4,5;183:22;
184:8;186:15;197:9;
200:3;203:4;207:5,
14;208:10,18;
213:25;214:13;
223:6;225:16,21;
226:25;227:19;
230:23;231:2;296:2;
306:24
Continued (8)
157:17;171:8;
199:14;225:12,23;
226:16;242:13;
287:10
continues (3)
184:1;205:19;
279:16
continuing (2)
207:7;319:24
contour (1)
317:16
contoured (2)
315:5;319:1
contract (2)
144:14;152:21
contradiction (1)
284:6
contributory (1)
310:2
control (2)
133:25;144:23
controlling (1)
162:12
contusion (1)
269:20
contusions (1)
269:6
conversation (4)
215:19,20;237:4;
240:2
convexity (1)
148:16
coordination (1)
180:5
cord (35)
128:22;135:1,17,
20,21;137:20;144:12,
25;148:12;152:15,
22;153:3,5;154:14;
156:14,15,19,19;
157:8,11;161:14;
164:9,9,11;176:6,11;
184:20,23;185:2,6;
186:1;207:12;267:3;
280:14;300:15
Cornell (1)
128:8
corrected (2)
280:17;286:25
correcting (1)
315:25
correctly (1)
214:8
correspondence (1)
191:9
corresponding (2)
234:18;263:8
corroborate (1)
136:25
cost (8)
212:24,25;244:16,
22;245:14,19,22;
256:1
costs (2)
213:1;245:12
Counsel (5)
178:1;188:6,18;
191:10;225:20
count (1)
261:4
counter (2)
163:13;194:24
couple (5)
183:25;221:16,17;
297:14;316:25
course (16)
141:9,11;150:16,
22;158:13;159:8;
166:3;167:24;
168:14;171:17;
187:11;200:3;203:4;
210:14;215:11;
227:13
COURT (146)
124:15,21;125:1,9,
16,20,23,24;126:2,4,
12,17,23;127:2,6,9;
129:18;140:12;
141:6;145:22,25;
146:5;149:20;151:3,
6;156:5;169:12,14;
173:11,14,17;175:2,
23;177:22,24;178:1,
4,15,19;179:6,12,15,
17,22;180:1,12,15,
16;184:5,11;185:16;
186:20;187:20,24,25;
188:2;191:22;192:6;
221:12,15,18;222:11,
15,17;223:24;224:5,
20,23;225:4,6,8,13,
16,22;232:8;233:12,
22;234:1,10,12;
235:8,25;236:6,10,
25;237:6,13,22;
238:8;239:2;240:8,
12,25;241:18;242:4,
12;243:2;246:11;
247:10;248:10;
249:1,19;251:6,17;
253:17;254:10;
255:6;276:1;283:5;
287:5,8,9;288:1,4,18;
290:1;297:25;
300:20;302:6,23;
303:10;304:23;
305:8,14;306:2,9,14,
25;308:12;309:24;
310:24;311:2,7,11;
312:2,9,16;313:19,
25;314:3;317:14;
318:1,7;320:5,8,12
courtroom (9)
125:25;144:21;
188:1;225:5,14;
234:2;243:1;288:2;
320:13
court's (2)
150:24;169:15
cover (2)
193:15;260:14
coverage (6)
189:23;190:8,9;
222:7,8,12
covered (2)
310:23,25
covering (1)
255:25
cramping (1)
146:23
cranial (4)
196:13,14,17;
197:3
CROSS (9)
188:3;225:20;
233:23;238:22;
240:10;243:5;311:8;
313:21;318:1
cross-examination (1)
187:21
crossover (1)
128:23
crystal (1)
183:24

CSF (2)
157:7,12
CT (20)
187:16;199:6; 231:18;257:19; 268:18,19;274:4; 276:4,20;277:21; 301:2,3,6,11;304:6,9, 19,22;306:6;310:9
CTs (1)
199:7
CT's (3)
174:16;276:9; 311:21
cumulative (7)
169:11;175:22; 178:21,21;179:7,9; 185:15
curative (1)
215:24
current (5)
128:3;200:3;203:4; 214:7,8
currently (5)
128:13;247:13,20; 248:15,22
curvature (1)
148:15
curve (1)
316:15
curves (2)
148:16,17
custom (1)
286:20
cut (2)
153:24;168:22
cutting (1)
198:21

D

daily (8)
129:16;131:21; 134:1;162:22;167:2; 172:1,3;265:24
damage (16)
134:25;135:16,17; 137:17;145:4,4; 146:8;148:10,11,22; 149:9;153:5;154:23; 224:16;273:6;307:8
damaged (6)
124:4;137:19; 153:2,3,6;160:22
Danek (1)
254:14
dangerous (1)
182:21
dash (1)
257:19
date (31)
143:7,22;145:23; 147:15;164:18; 166:12,17,25;167:8, 21;177:2;203:16; 207:22;211:16,19; 220:5;227:1;230:23; 241:12;263:6;267:7, 8;268:19,22;279:22; 288:21,22;292:22; 303:21;308:14,24
dates (3)
193:14,16,18
day (21)
141:18;149:11; 159:8;167:16; 191:17;214:12; 226:7,13,13;228:5; 229:8,18;232:20; 233:18;235:11; 289:23;301:12; 304:2;306:10,17; 310:19
days (12)
133:15;142:19; 159:3;166:1,1; 183:14,14;244:2,4; 257:9;310:8,15
day-to-day (2)
129:17;147:3
deal (2)
129:2;172:4
dealing (1)
298:11
deals (1)
129:10
deceased (1)
147:25
December (3)
219:5;295:22; 296:19
decided (1)
272:2
decides (1)
144:8
deciding (1)
298:5
decision (2)
125:20;259:16
decline (2)
215:11;216:8
declined (4)
215:9;216:4; 297:16,18
declines (2)
163:23;216:15
decrease (2)
135:9;232:11
decreased (2)
166:16;205:11
decreasing (1)
233:2
deemed (1)
132:8
deep (1)
270:1
defendant (1)
189:8
Defendants (2)
188:8,21
Defendant's (1)
234:4
defense (4)
188:17;225:20; 235:2,8
defer (1)
210:11
defined (1)
127:25
definitive (1)
277:5
deformities (3)
282:6;298:13,18
deformity (18)
228:2,24;230:4; 231:5,8;233:16; 273:19;286:24; 298:11,19;314:17,19; 315:4,25;316:9; 317:17,19;319:25
degeneration (5)
141:22;180:8; 241:16,17;308:25
degenerative (58)
141:2,7,18,20; 142:24;176:1,17; 177:3;178:9,11; 217:25;236:24; 239:6;262:21,23; 263:7;264:5,7,9,13; 273:8,12,14,19; 275:16;277:6;278:6, 16,21;279:1,20; 282:3,18,20,21; 289:13,14;290:3,6,8; 291:9,16;292:13; 294:22;299:3,10; 307:24;308:1,3,7,22, 25;309:3,4,4;312:23; 313:1,5
degree (38)
127:21,24;161:19; 174:19;175:14; 176:4;177:6;181:23; 182:11,13;183:5,9, 19;184:6;186:7,13; 187:3,15;226:6,8,10, 23;228:6,14;229:5, 11,13,20;230:7,14, 21;231:9,16,24; 232:13;233:6,19; 313:14
degrees (10)
137:11,11,14,14, 15;139:3,3;153:24; 168:11,12
deliberations (1)
124:14
demonstrated (1)
269:6
demonstrative (3)
124:12,18,24
denied (8)
133:23;134:4; 146:23;194:14; 221:3,5;303:20,21
denies (3)
266:20,23,25
dense (2)
276:25;309:15
density (7)
218:2,4,5,8,18; 276:18,23
department (7)
257:7,19,21,24; 258:2,5,8
departments (1)
258:19
depending (12)
130:18;161:21; 162:17;183:14; 186:25,25;243:23; 244:19,20;246:3; 261:21;285:22
depends (5)
137:25;138:5; 164:12,12;245:15
depict (3)
124:7;151:18; 301:13
depicted (2)
177:8;303:8
depiction (4)
151:22;185:23; 301:3,7
Depuy (1)
254:15
derangement (1)
142:22
derivative (1)
159:15
describe (4)
212:3,24;276:17; 309:3
described (1)
165:18
description (2)
277:16;291:25
descriptive (3)
276:19;282:17; 289:11
despite (3)
158:15;212:14; 224:11
detail (1)
161:6
detailed (1)
212:6
detective (1)
131:13
deteriorate (2)
182:7;183:22
deteriorated (4)
158:11,14;165:25; 166:4
deterioration (3)
155:23;160:24; 162:19
determine (4)
139:25;153:4; 210:6;270:11
determined (1)
136:6
determines (1)
145:3
determining (1)
139:23
develop (1)
141:9
developed (2)
184:13;257:9
development (1)
262:25
develops (1)
282:8
device (1)
250:13
devices (3)
250:8;254:8;255:3
diagnosed (2)
228:3,3
diagnoses (4)
149:22;271:11,18; 272:3
diagnosis (14)
142:13,13;270:16, 17,18,21,24;271:1,1, 2,5,21;272:1,8
diagnostic (11)
131:11;140:18; 143:9;149:7;187:9, 16;192:25;231:6,17, 21;295:19
diagram (2)
151:11;283:20
dictated (2)
284:8,13
dictating (1)
284:18
difference (3)
147:22;159:12; 245:4
different (33)
128:12;130:4,6,17; 131:13,22;156:10,25; 157:13;160:17,25; 164:10;167:23; 170:11;182:7;185:6, 6,24;186:1;215:21; 220:23,23;235:8,13; 236:1;255:19; 264:23;270:13; 271:8,10,18,19,25
differential (11)
270:16,16,17,24;

271:7,11,17;272:1,4,6,8
differentials (3)
270:9,13;271:3
differentiation (1)
269:8
difficult (1)
248:12
difficulties (1)
206:25
difficulty (7)
139:10,13;168:6,6,7;170:10;201:16
diffuse (8)
276:14;277:9,9,13,14;309:12,16,19
diffused (2)
219:24;220:10
diffusedly (1)
290:11
dilated (2)
269:24;270:9
dilemma (1)
270:21
diminished (2)
165:2;168:2
DIRECT (11)
127:11;180:19;202:7;225:19,23;261:11;291:20;310:23,25;313:18,19
directly (1)
255:23
disagree (3)
155:6;238:2;292:2
disagreement (1)
240:14
disc (39)
136:12;137:7;142:8;152:12;154:3,8,11,18,19,22;156:16,17,18,20;157:10;277:4;278:23;279:2,3,4,7,11;280:24;281:3;290:8;291:11,17;292:7,12,16;307:16,22,23;311:21,25;312:6,9,12;313:7
discharged (1)
208:22
disclose (3)
250:13;253:3,7
disclosure (6)
177:17,20;178:5,7;179:11;250:20
discogenic (3)
278:6,16;279:20
discomfort (1)
172:4
discrepancy (1)
138:10
discriminate (1)
130:16
discs (2)
154:7;155:10
discuss (9)
187:21;211:25;212:3;215:2;225:1,2,3;233:25;320:11
discussed (10)
147:3;163:5,25;170:23;174:16;207:11;216:20;217:1;235:5;237:10
discussing (3)
151:13;222:3,4
Discussion (7)
151:7;156:6;212:6;214:24;215:8;216:3;306:23
discussions (2)
216:7,7
disease (9)
141:7;142:25;176:1,17;177:3;217:25;278:6,16;279:20
disingenuous (1)
238:18
disk (4)
176:15,20,20;264:16
disks (2)
160:16;264:19
disorder (1)
130:2
disorders (1)
128:21
displacing (1)
157:12
displayed (2)
185:22;268:14
displaying (2)
282:18,19
distinguishes (1)
261:25
diverse (1)
277:24
divest (1)
251:9
divested (1)
251:22
divided (1)
152:8
dizziness (2)
194:14;206:22
doctor (99)
124:23;125:2,11;126:6,6,7;127:2;136:3;139:17;140:4;142:2;149:1,4;152:1;156:7;157:15;163:3,3,4;169:12,17;171:9,9;173:7;178:14;179:23;180:9,10;182:8;184:3;186:5,6,22;189:20;192:23;201:13;208:4;221:3,22,24,24;222:4;224:20;225:17;227:5,9;228:25;233:5;235:14;236:10,11;238:19;239:11;240:4;243:7,12,19;250:2,3;251:4;252:3;257:1;260:11;261:11;266:4;267:12;268:15,17;270:14;271:8,17,24;272:5,6;273:21;276:3,13;277:8;279:22;282:24;283:9,11,17;284:11,14,16,18;291:6;292:15,22;293:22;299:22;307:1;313:20;315:3;318:2,3;319:6;320:5
doctors (13)
140:11;172:2;189:25;191:3;236:15,15,23;238:9,21,24;257:10;258:19;316:14
doctor's (1)
208:4
document (1)
170:13
dollar (1)
191:25
dollars (5)
191:15;192:3,4;213:2;245:24
done (34)
130:6;164:5,7,8,11,13;172:3;174:13,13;188:14;199:7;219:4;226:3;227:6,21;243:9;244:11;254:22,24,25;255:10,16;260:5;279:24;283:23;284:8,15;288:6;296:8;301:11;312:3,4;314:17;320:8
double (2)
179:5;180:4
doubt (2)
236:25;303:5
down (53)
133:20;137:5,15,16;144:12;146:9;149:3;151:1,8,19;152:19;153:1,12;154:1,7,13,16;155:21;156:15;157:16;165:16,16,21;166:16;168:22;172:19,24;174:22;180:3;185:24;196:22;197:6;202:14;207:1;212:2;216:24;217:2;224:14,21;247:24;252:19;297:22,23;298:1,2;301:5;310:14;314:11;315:1,24;316:20;318:25;320:6
Downstate (2)
256:11,11
dozen (2)
188:15;192:2
Dr (61)
127:13;131:3;132:21;145:15;149:10,12,23,24,25;150:21,25;151:1,8;155:3;156:1;178:15,17;188:5;190:12;192:18;216:9;220:21;221:11,21;223:10,11;225:17,25;226:2;234:14,15,19;235:19;237:19;238:23;239:9,18;247:1;283:14;285:6;288:5;295:2,9,15,20;297:8,20;298:5;299:25,25;300:5,11,14,18,25;301:9,15;310:4;313:21;314:16;318:12
dressing (7)
139:10,13;148:3;165:8;166:21;168:7;206:25
drink (1)
287:6
dropping (1)
240:17
drowsy (3)
163:7;164:23;167:18
drug (2)
194:22,24
dry (1)
155:12
Drying (1)
264:21
due (1)
136:11
Duke (1)
127:22
duly (1)
126:15
during (11)
125:3;139:14,16;162:2;167:16;168:14;203:23;252:23,24;261:11;268:9
duty (1)
299:13
DV (1)
219:10
dysfunction (9)
134:25;135:19;150:5;162:13,15;167:1;175:5;217:6;220:3

E

earlier (3)
256:13;289:23;297:20
ears (1)
196:18
easel (1)
151:2
easily (1)
286:11
educational (1)
127:19
effect (8)
172:9;180:7;192:4;198:18;206:3;212:7;251:10;269:6
effective (5)
161:15;171:22;210:21;214:8,11
effects (3)
160:18;164:20;167:11
effusion (2)
169:10;281:13
eight (3)
191:19,20;270:6
either (18)
135:1,17;144:18,24;148:11;150:20;152:21;153:2;154:19;187:16;203:19;238:18;240:17;241:5;255:24;256:10;297:1;312:22
electric (4)
144:17;149:3,7;185:9
electrical (8)
144:20;160:11,19;161:10,12;185:4,7;186:3
electricity (3)
144:11,12,18
electrode (1)
144:8
electrodes (6)
161:9,23;185:5,19,24;213:5
Electromyography (1)
144:5

electronic (2)
249:8,8
elements (1)
285:17
Eleven (1)
316:7
eligible (1)
160:9
eliminate (1)
215:25
else (10)
153:7;158:10;
198:9;207:17;
259:21;295:13;
305:23;306:4;309:8;
315:19
else's (1)
153:17
emergency (8)
133:13;169:8,8;
284:1;303:5,7,22;
305:11
EMG (11)
144:4,19;148:21;
149:8;152:24,24;
153:1;187:16;
224:13,15,16
EMGs (2)
174:16;187:13
emits (1)
185:4
employ (2)
131:24;132:1
employed (1)
130:5
EMS (1)
305:5
encroachment (1)
294:21
end (5)
145:8;240:18;
252:8;275:19;278:21
ended (1)
312:20
endplate (1)
310:11
ends (1)
154:15
enjoy (1)
162:16
enlargements (1)
131:3
enough (3)
246:24;249:2;
284:7
entails (2)
129:9,21
entered (4)
168:15;188:1;
243:1;268:8
entering (3)
125:24;225:13;
288:1
enters (3)
125:25;225:14;
288:2
entire (8)
245:22;252:23;
266:12;279:6;
298:16,20;316:13,19
entirely (1)
178:9
entity (1)
143:17
Epidural (20)
163:24;164:4,16;
214:17,22;215:2,3,5,
12,16,22;216:4,11,
17,19,20;224:2;
286:6;300:12,13
epidurals (1)
184:18
equina (2)
154:14;164:10
equipment (4)
250:23;251:1,3;
254:7
erectile (6)
162:13,15;167:1;
175:4;217:5;221:3
erection (1)
162:17
ESIS (1)
163:23
especially (4)
162:23;167:16,18;
184:12
essential (1)
168:2
essentially (6)
173:3;202:2;207:4;
213:25;231:14;
261:21
establish (1)
131:19
etc (1)
233:4
evaluation (7)
129:11;170:5,5;
192:20;275:4,13,15
evaluations (1)
184:12
even (15)
124:17,17;141:15,
21;151:17;179:21;
190:2;236:19;
239:25;240:20;
241:6;257:21;259:2;
264:5;302:3
event (1)
223:25
eventual (1)
215:25
eventually (5)
139:22;161:3,4;
197:4;262:7
everyday (1)
131:23
evidence (41)
124:3,6,13,22;
125:4,5,19,21;132:8;
143:11,12;149:10;
162:1;168:16;
169:22;171:25;
173:12;201:14;
234:14,17,19,24;
235:15,19,24;236:7;
237:13;238:19;
240:9,20,22;241:11,
24;242:1;269:19;
270:19;274:19;
281:6;293:11;
300:24;305:10
evidentiary (1)
241:19
Evoked (1)
144:3
exacerbation (4)
142:24;143:1;
178:6;179:8
exact (6)
180:4;218:7;
246:12;247:6,12,22
exactly (9)
191:23;192:12;
211:19;215:10,19;
237:5;239:3;240:25;
284:11
exaggerated (14)
148:2,13;202:8,22;
208:10;262:5,17;
274:8;304:13;
306:18;307:4,20;
317:22;318:4
exaggeration (2)
274:4;307:2
exam (20)
135:11,24;136:21;
139:16;142:4;145:8,
20;146:2,16;147:5;
148:4,7;164:24;
165:9;166:2,22;
168:2,7;225:19;
292:22
EXAMINATION (38)
127:11;131:14,21;
134:14;139:11,15;
140:17;142:18;
147:21,22;167:21;
170:8;171:4;180:19;
188:3;195:5,12,15,
17;196:10,16;197:3;
200:2;202:1,7,11;
206:11;217:16,19;
221:19;225:20,23;
233:24;243:5;
291:21;299:23;
314:14;319:7
examinations (1)
197:6
examine (1)
240:10
examined (4)
135:24;137:1;
170:18;238:22
examiner (2)
138:1,9
examining (3)
136:15;247:14;
259:3
example (11)
130:8;136:17;
138:2;144:8,21;
160:21;187:11;
212:3;262:4,24;
271:12
exams (4)
146:1,5,7,8
exception (1)
235:22
excess (1)
307:9
exclusive (1)
270:25
exercise (2)
173:4;214:1
exercises (7)
160:8;161:1;163:2;
208:18;209:1;
210:15;214:13
exercising (1)
160:22
exhibit (15)
156:8;169:24;
170:2;173:20;
177:10;234:4;
260:22,24;267:12,14;
283:6;288:9,19;
293:3;315:11
exhibited (1)
175:15
existing (2)
274:8;290:19
exists (1)
124:8
exiting (7)
151:19,24;225:4;
234:1;290:21,22;
320:12
exits (4)
154:16;225:5;
234:2;320:13
expand (1)
193:6
expect (2)
183:11;184:1
experience (1)
205:9
experiencing (4)
162:11;166:24;
170:25;217:4
expert (6)
177:19;178:13;
179:10;189:7;
190:13;236:18
experts (2)
180:6;239:14
explain (3)
136:7;155:8;
171:11
explained (1)
167:14
extending (1)
137:5
extension (1)
138:23
extensive (1)
257:6
extent (3)
180:1;193:5;318:1
extra (1)
269:11
Extremely (2)
251:13,18
extremities (12)
134:24;135:11;
148:9;168:1;174:11;
197:14,24;198:6;
206:20;219:25;
266:20,23
extremity (6)
135:15;148:22;
151:15,20;208:12;
219:2
eyes (2)
196:18;269:14

