User Name: Jasen Abrahamsen
Date and Time: Friday, June 3, 2022 12:29:00 PM EDT
Job Number: 172462970

Document (1)

1. *EXPERT DEPOSITION OF ANDREW MEROLA, M.D. ; 2015 DEPO. TRANS. LEXIS 6280*
   Client/Matter: 000000.000000
   Search Terms: andrew /2 merola
   Search Type: Natural Language
   Narrowed by:

Content Type	Narrowed by
Expert Witness Analysis	-None-

EXPERT DEPOSITION OF ANDREW MEROLA, M.D. ; 2015 DEPO. TRANS. LEXIS 6280

UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF GEORGIA, ATLANTA DIVISION

CIVIL ACTION FILE NO. 1:15-cv-02530-CAP

January 29, 2015

Reporter
2015 DEPO. TRANS. LEXIS 6280

CLYDE HUNT, JR., Plaintiff, -against- BISER S. GEORGIEV; MEADOWBROOK MEAT COMPANY, INC. d/b/a MBM CORPORATION; JOHN DOES 1-3; And JOHN DOES 4-6, Defendants.

Expert Name: Andrew Merola, M.D.

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Counsel

BUDDOO & ASSOCIATES P.C., Attorneys for Plaintiffs, Atlanta, Georgia, BY: JEFF M. WASICK, ESQ.

GOLDBERG SEGALLA, LLP, Attorneys for Defendants, Princeton, New Jersey, BY: ROBERT M. HANLON, JR., ESQ.

Proceedings

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600 Lexington Avenue

New York, New York

January 29, 2015

1:08 P.M.

EXAMINATION BEFORE TRIAL OF ANDREW MEROLA, M.D., a Non-Party Witness herein, taken pursuant to Order, and held at the above time and place before Terri Fudens, a Stenotype Reporter and Notary Public of the State of New York.

CSI GLOBAL DEPOSITION SERVICES

972-719-5000

[2]

[17]NOT PRESENT:

[18]HAWKINS PARNELL THACKSTON & YOUNG LLP
Attorneys for Defendants

[19]303 Peachtree Street, N.E.
Suite 4000

[20]Atlanta, Georgia 30308-3243
404.614.7400

[21]

[22]* * * *

[23]

[24]

[25]

[3]

[1]

[2]

[3]FEDERAL STIPULATIONS

[4]

[5]IT IS HEREBY STIPULATED AND AGREED by and

[6]between the attorneys for the respective parties

[7]hereto, that filing, sealing, and certifications

[8]are hereby waived;

[9]

[10]IT IS FURTHER STIPULATED AND AGREED that

[11]all objections, except as to the form of the

[12]question, shall be reserved to the time of the

[13]trial;

[14]

[15]IT IS FURTHER STIPULATED AND AGREED that

[16]the within Deposition may be signed before any

[17]Notary Public with the same force and effect as

[18]though subscribed and sworn to before this Court.

[19]

[20]*** *

[21]

[22]

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[4]

[1]

[2](Exhibit AM-1, Medical records

[3]from Chiropractic Healthcare of

[4]Buckhead concerning Clyde Hunt Jr.

[5]with DOS: 03/09/2013 marked for

[6]Identification as of this date.)

[7](Exhibit AM-2, Medical records

[8]from Chiropractic Healthcare of

[9]Buckhead concerning Clyde Hunt Jr.

[10]with DOS: 05/04/2013 marked for

[11]Identification as of this date.)

[12](Exhibit AM-3, Medical records

[13]from University Orthopaedics -

[14]Northside concerning Clyde Hunt, Jr.

[15]with a visit date of 5/30/2013 marked

[16]for Identification as of this date.)

[17](Exhibit AM-4, Lumbar MRI

[18]documents marked for Identification

[19]as of this date.)

[20](Exhibit AM-5, Medical records

[21]from University Orthopaedics -

[22]Northside concerning Clyde Hunt, Jr.

[23]with a visit date of 6/11/2013

[24]marked for Identification as of this

[25]date.)

[5]

[1]

[2](Exhibit AM-6, Operative Notes

[3]from University Orthopaedics -

[4]Northside for Clyde Hunt Jr., date of

[5]surgery, 7/9/13 marked for

[6]Identification as of this date.)

[7](Exhibit AM-7, Operative Notes

[8]from University Orthopaedics -

[9]Northside for Clyde Hunt Jr., date of

[10]surgery, 8/6/13 marked for

[11]Identification as of this date.)

[12](Exhibit AM-8, Operative Notes

[13]from University Orthopaedics -

[14]Northside for Clyde Hunt Jr., date of

[15]surgery, 8/20/13 marked for

[16]Identification as of this date.)

[17](Exhibit AM-9, University

[18]Orthopaedics - Northside Spine

[19]Follow-Up dated 9/10/2013 marked for

[20]Identification as of this date.)

[21](Exhibit AM-10, an office note

[22]by Andrew Merola, M.D. concerning

[23]Clyde Hunt dated 12/2/2013 marked for

[24]Identification as of this date.)

[25](Exhibit AM-11, an office note

[6]

[1]

[2]by Andrew Merola, M.D. concerning

[3]Clyde Hunt dated 12/10/2013 marked

[4]for Identification as of this date.)

[5](Exhibit AM-12, NYP Lower

[6]Manhattan Hospital Report of

[7]Operation regarding Clyde Hunt, date

[8]of operation, 12/11/2013 marked for

[9]Identification as of this date.)

[10](Exhibit AM-13, New York

[11]Presbyterian Lower Manhattan Hospital

[12]Ambulatory Surgery History and

[13]Physical for Clyde Hunt marked for

[14]Identification as of this date.)

[15](Exhibit AM-14, an office note

[16]by Andrew Merola, M.D. concerning

[17]Clyde Hunt dated 12/16/2013 marked

[18]for Identification as of this date.)

[19](Exhibit AM-15, a copy of a

[20]prescription given by Dr. Merola to

[21]Clyde Hunt marked for Identification

[22]as of this date.)