F

face (1)
196:18
facet (5)
155:5;290:10;
309:22;315:21;
319:15
facilities (1)
191:4
facility (5)
132:2;133:15;
160:12;234:16;
302:19
fact (24)
135:22;140:9,12;
145:19;146:8;
158:16;166:5;
168:15,16,19;178:20;
179:22;203:3;
227:23;257:9;259:2;
260:1;264:12;
283:20;290:3;
294:17;302:1;
307:22;313:7
facts (3)
173:12;181:1;
227:23

fail (1)
305:13
failed (2)
140:7;243:15
failure (1)
293:21
fair (5)
151:22;249:2;
284:7;301:2,6
fairly (4)
124:7;151:18;
257:6;301:13
fall (13)
170:6;175:6,24;
176:7,11;177:7,11;
228:12;229:15;
281:23;305:5;
311:24;319:11
fallen (2)
133:8;173:19
falling (1)
182:22
familiar (1)
302:12
family (1)
197:2
fancy (2)
172:13,14
far (14)
134:20;138:3;
150:18;156:19;
182:11;208:25;
209:2,20;213:6;
230:5;236:1;240:5;
268:5;305:1
fast (1)
228:25
fatigue (1)
255:12
fault (2)
237:11;240:15
favorable (1)
237:2
fax (1)
191:8
FDA (1)
254:25
February (13)
146:16,19;147:11,
21;149:18;150:8;
200:16;201:18;
202:2;204:1;293:23;
294:18;297:3
fee (1)
130:24
feel (10)
136:18;163:7;
164:23;185:8;
198:16;201:23;
212:9;222:2,3;
264:16
feeling (12)
135:12;146:21,22;
162:9,10;173:1;
185:8,10;198:14,16,
20;204:24
feels (1)
201:22
feet (4)
162:9;172:25;
207:2;227:25
fell (7)
151:11;175:10;
227:24;238:25;
299:13;303:7;311:25
fellowship (1)
128:1
fellowships (1)
128:3
few (5)
133:15;159:4;
163:10;193:16;
233:24
fibers (1)
270:3
field (3)
129:8,10;257:11
fields (1)
257:10
fifty (7)
244:24;247:14,23;
248:14,16,22;264:10
fifty-two (1)
264:12
figure (4)
129:3,4;130:3;
192:2
file (18)
131:3;132:8,13,16;
190:23;191:6;
193:14;194:6;247:1;
266:4,6;268:15;
289:3;291:1,6;
292:24;300:1;301:18
files (1)
249:6
filling (1)
133:22
film (17)
132:4;155:2;230:7;
235:15;236:21;
259:15;277:12;
288:19;291:25;
302:10;306:16,17;
308:1;318:3,8,9,11
films (29)
150:14,17,18,19;
153:14;199:11;
218:14;234:14,21,24;
235:2,3,9,11,20,20;
236:1,5,17;238:13;
259:5;267:19;276:8,
11;288:6,20;301:24;
302:2,25
finally (3)
186:5;224:11;
233:5
finances (1)
246:17
financial (7)
250:7,22;251:2,7,
9;252:25;253:15
find (15)
131:14;136:22,23;
197:7;202:19;
203:23;220:24;
254:6;266:14;274:7;
283:1,2;291:14,23;
303:15
finding (15)
134:23;136:16,24;
221:6;239:18,21;
259:21;270:5;
276:21;289:14;
291:9;292:2;293:16;
294:2,12
findings (38)
136:4;149:7;
153:18;156:7,24;
162:2,6;164:18;
166:11,13;169:25;
173:3;174:1,14,15,
16;177:9;181:2,2,25;
202:3;218:14;
220:12;224:11,13;
237:21;269:4;
272:20;274:3;
275:12;284:11;
293:8;303:4;304:12;
312:18,23;313:1,6
finds (3)
149:4;317:11,17
fine (1)
249:20
finger (2)
261:7,8
finish (4)
126:5,7;248:25;
287:6
finished (3)
193:23;208:21;
253:2
fire (1)
144:11
firm (4)
188:12;189:1;
247:15;248:16
first (59)
126:15,25;132:12,
16;133:2,5;136:7;
139:18,22;140:19,20;
142:13;143:6,22;
145:13;146:2;147:5;
148:7;151:17;158:1,
6;159:1;160:1;
174:20;175:21;
177:14;181:1;
193:16;194:11;
197:9;200:1;204:22;
209:13,14,18;210:3;
211:4,16,19;212:13;
214:17,18,19;215:7;
216:12;218:24;
220:21;222:22;
227:6;229:1;231:24;
234:9;237:8;260:1;
295:2,5;297:3,12;
307:21
fist (1)
144:9
fit (2)
315:4;318:19
fitted (1)
315:3
five (33)
134:16,18,18,19;
135:6,7,8;144:22,23;
152:11;161:22;
166:15;168:1;
170:21;191:14,20,23;
197:15,15,24,24;
203:25;205:21;
207:4;213:4;232:1,9;
235:7;248:1,5;
249:13;252:4;287:5
fix (2)
215:24;316:9
fixing (1)
298:10
fixture (1)
145:1
flat (1)
157:1
Flexeril (2)
170:23;173:2
flexibility (4)
233:3;264:25;
265:3,6
flexion (7)
138:4,8,16,17,21;
139:4,5
Flexoril (2)
167:13,17
fluid (1)
157:7
fluoroscope (1)
286:18
focus (1)
172:7
follow (6)
201:15;221:12;
223:6,7,10;308:13
followed (2)
130:17;224:5
following (11)
125:25;173:8,15;
177:25;180:14;
187:24;200:1;
225:14;237:20;
287:8;288:2
follows (1)
126:16
foot (10)
146:22;152:20;
281:18,18,20,21,25;
282:2,14,22
foraminal (1)
290:14
forget (2)
225:2;226:9
form (2)
182:16;294:9
formal (2)
143:13,18
formation (1)
273:10
forth (1)
179:3
forty (2)
192:4,10
forty-five (1)
163:1
forward (11)
138:21,25;148:17,
20;168:10,13;
187:13;263:6;
268:17;286:5;319:25
found (18)
133:10;134:15;
135:5,5,6,7,10,25;
136:15;137:2;171:7;
174:17,18;197:20;
202:7;219:10;
288:11;315:4
four (20)
135:5,5;144:23;
150:22;166:3;206:9,
16,18;208:13,15;
209:6;235:11;
241:12;249:13;
257:4,6;293:14;
296:3;297:15;310:21
fourteen (1)
263:4
four-to-six-weeks (2)
296:11,16
fracture (48)
133:11;135:22;
142:7,8,9;169:5,7;
226:18;230:16;
272:23;274:21,25;
277:24;279:17;
285:6,8,12,15;286:1;
293:11,19;303:13,13;
305:3,3;309:9,21,22,
22;314:19,20,20,21,
22;315:9,10,16;
316:3,5,12,17,18;
317:6,9,19;318:15,
17,20
fractured (2)
273:7;315:19
fractures (42)
133:11;141:1;
142:6,23;148:18;

150:11;169:5;174:3,4;175:10;182:4;227:4,17;228:2,4,5,8,12,13,24;230:3;233:15;267:24,25;278:2,7,13;279:19;285:1;286:9;307:6,9,22;310:3;313:11;314:5,5,6,8;319:13,14,15
fragment (1)
294:3
fragments (4)
133:12;142:11;154:22;169:6
Frampaong (4)
300:25;301:9,15;318:12
F-r-a-m-p-a-o-n-g (1)
300:22
Frampong (6)
283:10,11,14,17;284:12,19
Francis (2)
252:17,18
frank (1)
239:17
Frempong (3)
300:18,19;310:5
frequency (2)
186:5;209:17
frequent (1)
187:14
Friday (1)
306:18
front (18)
125:14,17;152:4;156:12,21;209:10;236:21;260:13;270:19;274:17,23,24;280:3;295:5;308:3,21;309:11;311:6
full (9)
134:19,19;138:22;164:9;191:17;200:1;260:16;299:13,13
function (7)
129:17;133:25;144:6;196:17;232:11,25;265:24
functional (2)
140:17;171:23
functioning (1)
150:7
functions (1)
144:7
further (17)
138:7;139:17;145:6,12;173:23,25;174:5,8,12;184:15;193:1;216:15;224:18;233:21;285:14;307:8;314:12
fused (7)
155:15,19;181:19;232:22;261:3,5;319:24
fusion (9)
174:6;244:16;245:11,13,14;261:2;293:8;298:7;313:11
fusions (1)
258:24
future (19)
124:19;183:12,22;186:9,23;187:5;202:20;226:3,3,11,15,19;227:1,15;230:23;231:17;233:7;271:24;297:8

G

gait (5)
139:9;148:2;165:7;166:20;168:5
ganglia (1)
269:22
GANNON (113)
124:9,25;125:13;141:4;143:16,20;145:21,24;146:3;149:17,19;151:4;156:3;159:5;169:11,19;173:10;175:1,20,22;177:13,16,19;178:13,24;179:10,14,24;180:3,13;184:4,10;185:15;186:17,19;188:4,7;220:19;221:11;222:9,14;223:23;224:4,19;232:5,7;233:10;234:6;237:5,8;238:2,16;239:5,15,17;242:3,8,11;243:4,6;248:25;249:2;260:22;267:7,10,15;277:21;278:9,12;283:3;287:3;291:5;297:6;299:22;301:19;302:5,9,11,22;303:9,16,20;304:3,7,8,18,20;305:7,12,15,25;306:5,7,13,21;307:3;308:4,8;309:23;310:22;311:1,5,10;312:1,3,7,15,18;313:17,22;314:13,15;320:4
gastrointestinal (2)
195:17;257:22
gated (1)
185:25
gave (6)
133:3;152:23;175:8;206:12;236:2;248:2
gears (1)
260:11
general (8)
165:25;172:14;178:7;190:19;195:5;197:3;220:25;245:15
Generally (18)
129:23;132:2,6;159:25;161:16;164:7,13;171:17;172:5;202:4;213:4;218:11;236:6;260:12,13;270:17;272:4,4
generated (2)
144:5;161:13
generator (3)
185:4,12,18
genetic (1)
294:12
gentle (1)
261:18
gentleman (1)
308:2
gets (3)
144:18;155:11;181:20
given (10)
145:19;151:9;164:5;179:20;180:25;189:24;206:13;255:24;264:4;297:18
giving (6)
178:12;214:10;221:7,23;248:2;277:17
goes (8)
125:11;144:13;176:25;185:25;191:19;231:22;290:19;316:24
goniometer (1)
137:24
Good (17)
126:2,3,5;127:2,13,14;138:13;183:13;188:6;217:10;225:25;226:1;242:1;243:7,8;271:12;320:10
grade (2)
134:19;171:19
graded (2)
170:7,21
graduated (2)
127:22,23
Grand (1)
126:21
gravity (1)
155:16
gray (1)
269:8
great (3)
127:7;172:4;298:10
groin (1)
207:1
gross (1)
195:21
group (1)
198:3
groups (4)
160:22;198:1,1,5
grow (1)
141:16
guarded (1)
145:9
guess (6)
128:24;216:9;227:10;237:2;244:12;297:14
guidance (1)
164:14
guide (1)
196:23
guidelines (1)
222:20
guy (1)
299:17

H

half (1)
310:21
Hallux (1)
282:3
hammer (4)
282:6,9,10,11
hand (6)
126:13;135:4;144:9;197:10,20;260:23
handed (2)
170:2;260:24
handle (2)
186:1,22
handles (1)
246:17
hands (5)
137:5;138:6;141:11;162:9;197:21
handwriting (2)
208:5,6
handwritten (9)
146:12,14;159:18;163:9;165:11;171:10;203:18,18;267:10
happen (2)
227:12;262:20
happened (4)
133:4;203:24;236:8;317:1
happening (1)
279:3
happens (5)
141:12,16;144:15;155:16;218:11
happy (1)
248:20
hard (6)
127:3,5;142:8;255:7;279:3;284:5
hardware (8)
250:17;280:10;281:11;293:8,17;294:19;314:22,24
hate (1)
233:15
Hauscknecht's (1)
299:25
Hausknech (1)
126:9
Hausknecht (18)
126:20;127:13;145:15;151:1,8;188:5;190:12;192:18;216:9;220:21;221:11,21;295:15;297:20;300:6,11,14;313:21
H-a-u-s-k-n-e-c-h-t (1)
126:25
Hausknecht's (1)
180:11
HB (1)
319:20
head (37)
133:9;137:4;138:6,11,12,19;140:22;142:15,17,20,21;173:23,24;196:19;257:24;261:22;262:8;266:11,15,18;268:12,18,19;269:2;270:17;271:3;304:1,5,19,25;305:3,4,4,6,10,21;306:8
headaches (2)
194:14;206:22
heads (2)
286:21;315:8
heal (1)
150:11
health (3)
189:23;190:8,9
healthy (1)
155:11
hear (4)
127:3;217:17;242:5;243:21
heard (5)
127:25;128:17;141:17;223:20;297:20

hearing (1)
196:21
heart (3)
157:7;185:19;
195:11
heat (1)
160:19
height (10)
173:19;177:8;
227:24,25;228:13;
299:14;303:7;
307:16,23;311:25
held (1)
128:3
help (8)
160:19,22;161:13,
14;164:2;186:3;
204:14;224:10
helpful (1)
201:1
helping (4)
131:19;133:6;
146:25;214:11
helps (10)
160:20,20,23;
171:13,20;204:10,12,
15;205:25;212:9
hemorrhage (2)
269:6,19
Here's (3)
239:11,12;240:17
herniation (19)
154:20;155:4,9;
156:18,20;176:14,20;
177:4,15;180:23;
181:5;229:2;230:9,
11,16,19;292:7;
312:5,14
herniations (6)
177:12;180:25;
228:15,16;229:7,14
hesitant (7)
216:14;224:1,1,2,3,
6,7
high (1)
314:23
higher (3)
245:13;247:18;
248:19
Hill (13)
234:4,17;237:14;
260:7,8,9;288:6,13;
292:23;293:7,16,23;
313:3
himself (3)
182:22;235:14;
263:24
hinted (1)
240:13
hip (2)
135:5,6
hips (9)
165:1;166:15;
197:22;261:22;
262:8;265:12,13,14,
25
hired (3)
179:2;236:18,18
history (21)
133:1,2,3,6;134:4;
139:19,24;142:3,17;
146:18;197:2,2;
200:22;203:21;
206:12,13;221:22,25;
235:12;248:6;302:4
hit (4)
142:17;266:11,11,
15
hold (7)
230:8;260:19;
261:9;300:24;
301:10;306:15;
309:18
holding (2)
228:16;229:6
holidays (3)
244:4,5,6
home (12)
160:6,13;163:2;
173:4;208:18;209:1;
210:16,24;212:8;
213:25;214:13;
251:19
honestly (1)
253:19
Honor (33)
124:1,9;125:22;
127:8;151:4;156:3;
169:15;180:13;
220:19;221:13;
224:19,22;225:21;
234:6,8;237:8;239:5,
15;242:3;283:3;
287:3;297:6;304:4;
305:7,25;306:7,13,
22,24;308:4;310:22;
311:5;313:22
Hope (2)
126:4;221:13
hopefully (1)
272:7
horns (1)
270:21
horse's (1)
154:14
Hospital (43)
128:7,13;133:10,
14,14;140:20;
168:15;170:6;
173:25;174:1,9;
181:2;203:14;
218:17;232:23;
235:20,20,21;238:9;
242:9;244:21,22;
245:10;252:17,19,21,
22,24;254:1,2;
256:10;260:4;
266:10;268:3,8,25;
272:15;302:2,19;
309:13;311:20;
312:24;313:10
hospitalization (2)
177:10;245:22
hospitals (2)
128:12;250:15
hour (5)
130:25;191:15,19;
224:24,24
hours (1)
191:19
HPI (9)
203:20;204:6,22;
205:10;206:7,13;
207:20,21;208:7
human (4)
144:7;152:2;
261:12,20
hunched (2)
165:7;172:18
hunching (1)
148:20
hundred (14)
191:15,20;241:20;
243:21,22,25;244:1,
3,7,7,12;245:7,10;
247:20
Hydrocodone (1)
159:16
hyper (1)
319:16
hyperactive (1)
135:10
hyperlordosis (4)
311:17;318:11;
319:10,12
hypesthesia (2)
198:12,14
hypodensity (1)
270:6
hypothetical (3)
181:1,1,8
hypothetically (1)
178:12

I

Ibuprofen (5)
134:5;170:22;
194:18,20;200:8
ID (4)
124:3;125:3,10;
184:21
idea (1)
138:13
identical (2)
147:24;166:2
identification (4)
151:12,16;234:5;
239:24
identified (4)
189:25;197:14;
198:8;199:4
identify (1)
197:16
illness (1)
203:21
illustration (2)
124:11;125:8
illustrations (1)
131:6
image (4)
156:10,10,20;
185:21
imagine (2)
153:23;157:1
imaging (4)
131:18;184:13;
231:6;257:15
imagining (2)
130:5;295:19
imbalance (3)
230:2;231:7;317:2
immediately (1)
203:15
impact (7)
250:17;267:3,13,
18,22;274:23,24
impacting (1)
285:18
impairments (1)
160:23
impingement (1)
176:11
impingements (2)
229:14;233:17
implant (2)
255:13;293:21
implanted (1)
185:13
implants (21)
244:20;245:9,15,
22;246:3;253:24,25;
254:19,20,20,21,23,
24;255:1,8,9,12,13,
25;319:20,22
important (5)
131:11,19;140:1;
259:7,12
impressed (1)
142:14
impression (17)
142:12;150:1;
159:23;197:5,5,6;
200:14;202:17,18;
217:22;241:12,13;
273:18;279:17;
288:14;290:7;291:8
improve (3)
129:14;170:12;
205:19
improved (1)
205:10
improvement (3)
166:6;205:2,13
improving (3)
205:5;206:16,25
impulse (1)
144:8
impulses (5)
161:10,12;185:4,7,
8
inability (1)
266:23
incident (3)
272:11;285:25;
299:1
include (2)
192:6,8
included (1)
244:22
includes (2)
128:10,22
including (4)
128:12;170:22;
234:16;245:22
income (3)
191:21;246:5,7
inconsistent (1)
221:8
incontinence (9)
162:12,15;173:1;
209:14,19,24;210:4;
217:5;266:25
increase (1)
129:16
increased (1)
181:21
indeed (1)
224:13
indeterminate (1)
269:23
index (2)
261:7,8
indicate (6)
134:9;159:22;
193:9;201:6;211:14;
307:19
indicated (9)
133:17;134:11;
140:2;158:16;163:1,
7;216:13;231:22;
241:3
indicates (5)
170:6;171:23;
200:25;274:4,11
Indicating (1)
274:7
indication (6)
134:25;148:11;
162:19;275:10,23;
276:14
indicative (1)
149:9
individual (3)
158:12;189:1;

262:4
individuals (3)
247:14;249:3,15
induced (1)
314:7
inductors (2)
134:16,17
ineffective (1)
163:11
inevitable (2)
226:12;232:14
infarct (2)
269:23;270:9
infarcts (1)
269:24
inflammation (3)
154:23;164:2;
181:12
informatics (1)
258:17
information (8)
132:4;152:20,22;
190:16;212:17;
220:25;239:14;
263:21
initial (3)
142:13;192:20;
218:16
Initially (3)
142:14;158:5;
162:25
injected (1)
164:17
injection (7)
129:5;164:1;
215:12;216:14,21;
300:13,13
injections (21)
163:5,24;164:4,13;
171:18;207:12;
214:17,22;215:2,3,5,
16,22;216:4,11,17,
17,20;224:2,9;297:21
injured (7)
133:7;137:8;150:6;
160:20;189:24;
190:2;232:4
injuries (9)
149:13;160:16,16;
162:15;169:2;175:5;
227:16;228:2;305:10
injury (26)
133:9;134:4;135:2,
2,17,21;136:12;
140:23;145:10;
149:16,21;178:25,25;
196:19,20;206:7;
227:3;229:14;
230:18;231:25;
232:2,10;263:15;
273:15;305:3,5
innervated (1)
198:3
input (1)
298:7
inserted (2)
185:5;300:16
inside (3)
152:13;185:13,17
insignificant (2)
251:24;252:1
instead (3)
169:16;185:8;
266:12
instructed (2)
145:7;160:7
instrumentation (1)
311:17
intact (8)
166:18;168:3;
195:22,24;280:10;
284:1,4,22
integrity (3)
144:6;227:11;
231:23
intend (3)
239:20,20;240:2
intense (1)
276:24
intention (3)
234:25;235:1;
237:19
interest (10)
125:9;250:16,22;
251:7,11;252:6,13,
16,25;253:15
interesting (1)
241:18
interests (3)
250:7;251:2,21
interject (1)
308:10
internship (1)
128:5
interplay (2)
132:22;179:1
interpret (3)
131:9;301:24;
302:25
interpretation (5)
155:6;235:10;
236:19,20;240:7
interpreted (1)
153:13
interrupt (1)
227:9
intervention (2)
184:16;198:18
interventional (4)
185:2;216:16,18;
258:13
into (63)
124:2,6,13,22;
125:19;133:13;
135:22;136:16;
142:11;144:13,19;
152:8;154:5;162:8,8;
163:22;164:2,16,17;
168:16;173:24;
174:11,23;183:22;
185:5;186:9,23;
187:5;192:18;
196:22;203:14;
206:9;207:1,1;217:8;
218:1;226:5;227:15;
230:20,23;234:14,17;
235:23;237:13;
238:19;240:9,20,22;
241:24;251:10;
261:14;266:10;
286:20;287:4;305:1;
307:7,8;311:18;
315:8;316:17;319:2,
23;320:1
intracranial (2)
269:5,19
invested (1)
251:11
investments (1)
251:19
involuntary (1)
136:11
involved (2)
245:16;254:19
involves (1)
298:19
Ireland (1)
263:25
irritation (3)
154:23;164:3;
181:12
ish (1)
156:15
Israel (2)
128:6,12
issue (9)
180:8;216:11,19;
218:15;234:12;
240:10;280:12;
285:25;298:23
issues (12)
210:2;218:1;221:3,
3;239:6;257:22;
262:23;270:16;
281:11;299:1,5,8

J

January (7)
163:10;214:16,21;
215:1,13;295:24;
296:1
Jersey (1)
193:10
job (6)
129:3,3,13;130:3;
133:8;298:10
jobs (1)
172:2
Johnson (2)
254:15,15
joined (2)
252:13;257:1
joint (11)
141:7;142:25;
150:5;155:5;176:1,
17;177:3;217:25;
282:13,18;290:10
joints (3)
155:15;172:19;
315:21
Judge (5)
233:21;236:14;
306:11;308:6;313:24
Judge's (1)
177:25
judgment (1)
250:18
July (2)
205:24;296:18
junction (1)
145:2
June (14)
161:25;164:18;
205:18,24;209:5;
214:15;217:4,15,18;
220:7;230:10;
292:22,25;293:1
JURORS (1)
126:3
jury (140)
124:14,23;125:2,3,
15,17,24,25;127:15,
25;128:1,17;129:7,
20;130:13;131:9;
133:1,2;136:3;
139:21;141:17;
143:1,25;145:6;
146:7;148:6,14,21;
150:1;151:8,13;
152:23;153:16,17;
155:8;156:1,23;
159:12,20;160:6,14;
161:5;162:14;
165:12;169:10,24;
171:12;172:11;
174:10,15,16,25;
175:7,15,18;176:6,
13;178:3;180:24;
181:7,15,24;183:6;
184:23;185:22;
188:1;190:18;
201:14,15;206:8;
207:20;208:7;223:4,
16,25;224:13;225:4,
5,13,14;226:4,6,10,
24;228:4,10,20;
229:7,10,17,24;
230:13;231:25;
232:1,19;233:13;
234:1,2;235:18;
237:2,20,24,25;
239:3,14,20,25;
241:7;242:5,12;
243:1;246:5;260:13;
261:2;267:14;269:5;
276:8,11;283:7;
286:21;288:1,2;
303:6;304:17;
305:19,23;306:3,17;
307:3;309:7,12;
310:18;311:6,13,24;
312:13;314:6;
319:10;320:12,13
justification (1)
213:15
jut (1)
251:23

K

keep (3)
127:3;214:3;249:3
kept (2)
124:19;265:18
Kesler (1)
208:23
Kessler (10)
170:19;193:10,12,
14,20,22;194:5,8;
200:6;208:21
Kettering (1)
128:8
kids (3)
246:24;251:19,20
killer (3)
163:15,21;164:22
kind (6)
140:18;196:23;
246:4;261:25;
274:22;282:9
knees (5)
135:7,11;141:11;
165:2;197:22
knew (3)
227:23;236:16;
260:12
knowing (3)
132:13;305:2,4
knowledge (7)
140:18;149:14,15;
160:3;161:3;303:24;
306:9
known (10)
137:24;141:2,8;
143:24;154:14;
159:15;160:10;
185:25;218:10;314:9
knows (1)
133:1
kyphos (1)
319:24
kyphoscoliosis (5)
165:6;172:15;
184:14;217:15,19

kyphosis (28)
148:2,13,17;202:8,22;226:18,18;261:14;262:22;309:6,7,9;311:16,19;313:12;315:7;316:19,20,22,23,25;317:1,3,5,6,9,11,13
kyphotic (15)
228:2,24;230:4;231:5;286:24;314:17,19;315:4,25;316:9;317:17;318:19;319:17,18,25
kyphotically (1)
262:17

L

L1 (2)
142:8;152:12
L1/L2 (1)
279:8
L1-L2 (1)
290:8
L2/L3 (1)
279:8
L2-L3 (3)
288:15;289:6;290:8
L3 (7)
261:5,5;315:2,24;318:14,15,25
L3/L4 (2)
279:8,11
L3-L4 (2)
288:11;292:18
L4 (1)
292:20
L4/L5 (2)
198:4;281:3
L4-L5 (3)
288:11;290:8,17
L5 (4)
152:12;294:2,8,17
L5-S1 (3)
219:6,22;220:8
labor (2)
182:16,21
lack (1)
270:18
lacunar (4)
269:23,24;270:1,9
lamina (1)
157:4
landed (3)
173:20;228:1;303:7
large (1)
154:1
larger (2)
169:22;181:13
last (18)
126:5,7;130:12;165:10;172:20;184:7;187:8;213:3;225:17;229:16;246:5,9,15;261:5;275:12;310:21;312:9;314:2
lasting (1)
227:19
latent (1)
181:4
later (6)
184:2;186:6;204:22;207:3;305:24;310:9
lateral (9)
138:4,8,15,17;139:4,5;280:13;288:15;289:6
laterally (1)
165:6
law (9)
188:11;189:1;235:3;236:5;238:4,14;247:15;248:16;249:15
lawyer's (2)
191:5,7
laying (1)
157:1
lead (2)
285:21,22
leads (1)
185:19
learn (1)
263:21
learned (1)
210:3
least (7)
228:1;247:14;248:14,16;303:12;310:4,6
leave (1)
125:10
left (37)
133:20;135:4,6,7;137:11,15,15;138:3,4,7,8,11,12,15,16,18,19;139:4,4,5,6;144:10;146:22;153:24;157:4;171:2,6;197:10,19,21,22;226:2;280:12,13;281:20;282:14;292:5
leg (17)
133:20,22;137:10,12,13,15,16;146:9;149:3,5;152:19;153:2,2;165:5;166:19;168:4;207:1
legal (1)
237:18
legs (20)
134:15;135:9;146:22;147:25;148:1;162:9;164:25;165:17,22;166:16;170:9;171:6;172:25;173:1;174:22;198:5,25;207:2;220:4;233:4
length (2)
244:20;316:13
Lenox (13)
234:4,17;237:14;260:7,8,9;288:6,13;292:23;293:7,16,23;313:2
less (19)
158:7;159:11;176:20;186:25;188:16;191:23;196:25;197:8;202:5;212:1;214:2;220:13;247:23;252:5;263:2;265:6;276:24,24,25
letterhead (1)
191:8
letting (1)
242:5
level (33)
127:6;152:17,17;153:4;154:15,17;155:4;156:17;157:9;171:11,14;174:7;181:15,17,20;208:13;209:6;241:4;244:15,15;245:2,14,20;246:1,2;265:18;275:21;292:4;311:16;312:13;314:24;315:1;319:20
levels (12)
155:7,17,18,19,21,23;174:7;181:21;228:17;245:11;313:11;315:23
license (1)
127:17
licensed (4)
127:15;243:12,19;250:3
lie (1)
248:7
life (5)
129:15;183:18;186:12,24;231:14
lifetime (1)
141:9
lifting (7)
134:2;162:23;167:6;172:6;182:21;183:1,4
light (2)
152:23;198:23
lights (2)
144:22,23
likelihood (1)
216:1
likely (2)
176:20;294:13
Likewise (1)
176:7
limbs (1)
160:22
limit (1)
198:24
limited (7)
139:1,2,7;164:24;166:14;266:3;308:23
limits (2)
195:8;196:8
limping (2)
139:10;148:3
line (1)
275:11
list (6)
237:16;270:23;271:6,10,19;272:4
listed (2)
272:3;312:23
little (14)
129:20;140:24;148:16;155:1;161:6,8;214:4;233:22;235:12;238:14;245:4;284:6;309:3,3
living (4)
134:1;147:3;167:2;172:1
loaded (1)
239:5
located (3)
152:15;270:1,3
location (3)
289:15;316:3;318:16
locations (1)
307:22
locked (1)
136:22
locking (1)
286:25
long (16)
145:5;153:25;183:1;195:24;213:3,3;222:8;227:19;234:11;240:21;241:7;252:6,22;253:19;256:23;270:11
longer (3)
160:9;182:5;264:10
long-term (1)
216:21
look (29)
132:5;157:5;179:10,12;210:2;217:8,11;218:1;220:22;235:9,16;236:11;241:12;245:20;255:19;260:2;264:13;270:16;271:24;272:6,9;276:3;282:1;291:1;293:22,25;301:1;309:25;318:7
looked (8)
153:13;239:25;240:6;260:4,7;285:24;293:3;318:9
looking (15)
153:22,25;154:3;155:2;157:13;170:13;191:6;202:3;205:10;265:18,19,19,20;271:14;301:11
looks (5)
131:20;155:7;161:6,8;193:19
loosening (1)
293:12
lordosis (22)
261:12,16;262:6,12,14,16,17,22;274:5,8;304:13;306:18;307:2,4,10,20;313:13;317:22;318:4,10,10;320:2
loss (18)
133:24,25;134:24;135:12;148:1;149:4;165:2;166:17,22;168:5,12;170:9,10;171:6;198:14,19;218:18;233:1
lost (9)
134:20;138:16,18,19,20,23;162:11;179:22;198:16
lot (7)
128:23;129:2,24;222:1;251:18;255:19;305:17
loud (2)
126:17;236:12
low (2)
136:4;227:2
lower (39)
133:18;135:10,12,15;136:8;137:18,18;138:24;148:8,22;151:15,20;152:5,18;158:23,25;163:4;166:9,10;168:1;170:21;172:14,24;174:11,22;197:14,24;198:6;208:11;219:2,25;224:17;226:14,16;229:4;231:4;294:8;311:17;312:22

lumbago (2)
172:11,13
lumbar (72)
124:4;136:1,8;
141:1;142:5,22;
148:12;152:5,9,11;
153:14,21;155:2;
162:18;166:18,23;
167:6;174:6;175:16;
181:25;205:13;
215:14,17;217:12;
228:15,17,22,23;
229:22;230:6;
233:17;244:17;
245:8,9;261:4,16;
262:16,21;263:9;
265:2,25;267:25;
268:6;272:10,12,13,
20;273:1,9,16;
277:18,20,21;278:2,
6,16,23;279:16,20;
288:10,25;293:4;
296:15;299:6,8;
307:12;308:24;
311:21;313:2,7,16;
320:1
lumbosacral (1)
292:15
lunch (1)
224:24
luncheon (1)
225:9
lying (1)
247:21