[23](Exhibit AM-16, BenchMark Rehab

[24]Partners Initial Evaluation marked

[25]for Identification as of this date.)

[7]

[1]ANDREW MEROLA, M.D.

[2](Exhibit AM-17, BenchMark Rehab

[3]Partners Discharge Summary marked for

[4]Identification as of this date.)

[5]ANDREW MEROLA, M.D., the

[6]Non-Party Witness herein, having been

[7]first duly sworn by Terri Fudens, a

[8]Notary Public of the State of New

[9]York, was examined and testified as

[10]follows:

[11]EXAMINATION BY

[12]MR. HANLON:

[13]Q Please state your name for the

[14]record.

[15]A Andrew Merola, M.D.

[16]Q Where do you presently reside?

[17]A 567 First Street, Brooklyn, New York,

[18]11215.

[19]Q Good afternoon, Doctor.

[20]A Good afternoon.

[21]Q My name is Robert Hanlon, Junior.

[22]I'm with the law firm of Goldberg Segalla, and we

[23]represent the defendants in this matter.

[24]I assume you've been deposed before?

[25]A Yes, I have.

[8]

[1]

[2]Q About how many times?

[3]A A deposition such as -- well, I do

[4]depositions for -- I treat patients with

[5]work-related injuries, so I do Workers'

[6]Compensation depositions.

[7]Q Including all of those?

[8]A Right. A lot. Generally we do those

[9]over the telephone. So those are undertaken

[10]during the normal course of treating a Workers'

[11]Compensation patient. So we do those telephone

[12]depositions on a weekly basis, maybe once a week

[13]or something like that.

[14]Q Fair to say you're fully familiar

[15]with the procedure?

[16]A Yes.

[17]Q I don't think we're going to be too

[18]long today. If at any time you need a break, just

[19]let me know. Okay?

[20]A Will do.

[21]Q If I ask you a question you don't

[22]understand, just let me know, and I will do my

[23]best to clarify.

[24]A Will do.

[25]Q Today is not a memory test. If I ask

[9]

[1]

[2]you a question and it would help you to refer to a

[3]document, let me know. I may ask you to give your

[4]best answer before reviewing the document, but I

[5]promise you I will give you an opportunity to

[6]review any documents you want. Okay?

[7]A Yes.

[8]Q Any questions before we get going?

[9]A No.

[10]Q Doctor, did you review anything in

[11]preparation for your deposition today?

[12]A Yes.

[13]Q What did you review?

[14]A Prior treatment notes regarding

[15]Mr. Clyde Hunt whereby he had gotten conservative

[16]treatment at a chiropractic facility. Also at the

[17]University of Orthopaedics where he had seen a

[18]surgical consultant before I initially saw him.

[19]I also had an opportunity to review

[20]MRI films, and I did use MRI films when I saw and

[21]evaluated the patient on my initial examination.

[22]Q You mentioned the chiropractic

[23]records; correct?

[24]A Correct.

[25]Q And then the orthopedic records.

[10]

[1]

[2]That was Dr. Bendiks; correct?

[3]A Yes.

[4]Q The MRI, was that the lumbar MRI done

[5]on June 4, 2013?

[6]A Correct. Yes.

[7]Q Anything else?

[8]A That's what I can remember having

[9]reviewed.

[10]Q The chiropractic records, were they

[11]from Chiropractic Health Care of Buckhead, a

[12]Dr. Bruce Salzinger?

[13]A Yes.

[14]Q First visit, March 9, 2013; is that

[15]correct?

[16]A Yes.

[17]Q And the last visit, May 4, 2013?

[18]A Yes.

[19]Q Dr. Bendiks, he's at University

[20]Orthopedics-Northside; correct?

[21]A Yes.

[22]Q The first visit was May 30, 2013;

[23]correct?

[24]A Yes.

[25]Q Before Mr. Hunt came up here to see

[11]

[1]

[2]you and have surgery, he last saw Dr. Bendiks on

[3]September 10 of 2013.

[4]Have you reviewed any of Dr. Bendiks'

[5]records after your surgery?

[6]A Yes.

[7]Q You reviewed that in preparation for

[8]today?

[9]A Yes.

[10]Q And have you reviewed any MRIs,

[11]either the reports or the actual MRI, other than

[12]the lumbar MRI on June 4, 2013?

[13]A There was a postoperative MRI done as

[14]well. I looked at the report.

[15]Q So the one before your surgery, you

[16]looked at the report and film?

[17]A Yes.

[18]Q And the postoperative report only;

[19]correct?

[20]A Yes.

[21]Q Doctor, I have reports from you dated

[22]December 2nd, 2013 pertaining to your initial

[23]evaluation; correct?

[24]A Yes.

[25]Q And then you did an addendum to that

[12]

[1]

[2]a few days later on December 10th; correct?

[3]A Yes.

[4]Q And then of course there is the

[5]hospital records for the surgery?

[6]A Correct.

[7]Q And then you saw Mr. Hunt once after

[8]your surgery, which was December 16, 2013; is that

[9]right?

[10]A Yes.

[11]Q Other than your reports, those three

[12]reports that we just went through, December 2nd,

[13]December 10 and December 16, do you have any other

[14]types of reports pertaining to Mr. Hunt?

[15]A No.

[16]Q Have you seen Mr. Hunt since his last

[17]visit to you on December 16, 2013?

[18]A No.

[19]Q To the extent that you've reviewed

[20]medical records dating after December 16, 2013,

[21]you have not written any type of report about

[22]those; is that correct?

[23]A Correct.

[24]Q The chiropractic records that you

[25]reviewed, when did you review those for the first

[13]

[1]

[2]time, before or after the surgery you performed?

[3]A I reviewed -- I don't specifically

[4]remember looking at the chiropractic records

[5]beforehand, although I specifically remember

[6]looking at Dr. Bendiks' records prior to surgery.

[7]Q At any time have you reviewed any

[8]other records that we haven't covered so far?