M

machine (3)
222:22;255:11,11
magnetic (1)
156:10
main (1)
125:1
maintain (3)
162:17;232:10;
263:9
maintained (4)
138:22;249:7;
307:17,23
maintaining (1)
233:3
maintains (1)
249:6
major (5)
127:20;155:20;
227:3;230:18;310:2
majoring (1)
127:22
makes (1)
245:4
making (5)
146:18;202:3;
237:19;254:21;296:5
male (1)
262:25
man (3)
182:15;183:11;
226:25
management (19)
128:15,16;129:1,8,
10,12,22;150:9;
158:9;160:15;
163:25;183:10;
184:20,22;186:16;
216:16,18;296:2;
300:5
manager (1)
246:18
maneuver (6)
137:3,7,20;165:4;
166:19;168:4
Manhattan (3)
128:6,11;130:22
manipulating (1)
202:2
manual (2)
182:15,21
manually (1)
138:1
manufacture (1)
251:1
manufactured (1)
254:7
manufactures (3)
250:7,23;251:3
many (15)
186:1;188:14;
192:11,13,13;218:23;
220:22,23;244:2,10,
10;247:10;249:10;
257:10;297:13
March (7)
172:22;193:23;
204:2,22;223:5;
296:5;297:4
margins (1)
294:15
mark (4)
234:7,17;239:23;
294:25
marked (4)
153:16;234:5;
288:9,19
market (4)
254:23,25;255:4,9
marketed (1)
254:25
mass (1)
269:5
matches (1)
316:15
material (5)
154:3,18,22;
156:17;157:11
matter (2)
269:8;320:15
matterand (2)
187:23;287:7
Maturity (1)
263:3
may (23)
124:10;127:8;
141:14,15;156:3;
185:13;189:19;
193:4;202:14;216:4;
225:21;227:21;
237:24;253:1;257:3;
259:9;270:22;
274:12;296:18;
301:18;305:23;
306:24;320:6
Mayar (1)
131:1
maybe (10)
188:15;189:7;
192:4;208:1;222:3;
238:14;245:23;
247:20;249:13;284:8
McCRORIE (110)
124:1,19;125:5,14,
18,22;126:9;127:8,
10,12;143:21;
150:24;169:13,20;
173:13,15;177:18,21,
23;178:6,17,23;
179:13,16,19,24;
180:4,10,18,20;
187:19;197:18;
208:1;221:13,17,20;
222:10;224:18;
225:7,21,24;233:21;
234:23;236:4,9,14;
237:9;238:1,10,17;
239:9,16;240:4,9,23;
241:9;242:7,9;246:8,
10,22;247:9;248:9,
24;249:17,20;251:5,
16;252:20;253:16;
254:9;255:5;263:25;
267:5,8,11;275:25;
277:20;278:7,10;
279:25;288:5,17,21;
289:25;291:4;
297:23;299:24;
304:5,9,19,21;
306:11;308:6,9;
310:25;311:3;312:5,
8;313:20,22,24;
314:1,12,16;317:13,
24;318:6;319:8;
320:3
MCRORIE (1)
169:15
MD (2)
126:10,20
mean (33)
141:19,20;159:20;
163:11;172:12;
189:22,23;190:7;
195:10;198:2,13,19;
205:4;212:13,24;
220:2;224:2,6;235:4;
241:15;257:11;
262:25;271:1;272:4,
5;279:5;289:8;291:4;
304:17;308:3,21;
309:1;310:12
meaning (19)
133:12;139:9;
142:10;145:9;
148:25;162:12;
164:25;169:6;
176:18,21;188:23;
198:14;206:2;
224:12;271:18;
281:9;285:1,17;
299:11
means (45)
129:14;143:1,3;
144:24;148:23;
150:4,5;155:14;
172:16;187:9;
189:24;195:20;
204:8,12,13;262:6;
273:4;274:16,18;
275:3;276:22;277:2,
4,9,12,13,16;279:6;
280:16;284:5;
289:17;294:7,8;
299:11;304:17,24;
305:19;307:21,23;
308:23;309:12,15,16,
16;310:13
measure (2)
138:3;144:6
measured (1)
138:14
measurement (1)
138:13
measuring (4)
144:17,20;265:17,
21
mechanical (2)
135:24;197:4
median (4)
219:13,15;220:5,
14
mediations (1)
159:14
Medical (68)
127:23,24;128:5,6,
8,12;131:6;133:7;
135:14;139:19,24;
147:19,23;148:8;
153:18;156:7,24;
161:19;168:17,23,24;
169:2;170:14;
174:20;175:14;
176:5;177:6;179:20;
181:24;182:11,14;
183:5,9,19;184:6;
186:7,14;187:4,15;
213:14;215:15,21;
220:23,23;226:8,11,
23;228:6,15;229:5,
13,21;230:7,14,22;
231:10,16,24;232:13;
233:6,19;249:8;
250:13;254:8,255:3;
256:11;272:7;313:14
medically (3)
134:22;143:2;
162:5
medication (15)
134:9;158:13;
159:3,3,6,7;184:24;
185:1;194:17;
200:12;203:10;
204:17;206:3;
222:24;223:7
medications (26)
129:5;130:10;
134:6;143:8;147:11;
150:12;159:10,22;
163:14,16;164:20;
167:8,9,10,12,20;
170:22;171:18;
173:5;183:15;
184:18;186:9;207:8,
11;222:25;300:9
medicine (5)
127:16,17;129:10;
257:9;258:8
medicines (1)
159:17
MediVisuals (3)
301:1,2,7
Medtronics (1)
254:14
meet (5)
131:1;196:23;
302:7,19,21
Memorial (1)
128:8
memory (4)
194:15;195:22,24;
196:20
mental (1)
196:10
mention (9)
202:22,24,25;
210:23;218:15;
269:22;280:24;
289:22,23
mentioned (20)
192:24;199:2;
216:11;218:20;
220:21;223:16;
251:20;261:11,20,25;
263:25;264:24;
267:18;277:24;
286:21;299:15,17;
305:22;306:4,12
mentions (1)
286:5

Merola (39)
131:3;132:21;
149:25;150:21,25;
155:3;156:1;163:3,4;
169:12;178:14,15,18;
180:9;184:3;192:23;
223:10;225:17,25;
226:2;234:15,16,19;
235:19;237:19;
239:9,18;243:7;
247:1;250:2;267:12;
279:22;285:6;288:5;
295:2;297:8;298:5;
299:25;314:16
Merola's (1)
149:11
met (2)
188:7,9
metal (3)
154:6;223:21;
255:12
metallic (2)
293:8,11
Metavisual (1)
301:13
Metivisual (2)
267:13;283:20
mid (15)
133:18;136:4;
158:23,25;166:9,10;
170:20;172:24;
227:2;265:10;
266:11,15,18;270:2;
292:5
middle (3)
136:8;241:1;
309:11
might (9)
129:8;130:5,8;
141:22;163:25;
191:4;208:2;230:20;
314:4
Milbauer (1)
238:23
mild (27)
167:15;219:24;
220:3;269:16;273:8,
19;276:14;277:9,13,
25;278:5,15;279:19;
280:20;281:2;
288:14;289:5;
290:10,14;291:8;
308:25;309:1,2,12,
16,19;310:10
mildly (2)
290:6,7
millimeter (1)
270:6
mind (1)
260:20
mineralization (1)
218:5
minimal (14)
275:16,20;294:24;
307:24;308:1,3,7,21,
23;309:1,2,3,17;
310:11
minimalized (1)
310:1
minimally (1)
280:13
minimize (1)
167:11
minimum (2)
252:2,3
minus (7)
134:16,19;135:6,7,
8;166:15;168:1
minute (1)
187:20
minutes (5)
163:1;221:16,17;
233:24;287:5
misread (1)
278:9
missed (1)
140:4
missing (1)
141:25
mistakenly (1)
241:22
mobility (8)
148:1;166:22;
170:10;232:11;
233:2;264:25;
265:22,23
mobilized (2)
232:24;307:7
model (5)
151:10;152:2;
260:15,16;315:10
moderate (8)
272:23;273:18;
278:5,15;279:19;
288:15;289:6;290:10
mold (1)
319:2
moment (4)
220:20;297:7;
303:19,25
money (3)
251:18;252:2;
256:4
monitor (7)
130:7;150:21;
171:13,20;231:18,22;
268:14
monitoring (1)
166:3
monitors (1)
201:14
month (4)
158:5,7;171:17;
301:12
months (6)
161:24;183:25;
186:24;204:21,22;
207:3
more (38)
128:1;129:20;
138:24;155:18;
158:7;159:11;161:6;
166:9;180:8;181:22;
182:9;186:25;
188:16;189:11,12,13;
190:23;196:25;
197:8;202:5;212:1;
213:5;214:2;220:13,
25;226:21;245:2,16;
246:18;248:7;262:6;
263:2;265:23;
285:25;292:5;
298:12;311:8;320:1
morning (13)
126:2,3;127:2,13,
14;130:22;132:14;
146:23;162:10;
172:25;188:7;
272:11;320:9
morphine (1)
159:15
Moshell (2)
284:14,16
most (14)
140:25;141:10;
142:5;158:24;171:1;
174:3;185:9;188:22;
189:7;254:25;255:2;
266:3;294:8,13
motion (12)
137:23,25;138:1,
22;167:22;168:5;
197:4;265:17,19,20;
266:2,3
Motor (10)
134:18,24;135:4,
18,19;171:5;197:10,
13,23;270:3
Motrin (7)
163:13;170:23;
194:21;204:4,6,9;
205:22
Mount (10)
127:23;250:4;
252:14;256:23,24;
257:1,3,5,13;258:2
move (8)
125:19;136:23;
155:15;181:19;
182:5;184:4;193:4;
216:9
moved (1)
133:12
movement (7)
138:13,17,18;
155:16;181:19;
265:14,15
movements (2)
138:10;166:20
moves (2)
261:14;265:20
moving (5)
125:9;165:7;166:5;
214:3;266:23
MRI (34)
131:15;132:3;
150:14,17;153:21;
154:4,5;155:25;
156:9;174:15;181:3;
187:16;191:3;230:7,
9;231:18;234:14,18,
24;238:18;239:21;
240:5;257:19;
259:20;288:9,25;
291:1;292:11,15;
302:15,16,17,19;
306:17
MRIs (4)
184:14;187:12;
260:2;268:9
MRI's (8)
131:8,18,22;
143:10;238:13;
239:1;295:12;302:12
MTS (1)
255:11
much (22)
129:15;153:11;
161:21;165:15;
185:10;190:16;
201:8;208:9;221:11;
226:21;232:11;
236:11;245:16;
246:21;251:15;
252:5;265:6,23,25;
309:17;311:8;317:15
multi-level (8)
258:24;273:8;
278:6,15,21,23;
290:14;308:25
multiple (13)
133:11;141:1;
142:6,23;169:5;
175:10;187:10;
227:4,17;230:3;
307:5;310:2;319:14
multiplier (4)
245:12,13,18,19
muscle (15)
135:9,9;136:2,10,
11,22;144:13,18;
145:2;160:21,22;
167:13,17;170:23;
198:5
muscles (10)
134:17;136:15;
144:14,14,19;152:21;
161:11,14;198:3;
275:8
muscular (1)
136:1
musculo-skeletal (1)
258:3
mutually (1)
270:25
myotomal (2)
198:1,1
myself (5)
131:1;150:21;
254:18;255:24;
259:15

N

name (5)
126:18,20,24;
127:1;188:7
Naprosyn (3)
167:12,15;173:2
narcotic (8)
147:1;159:14;
163:15,21;164:22;
167:14;194:22;
200:11
narrowing (4)
275:20;290:23;
292:20;310:14
natural (3)
317:3,5,16
Naturally (2)
265:2,23
nature (4)
125:6;155:8;182:1;
279:1
NCV (1)
144:16
NCV-EMG (4)
143:24;144:4;
218:20;219:1
necessarily (2)
216:16;240:15
neck (75)
129:2,24;133:18;
135:24;136:4,7,18,
20,23;137:2,23;
138:2,14,15;140:3,4,
5,6,24;141:22,23,25;
143:23;146:20;
148:1;150:14,17,20;
158:24;162:7,7;
164:5,8;165:15;
166:5,6,8;168:3,5;
172:13;175:3,9;
177:5;180:23;182:8,
9;183:7,23;187:5,12,
13,17;205:5,6,10,11,
17,19;206:7,9,15,15,
18;208:10;215:23;
227:2;229:15,17;
257:24;265:11,24,24;
305:6;312:19;314:5
need (16)
125:4;145:11;
161:17,20,22;184:2,
24;185:1;186:5;

193:6;201:23;
215:25;227:22;
246:18;288:22;
301:23
needed (11)
150:12;200:8;
201:4,19;204:8,12,
13;210:18;213:15;
230:21;309:6
needle (1)
164:15
needles (1)
144:19
needs (2)
213:5;232:14
negative (1)
265:22
neighborhood (8)
243:25;244:13,21,
24;245:7,10,21,23
neither (1)
234:12
nerve (53)
130:7;131:15;
134:25;135:2,16,17;
136:12;137:7,19;
143:9,23;144:4,10,
13,17;145:1,3,4,17;
146:8;148:10,12,22,
24;149:9;151:14,19,
24;152:18,19;153:2,
5;154:9,13,16,20;
162:17;164:3;185:6;
196:13;198:3;
219:10,12,13,15,16;
220:5,14,16;224:16;
289:12;290:20,22
nerves (17)
124:4,6;125:7,8;
128:23,25;153:1,6;
154:24;160:21;
161:15;162:20;
196:14,17;197:3;
198:21;220:3
nervous (5)
128:21,21;144:6,7;
320:9
neural (1)
290:14
neuroforamen (1)
153:4
neuroforamin (2)
152:17,18
neuroforaminal (2)
275:20;279:13
neurologic (1)
190:3
neurological (13)
134:25;158:8;
168:23;169:8,25;
170:15;178:23,25;
179:4;181:16;
285:20,22;295:14
neurologically (1)
284:1
neurologist (10)
128:19,20,24;
129:1;179:2;183:11;
184:22;186:16,18,18
neurology (6)
128:7,13,14;
129:22;132:23;
295:19
neuromuscular (1)
145:2
neuron (2)
135:19,19
neurons (1)
144:10
Neuropathy (1)
220:3
neuroradiologist (1)
301:21
neuroradiology (3)
256:21;258:5,21
New (11)
126:21;127:16,18;
128:7,12;151:11;
161:23;193:10;
243:12;250:3;302:13
next (16)
126:8;145:15;
146:16;157:17;
199:14;200:16;
204:1;205:7,18;
206:21,23;216:3;
242:13;268:21;
272:9;287:10
night (4)
167:18;246:24;
307:1;320:10
ninety (3)
189:5,17,18
Nobody (1)
161:11
nobody's (1)
240:15
node (1)
241:14
noncontiguous (4)
227:4,17;307:6;
310:3
non-contrast (1)
268:18
None (4)
192:16;278:8,10,
11
Non-specific (1)
270:6
non-steroidal (1)
163:12
Norco (13)
159:13;163:6,20;
164:22;167:8,12,14,
16;170:25;173:2;
210:18,20;214:12
Normal (34)
139:3;148:15,15;
151:18,23;155:11;
195:8;196:8,8,11;
198:9,24;219:10,13,
15,19;220:5,6,12,14,
15,16;233:23;262:7;
269:8,14;272:21;
274:5;275:5,14;
276:21,23;307:2,13
Normally (4)
130:22;137:13;
148:16;168:11
nose (1)
196:18
notable (1)
171:1
notably (2)
140:25;174:3
notation (3)
202:6;204:6;
282:13
note (46)
132:19;134:11;
142:13;143:12;
146:10;155:25;
159:1,22,23;161:25;
163:9;165:10,12;
192:24;197:10,13;
205:1,9,13,18,24;
207:24;209:9,10;
210:11,14;213:11,13;
215:1;217:4,18,18,
21,22;221:21,23;
222:22;276:13;
278:5;279:8;280:5;
281:2;282:2;284:3;
292:16,18
noted (14)
135:12;139:9;
148:1;158:17,19;
160:1;170:18;171:4;
214:7;217:15;
267:22;277:8;
278:11,17
notes (37)
132:9;134:9;
143:11,12,15,19;
146:11,11,13;149:11;
159:18,19;162:1,2;
163:10;165:11;
170:16;171:10,12,23;
174:17;179:13;
180:2,11;193:20;
203:17;206:8;
207:19;214:21;
216:10,12;223:3;
238:21;273:8;
275:16;283:25;
299:25
notice (5)
179:8;234:25,25;
235:1;236:2
noticed (3)
146:22;198:11;
267:18
noticing (1)
204:16
noting (5)
200:19;273:14;
275:19;281:2;309:14
November (10)
132:18;149:12;
153:14;165:24;
174:14;192:20;
194:12;288:24;
291:2;295:2
NSAID (1)
163:12
NSAIDS (1)
163:13
N-S-A-I-D-S (1)
163:10
nuclear (1)
258:8
numb (2)
146:21;162:10
number (24)
152:14;171:11,20;
173:24;191:24;
192:9;194:1;235:7;
241:13;246:12;
247:5,6,12,17,22,24;
248:2,11,12,17,18,
20;251:14,15
numbered (2)
152:10,12
numbness (12)
133:20;170:25;
171:2;172:25;
174:11,11;175:4;
206:10,17,19;207:1;
266:20
numerous (1)
182:5

O

Oak (1)
292:11
object (4)
124:23;236:2;
238:11;306:7
objected (2)
124:9;249:19
objecting (4)
124:21;125:16;
178:20;179:9
objection (81)
124:12,16,17;
141:4;143:16,20;
145:21,24;146:3;
149:17,19;156:3;
159:5;169:11;
173:10;175:1,20,22;
177:13,16;180:12,13,
16;184:4,10;185:15;
186:17,19;222:9,14;
223:23;224:4;225:6;
232:5,7;233:10;
234:22,23;246:8,10;
247:9;248:9,24;
249:17;251:5,16;
253:16;254:9;255:5;
275:25;288:17;
289:25;297:23;
302:5,9,11,22;303:9;
304:3,18,20;305:7,
12,15,25;306:5,13,
21;308:4,12;309:23;
310:22;311:10;
312:1,7,15;313:17;
314:3;317:13,24;
318:6
objections (1)
241:1
objective (4)
136:5,16,24;138:8
objectively (1)
145:3
obligation (1)
250:6
oblong (1)
157:8
observation (1)
284:21
observed (1)
139:14
observer (1)
136:19
observing (2)
284:18,19
obtain (1)
162:17
obtained (1)
211:2
obvious (2)
227:21;314:4
obviously (15)
190:13,23;197:2;
234:19;237:8,12;
239:22;248:8;
249:15;250:15;
255:15;258:5;
260:16;264:24;
281:23
occasion (4)
158:17;159:20;
188:19;189:3
occasions (2)
147:16;255:3
occupation (1)
140:25
occur (3)
175:25;274:20;
317:3
occurred (10)
126:1;148:19;
153:5;177:25;

180:14;215:20; 225:15;288:3; 309:22;314:7
occurring (1)
164:3
occurs (3)
151:14;294:10; 312:12
October (13)
155:24;169:18,23; 170:13,16;209:9,16; 214:16;219:4,21; 292:11,15;296:22
off (15)
124:22;133:8; 139:11;144:11; 148:4;151:7,11; 156:6;161:9;165:8; 166:21;168:7;221:1; 299:14;306:23
offered (2)
184:17;223:17
office (28)
128:10;130:7,18, 25;131:12;145:16; 147:16,17,18;159:7, 11;183:25;188:24; 189:7;190:21,24; 191:5,7;203:20; 238:21;246:18; 249:7,11,12,16,25; 302:2;303:3
OFFICER (8)
125:24;126:12,17; 225:4,13;234:1; 288:1;320:12
offices (1)
249:6
official (1)
301:17
often (4)
158:4;161:19; 201:8;299:19
Oftentimes (1)
130:4
old (3)
141:16;209:21; 263:1
once (20)
130:3;135:16; 137:17;146:23; 148:10;155:10; 156:9;163:20; 164:23;176:8;181:9; 185:24;213:4; 221:24;230:1; 233:15;246:20; 247:24;248:2;309:2
one (75)
124:16;132:4; 134:8,19;135:2; 140:7,11;144:10,13, 15;149:13,22;153:21, 25;154:4;156:21; 157:2;160:11,18; 162:1;164:5;172:1; 174:7;177:7;180:24; 187:8;189:25; 193:16;205:7; 206:23;216:20; 218:24;219:21; 220:7,19;221:15; 222:18;223:4; 224:24,24,25;226:3; 231:25;233:5; 238:21;241:12; 245:2;251:7;260:11; 261:8;263:15; 271:16,21;276:4,8; 277:8,19,24;278:8; 279:16;298:17; 301:12;303:16,19; 304:7;305:17;307:5; 315:18;316:3,7,7,25; 318:15,24;319:9
ones (1)
162:5
ongoing (1)
216:7
only (17)
139:2;161:16; 168:12;179:24; 184:21;186:1;191:8; 207:10;216:6; 228:25;230:7;245:3; 248:4,5;259:14,19; 313:21
open (4)
180:14;187:24; 287:8;304:1
opened (1)
319:3
opening (1)
157:6
openings (1)
152:14
operate (1)
303:2
operated (2)
185:4;261:1
operating (1)
258:25
operation (8)
232:19;235:3; 236:4;238:4,14; 260:5;282:25;284:14
operative (10)
282:24;283:1,7,21, 25;284:7;309:5; 316:1,8;317:8
opinion (72)
174:19,25;175:3,8, 13,18,21,24;176:4; 177:6,11;179:3; 180:11,22,25;181:3, 8,23;182:1,3,13; 183:20;184:8;186:7, 13;187:3;215:16; 221:7;226:3,5,24; 227:6,8,10,11,14,16; 228:6,10,14,17,20, 22;229:4,10,13,20, 24;230:1,1,6,10,13, 21;231:1,2,9,16,20, 21;232:15;233:6; 236:13;259:8,14; 270:24;307:3;309:8, 20;313:13,23;319:11
opinions (7)
168:20;178:17; 182:10;226:5,7; 233:18;236:1
opposed (2)
164:9;309:1
option (1)
184:19
options (2)
207:11;215:4
orbits (1)
269:14
order (5)
139:25;261:22; 315:7;316:14;317:16
ordered (1)
150:20
ordering (1)
144:1
orient (1)
226:2
original (3)
233:15;236:20; 298:6
orthopedic (12)
128:18;178:25; 179:4;180:7;230:24; 231:3,11,13,15; 232:6;236:14;256:14
orthopedics (1)
256:5
orthopedist (7)
128:23;132:23,24, 24;146:25;149:23; 192:23
ossifice (3)
304:14;305:19,20
Osteoarthritis (9)
141:7,9,13;176:17, 19;217:22,24;218:13, 15
osteopenia (14)
276:14,16,17,21, 22;277:9,13,14; 309:12,13,15,20,21; 310:1
osteophyte (4)
273:9,12;277:7; 294:22
osteophytes (4)
141:13;278:19; 292:13;294:14
osteophytic (1)
294:21
osteoporosis (2)
218:10,19
Otherwise (3)
171:3;220:12; 307:13
ours (1)
140:13
out (64)
124:20;125:2; 129:3;130:3;131:4; 141:12;151:15; 152:18,19;154:8,8; 155:10,12,18;156:7, 23;166:6;170:17; 171:11;173:16; 175:15;176:5;179:7; 192:19;197:15,24; 201:13;205:21; 206:9,16,18;207:4; 208:13,15,15;209:6, 6;222:21,23;223:21; 228:16;229:7; 236:12;239:4; 252:10,11;254:14,15, 23;259:7;261:2; 264:21;280:7; 282:24;301:20; 303:11,18,25;309:6; 311:3,8,15;313:23; 314:4
outpatient (1)
200:3
outside (8)
136:19;177:16,19; 178:2;185:14;304:3; 306:9;311:1
over (40)
127:4;131:2; 140:16;141:11; 150:16,22;154:4,9, 25;158:13;162:2; 163:13;166:2,13; 167:2,21;169:12; 170:8,21;171:17,21; 172:18;173:2; 183:25;187:9; 194:24;203:24; 227:12;234:10; 265:9;279:2;282:8; 300:14;301:19; 303:16,17;305:18; 310:20;312:5,13
overall (6)
171:10;205:21; 208:13;209:6; 245:14;266:2
overcome (1)
160:23
override (1)
185:7
overrule (2)
180:12;308:12
Overruled (25)
141:6;149:20; 175:2,23;180:16; 184:11;185:16; 186:20;222:15; 232:8;233:12; 246:11;248:10; 251:6,17;253:17; 254:10;255:6;276:1; 288:18;290:1; 309:24;312:16; 317:14;318:7
overwhelm (1)
186:2
ovoid (1)
270:6
own (7)
160:9,13;190:21; 208:6;210:16;240:5; 259:5
owns (1)
132:2
oxycodone (1)
170:24

P

pacemaker (2)
185:17,18
page (5)
157:17;170:11; 199:14;242:13; 287:10
paid (4)
130:20;256:4,7,9
pain (145)
128:15,15;129:1,2, 3,4,8,10,11,12,12,13, 15,22,24;130:4; 133:18,19;134:6,6; 137:16;140:6; 141:24;146:21; 147:1;149:3,3; 150:12;158:9,16,18, 19,21,23,24,25; 160:15,20;161:13; 162:7,7,8;163:1,6,15, 21,24;164:22,24; 165:16;166:7,8,9,13; 167:15,16;170:7,21; 171:10,13,14,16,16, 19;172:4,13,14,24, 24;173:1;174:21,22, 22;175:3;183:3,10, 12,13;184:20,22; 185:8,8,10,11,25; 186:2,4,8,16;194:11; 195:4,4;198:23; 200:9;201:4,19,23, 23;204:16;205:11,13, 13,21;206:9,15,15,

18,24;207:1,4;
208:10,13;209:6;
210:18;211:11;
214:11;215:23;
216:16,18,21;217:2;
222:25;226:14,21;
227:1,14,19,20;
232:12;233:8,14;
239:8,10,13;266:18,
18;285:19,21,22;
299:12,15,19,21;
300:5;305:6
pains (5)
165:16,18,21;
166:12;175:3
palliative (1)
232:10
palpating (1)
136:14
paracentral (1)
277:4
paragraph (1)
275:13
paralyzed (1)
134:21
paraspinal (5)
275:2,3,4,7,13
paravertebral (4)
135:25;136:2,9;
165:4
parenchymal (1)
269:20
part (28)
131:11,20,20,21;
169:21;179:15;
184:7;200:22;
233:14;241:19;
242:10;249:8;
250:12;255:13;
267:16;274:8;
275:24;283:6,6;
285:10,18;291:25;
292:4;299:25;305:2,
9,17,21
particular (8)
147:15;159:8;
172:7;195:3;213:1;
214:12;255:9;270:20
particularly (2)
311:16;319:20
parties (3)
178:2;187:25;
287:9
partly (1)
294:3
parts (7)
141:10;152:9;
160:20;169:4;182:7;
185:6;239:8
Passive (3)
138:1,7,10
passively (1)
137:24
past (13)
139:19,24;150:22;
159:4;171:17;
183:25;188:12;
191:18;197:2;
203:25;230:23;
254:11;297:15
patchy (2)
198:12,14
pathology (3)
131:19;137:17;
149:8
pathways (1)
186:2
patient (35)
130:5,9,18;132:3,
10,17,20;137:25;
138:2,5;139:22;
149:2;164:14;
171:15;188:23;
189:6,17;191:2;
196:24;200:19;
203:24;212:2,5;
235:12;255:15;
259:17;266:14;
270:14,20;271:9;
301:24;302:4,7,20,21
patients (16)
129:23;130:15,17,
23,23;132:23,24;
140:9;172:5;246:19;
248:13;249:5;
254:21;255:13;
303:1,2
patient's (7)
130:8;137:21;
140:13;171:14,20;
227:12;286:24
paying (1)
240:18
payment (2)
255:21,23
Pediatric (1)
258:11
pediatrics (1)
129:23
peeks (1)
262:25
pelvis (3)
152:7;232:22;
265:18
pen (1)
153:17
people (8)
129:2,24;167:18;
172:3;185:9;248:23;
265:23;305:10
per (6)
130:25;183:2;
246:1,2;265:15;
285:15
percent (19)
138:17,18,20,20,
24;139:1,2,8;168:12;
189:5,7,9,17,18;
191:23;208:9;252:4,
4;294:10
percentage (7)
188:20;189:4,14;
251:11,15,21;252:5
perception (1)
198:24
Percocet (1)
170:24
perform (5)
129:16;137:20;
146:4;243:21,24
performed (11)
134:14;137:4,12;
138:1,9;144:16,19;
145:17;218:25;
274:1;284:19
performing (1)
142:4
perhaps (4)
244:13;252:5,7;
258:20
period (9)
183:1,17;186:11,
22,23;187:9;225:18;
227:15;231:10
periods (1)
233:8
peripheral (2)
128:22;135:17
perivascular (2)
269:24;270:9
permanent (1)
183:7
permission (3)
150:24;169:16;
212:22
person (14)
129:12;131:14;
136:17;137:13,13;
140:1;144:8;148:25;
157:1;164:12;
168:11;213:11;
236:20;262:24
personal (1)
222:2
personally (1)
132:9
person's (7)
129:14;130:4;
137:4;138:6;218:9;
265:6;316:16
perspective (3)
156:25;157:14;
158:9
PET (1)
258:8
ph (1)
205:7
phone (1)
301:1
phonetic (1)
300:23
photograph (2)
173:19;177:8
photographs (1)
303:8
photos (1)
305:24
phrase (3)
189:19;254:6;
265:5
phrased (1)
242:2
physical (53)
127:23;129:5;
130:9;134:14;142:4;
143:7;146:24;
147:21;160:2,3,6,9,
12,14,17,18,25;
164:18,24;167:21;
170:5,18;172:8;
173:2;187:5;193:10;
194:1,5,8;195:5;
197:3;200:3,20,25;
202:1,10;204:18;
207:5,8,15;208:24;
210:15;212:9,20;
217:16,19;223:6;
232:3,9,15,18,23,24
physically (3)
136:15;138:12;
302:16
physician (10)
128:20;147:19;
160:15;183:10;
184:22;186:15,16;
203:19;283:7;284:13
physicians (1)
254:19
pick (2)
223:4;226:4
picked (1)
131:3
picture (2)
131:17;157:13
pictures (1)
241:3
piece (2)
124:13;310:13
pieces (5)
131:13,16;132:3;
205:17;250:17
pinched (4)
136:12;137:7,19;
148:24
pinned (1)
247:24
place (15)
126:21;142:18;
155:10;187:24;
273:4;279:2;280:8;
281:11;287:1,8;
293:9,17;294:19;
318:24;319:2
placed (5)
164:14;185:5;
286:20;315:8,22
places (1)
316:15
placing (1)
144:19
Plaintiff (8)
126:9,15;188:23;
189:8;234:21;239:7;
270:15;271:9
plaintiffs (3)
188:21;189:10,15
Plaintiff's (34)
124:3;151:10,11,
12,18,23;152:25;
153:20;155:24;
168:16;169:24;
173:20;174:2;177:9,
10;178:6;184:21;
189:1;191:10;
227:24;229:6;230:8;
237:3;260:22;
267:14;276:8;283:6;
288:9,19;293:3;
300:24;301:10;
306:17;315:11
plan (15)
143:6;145:6;150:8,
9;189:23,25;190:6,7;
200:2;203:3;210:23;
223:5,8,14;259:24
plastic (1)
152:2
plate (2)
275:20;278:21
plates (1)
250:17
pleasant (1)
185:10
Please (29)
126:17,18,23;
127:2;128:1,17,18;
129:7;133:2;134:13;
140:15;142:2;
148:14;152:1;
172:11;174:25;
175:7,18;181:7;
201:16;209:10;
224:24;229:10,11,24;
230:13;233:24;
243:15;320:11
pled (2)
178:10;179:20
pleural (1)
281:13
plural (1)
169:10
plus (2)
135:5,6
pm (2)
273:24;307:1

point (40)
125:2;134:14; 139:12;145:9; 154:15;156:7,23; 178:24;179:14; 199:7,12,12;200:11; 201:3,9;203:9,13; 204:19;207:13,17; 208:17,20;216:10,15; 226:20;240:1,12; 251:24;252:5;261:2; 265:21;272:2;279:2; 285:24;290:23; 303:24;306:11; 310:1,6;311:6
pointed (12)
175:15;176:5; 179:7,25;222:21,23; 228:16;229:7; 301:20;303:11,17; 314:4
polyneuropathy (2)
219:24;220:10
poor (2)
218:7,8
population (1)
294:11
portion (13)
137:18;144:16,19; 152:2;181:18; 226:16;231:4;261:6; 270:1;277:6,7;294:9; 311:18
portions (1)
182:5
posed (1)
136:16
position (7)
128:4;164:15; 179:1;182:25;237:3; 307:7,8
positions (2)
128:3;286:17
positive (14)
137:3,8,10;149:5; 160:17;165:5,5; 166:19,20;168:4,5; 208:11;224:11; 265:22
possibilities (6)
270:22,23;271:6,9, 14;272:1
possibility (3)
217:1;271:21,22
possible (6)
129:15;176:21; 181:10;221:4; 232:11;266:13
possibly (1)
217:2
post (10)
206:24;232:2,15, 18;254:25;255:9; 280:5,16;281:21; 293:14
posterior (13)
198:12;245:4,5,6, 9;269:16;275:19; 277:25;292:12; 304:14;305:18,20; 319:14
posteriorly (1)
286:25
postmenopausal (1)
218:12
post-operative (1)
281:6
posttraumatic (11)
226:17,18;228:24; 230:4;231:5;233:16; 298:11,13;311:19; 317:1;319:25
potent (1)
163:14
potential (8)
135:1,16;144:3; 169:7;217:9;224:8, 10;272:3
potentially (2)
182:20,23
power (2)
149:4;162:11
practice (19)
127:16,17;128:9, 10;129:21,22;130:13, 21;131:10,25; 188:15;212:2;244:9; 247:16;248:6; 259:10;270:14; 298:9;302:18
practicing (1)
247:11
pre (1)
255:9
preexisting (9)
239:6;306:4;309:8; 317:10,13,23,25; 318:4;319:11
pre-existing (6)
177:3,4,12;180:23; 262:12;275:23
prefer (1)
185:10
prep (3)
249:21,22,25
preparation (2)
249:18;301:1
prepare (1)
187:21
preparing (1)
192:7
preponderance (1)
270:19
prerequisite (1)
303:12
prescribe (9)
130:10;200:11; 201:9,11;212:7; 214:22,23,24;222:23
prescribed (20)
159:6,7,9,21; 160:10;161:2; 167:10,12;195:3; 201:18;203:11; 207:8;209:4;210:24; 211:16,21,24;212:20; 213:1;214:13
prescribes (2)
147:19;159:3
prescribing (3)
131:21;159:2,10
prescription (4)
159:24;210:25; 213:14;214:10
prescriptions (2)
147:13,16
presence (1)
178:2
present (7)
136:6;158:2; 187:25;203:21; 287:9;296:2;313:2
presented (1)
262:24
presents (3)
149:1;270:14; 271:10
preserved (1)
273:2
pressed (1)
156:17
pressing (1)
157:10
pressure (6)
137:5,19;154:23; 156:18;157:11; 195:11
pressures (1)
182:6
pretty (8)
132:25;138:13; 145:10;165:15; 176:10;217:10; 222:2;272:4
prevent (2)
160:23;226:15
prevertebral (2)
274:12,16
previous (2)
177:14;178:8
previously (4)
142:24;159:1; 163:5;313:15
Primarily (4)
172:24;205:5,6,10
prior (13)
134:4;147:22; 168:19;172:20; 174:2;177:1,2; 180:23;190:17; 214:21;215:1;297:4; 299:3
private (3)
128:9,10;244:9
privileges (1)
256:25
PRN (4)
204:8,11,13; 208:11
probably (15)
161:22,23;194:10; 225:1;239:22; 243:25;244:24; 245:20;247:18; 249:12;262:18; 263:24;264:16,19; 311:8
problem (14)
137:14;139:25; 140:2,3;144:24,25; 145:1;166:10;175:9; 176:3,12;209:25; 210:1;215:24
problems (26)
133:25;134:5; 139:11;147:2;148:3, 4;162:12,22,25; 165:8;166:21;167:5, 19;172:6;175:4,12; 176:2,23,24;181:14; 194:15;196:4,14,20, 21;293:18
procedure (3)
163:25;164:10; 184:20
procedures (2)
130:14;297:21
proceed (5)
127:8;216:14; 224:1,1;259:16
proceeds (1)
232:24
process (10)
131:12;157:4,5; 174:4;212:18;228:5; 267:17;314:9; 315:21;319:14
produce (2)
191:14;227:19
producing (3)
227:18;228:13; 230:4
product (1)
277:2
prognosis (2)
145:7,9
program (3)
128:7;160:4;173:4
progress (4)
150:22;183:22; 184:8;312:13
progressed (2)
155:4;183:21
progression (2)
229:18,21
progressive (15)
155:8,22;162:19; 172:15;181:25; 183:11;184:14,15; 226:16;228:23; 229:18,22;233:17; 311:15,17
progressively (1)
172:18
project (1)
304:14
projecting (3)
127:5;294:14; 305:18
pronounced (1)
262:6
proof (1)
205:7
proper (3)
180:9;234:25; 235:1
properly (2)
150:7;182:5
prostrate (1)
210:1
protrusion (9)
154:19;155:4,9; 175:15,25;176:5,9, 10,15
Protrusions (1)
175:25
Provacado (1)
205:7
proven (1)
178:11
provide (5)
152:20,21;210:6; 212:4;215:17
provided (3)
190:9;211:10,14
providers (1)
220:24
providing (2)
249:15;255:25
provoked (1)
133:21
proximally (1)
168:1
Psychiatry (1)
128:14
pull (2)
192:19;282:24
pulling (1)
182:22
pulmonary (1)
195:12
pulse (1)
185:12
pulverized (1)
142:10

purpose (11)
125:1;160:14;
161:7;195:1;215:18;
226:18;232:3,9,18;
249:14;285:9
purposes (5)
124:13,18,24;
160:25;216:20
push (2)
138:6;154:8
pushed (1)
138:12
pushing (3)
154:8,12;182:22
put (29)
124:6;131:16;
132:2;137:7;138:21;
143:18;154:22;
156:22;173:24;
179:3;182:22;
234:17,18;235:9;
238:3,23;241:24,25;
251:14,15;268:12;
271:16;272:6;276:8;
280:17;301:17;
307:7;318:12,24
puts (2)
235:11;307:8
putting (7)
137:5;144:16;
156:18;157:11;
182:6;237:11;242:1
puzzle (2)
131:14,16

Q

quality (1)
129:14
quantify (1)
168:9
Queens (1)
128:11
quick (2)
221:14;287:5
quicker (1)
155:1
quickly (1)
144:17
quite (2)
158:24;187:14
quote (3)
202:14;276:22;
308:5