[9]A Of course there's the hospital record

[10]and reports from the hospital where the operation

[11]was done, including my operative report.

[12]Q Yes.

[13]A I also looked at physical therapy

[14]records from BenchMark Rehabilitation. I believe

[15]those are postoperative physical therapy notes

[16]after the surgery.

[17]Q Okay.

[18]A I have looked at records from

[19]Dr. Walkup, who is with Peach Tree Neurosurgery.

[20]Those are postoperative records, I believe. Yes,

[21]they are. So those are post-op.

[22]And I also saw some records from a

[23]plastic surgical group regarding a scar revision,

[24]if I'm not mistaken.

[25]Q A surgical scar?

[14]

[1]

[2]A Yes.

[3]Q Anything else?

[4]A I also reviewed Mr. Hunt's -- he had

[5]a deposition done.

[6]Q Yes.

[7]A I looked at and I was able to read

[8]that as well. I read that before I came here,

[9]last night.

[10]Q So the chiropractic records from

[11]Dr. Salzinger pertained to treatment that occurred

[12]before your surgery. But you first reviewed those

[13]reports after your surgery in preparation for your

[14]dep today; is that right?

[15]A I believe so. I just want to check

[16]my first note to see if I wrote anything else in

[17]here. I think that's pretty accurate.

[18]Q When you say you're looking at your

[19]first note, is that your December 2nd, 2013

[20]report?

[21]A Correct. Yes.

[22]Q Then Dr. Bendiks at University

[23]Orthopedics, to the extent that he treated

[24]Mr. Hunt before your surgery, you reviewed those

[25]before your surgery; right?

[15]

[1]

[2]A Yes.

[3]Q And then you have since reviewed

[4]post-op notes by Dr. Bendiks; right?

[5]A Correct. Yes.

[6]Q It's probably obvious, but the

[7]preoperative MRI, you reviewed both the report and

[8]the film before your surgery?

[9]A Yes.

[10]Q Now, you last saw Mr. Hunt in

[11]December of 2013. When was it that you received

[12]the additional postoperative records? Do you

[13]recall? Was it just a couple of days or a couple

[14]of weeks ago in preparation for your deposition

[15]today?

[16]A I don't recall specifically when I

[17]had gotten those. But I know that I reviewed them

[18]at least a couple of days ago, maybe even last

[19]week, because I knew I was coming in for a

[20]deposition.

[21]Q The purpose of them being sent to you

[22]was to review them prior to your deposition?

[23]A I believe so.

[24]Q Are you still treating Mr. Hunt?

[25]A Well, I haven't seen him since 2013.

[16]

[1]

[2]I know he's treating with Dr. Bendiks

[3]post-surgically. And he had another surgical

[4]consultation from from Peach Tree Neurosurgery.

[5]So I guess I would see him if he was

[6]interested in having any other opinion regarding

[7]future treatment. I don't know if he's made an

[8]appointment to come back and see me or not. I

[9]haven't checked.

[10]MR. HANLON: Let's go off the

[11]record for one second.

[12](At this time, a brief recess

[13]was taken.)

[14]CONTINUED EXAMINATION

[15]BY MR. HANLON:

[16]Q Doctor, to help move things along

[17]today, I try not to take long depositions, I

[18]premarked our exhibits. So let's get started with

[19]those.

[20]Exhibit 1, is that the initial record

[21]of March 9, 2013 for the chiropractor

[22]Dr. Salzinger?

[23]A Yes.

[24]Q That was one of the documents that

[25]were provided to you after surgery; correct?

[17]

[1]

[2]A Yes. I don't know when I got the

[3]document, but I know that I really wasn't too

[4]interested in the chiropractic treatment

[5]beforehand. I was more interested in the surgical

[6]treatment and opinion of Dr. Bendiks, since he had

[7]come in for a second opinion, surgical

[8]consultation. So I don't know when I got that

[9]record, but I absolutely remember having reviewed

[10]it before I got here.

[11]Q So our accident was February 15,

[12]2013. This note is dated March 9, 2013.

[13]Are you aware whether Mr. Hunt

[14]received any medical treatment after the time of

[15]the accident and before this trip to the

[16]chiropractor?

[17]A I didn't see any medical records in

[18]the interim period of time between the actual

[19]accident and then the chiropractic treatment.

[20]Q Okay. Doctor, I'm going to ask you

[21]just a couple of questions about this record.

[22]On page 1 in the top paragraph

[23]there --

[24]A Yes.

[25]Q -- the chiropractor is reporting on

[18]

[1]

[2]the happening of the accident and writes the

[3]following: "He claimed not to feel pain time of

[4]impact."

[5]Do you see that?

[6]A He claimed not to feel pain

[7]immediately after the accident, yes.

[8]Q I'm going to try to go in

[9]chronological order. Why don't you pull out

[10]Exhibit 10. That's your initial report. We'll

[11]probably be coming back to that.

[12]A Okay. Yes.

[13]Q On page 2, you comment on the pre-op

[14]MRI; correct?

[15]A Yes.

[16]Q Your reading of that is bilateral

[17]impingements with herniations are noted at L4-L5;

[18]is that correct?

[19]A Yes. I wrote bilateral impingements

[20]with herniations noted at L4-L5 segment with

[21]neuroforaminal impingement present and also

[22]central component of herniation, yes.

[23]Q When we get to this chronologically,

[24]I will ask you to explain what all that means.

[25]Okay?

[19]

[1]

[2]A Yes.

[3]Q My immediate question is if that

[4]condition were to occur as the result of a

[5]traumatic event, would you expect the person to

[6]experience pain immediately during or after that

[7]event?

[8]A The expression of pain within that

[9]particular region or body part depends upon the

[10]amount of disk material that is herniating through

[11]the annulus. So it depends on the spectrum of

[12]injury to the disk in terms of being able to

[13]correlate it with chronology of pain complaints.

[14]Also, other factors were involved,

[15]including distracting injuries and other potential

[16]distracting factors, yes.

[17]Q The disk in the condition that you

[18]saw it on the MRI --

[19]A Yes.

[20]Q -- if it were to be rendered in that

[21]condition as a result of a singular traumatic

[22]event, would you expect that to cause pain?

[23]A Well, at some point in time, that

[24]disk would be expected to result in symptoms and

[25]then physical findings at some point in time, yes.

[20]

[1]

[2]Q Would you expect the onset of those

[3]symptoms to be immediately after the accident?

[4]A Not necessarily, no.

[5]Q How do you explain that? In other

[6]words, if we popped up on the screen here the

[7]MRI --

[8]A Sure.

[9]Q -- and if it showed what you describe

[10]here in your first report, if it were put into

[11]that condition in a singular traumatic event, like

[12]a car accident, how could it be that that would

[13]not result in pain?

[14]A Disk herniations can happen -- well,

[15]a disk herniation, in order for it to happen,

[16]needs to have a disruption in what's called the

[17]annulus of the disk. Those are the outer fibers

[18]of the disc that contain that inner nuclear

[19]portion of disc material.

[20]The disc material itself makes its

[21]way out of the annulus in any number of ways, and

[22]the amount of time that it takes to get outside

[23]the annulus or penetrate the annulus can vary

[24]depending on the original injury to the annulus.

[25]The nerve fibers can also vary in

[21]

[1]

[2]terms of their resilience to feeling pressure, or

[3]pain receptors, or chemical irritation from the

[4]disc. So it doesn't all have to happen exactly at

[5]the same time that the accident happens, but it

[6]can happen gradually over the course of time,

[7]because there is a spectrum of potential disc

[8]injury and nerve injury that can occur over time.

[9]So it's not an all or none phenomenon.

[10]Q Exhibit 1, the initial chiropractic

[11]note, towards the bottom of the page, literally

[12]the second line up from the bottom --

[13]A Yes.

[14]Q -- it is reported that Mr. Hunt is

[15]including in his symptoms pain radiating down the

[16]leg below the knee on the right.

[17]A Yes.

[18]Q Now, in this initial chiropractic

[19]report, you agree there's no indication of pain

[20]radiating down the left leg; is that correct?

[21]A Yes, in that what he has is the

[22]history of present illness/condition section.

[23]Q I guess describe for us how is it

[24]that a lumbar injury -- what is it that happens

[25]that can cause pain radiating down the right leg?

[22]

[1]

[2]A In terms of this patient's symptoms?

[3]Q Or in general. In other words, if

[4]you have a lumbar injury and a report of pain

[5]radiating down the right leg, how do you go from

[6]the lumbar injury to the pain down the right leg?

[7]What's going on in the lumbar area to cause that?

[8]A Okay. So in the low-back area, in

[9]the area where the spinal canal is are the disks

[10]and the bones. And the nerves travel past the

[11]lumbar spinal canal into the legs and the feet,

[12]and they travel in a specific distribution.

[13]And the leg nerves start at L2 and go

[14]all the way down to S1. So the first nerve is

[15]generally the second lumbar nerve, the L2 nerve,

[16]and it proceeds all the way down to the first

[17]sacral nerve or S1.

[18]Now, those nerves are responsible for

[19]sensation in the legs, reflexes in the legs, motor

[20]function of the legs, that is muscles, and what we

[21]call position sense so you know what position your

[22]leg is in at any point in time, and also for

[23]feeling pain, because they have pain fibers within

[24]the nerve.

[25]Depending upon the amount of

[23]

[1]

[2]inflammation that's happening to the nerve, or

[3]depending on the amount of pressure that a

[4]particular nerve has, it can become what we call

[5]symptomatic. That is produce symptoms along its

[6]distribution.

[7]So the ability of a nerve to produce

[8]symptoms along the distribution of that nerve

[9]depends upon the amount of inflammation that a

[10]particular nerve has and/or the amount of pressure

[11]that that nerve has combined with its own inherent

[12]resiliency towards resisting inflammation and/or

[13]pressure.

[14]Q So if we were looking at someone from

[15]the back, spinal column, and you have nerve roots

[16]coming off of the spinal column?

[17]A Yes. Correct.

[18]Q At these levels you talked about,

[19]again, if we're facing the back of someone, it

[20]would be coming off from the right, which would go

[21]down the right leg, and some nerve roots would

[22]come off the left of the spinal column and go down

[23]the left leg?

[24]A Correct. Yes.

[25]Q When you have a bulge or a

[24]

[1]

[2]herniation, it can be one side or the other;

[3]correct?

[4]A Bulges and/or herniations can have

[5]a -- in general if you're looking at a bulge, a

[6]bulge is more symmetric than a herniation. A

[7]herniation is more asymmetrical.

[8]That being said though, the

[9]compression can occur within the canal region. So

[10]if we think of the spinal area where the nerves

[11]are located, and we talk about the neuroforamina

[12]as the area where the nerve roots exit,

[13]compression can exist to varying degrees in any of

[14]those particular anatomical locations.

[15]Q With a report of pain radiating down

[16]the right knee, then you would expect inflammation

[17]of the right neuro foramina?

[18]A At that point in time you would

[19]expect inflammatory changes involving the

[20]right-sided nerve roots more so than the

[21]left-sided nerve roots, correct.

[22]Q And if you look, sticking with

[23]Exhibit 1, and flip to page 3, you will see the

[24]notes of the orthopedic examinations; correct?

[25]The bottom of page 3.

[25]

[1]

[2]A Yes.

[3]Q For example, it indicates a Kemp's

[4]test was negative on the left and positive on the

[5]right.

[6]A Yes.

[7]Q Again, is that a further indication

[8]that the nerve roots on the right side were

[9]aggravated at that time, but not on the left?

[10]A Yes.

[11]Q What is a Kemp's test?

[12]A It describes an amount of compression

[13]that's placed along the lumbar spine whereby

[14]you're palpating spasm in order to try to elicit

[15]painful symptoms.