R

radiating (5)
172:24;174:21;
206:9,18;207:1
radicular (2)
125:6;208:12
radiculopathy (13)
148:23,24,25;
149:2,6,7,9;151:13,
13;165:19;219:6,22;
220:8
radiographs (1)
293:5
radiological (2)
303:15;312:24
radiologist (24)
131:24;132:1,2,5,
7;235:9,10;236:9,21;
241:2;258:24;259:8,
9;277:16;301:21,23;
302:1,7,16,18;
307:25,25;308:19;
309:13
radiologists (3)
235:8;258:20;
259:2
Radiology (18)
234:4;256:19;
257:6,11,14,21,24;
258:2,11,13,17;
260:8,9;288:7,13;
293:7,16,23
raise (6)
126:12;134:17;
137:10;149:5;
166:19;234:12
raised (2)
137:12;179:24
raises (1)
241:2
raising (2)
137:12;168:4
range (10)
137:23,25;138:1;
167:22;197:4;
244:21;245:18;
246:16;266:2,3
rate (3)
191:17;195:11,11
rated (1)
134:18
rather (4)
209:17;239:2;
241:9,10
rationale (1)
226:15
reaching (1)
206:25
reaction (2)
144:11;215:10
read (24)
131:24,25;132:8;
174:10;206:8;
207:20;208:6,7;
222:22;236:12;
241:5,6,9;259:5,15;
270:8;303:20;304:7,
12;307:3;308:9,10;
310:4;311:20
reading (7)
214:7;235:8;
259:20;281:9;
283:21;288:13;308:6
readjusting (1)
261:22
reads (2)
235:11;302:2
ready (1)
243:3
really (12)
140:22;161:11;
163:5;180:8;218:12;
222:4;251:24;
260:16;263:6;265:9,
24;299:19
re-ask (1)
180:18
reason (5)
213:6;239:7;
241:23;265:9;303:5
reasonable (37)
161:19;174:19;
175:14;176:4;177:6;
181:23;182:10,13;
183:5,9,19;184:6;
186:7,13;187:3,15;
216:1;226:6,8,10,23;
228:6,14;229:5,11,
13,20;230:6,14,21;
231:9,16,24;232:13;
233:6,19;313:14
reasonably (1)
245:21
reasons (2)
262:21;297:18
rebar (3)
173:20,21;303:8
recall (10)
124:10;194:7;
199:11;249:12;
252:12;253:8,8,19;
288:7;293:4
receive (1)
255:21
received (4)
127:17;171:19;
255:23;256:1
recently (1)
252:10
receptive (1)
196:1
recess (7)
187:23,24;225:9;
234:3;280:14;287:7,
8
recessed (1)
144:22
recognize (1)
131:10
recollect (1)
192:15
recommend (4)
170:11;208:17;
210:6;296:15
recommendation (8)
200:2;203:7;
254:22;295:8,11;
296:1;297:8,12
recommendations (3)
147:7;254:21;
295:18
recommended (10)
143:7;147:6;171:8;
173:3;200:8;203:10;
214:17,18;296:10;
297:21
recommending (6)
202:19;207:7,17;
215:12;250:16;
297:15
reconstruction (5)
226:22;227:18;
232:21;256:16;
301:14
record (34)
151:7;156:6;
168:15,17,19,24;
169:2,22,23,24;
174:2;178:1;182:18;
183:17;227:5;228:7;
230:5;235:21;249:8,
9;266:13;267:5,8;
271:25;301:18;
303:12;305:2,6,9,23;
306:23;308:5,10;
312:4
records (33)
133:7;140:21;
169:17;170:1;
179:20;190:20,21,24;
191:1,7,13,14;
192:19,25;193:1,12;
194:4,8;220:23;
221:5;234:5,10;
235:21;236:14;
237:10,12;238:5,6;
249:3,5;266:6,7;
311:20
recover (2)
145:11;160:21
recovery (1)
145:11
RECROSS (1)
314:14
red (3)
153:17;156:1,2
redaction (1)
234:13
REDIRECT (3)
221:19;299:23;
312:4
reduce (3)
129:15;164:2;
315:8
reducing (1)
317:8
reduction (2)
280:16;316:18
refer (4)
132:23,24;133:24;
136:9
reference (2)
189:19;308:8
referred (5)
132:21;149:12;
181:18;192:23;
295:20
referring (6)
135:20;152:4;
190:6;216:18;
219:13;282:17
refers (6)
148:24;172:1;
218:5;219:15;220:3;
282:17
reflex (1)
165:2
reflexes (5)
135:10,18;149:5;
166:16;168:2
refresh (1)
235:16
regard (3)
228:1;234:12;
307:11
Regarding (15)
131:8;147:7;
150:14;158:8;
162:15;167:3;218:1;
226:3;228:22;230:1;
276:19;277:17;
289:11;309:13;
311:21
regardless (1)
310:17
regards (1)
229:17
region (27)
148:12,18;152:9;
162:18;166:23;
228:17;262:18;
263:7,9,9;264:24;
265:2,6,10,16,25;
266:3;267:19,23,25;
268:4,6;273:15;
311:16;313:7;
314:18;316:10
regions (1)
264:23
regular (2)
125:6;158:2
regularity (1)
231:12
regularly (1)
231:14
rehab (1)
133:15
rehabilitation (6)
133:16;170:4,17;

203:5,8;208:21
related (4)
151:23;175:5;
217:12;222:13
relation (1)
218:12
relationship (1)
250:13
relationships (1)
250:25
relative (2)
276:22,22
relatively (4)
138:22;198:20;
225:18;266:1
relax (2)
144:14;152:21
relaxer (3)
167:13,17;170:23
released (1)
174:8
releases (1)
144:11
relief (10)
160:18;164:1;
204:16;208:11;
211:11,14;212:4;
215:17,23;216:2
relieve (3)
150:12;216:21;
217:2
religious (1)
244:5
rely (3)
132:6;235:17;
259:14
relying (1)
139:12
remainder (4)
197:13;198:22,23;
273:1
remember (4)
126:5;180:17;
311:22;318:3
removing (1)
168:6
rendering (1)
168:20
renew (1)
210:24
renewing (2)
159:24,25
repair (1)
142:23
repeat (2)
211:12;218:25
repetitive (1)
233:16
replaced (4)
161:17,20,24;
213:5
report (63)
132:5;197:5,9;
198:11;199:4;
200:16,22;202:18;
235:14,15,16,17,19;
236:21;237:1,7,15,
25;238:8,20;239:3,
12,19,21,23;240:6,9;
241:6,8,17,20;268:3,
15;271:19;276:7,13;
282:25;283:1,7,21,
25;284:7,8,11,14;
289:3,5;290:7,11;
291:4,5;292:23;
294:5;295:5,8;
305:10,13,16;309:5;
312:24;316:1,8;
317:8
reported (2)
266:10;303:6
REPORTER (2)
126:23;300:20
reporting (1)
171:15
reports (27)
140:21;196:22;
199:9,12;218:21;
234:18,20;235:3,5,
13,21;236:6,8;
237:14,15,21;238:3,
18,19;266:15,18;
268:12;288:20;
293:7;301:19;
303:15,18
re-prescribe (1)
213:18
re-prescribed (3)
211:22;213:19,20
represent (1)
188:8
reproduce (1)
137:21
request (4)
143:14,22;194:8;
296:5
requesting (2)
143:13,18
requests (2)
143:18;187:2
require (7)
182:25;184:15;
186:8;187:13,16;
231:3;232:15
required (8)
133:13;143:14;
163:17;175:7;
227:17;231:22;
304:1;305:4
requiring (2)
142:23;182:4
RE-REDIRECT (1)
319:7
research (5)
254:17;255:7,10,
14;256:11
reserving (1)
125:20
reset (1)
161:15
residency (3)
128:1,2,7
resident (2)
284:17,18
residual (1)
310:11
resolved (2)
281:16;285:7
resolving (3)
206:9,18,24
respective (1)
154:17
respiratory (1)
195:11
respond (1)
238:1
responding (1)
130:11
response (2)
130:8;228:23
responsible (1)
230:19
rest (6)
161:25;183:18;
186:12,24;231:14;
312:23
restrict (3)
145:12;147:6;
150:10
restrictions (2)
138:15,25
result (1)
318:17
resultant (1)
182:4
results (2)
140:17;146:7
resume (1)
320:9
retropulsed (2)
133:12;284:24
retropulsion (5)
142:10;169:6;
277:25;310:5,12
return (4)
147:9;182:15;
247:5;296:3
returned (1)
145:16
returning (1)
147:7
returns (2)
247:1,3
reveal (1)
250:6
revealed (1)
219:6
reversible (1)
313:13
review (8)
168:16;193:1,12;
194:4;199:12;236:5;
254:20;288:20
reviewed (14)
132:13;142:4;
150:13,17;168:19;
174:2;190:20;
192:25;199:3,9;
235:14;239:19;
240:5;267:19
reviewing (3)
131:22;142:3;
159:1
reviews (1)
235:2
revision (1)
231:4
rheumatological (1)
130:2
ridge (5)
277:4,6,6;279:11;
280:25
ridiculous (1)
305:22
Right (122)
124:21;125:10,20;
126:12;127:6;
133:21;135:5;137:3,
9,10,16,16;138:17,
18,20;139:5,5,6,7;
144:9;146:9,21,25;
149:13,15,21;150:2;
152:15;153:24;
157:4,10;162:8;
163:19,22;164:19;
165:1,3,5;166:16;
167:22;168:1;171:1;
174:10;177:23;
178:24;179:3;
190:11;192:18;
196:4,5;198:25;
201:25;204:25;
205:7,12;206:5,10,
16,17,19,24;207:1;
208:9;210:16;211:1;
213:10;219:6,22;
220:8;223:12,18;
236:6;237:22;
241:19;243:21;
244:5;247:18;248:7;
249:16;254:6;
256:25;258:17;
259:7;262:6;263:1,
12;264:21;265:21;
268:21;269:22;
271:4;274:13;
275:20;276:25;
277:10;278:12;
279:8;285:4,21;
286:2,18;291:5;
298:17,21;299:5;
303:6;305:17;
307:11,12;314:24;
315:6,12,12;316:14,
19;317:10,20,22;
318:9;319:2,5,21
rise (6)
125:24;225:4,13;
234:1;288:1;320:12
risk (1)
182:22
risks (2)
215:20;224:8
road (1)
180:3
robing (1)
177:25
rod (15)
286:20,25;287:1;
315:3,5,22,24;316:9,
13;317:16;318:12,19,
24,25;319:1
rods (5)
250:17;253:24,25;
280:17;316:15
room (8)
124:23;178:1;
237:25;258:25;
284:1;303:5,7,22
rooms (1)
305:11
root (4)
144:13;145:1;
290:20,22
roots (15)
135:2;148:12;
151:14,19,24;152:18,
19;154:10,13,16,20;
162:18;164:3;185:6;
198:4
rotation (4)
138:19,20;139:6,6
route (1)
184:25
rule (1)
251:10
rules (2)
130:14,17
run (1)
271:2
Running (1)
152:14
Rx (5)
159:19,21,22;
214:7,8

S

Sacks (19)
140:9,9;188:11;
192:14,14;247:11,11,
15,15;248:5,6,13,13,
15,15;249:10,10,24,
24
sacralized (2)

294:3,7
sacrum (2)
152:6;294:9
sagittal (6)
153:22;155:25;
156:10;230:2;231:7;
301:5
salary (1)
256:1
same (37)
138:12;155:2;
157:12;165:15,23;
167:23;175:19;
180:5;181:1,1,2,2,8;
182:18;185:20;
187:3;228:21;
229:25;230:15;
231:1;234:20;
235:23,25;239:11;
262:16;272:11;
296:15;305:16;
308:24;313:9,10,10,
11,12,12,23,24
Saturdays (1)
244:4
save (1)
169:17
saw (14)
133:17;145:13;
157:12;158:1;
197:19;204:1;
211:13;221:5,24;
295:2,22,24;297:3;
318:3
saying (12)
131:14;136:19;
205:16;213:12;
235:15,18;237:16;
240:21;255:2;
271:14,23;316:24
scaffold (2)
133:8;305:5
scaffolding (1)
266:15
scale (5)
134:18;171:13,15,
15;260:16
scalp (5)
133:9;140:22;
304:14,15,25
scan (18)
140:21;142:5;
231:18;258:8;
259:20;268:12;
269:2;273:22;
276:20,24;277:12,18;
279:16;280:2;301:2,
11;304:6;310:9
scans (13)
130:6;131:8,15,18,
22;132:3;140:23;
142:4;187:16;199:6;
218:17;268:9;288:6
scar (2)
198:16,18
scars (1)
198:13
Schmorl's (1)
241:14
School (5)
127:24;246:24;
251:19;253:2;272:7
sciatic (1)
149:1
scleroses (1)
275:20
scope (5)
177:16,19;304:3,
18;311:1
screen (2)
238:23;241:25
screw (4)
280:13;286:17,20;
315:8
screws (8)
154:5;155:13,14,
14;250:17;253:24,
25;286:15
se (3)
183:2;265:15;
285:15
seat (6)
126:4,17;188:2;
225:16;243:2;288:4
second (8)
134:8;144:15;
171:2,6;259:8;
260:12;275:13;
313:23
secondary (2)
281:3;310:11
section (5)
159:19;171:10;
196:13;202:18;270:2
sections (1)
196:23
secured (1)
286:21
sedation (1)
164:14
seeing (17)
130:23;132:3;
139:18;146:25;
163:3;165:24;
201:16;202:13;
207:24;222:12,19;
223:11;230:23;
249:4;271:13;
284:12;300:4
seek (2)
259:8;270:24
seemed (2)
133:21;146:24
seems (2)
210:20;240:19
sees (3)
231:15;277:17;
316:15
segment (4)
230:17;294:8;
314:11,11
self (1)
171:14
self-explanatory (1)
129:8
send (3)
130:5,8;246:24
sending (1)
295:9
sensation (6)
149:5;165:3;
166:17,17;171:6;
185:9
sensory (6)
135:11;168:2;
186:1;196:20;197:4;
198:11
sentence (2)
240:18;275:12
separate (4)
152:8,14;156:11;
312:18
September (4)
206:6;281:19,20;
296:18
sequela (1)
196:20
sequella (1)
142:20
serial (3)
184:13;187:8,9
series (4)
164:5,7;173:7;
276:9
serious (1)
145:10
serves (1)
161:7
sesamoid (1)
282:3
set (2)
144:14;233:23
sets (3)
150:19;187:12,12
setting (1)
187:2
seven (1)
174:6
seventy-five (2)
189:9;244:25
several (6)
128:11;160:17,25;
271:6,8;310:19
severe (3)
145:4;158:25;
166:9
severity (1)
170:8
sexual (1)
133:25
shape (7)
156:15,16;157:7,8;
306:15,16,18
shaped (1)
286:20
shapes (1)
154:2
shock (1)
144:17
shooting (7)
137:15,16;165:16,
18,21;166:12;175:3
short (5)
157:2,3;195:22;
225:18,19
shot (2)
180:4;313:23
shots (2)
298:1,2
shoulder (20)
134:16,17;147:1;
149:13,15,21,23,25;
150:2,6,6;197:10;
206:10,17,17,19,24;
208:9;223:11;295:20
shoulders (6)
141:11;165:1;
166:14,15;197:19,21
show (12)
125:6,10;155:24;
169:17,21,22;177:1;
215:1;237:20;
239:20;266:9,13
showed (11)
140:22,24,25;
142:6;146:8;218:17;
224:16;228:4;
310:19;312:13;
319:10
showing (2)
177:8;274:23
shows (5)
125:3;131:15,16;
153:5;184:14
shrinking (1)
135:8
sick (1)
206:3
side (10)
137:9,11,11;
144:10,13;151:5;
153:22,22;167:11;
234:12
sight (1)
179:22
sign (5)
135:18;136:24;
137:17;148:10;247:3
signal (1)
276:24
signals (2)
161:13;186:4
signed (2)
146:13;247:7
significance (12)
135:14;147:23;
148:8;156:8,24;
162:14;168:24;
169:25;170:14;
290:2,4;291:14
significant (21)
134:22;138:15,24;
139:21;142:20;
153:18;162:5;169:3;
170:9;176:10;197:7;
202:19;220:22;
221:2,6;230:17;
279:13;291:24;
308:23;309:4,17
signs (4)
135:16;149:6;
195:8,10
similar (12)
124:12;146:20;
147:24;159:14,17;
160:11;162:6;
170:24;185:3;
186:15;187:14;212:8
simply (1)
241:11
Sinai (10)
127:23;250:4,
252:14;256:23,24;
257:2,4,5,13;258:2
single (1)
244:15
singling (1)
166:5
sit (3)
153:12;157:15;
212:2
site (2)
317:6,9
sits (1)
152:12
sitting (11)
134:1;147:3;
155:20;162:23;
167:3,5;171:2;172:6;
183:1,2;233:8
situation (1)
201:21
six (7)
161:24;203:25;
223:8;235:7;252:4;
296:3;300:4
sixteen (2)
263:1;264:10
sixty (1)
263:16
sixty-five (2)
244:3;263:12
sixty-six (1)
168:12
skeletal (2)