[16]Q Similarly, straight leg testing,

[17]negative on the left, positive on the right?

[18]A Yes.

[19]Q Same indication. The right nerve

[20]root was irritated, the left was not at that time;

[21]right?

[22]A Correct. Yes.

[23]Q The next page, a Yeoman's test.

[24]A Yes.

[25]Q The same results, negative on the

[26]

[1]

[2]left, positive on the right?

[3]A Yes.

[4]Q What's a Yeoman's test?

[5]A That's another test whereby you are

[6]compressing the lumbar area to put pressure on the

[7]nerve roots in order to further irritate them to

[8]see whether or not those nerve roots would

[9]reproduce symptoms.

[10]Q A little further down, how do you

[11]pronounce that?

[12]A Lasegue. That's also a straight leg

[13]raise test.

[14]Q A Lasegue test, negative on the left,

[15]positive on the right.

[16]A Yes.

[17]Q You're saying that's a straight leg

[18]test?

[19]A Yes. That's correct.

[20]Q And the point of a straight leg test

[21]is you are essentially -- if you're doing a

[22]straight leg test with your right leg, you're

[23]stretching that nerve to see whether it's

[24]irritated?

[25]A Yes.

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[1]

[2]Q Close enough; right?

[3]A Very good, yes.

[4]Q The last one, a Nachlas Test was

[5]positive bilaterally.

[6]A Yes.

[7]Q Before we get into the bilateral,

[8]what is that test?

[9]A So that's a test whereby you're

[10]focusing a little bit more on the upper portion of

[11]the lumbar spine. In fact, I think there is a

[12]qualifying statement here where I think he says

[13]this test indicates inflammation of the upper

[14]lumbar nerve roots.

[15]Those are the nerve roots closer to

[16]the groin and thigh regions. So once again,

[17]you're basically trying to compress or irritate

[18]those nerves to see whether or not they produce

[19]pain.

[20]Q But that's outside the area of where

[21]your surgery occurred?

[22]A That would be -- I would consider --

[23]personally I would consider the upper lumbar nerve

[24]roots, L1 through L3, and then the lower roots, L4

[25]and below.

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[1]

[2]Q You operated at what level?

[3]A L4-L5.

[4]Q Flip to the next page. You will see

[5]some questionnaires were done, one about the neck

[6]and one about the back.

[7]A Yes.

[8]Q There is an acronym there, Oswestry.

[9]A Correct.

[10]Q So the record is clear, this section

[11]of the report is titled, "Oswestry back

[12]pain-modified questionnaire."

[13]A Yes.

[14]Q What's that all about?

[15]A An Oswestry is a questionnaire that

[16]was designed with questions specifically referable

[17]to the low back regarding certain personal

[18]activities of daily living that either do or do

[19]not reproduce pain and/or symptoms, and then

[20]something about the amount of pain that is

[21]produced during those activities.

[22]So there is a series of questions,

[23]and they are listed here, and they're listed from

[24]numbers 1 through 10. And then the answer is

[25]listed under the section, and then those answers

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[1]

[2]qualify the amount of pain for those particular

[3]activities.

[4]It's a way of getting a snapshot in

[5]terms of what the patient's activities of daily

[6]living are like, what does or does not reproduce

[7]pain and subjectively gives you a better idea of

[8]what their overall low-back pain status is.

[9]Q So these are standardized questions?

[10]A Yes, they are.

[11]Q It's not as if Dr. Salzinger is

[12]making these up?

[13]A Correct.

[14]Q So it's a standard question. Tell me

[15]about how they're administered. Does a doctor or

[16]a nurse literally ask the patient, and the patient

[17]gives a verbal response, which is then typed into

[18]the report?

[19]A There are several ways they can

[20]actually be administered. That's one way of

[21]administering them is by interview. The other way

[22]that you can administer them is it to actually

[23]give the patient a form with the questions on it

[24]whereby the patient would then answer each

[25]particular question and check off the response.

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[2]Q Either way the answers come from the

[3]patients?

[4]A Yes. Precisely. It's a subjective

[5]description of the patient's symptoms based on

[6]those particular activities of daily living.

[7]Q So at least as of this time, March 9,

[8]2013, talking about his back, Mr. Hunt stated that

[9]his normal job and homemaking activities do not

[10]cause him any pain; correct?

[11]A Let's see. Under employment and

[12]homemaking, number 10, it's indicated that my

[13]normal job/homemaking activities do not cause

[14]pain, yes.

[15]Q So the questions and answers are what

[16]they are. We don't have to read them all here.

[17]Let me draw your attention just below

[18]number 10 that we just referred to. Do you see

[19]sort of a conclusion there? It says score,

[20]26 percent.

[21]A Yes.

[22]Q What's that all about? How did

[23]someone look at these questions and answers and

[24]come up with 26 percent?

[25]A So, each answer has a numerical value

[31]

[1]

[2]assigned to it. Then those numerical values are

[3]added up to obtain the final numerical value,

[4]which you then grade, as indicated here, between

[5]zero and 100. And this particular score was 26.

[6]Q That's meant to be a pain scale?

[7]A Well, really technically they refer

[8]to it as an Oswestry score. One of the ways that

[9]you can use an Oswestry score is to follow your

[10]patient over time to see whether or not the

[11]treatments that you're rendering are helpful or

[12]not, or if their clinical condition is improving

[13]or deteriorating depending upon what's happening

[14]to the patient.

[15]Q It seems like an effort to take some

[16]subjective feedback from a patient and make it a

[17]bit more objective so you can track it over time.

[18]Is that really what it's all about?

[19]A Yeah. A good way of describing it is

[20]to try to get some objectivity out of the

[21]subjective components of symptoms.

[22]Q Rather than go through all the

[23]chiropractic records, I marked as Exhibit 2, the

[24]final chiropractic record. That's dated May 4,

[25]2013; correct?

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[1]

[2]A Yes.

[3]Q Again, this particular one was

[4]included in the records that you've reviewed; yes?

[5]A Yes.

[6]Q So at this time, Mr. Hunt has been

[7]receiving some chiropractic care for both the

[8]upper back, which is the cervical thoracic area,

[9]and the low back; correct?

[10]A Yes.

[11]Q You see on the first page there is a

[12]section entitled history of present illness

[13]condition; is that right?

[14]A Yes.

[15]Q As of May 4, 2013, for his low back,

[16]Mr. Hunt was reporting pain at a level of 1 on a

[17]scale of 0 to 10; correct?

[18]A Yes.

[19]Q A little further down in that

[20]paragraph he subjectively describes it as dull and

[21]aching; is that correct?

[22]A Yes.

[23]Q Fair to say that is a good indication

[24]that at least as of that time, the chiropractic

[25]care had provided him relief of his low-back pain?

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[2]A According to this chiropractic record

[3]with respect to the lower back, yes, the

[4]chiropractic treatment, according to this note,

[5]was helpful with the low-back pain as of this

[6]date.

[7]Q Doctor, just a general question I'm

[8]going to ask you before I forget.

[9]When you look at an MRI -- so you

[10]looked at one here, and your interpretation was

[11]herniation; correct?

[12]A With bilateral neuroforaminal

[13]inpingement and some other things, yes.

[14]Q Is there any way to look at an MRI

[15]and date a herniation, and say that's been there

[16]for one week, two weeks or two years?

[17]A It's hard to be able to give a

[18]temporal relationship to the disk herniation

[19]itself that occurs in the MRI. It depends on many

[20]different factors.

[21]For example, there are times when you

[22]can see something called an annular tear or a high

[23]intensity zone, and those can tip you off that an

[24]acute process has occurred. But the ability to

[25]see an annular tear is variable.

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[2]Also, there are times where you can

[3]see what we call marrow end plate edema changes in

[4]the area of a disc herniation or edema within a

[5]nerve root. But those findings on an MRI are also

[6]variable as well.

[7]So it's difficult with any given

[8]certainty to always be able to predict or give a

[9]temporal relationship to the timing of a

[10]herniation based on only the MRI film.

[11]Q A herniation can certainly be caused

[12]by trauma; correct?

[13]A Yes. Correct.

[14]Q It can also be caused by wear and

[15]tear and the aging process; correct?

[16]A Yes.

[17]Q And within the wear and tear and

[18]aging process, there are some risk factors, one of

[19]which is a person's weight; is that correct?

[20]A Weight can be -- weight, along with

[21]other risk factors, can exist in terms of the

[22]predisposition for herniations, yes.

[23]Q Is weight a factor for the simple

[24]reason that it puts more pressure on your spinal

[25]disks?

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[2]A It can be, but it's more likely a

[3]multi-factorial origin, which is to say you can --

[4]for example, you can be a body builder who has a

[5]very heavy weight, but it's mostly lean body mass

[6]with excellent posture. Or you can also be a

[7]smaller person with a very weak core strength and

[8]still develop a herniation based on the fact that

[9]you have poor posture and/or poor spinal

[10]biomechanics.

[11]So it's more likely a multi-factorial

[12]origin in terms of the propensity to develop, for

[13]example, a degenerative disc herniation over the

[14]course of time.

[15]Q In this case I saw some notes

[16]indicating Mr. Hunt's weight varied from somewhere

[17]in the range of 300 to 350. Does that comport

[18]with what you remember and your observations of

[19]him?

[20]A Yes.

[21]Q Not a body builder; right?

[22]A No.

[23]Q Would you agree that in this case,

[24]his particular body type, including his weight,

[25]would be a risk factor for lumbar problems?

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[2]A In this particular case, I would say

[3]that he had risk factors for the normal

[4]degenerative process that happens in the lumbar

[5]spine, as well as the remaining portions of his

[6]spine and his joints, and it would go along with

[7]his entire body habitus and physical makeup, yes.

[8]Q When I was asking you whether you can

[9]look at an MRI and date a herniation, you

[10]mentioned one thing you may see would be an

[11]annular tear; correct?

[12]A Yes. Correct.

[13]Q Am I correct, you did not see that in

[14]Mr. Hunt's MRI; is that right?

[15]A I did not see that on the film, no.

[16]Q If you looked at an MRI and saw an

[17]annular tear, that would be an indication that the

[18]herniation was caused by trauma; is that right?

[19]A If you looked at an MRI and saw an

[20]annular tear, it would tell you -- all it would

[21]tell you on the MRI is that there was edema or an

[22]increase in the fluid in the annular fibers

[23]resulting in a tear.

[24]But you would have to still put that

[25]MRI together with a history based on when the

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[2]patient became symptomatic.

[3]Q In talking about whether a

[4]herniation, as seen on MRI, can be dated, you

[5]mentioned an annular tear, you mentioned marrow

[6]end plate edema --

[7]A Yes.

[8]Q -- and you mentioned edema within the

[9]nerve root; correct?

[10]A Yes.

[11]Q All of those would be an indication

[12]of trauma; correct?

[13]A All of those can be an indication of

[14]trauma, but not necessarily. Because once

[15]again -- because the MRI is looking at water

[16]signal changes, so it's picking up signal changes

[17]in the water content of your particular tissues.

[18]So if there is an inflammatory

[19]process that it notices as a signal abnormality,

[20]the conclusion from the MRI is there is a signal

[21]abnormality demonstrating increased water content.

[22]But you would have to put that

[23]together with the history of symptoms to better

[24]give you an idea of the temporal relationship of

[25]the herniation or whatever the process was that

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[1]

[2]you were looking at.

[3]Q Okay. And for Mr. Hunt's MRI, am I

[4]correct, you did not see an annular tear or edema?

[5]A Correct. On the MRI film itself, I

[6]did not see an annular tear or edema.

[7]Q Going back to Exhibit 2, which is the

[8]last chiropractic record, on the bottom of page 3,

[9]the doctor's description of Mr. Hunt's pain level

[10]at that time is that he is experiencing no pain

[11]and is asymptomatic; is that right?