218:9;262:25
skeleton (1)
263:3
skin (3)
136:10;161:10;
304:24
skip (4)
154:25;161:25;
277:8;292:4
skipped (1)
174:7
slash (1)
258:8
sleep (1)
163:2
sleeping (2)
162:25;167:19
slice (2)
156:11;157:3
slices (2)
153:25;157:2
slipped (1)
137:7
slips (1)
155:10
Sloane (1)
128:8
slow (1)
166:20
slowly (3)
137:12;158:11;
165:7
small (11)
144:8;161:9,10,12;
185:3,4;251:13,18,
23,24;294:14
smoothly (1)
286:15
sneak (1)
179:5
social (1)
197:2
Sofamor (1)
254:13
soft (8)
269:16;274:12,16,
17,18;275:5,7,13
solution (1)
164:16
Somatosensory (1)
144:3
somebody's (1)
153:23
somehow (1)
240:11
someone (11)
139:23;153:17;
184:24;189:24;
195:1;198:17;
240:17;259:3;
262:11,20;271:16
someone's (1)
265:22
Sometimes (6)
155:11,12;176:1,8,
19;189:8
somewhere (9)
144:9;244:13,21,
24;245:6,10,21,23;
264:13
Soon (1)
279:23
sooner (2)
184:2;233:23
sorry (24)
140:15;163:18;
166:14,17;205:24;
206:6;207:13,23;
211:12;217:17;
219:5,14;227:9;
231:11;239:16;
249:23;257:1;
288:16;290:22;
291:15;293:20;
300:20;310:24;
315:12
sort (11)
130:12;131:12;
185:9,17;213:18;
240:13;241:18;
242:4;261:21;
262:25;280:17
sought (2)
146:1;300:18
source (1)
210:7
sources (2)
217:8,11
space (4)
164:16;264:16;
269:24;270:10
spaces (2)
307:16,23
spanning (1)
314:10
spasm (12)
136:1,2,4,6,11,16,
21,22;137:2;165:4;
166:18;168:3
spasms (1)
167:18
speaking (6)
158:8;196:21;
212:14;236:6;
245:21;308:1
special (2)
164:14,15
specialist (4)
129:1,13;257:14;
300:5
specializes (1)
128:20
specialty (1)
298:12
specific (5)
144:1;198:3;
248:11,12;307:25
specifically (13)
132:18;133:18;
134:1;140:21;142:5;
143:9;152:4;165:22;
169:4;214:19;215:3,
6;235:6
specifics (1)
230:20
speech (1)
196:20
spell (3)
126:23;196:6;
300:20
spelling (1)
300:23
spend (1)
192:7
spikes (1)
154:4
spinal (81)
128:22;132:21;
133:11,13;134:4,4,5;
135:1,17,20,21,23;
137:19;142:11;
144:12,25;148:12;
152:3,8,13,15,15,16,
22;153:3,5;154:9,14,
16,20;156:14,14,19;
157:6,7,8,11;160:16;
161:14;162:15;
164:2,8,9,11;169:7;
173:6;174:6,6;175:5;
176:6,10;184:19,23;
185:2,5,6;186:1;
207:12;223:17,20;
230:2;243:22;
244:16;250:23;
251:4;254:8,18;
255:3;256:16;
265:17,19;267:3;
285:18;298:19;
300:14;301:13,23;
302:25;310:2;
311:15;317:1
spine (157)
128:18,24,25;
135:2;136:14;137:6;
138:4,8;141:1,11;
142:5;148:2,13,16,
16,19;149:25;151:9,
19,23;152:5,5,10,11;
153:22,23,25;155:20;
157:2;165:6,6;168:9;
169:3,4;172:17,19;
175:11,11,16;176:19;
181:18,20,25;182:3,
5,7,20;185:20,24;
202:8,15,23,25;
217:12;223:10;
226:17,19;227:3,12,
17;228:1,13,22,23;
229:22;230:3,18,24;
231:3,4,18,22,25;
232:3,21,22;233:17;
260:14,16;261:4,11,
12,20,21;262:7,13;
264:14;265:7,14,15,
20;267:16,24;272:10,
20;273:9,16,21;
274:4,11,18;275:3,9,
24;276:3;277:15,21;
278:2,6,16,24;
279:16,20;280:2,8,
17;285:10;288:10,
25;290:23;291:2;
292:11,15;293:4,4;
298:7,10,14,16,18,20,
23;299:6,8,14;
304:10;307:8,12,22;
310:9,17,20;311:9;
313:2,12,16;315:23;
316:15;317:11,18;
319:1,3,13,21,23,24;
320:1
spinous (7)
142:6;174:4;228:5;
267:17;314:9;
315:21;319:14
split (2)
241:23;304:1
spoke (1)
283:17
spoken (2)
263:22;283:11
spondylolisthesis (1)
307:13
spondylosis (9)
288:15;289:6,8,9,
23;291:8,15,17;
294:24
spot (1)
309:14
Spurling (5)
137:3,4;165:4;
166:19;168:4
spurs (1)
141:13
square (1)
156:15
squares (1)
154:2
SSEP (6)
143:24;144:3,16;
219:8,10;220:14
SSEP's (3)
220:6,15,17
St (18)
252:17,18,20,21,
21,24;253:1,3,5,7,11,
11,13;254:1,1;
256:10,24,25
stabilization (3)
155:13;182:4;
184:3
stabilize (4)
226:19;231:4;
285:10,12
stabilized (4)
169:9;285:8,25;
286:3
stable (2)
171:8;266:1
staff (4)
250:4;253:11,14;
255:24
stand (6)
126:11,12,16;
178:14;188:8;262:1
standard (1)
272:5
standby (1)
301:22
standing (11)
134:1;147:4;
155:17,20;162:23;
167:4,5;172:6;183:1,
2;233:8
standpoint (6)
168:23;170:15;
179:4,4;181:16;
232:6
stands (4)
144:3,4,4;171:24
staple (1)
304:14
staples (9)
173:24;304:1,24;
305:4,18;306:1,3,8,
10
start (3)
151:5;211:4;252:8
started (10)
140:6;165:23;
211:23;216:12;
220:21;234:9;244:9;
247:11;249:1;251:8
Starting (7)
127:19;128:2;
148:19;154:7,8;
182:6;303:15
starts (1)
232:22
state (5)
126:18;127:16,18;
155:11;230:14
statement (1)
248:5
states (2)
178:8;264:1
statistics (2)
247:25;248:3
status (2)
196:10;206:24
stay (4)
244:20;245:10;
261:22;262:1
stayed (4)
165:23;167:23;

262:8;310:20
stem (1)
156:13
stemming (1)
233:15
stenosis (9)
279:14;280:20,22;
281:3;290:14,23;
292:5,18;310:10
step (5)
151:1,8;224:21;
303:19;320:6
steroid (3)
164:2,4;216:11
steroidal (1)
163:24
sticker (1)
151:10
sticking (1)
305:16
stiffness (2)
133:18;137:1
still (17)
133:17;141:23;
146:20;147:24;
148:2;162:7,24;
163:3;166:24;167:5,
25;170:19,20;
185:10;204:18;
206:25;301:22
stimulation (4)
160:11,19;186:3;
212:8
stimulator (5)
184:20,23;185:2;
207:12;300:15
stimuli (1)
186:2
stinging (2)
133:19;149:3
stipulate (1)
306:8
stoic (3)
158:12,15;299:17
stop (3)
134:8;227:5;279:4
stopped (4)
160:4;166:12;
222:8;286:11
story (1)
228:1
straight (6)
137:10,12;149:5;
165:5;166:19;168:4
straightened (1)
309:6
strange (2)
282:9;305:10
strength (8)
134:18,19,20,20,
24;170:9;197:13,23
strengthening (1)
160:8
stress (4)
137:8;155:20;
181:20,21
stresses (1)
137:20
stretch (1)
287:6
stretching (2)
160:8;209:1
Stricken (1)
184:5
strike (2)
184:4;294:17
strong (1)
167:16
structural (4)
131:19;226:20,21;
227:11
structure (2)
195:21;270:3
studies (13)
130:5;131:18;
184:13;218:2,15,25;
219:4,5;231:6,17,21;
279:24;295:19
study (11)
143:24;219:1,8,10,
10;220:5,14,14,16;
281:9;309:19
stuff (1)
246:4
sub-anatomical (1)
270:3
subcutaneous (1)
136:10
Subject (2)
222:10;234:13
subjective (4)
136:5,17,18,25
subpoena (4)
191:11,12,13;
238:5
subpoenaed (5)
234:10;237:10,12;
238:7,12
subsequent (2)
142:19;177:9
subspecialty (3)
256:16;258:21;
259:9
substance (1)
215:11
substantial (2)
175:25;176:12
successful (1)
281:10
succinctly (1)
180:18
suffered (1)
319:13
suffering (1)
231:7
suggested (1)
143:8
suggesting (3)
226:12;259:18;
283:15
sum (1)
215:11
Sundays (1)
244:4
Sunshine (5)
250:11,12;251:10;
252:10;253:9
superficial (1)
161:11
superior (1)
310:11
supervised (2)
160:9;210:15
supplied (3)
191:1,2,3
supplies (2)
212:21;250:8
support (4)
162:24;167:6;
170:19;171:4
supposed (1)
154:21
Sure (35)
125:14;126:25;
127:17;136:7;
147:15,17;148:15;
151:6;153:9;156:9,
25;159:9;161:11;
162:4,22;166:8;
168:25;171:21;
172:2;191:23;193:8;
211:5,21;212:6;
214:18;216:6;218:7;
221:9;240:6;243:9;
260:21;261:4;
266:14;283:9;309:18
surgeon (17)
128:18;132:21;
223:11,12;224:1;
230:24;231:3,11,13,
15;250:16;254:1;
283:9;286:11;298:6;
301:14,23
surgeries (15)
150:11;223:17;
243:22;244:8,11,14;
246:6,22,23;250:24;
258:23;283:23;
301:14;302:24,25
surgery (78)
127:18;129:6;
133:13,14;135:13;
155:22;163:4;169:8;
170:7;171:3;173:6;
184:3;198:21;
206:24;210:12;
215:25;216:13,15;
217:1;223:20;224:9;
226:3,4,11,15,19;
231:4;232:14;233:7;
244:16,19;245:14;
246:7;250:8,18;
251:4;254:8,18;
255:4;256:14;
259:19;272:18;
274:1;279:22;280:3,
5,8;281:10,15,21;
283:8,14,18,21;
284:9,19;285:6,8,9,
15,25;293:14;296:5,
15;297:9,16;298:5;
301:9,12,15;310:5,6,
15,18;311:4;314:17;
315:3;319:3
surgical (6)
142:23;198:13,17;
232:15,18;304:24
surprise (3)
247:13;262:12;
264:4
surprised (4)
208:6;247:17;
248:17;264:12
Survalet (1)
205:6
susceptible (2)
155:18;181:22
Suspected (1)
282:6
suspense (1)
239:2
sustain (3)
142:21;173:11;
224:6
sustained (33)
133:9;135:1,21;
142:14,19;145:22,25;
146:5;148:11;169:3,
14;174:4;175:6,10;
177:7;196:19;
222:11;223:24;
225:6;230:3,18;
232:1;297:25;302:6,
23;303:10;305:8,14;
306:2;311:2;313:19,
25;314:3
swatch (1)
154:7
swelling (4)
140:22;269:16;
274:12,19
switch (3)
144:24;152:24;
260:11
switches (2)
144:22,23
swollen (1)
274:19
sworn (2)
178:3;243:1
sworn/affirm (1)
126:16
symptomatic (5)
143:5;160:18;
181:5;215:23;216:2
symptoms (16)
133:23,24;137:21;
141:14;144:1;
146:24;149:6;158:9;
174:20;175:13;
181:13;184:13;
208:12;209:16;
232:12;233:2
symtomology (1)
170:12
syndrome (3)
148:25;227:19;
233:14
system (7)
128:21,22;143:14;
144:6,7;197:10;
218:9
systems (1)
195:17

T

T1 (2)
152:11;153:21
T10 (14)
142:7,7;228:5;
288:15;289:6;
303:13;305:3;
309:21;314:8,10,22;
315:15;318:17;
319:14
T-10 (1)
174:3
T11 (3)
142:7;288:15;
289:6
T12 (19)
133:12;135:22;
142:9;152:11;228:4;
230:17;303:13;
305:3;309:10,21;
310:11;314:8,11,21;
315:10,13;316:3;
318:15;319:15
T-12 (14)
169:5;174:3,7;
272:24;273:18;
279:17;280:20;
284:3,21;285:2,6,8,
14;286:1
T-12/L1 (1)
280:22
T12-L1 (3)
142:8;154:15;
277:5
T2 (1)
156:10
T2-T3 (1)
292:9
T7 (1)

142:6
T8 (10)
142:6;314:25; 315:24;316:20,20,24; 318:13,18,25;319:21
T-8 (2)
261:7,7
T9 (1)
142:7
table (7)
139:11;148:4; 157:1;164:15;165:9; 166:22;168:8
tact (1)
294:19
tail (3)
152:6;154:1,14
talk (12)
125:11,19;216:17; 222:2;236:23; 260:12;277:25; 280:12;291:13,20; 294:18;309:6
talked (10)
140:16;152:24; 175:13;184:19; 187:8;202:18; 261:18;281:4;286:6; 300:14
talking (17)
139:14;179:17; 201:22;205:12; 235:22,25;240:16; 244:17;265:15; 298:14;312:6; 314:20;315:25; 316:22,24;317:8,10
talks (4)
304:12;308:25; 310:10;316:8
taught (1)
232:25
tax (3)
247:1,3,5
teach (1)
254:17
team (2)
149:24;255:24
tear (4)
130:1;141:8,10; 217:25
Tech (12)
251:8,9,12,22; 252:6,13,16,25; 253:15,23,24,25
technical (1)
219:16
technician (3)
302:10,15,17
telling (8)
143:17;200:23; 203:13;204:25; 205:9;207:14;248:4, 22
temperature (1)
198:23
temporary (4)
161:16;164:1; 215:22;216:21
ten (17)
170:21;187:20; 189:7;192:12,13; 205:21;206:9,16,18; 207:4;208:14,15,15, 15;209:6,6,6
tend (1)
141:12
tenderness (6)
135:25;136:2; 137:2;165:4;166:18; 168:3
tends (1)
167:17
TENS (23)
160:10;161:2,3,8, 17;173:4;185:3; 209:4,5;210:24; 211:2,4,7,10,13,24, 25;212:3,25;213:12, 17;297:21;298:2
tenths (1)
144:15
term (10)
141:17;195:22,24; 215:6;218:8;270:19; 276:19;282:17; 289:11;309:15
terms (17)
127:25;168:10; 202:19;205:1; 214:25;218:2; 241:20;245:12; 246:15;255:21,25; 264:23;266:2; 270:21;280:8; 291:15;301:9
test (15)
131:15;137:4,10, 12;144:16;145:3; 149:6;152:24;153:4; 165:5;210:6;254:19; 255:8,15;265:14
tested (3)
198:1;219:16; 255:12
testified (22)
126:16;129:18; 140:12;155:3; 173:22;188:11,17,20, 25;189:6,10,14; 192:11;225:17; 234:15;247:10; 256:13;258:23; 268:8;288:10; 289:22;314:16
testify (10)
125:11;132:14; 188:22;190:13; 191:15;192:2,7; 194:9;238:22;263:24
testifying (6)
174:3;189:16; 190:17,20;191:22; 192:6
testimony (12)
124:24;125:21; 131:3;149:11; 172:21;180:5; 190:17;192:3; 259:18;297:25; 316:19;318:12
testing (23)
140:17,18;143:9,9, 14,22,23;145:17; 166:19;168:4;187:9, 16;192:25;197:5; 198:22;199:2,3,3; 219:2,2;255:20; 256:1;265:13
tests (9)
130:6,7;140:18; 144:1,5;153:1;177:1; 187:10;255:11
That' (1)
270:5
theory (4)
161:12;185:25; 237:6,9
therapy (44)
129:5;130:9;143:8; 146:24;150:10; 160:2,3,6,10,12,14, 17,19,25;170:5,19; 171:8;172:8;187:5; 193:10;194:2,5,9; 200:4,20,25;203:8; 204:18;207:5,8,10, 15;208:21,24; 210:15;212:9;214:1; 223:6;232:3,9,16,19, 23,24
thereabout (1)
223:8
thigh (7)
133:21;146:21; 152:20;165:3;171:1; 174:10;224:14
thinking (1)
308:18
third (2)
220:7;312:3
thirteen (1)
263:4
thirty (1)
244:1
thirty-five (2)
243:22;244:8
Thoracic (59)
136:8;142:5,22; 148:2,13,18;150:18; 152:9,10;172:15; 174:6;198:12;202:8, 23;230:8,9;245:1,3,6; 261:14;262:18,21; 263:9;265:6,14,16, 16,25;266:2;267:19; 272:12;273:1,9,15; 276:3;277:12,14; 280:2;285:10;293:4; 307:5,6;309:7,9; 310:9;311:16; 313:10,12;314:18; 315:7;316:10,23,23, 23;317:5;319:1,13, 23,24
Thoracics (1)
245:2
thoracolumbar (1)
168:9
thorax (1)
198:25
though (8)
210:23;223:4; 242:8;269:22;271:2; 276:24;280:24; 289:22
thought (3)
179:15;236:22; 241:22
thousand (9)
192:3,4,10;213:2; 241:21;244:14,25; 245:7,23
three (23)
141:19;150:19; 152:8;161:22;164:7; 167:19;186:24; 187:12,12;192:3; 193:20;194:5;208:1; 213:4;218:24; 228:16;241:12; 244:3,14;251:19; 257:4,5;313:8
throat (3)
196:18;274:23,25
throughout (7)
136:1;141:1,8; 159:7;171:5;277:10, 14
throwing (1)
311:18
tibial (3)
219:12,17;220:16
tight (2)
136:18,20
tightening (1)
136:11
tightness (1)
172:14
times (22)
133:19;163:7; 166:8;167:7,7; 188:14,16;191:20; 192:2,11,13,13; 194:1;211:24;214:4; 216:19;244:13; 249:10,13,24;300:3; 305:10
tingling (4)
206:10,19;266:20; 303:20
tingly (1)
162:9
tissue (5)
136:10;269:16; 274:12,16,17
tissues (7)
136:9;274:18,20; 275:5,7,8,13
title (1)
126:18
to- (1)
318:13
today (16)
168:20;172:21; 174:3,17;182:10; 183:21;190:21; 191:12,15;194:9; 216:12;233:18; 244:10;300:12; 311:9;320:8
toe (3)
171:3,6;282:6
toes (5)
174:11;224:14; 282:9,10,11
together (4)
131:16;141:19; 155:15;181:19
told (23)
134:10;145:12; 148:6;174:15; 176:13,14;180:24; 181:24;183:6; 212:18;224:13; 226:4;229:17; 232:19;247:13,21; 253:20;279:25; 288:10;300:11,11; 303:6;306:17
tolerate (1)
183:3
tolerated (4)
205:25;206:2; 208:11;210:21
tomorrow (1)
320:9
tone (2)
135:9;147:25
took (12)
126:16;142:18,18; 187:24;188:8;211:3; 234:6,8;241:3; 267:14;268:9;287:8
tool (3)