[12]A On the bottom of page 3 it says type

[13]of pain, no pain, asymptomatic. Correct.

[14]Q Now, on the top of page 4, it says

[15]the prognosis is maximum medical improvement and

[16]has improved. I think we all know what and has

[17]improved means.

[18]Is maximum medical improvement a

[19]standard medical term of art?

[20]A Maximum medical improvement is a term

[21]that's used in order to ascertain an end to

[22]treatment within a particular subspecialty. So in

[23]this case since it's written by the chiropractor,

[24]it indicates that from a chiropractic perspective,

[25]he indicated that his job, in terms of maximum

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[2]medical improvement from chiropractic management,

[3]had been achieved.

[4]Q Then we get into the questionnaires

[5]about the neck and the back again.

[6]A Yes.

[7]Q At this time for the low back,

[8]Mr. Hunt describes his low-back pain as mild and

[9]comes and goes; correct?

[10]A Yes.

[11]Q Then he again indicates that his

[12]normal job and homemaking activities do not cause

[13]him any low-back pain; correct?

[14]A Yes.

[15]Q All right. So this report is May 4,

[16]2013, and it looks like a couple of weeks later

[17]Mr. Hunt goes to see Dr. Bendiks; is that right?

[18]A Yes.

[19]Q That's Dr. Bendiks of University

[20]Orthopedics, and his first visit there was on

[21]May 30, 2013.

[22]A Yes.

[23]Q Do you have any records to suggest

[24]that Mr. Hunt went for any medical treatment in

[25]the interim, so between finishing up with the

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[1]

[2]chiropractor on May 4 and going to Dr. Bendiks on

[3]May 30?

[4]A No, I don't.

[5]MR. HANLON: Off the record.

[6](At this time, a brief recess

[7]was taken.)

[8]CONTINUED EXAMINATION

[9]BY MR. HANLON:

[10]Q Exhibit 3.

[11]A Yes.

[12]Q Dr. Bendiks's first visit. On the

[13]bottom of page 1, it indicated that he also did a

[14]straight leg test; correct?

[15]A Yes.

[16]Q So correct me if I'm wrong. That

[17]seems like a pretty standard test for low-back

[18]pain?

[19]A Correct. It is a standard -- well,

[20]it's a standard test for radiating pain, for

[21]radicular pain.

[22]Q So tell me about that. My low back

[23]hurts. What are you looking for when you do a

[24]straight leg test?

[25]A Great question. So there are two

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[2]different things happening here. Because the back

[3]contains bones, disks and joints, the back can

[4]have a problem. But because it contains nerves

[5]that go down into your legs, your legs can also

[6]have a problem. So there is what we call axial

[7]back pain, which is pain localized to the lower

[8]back, and then there's radiating pain or

[9]neurological changes to the lower extremities.

[10]So if you only have a patient that

[11]has back pain, without symptoms going into the

[12]legs, you don't necessarily have to do a straight

[13]leg raise, because you don't have to evaluate the

[14]nerve roots unless there is a nerve root problem.

[15]So it's a standard test, but it's a

[16]test looking for radiculopathy. It's not a test

[17]that's looking for back pain per se. So those two

[18]things, back pain, either mechanical and axial, or

[19]radiating, they can be joined together, or they

[20]could be separate.

[21]Q For radiating, you obviously have to

[22]involve the nerves at some level. That's what

[23]you're radiating, right, going down the nerve?

[24]A Correct. Yes.

[25]Q If we want to look at a picture of

[42]

[1]

[2]the back and where the nerves go and where they

[3]lead and can cause pain, that's called a dermatome

[4]chart; is that right?

[5]A Right. The dermatomes refer to the

[6]portions of the skin that are innovated by the

[7]nerves.

[8]Q So at least as of Dr. Bendiks'

[9]May 30, 2013 exam, Mr. Hunt's straight leg test

[10]was negative, indicating he was not experiencing

[11]radiating pain; correct?

[12]A He did a seated straight leg raise,

[13]according to him. There are actually two ways to

[14]do the straight leg raise. He has a negative

[15]reported seated straight leg raise.

[16]Q Which would indicate no radiating

[17]pain?

[18]A Which would indicate no sciatic nerve

[19]root irritation.

[20]Q Correct me if I'm wrong, but that

[21]result on May 30 appears to be consistent with the

[22]final chiropractic note on May 4 indicating that

[23]Mr. Hunt had gotten a fair amount of relief

[24]through his chiropractic treatment; true?

[25]A Yes. Correct.

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[2]Q So the accident was in February.

[3]March, April, May, so now we're three-ish months

[4]out; correct?

[5]A Yes.

[6]Q And you agree that if you do have

[7]some lumbar trauma in an incident, it's not

[8]uncommon to get relief over a period of six or

[9]eight or 10 weeks?

[10]A Yes. Correct.

[11]Q In that Exhibit 3, the very last

[12]page, it looks like Mr. Hunt, as of May 30, was

[13]6 feet 2 inches tall and 348 pounds.

[14]Does that seem about what you

[15]remember of him as a patient?

[16]A Correct. Yes.

[17]Q It appears that Dr. Bendiks sent

[18]Mr. Hunt for a lumbar MRI; right?

[19]A Yes, sir.

[20]Q So he saw Dr. Bendiks on May 30, and

[21]he had that lumbar MRI on June 4, 2013; right?

[22]A Yes.

[23]Q And that's Exhibit 4?

[24]A Yes.

[25]Q Just to make sure I understand,

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[2]that's the only preoperative lumbar MRI; right?

[3]A As far as I know, yes.

[4]Q And certainly the only MRI of any

[5]kind that you reviewed before your surgery?

[6]A Yes.

[7]Q And you reviewed the disc and the

[8]report?

[9]A Yes.

[10]Q So he went to OMI Diagnostics in

[11]Atlanta; correct?

[12]A Yes.

[13]Q So he gets the MRI and then a

[14]radiologist there interprets it and writes this

[15]report; true?