137:24;138:14; 185:3
top (6) 137:6;139:5;152:3, 14;156:11;308:14
total (4) 191:25;218:23,24; 244:22
touch (1) 198:23
Touliopoulos (7) 149:12,23,24; 163:3;223:11;295:9, 20
training (2) 128:7;131:20
transferred (1) 133:15
translated (2) 155:21;181:20
transmit (1) 161:10
transmitted (2) 144:12;155:17
transmitting (1) 144:7
transpedicular (1) 280:13
transpired (1) 183:25
transverse (2) 142:8;157:4
trauma (16) 134:5;139:22; 142:15,20,21;148:11; 169:3;175:11,11,24; 181:12;182:3; 230:17;275:10; 310:2;312:12
traumatic (2) 259:19;313:10
traumatically (2) 298:11;314:7
treat (2) 129:13;231:5
treated (6) 140:3,9;189:6,17; 248:5,13
treating (12) 149:22;179:19; 180:1;188:23;189:2; 235:14;236:18; 247:14,20;248:15,22; 271:17
treatment (28) 128:21;129:4,11; 130:8,11;141:24; 143:13;145:23; 150:16;159:8; 167:24;168:14; 171:17,18;172:7; 174:12;183:15; 187:11;202:20; 203:14;207:14; 214:25;215:4;249:5, 15;285:14;296:2; 313:10
treatments (4) 130:9;170:11; 171:21;215:21
trial (11) 125:3;225:12; 227:1,22;230:23; 234:9;249:18,21,22, 25;297:4
trick (1) 238:15
tried (2) 163:14;164:23
tristate (1) 302:13
true (6) 173:9,14,16;177:1; 238:7;313:5
trunk (1) 198:24
trusted (1) 237:12
truth (1) 190:13
try (14) 127:4;129:13; 130:3;131:13; 150:11;167:11,15; 172:2,7;180:18; 232:11;243:9;254:6; 261:9
trying (5) 134:6;179:5; 222:24;238:15;280:7
turn (3) 138:19;144:23; 153:23
turned (6) 216:24;217:2; 297:16,22;298:1,2
turning (4) 137:5;263:16; 297:23;319:23
twenty (5) 188:15;245:23; 264:3,6,7
twenty-five (2) 244:1,12
twice (2) 221:24;296:21
twist (2) 139:6,7
twisted (2) 165:7;172:18
twisting (1) 182:23
two (35) 132:3;144:15; 154:11;155:7;158:6; 180:6;186:24; 204:21,22;207:3; 211:3;216:10;233:5; 236:1;239:14; 241:12,13;243:21,22, 25;244:1,7,7,12,15; 252:7;267:5;270:8, 13;271:14;272:3; 301:14;306:16; 310:8,15
two-level (6) 244:17,19;245:3,6, 9,13
Tylenol (1) 159:16
type (26) 129:4,5;130:2,18; 140:1;149:1,3; 161:22;171:18; 182:21;184:20; 185:2,20;190:3; 191:9;198:18; 209:14,19;212:4; 227:3;230:18,24; 263:6;264:4;281:6; 310:2
typed (3) 146:11,14;209:9
types (11) 130:4,6,16;159:17; 170:11;172:5; 215:21;227:16; 244:19;307:24; 316:25
typewritten (5) 159:19;162:1; 165:10,12;196:22
typical (1) 261:12
typically (7) 135:19;164:4; 262:7;271:10,19; 274:20;302:21

U

ultimately (3) 211:2;263:8;267:3
Ultrasound (1) 258:15
unable (2) 134:7;243:16
unchanged (2) 173:3;280:25
unconscious (1) 173:22
under (27) 164:13;176:25; 178:10,23;181:7; 197:9;198:11;204:6, 22;206:7;207:20,21; 208:7;217:21; 222:12;234:25,25; 235:4,21;236:7; 237:6;241:20,21; 242:5;275:12;300:4; 305:17
undergone (3) 133:14;170:6; 227:18
undergraduate (1) 127:20
underlying (3) 136:12;142:24; 178:7
underneath (1) 286:8
understandable (1) 240:16
Understood (2) 225:7;242:7
underwent (2) 174:5;198:17
undressing (6) 139:10,13;148:4; 165:8;166:21;168:7
Unfortunately (1) 264:15
union (7) 189:20,24;190:6, 10;222:7,8,12
Unit (34) 160:10,11;161:2,3, 8,17,20,21,23;173:5; 185:3,18,23;209:4,5; 210:24;211:2,4,8,10, 14,24,25;212:3,8,16, 20,21,22,25;213:1, 12,17;297:22
United (1) 264:1
University (2) 127:22;256:4
unless (2) 236:7;243:16
unquote (1) 276:23
unremarkable (4) 195:13,15,18,20
unstable (2) 169:6;182:20
unsure (2) 271:5,20
up (67) 127:3;128:3,25; 134:17;136:22; 146:23;150:11; 152:8;153:16; 155:17,20;156:22; 157:9;162:10;163:1; 164:11;166:5; 177:21;185:24; 201:22;221:12; 223:4,6,7,10;224:5; 226:4;229:6;230:8; 232:24;233:23; 235:10,11;237:25; 238:23;239:13; 240:23;241:10; 244:10;245:12; 246:20;251:8; 253:12;260:23; 261:4,5,6;262:1; 268:12;269:4; 270:18;271:1,2; 276:8;281:14;287:6; 300:24;301:10,18; 306:15;308:13,16; 309:18;312:8; 314:24;315:24;319:3
upon (34) 142:17;161:21; 162:17;183:24; 184:12;185:5; 186:25,25;202:13; 205:9;206:11; 217:19;219:5;233:8; 240:1;243:23; 244:19,20;245:15; 246:3;259:14,19; 261:21;267:19; 270:18;272:16; 274:7;281:9;283:21, 25;284:21;285:22; 294:21;319:3
upper (9) 135:18,19;167:25; 197:14,23;198:5; 206:19;219:2,24
upwards (1) 137:13
urgency (7) 166:24,25;209:17, 18,19,23;210:3
urinary (13) 162:12,14;166:24, 25;209:17,18,19,23, 23;210:3,3;217:5; 221:3
use (24) 133:22;141:10; 151:11;160:12,13; 161:21;196:23; 210:24;211:13,20; 212:8,9,19,21;213:6, 7,8,21,22;244:20; 246:4;250:23;251:1; 254:4
used (8) 125:21;167:6; 250:8;251:3;254:1,8; 255:3;307:11
using (21) 124:17,23;125:17; 134:3;137:24; 138:14;147:4;148:5, 5;151:15;162:24; 164:16;173:4;211:4, 7,23;212:12;240:10; 245:16,17;310:18

usually (7)
132:6;135:18;
189:16;245:2;
246:17;257:10;
289:12

V

variable (2)
159:16;161:21
variant (1)
294:10
variety (1)
255:8
various (3)
130:10;170:22;
196:22
vascular (2)
195:17;258:13
Velocity (1)
144:4
ventral (3)
288:15;289:6;
294:24
Verdon (91)
132:10,16,20;
133:3,5;140:2;144:2;
145:7,15;146:18;
149:12,15;158:1,8,
15;160:4;161:3;
165:13;168:14;
172:20;173:19;
174:5,9,21;177:2,7;
184:17;186:8,14;
187:4;190:4;192:20,
22;193:22;200:2,23,
25;201:22;202:1;
203:4,13;205:2;
206:7;208:20;
209:13,21;210:11;
211:13,25;212:18;
214:22;215:2,15;
216:15;218:2;221:2;
223:18;226:12;
227:24;230:22;
231:15;232:1,14;
233:7;259:3,19;
260:1;261:1;263:11,
18;265:13;266:10;
277:13;282:21;
283:12;285:18;
295:2;296:24;297:9,
16,22;298:6;300:3,8;
301:24;303:5,20;
308:9;309:19;
311:25;312:21
Verdon's (17)
150:14;165:22;
169:1;180:23;
182:15;183:11;
206:11;215:8;
226:25;303:25;
304:25;307:4;
308:14;310:20;
311:9;313:2;317:11
verified (1)
286:17
versus (2)
188:21;269:24
vertebra (2)
157:6;261:7
vertebrae (4)
152:10,12;261:3,5
vertebral (25)
124:2;142:9;154:2;
156:16;157:3;169:5;
272:21,24;273:2,18;
274:17;276:18,19;
284:3,21;294:15;
307:12,16;309:16;
310:17;314:8,9,10;
315:17;316:5
vertex (1)
269:17
vibration (1)
198:23
Vicodin (18)
147:1,12,14;159:9,
13;163:6;170:25;
201:3,11,18,22;
204:4,6,9;205:22,25;
207:4;208:11
view (8)
131:9;153:22;
155:25;156:23;
176:6;226:20;284:3;
301:5
Vincent's (16)
252:20,21,21,24;
253:1,3,5,7,11,11,13;
254:1,2;256:10,24,25
visit (16)
133:3;140:19,20;
143:6;158:22;160:1;
162:3;171:14,14;
194:12;200:1;
203:20,23;205:21;
208:13;296:3
visits (2)
207:5;213:24
visualized (2)
269:11;273:1
vital (2)
195:8,10
voice (2)
126:18;127:3
voltage (1)
185:25

W

Wagman (3)
235:4;236:7;
241:20
waist (3)
138:25;139:2;
168:10
wake (1)
163:1
waking (1)
162:10
walk (1)
171:7
walking (8)
134:2;139:12;
155:21;162:23;
167:6;170:20;171:1;
172:7
wall (1)
185:18
wants (4)
210:11;237:1;
300:15;308:9
way (19)
136:23;153:25;
164:10;203:8;227:6;
234:20;235:6;
237:24;238:10;
242:2;249:1;253:14;
257:9;262:8;265:20;
285:9;311:13;
314:22;316:20
weak (3)
133:23;146:22;
173:1
weakening (1)
218:11
weakness (19)
134:15,16;135:4,
15;147:25;164:25;
165:1;166:14,15;
167:25;168:1;171:5;
175:4;197:19,19,20,
21;206:10,19
weaknesses (1)
197:10
wear (5)
130:1;141:8,9,12;
217:25
wearing (4)
145:13;155:18;
170:19;171:4
wedge (5)
154:2;156:16;
273:18;303:13;305:3
wedged (1)
272:23
week (4)
131:2;186:6;
225:18;263:15
weekend (1)
126:5
weekends (1)
244:6
weeks (6)
174:8;223:8;267:6;
296:3;300:4;306:16
weight (2)
155:16;221:24
Welcome (1)
126:4
weren't (1)
303:17
what's (32)
129:3,4;130:3;
139:25;141:2,8;
143:23;154:13;
160:10;183:24;
185:25;187:1;189:4;
191:24;192:9;196:2;
197:14;204:22;
206:21;207:22;
218:8;227:12;
229:18;239:13;
245:18,18;250:11;
261:21;279:3;280:8;
282:16;308:10
whatsoever (1)
182:25
Whenever (2)
243:2;300:8
whereby (4)
232:21,25;307:7,9
Whereupon (9)
170:2;180:14;
185:22;187:23;
188:1;243:1;260:24;
268:14;287:7
white (1)
269:8
whole (5)
146:17;150:25;
168:22;261:9;265:20
whose (1)
238:21
wide (1)
255:8
wife (2)
133:6;246:17
wires (1)
161:9
wiring (1)
144:25
wise (1)
263:3
withdrawn (3)
132:12;143:21;
302:20
within (30)
144:15;152:16;
153:3,5;154:20;
162:18;169:7;171:9;
172:10;174:8,19;
175:14;177:18;
195:8;196:8;198:24;
226:7,23;228:14;
229:5,20;230:6,14,
21;231:9;233:19;
257:13;258:19;
270:1;274:19
without (9)
137:14;143:17;
172:4;230:20;
280:14;290:19;
293:19,21;307:13
witness (21)
126:8,11,11,14,20,
25;127:4;146:6;
170:3;173:21;178:2;
224:22;240:3;
260:25;300:22;
303:6;312:11;
313:23,24;320:7,10
women (2)
218:12;263:3
word (12)
150:2;172:13,14;
173:16;204:9,23;
274:12;307:11,14;
308:3,21;309:11
words (8)
129:7;141:19;
172:10,12;198:8;
201:21;257:13;
308:19
work (13)
132:1;140:4;
141:25;143:14;
147:8,9;182:16;
222:6,12;244:6;
255:18;264:8;306:10
worked (1)
263:19
Workers' (1)
222:19
working (6)
141:23;142:13;
222:8;244:2,4;
299:13
work-related (2)
130:13;140:8
works (4)
161:7,11;184:23;
201:13
worry (1)
246:18
worse (13)
155:7,11;158:10;
165:23,25;166:2,4;
167:23;182:24;
183:3,4;184:1,1
worst (1)
171:16
worth (1)
264:8
write (4)
197:6;213:11,13;
222:24
writing (1)
147:13
wrong (4)
178:13;189:19;
202:15;221:22
wrote (4)
202:14;213:14;

224:7;308:19

X

x-ray (18)
131:15;164:13,16;
184:14;231:18;
238:13;272:10,15;
281:18,21,23;282:2;
288:14;293:16,22;
301:3;308:24;318:3
x-rays (13)
130:6;131:8,18,22;
140:23;259:20;
260:2;268:9;292:23;
293:3;301:10;309:5;
310:19

Y

year (16)
128:5;158:6;
191:21;192:2,5;
243:22,23;244:2,8;
246:5,9,15;252:7,11,
12;301:14
years (24)
150:22;159:4;
161:22;166:3;
188:15;203:25;
211:3;213:4;232:2,9;
241:4;247:16;257:4,
6;263:1;264:3,6,7;
293:14;297:13,14,15;
303:1;310:21
yesterday (1)
300:11
York (8)
126:21;127:16,18;
128:7,13;243:12;
250:3;302:13
younger (1)
263:4

Z

zero (4)
134:18;171:15,16;
192:15

0

0749 (1)
268:21

1

1 (6)
168:16;169:24;
174:2;177:10;
281:20;283:6
1/18/13 (1)
163:20
1/31/11 (1)
193:18
1:02 (1)
224:23
10 (9)
139:3;170:8;
171:11,16,16;173:2;
214:15;216:4;227:25
10/13/11 (1)
218:25
10:00 (2)
320:10,16
10458 (1)
126:22
10A (3)
155:9;175:16;
228:16
11 (8)
207:20,23;268:20;
272:14;276:4;
277:13,18;303:16
11:53 (1)
281:21
11A (2)
230:8,9
11th (8)
172:22;173:18;
261:2;267:7;268:13;
272:10;273:22;
309:22
12 (4)
152:10;279:25;
293:23;296:18
12/22/09 (2)
145:16;218:24
12A (1)
293:3
12th (2)
279:25;282:25
13 (6)
209:9,16;214:5;
219:21;280:2;296:18
13B (1)
319:19
13th (1)
310:8
14 (3)
173:20;177:9;
227:24
1440 (1)
276:4
14th (2)
169:20,23
15 (1)
227:25
16 (2)
151:10,14
1610 (1)
280:5
16th (3)
169:23;170:14,16
17 (8)
132:18;144:21;
151:11;153:14;
260:22;288:24;
291:2;315:11
17th (2)
192:20;194:12
18 (8)
138:20,24;205:18;
214:16,21;215:1;
295:24;296:1
18th (1)
163:10
19 (3)
214:16;267:14;
296:13
1936 (4)
273:22;277:19,22;
304:7
1965 (2)
263:19,25
1985 (1)
264:1
1987 (1)
127:22
1991 (1)
127:24
1992 (4)
127:18;128:6;
243:12,19
1995 (2)
128:9,9
1996 (2)
244:8,11
1st (2)
281:19;296:5

2

2/12/2004 (1)
319:16
2/2/10 (1)
145:18
20 (2)
241:4;301:10
200 (1)
302:24
2000 (2)
211:6,18
2005 (1)
288:24
2009 (42)
132:18,18;149:12;
150:14,20;153:14;
156:22;158:1;
165:24;169:18,23,23;
170:16;173:18;
181:25;192:20;
193:23;194:12;
199:6,7;219:5;257:2,
3;261:2;267:7;
268:13,20;272:10,14;
273:22;276:4;
277:14,18;281:19,20;
282:25;291:2;295:3;
303:16;304:7;
306:16;310:9
2010 (24)
146:16,19;147:21;
149:18;150:8,9;
200:16;201:18;
202:2;204:1,22;
205:18,24;206:6;
223:5;295:24;296:1,
5,13,18,18,19,19;
297:14
2011 (21)
150:18,20;154:25;
155:25;193:24;
207:20,23;208:23;
209:2,5,9,16,21;
213:25;219:21;
292:11,16;296:21,21,
22;299:2
2012 (6)
214:5,15,15,16;
296:24;300:4
2013 (36)
150:18,18,20;
155:2;161:25;
163:10;164:18;
165:12,13,24;181:25;
192:11;211:5;
212:14,23;213:23;
214:16,21;215:1,13;
216:4;217:4,15,18,
21;220:7;221:6;
230:10;243:24,25;
246:20;292:22,25;
293:1;297:1;300:4
2014 (4)
293:23;294:18;
297:4;320:15
21 (1)
300:24
211 (1)
211:21
22 (1)
219:5
23 (1)
184:21
24 (4)
184:21;206:6;
296:18,22
2488 (1)
126:21
25 (5)
139:3;217:4,15,18;
220:7
25th (1)
161:25
26,2010 (1)
204:2
261 (1)
244:5
28 (9)
124:3;138:20;
151:12,15,17,18,23;
152:25;225:6
29 (3)
230:10;292:22;
293:1
2A (1)
276:9
2C (1)
309:19
2nd (5)
146:16;200:16;
201:18;202:2;204:1

3

3/11 (2)
208:2,3
3/11/11 (1)
208:7
3/23/11 (1)
193:18
30 (3)
138:18;168:12;
205:24
300 (2)
301:14;302:24
3101 (2)
179:18,25
3rd (2)
209:5;297:3

4

4 (1)
156:17
40 (1)
138:16
45 (3)
137:11,14;234:25
4532a (1)
235:20
4A (2)
306:15,17
4B (1)
156:22
4th (1)
296:21

5

50 (2)
139:1,8
500 (1)
235:11
59 (1)
308:2
5A (4)
153:20;175:16;
288:9,19

6

6 (3)
173:1;217:21;

296:19
6/25/13 (2)
211:22;216:14
60 (3)
137:11,15;139:2
60-year-old (1)
308:2
62 (1)
209:22
63 (1)
308:15
63-year-old (1)
308:18
6th (2)
165:12,13

7

7 (2)
170:8;204:22
7:36 (4)
273:24;277:22;
304:14;307:1
7:49 (1)
268:19
70 (1)
294:10
7A (2)
155:24;229:6
7th (1)
295:22

8

8 (1)
215:13
8/11/09 (1)
133:8
8/11/11 (1)
207:25
8/12/09 (1)
174:6
8/13/09 (1)
301:11
8/14/09 (1)
170:4
8/6/13 (4)
211:22,23;216:13;
218:25
8:41 (2)
272:11,14
80 (2)
137:13;208:9

9

9 (7)
149:12;155:24;
292:11,15;295:2;
304:6;320:15
9/2/09 (2)
193:16,17
90 (3)
137:14;153:24;
168:11
96 (1)
244:13