[16]A Yes.

[17]Q And it looks like that's a

[18]Dr. Fuller, M.D.?

[19]A Yes.

[20]Q General question. Within the medical

[21]field, are some -- is there a difference between

[22]being a radiologist versus a surgeon? Is there

[23]separate training or certifications that go into

[24]you being a radiologist, the kind of guy that sits

[25]and reads MRI films all day?

[45]

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[2]A Yes.

[3]Q So what is it, a title, a

[4]certification?

[5]A After you graduate from medical

[6]school and you choose a particular area of

[7]training, that particular area of training that

[8]you go into focuses on a particular specialty or

[9]subspecialty.

[10]So a radiologist, for example, is a

[11]person who trains in reading diagnostic studies,

[12]which would include x-rays, CAT Scans, MRIs,

[13]ultrasounds, angiographies, other types of

[14]diagnostic studies, and then it writes reports

[15]based on their interpretation of the images that

[16]they see.

[17]Q Okay.

[18]A A surgeon, for example, and in my

[19]case an orthopedic surgeon with a subspecialty in

[20]spine, is a person who would train in the

[21]specifics of the musculoskeletal system, surgery

[22]involving the musculoskeletal system, examining

[23]patients and correlating diagnostic imaging

[24]studies with the patient's physical examinations.

[25]So there is overlap between

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[2]specialties. For example radiology, and

[3]orthopedics, and neurosurgery, and the other

[4]specialties. And in that sense, there is some

[5]overlap, and there are some specific differences

[6]as well.

[7]Q So you go to med school, then you

[8]continue on for further school in your area of

[9]specialty?

[10]A Correct. Yes.

[11]Q When you get licensed, it's in a

[12]particular field?

[13]A So when you get licensed -- you're

[14]actually licensed here in New York State, for

[15]example, in medicine and surgery. So it's a

[16]general license that is granted after you have

[17]taken the -- so there are three exams that you

[18]take, at least when I did this, which was a long

[19]time ago, because I'm getting older now.

[20]There are two exams that you take in

[21]medical school. They're called your first and

[22]second part board examinations. There is a third

[23]part board examination that you then take after

[24]you have completed your, what we call, internship.

[25]When you passed all three parts of

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[2]that exam, and that is a general medical surgical

examination, you can apply for your state license.

And then you're licensed to practice medicine and surgery in the state.

There are further credentials that are then granted based on what your academic training is. For example, in my case, I did an orthopedic residency program with a general surgery internship. So that was five years.

And then I did another year of fellowship training. And then I went on to become board certified in orthopedic surgery with a subspecialty in spinal surgery. Then when you apply -- it gets more complicated, because then you apply for what are called privileges to your hospitals.

Q Sure.

A Then those hospitals grant you those privileges based upon your education and training.

So, for example, a radiologist wouldn't be credentialed to perform surgery in a hospital, but a radiologist would be credentialed to read x-rays and diagnostic studies.

I would be credentialed to encompass

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all the things which are contained within my subspecialty, which would include admitting patients, treating and examining patients, performing surgery and interpreting diagnostic tests as well.

[7]Q If you were two med students, one is

[8]going to go on to do orthopedic surgery. The

[9]other is going to go on to be a radiologist. So

[10]they're both in med school together for the first

[11]four years; right?

[12]A Correct. Yes.

[13]Q Do they do the same type of

[14]internship after that, or do they part ways after

[15]that?

[16]A The radiologist can actually do --

[17]internships are generally either surgical or

[18]medical. And the radiologist could actually do

[19]either, a medical or a surgical internship --

[20]Q Okay.

[21]A -- in order to get that third level

[22]of education.

[23]Q Then you all take the same third

[24]level board?

[25]A Correct. Yes.

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[1]

[2]Q And then I assume you part ways?

[3]A Then you part ways and you go on to

[4]your subspecialty training. That's right. Yes.

[5]Q So a radiologist would just focus on

[6]radiology, whereas you're focusing, in your case,

[7]on orthopedic surgery; correct?

[8]A Yes.

[9]Q I assume you don't want to do this,

[10]but if you were to decide, okay, I'm done with

[11]surgery, I would like to go to work for a

[12]diagnostics company and read films, would you,

[13]Dr. Merola, have all the qualifications you need

[14]to go out and practice as a radiologist now, or

[15]would you have to go back and get some more

[16]qualifications, or a license, or something else?

[17]A That's a good question. It would

[18]depend on who was hiring you to read those films.

[19]So, for example, if I were reading films in what

[20]it is that I do, which is completely and entirely

[21]geared towards spinal reconstructive surgery, and

[22]I haven't done this, so I don't know whether or

[23]not I would be able to get a job as a reading

[24]radiologist, I mean a radiology company, for

[25]example, or a radiology practice may very well be

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[2]able to say listen, you practiced surgery for 20

[3]years and you read 20 million MRIs, we think you

[4]can read MRIs of the lumbar spine for us.

[5]Q From a medical licensing perspective,

[6]you would be allowed to do that?

[7]A From a licensing perspective, yes.

[8]There is further board subspecialty training in

[9]each particular field. A radiologist could be

[10]board trained and/or board certified in their

[11]field and me in my field.

[12]Q Okay. So in Exhibit 4, if you could

[13]turn to the dispositive page, which is the MRI

[14]report.

[15]Do you have that in front of you?

[16]A Yes.

[17]Q Since I don't have Dr. Fuller here,

[18]I'm going to ask you. I would like to walk

[19]through the findings and the opinion.

[20]You only treated Dr. Hunt's low back;

[21]correct?

[22]A Mr. Hunt's lower back, yes.

[23]Q I suppose we can skip the cervical.

[24]In the middle of the page, you see

[25]the section findings?

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[2]A Yes.

[3]Q Let me go back just one second. You

[4]looked at this film. Was it an okay film? Any

[5]flaws or defects or any problems with it?

[6]A No.

[7]Q The first finding, no bone injury is

[8]demonstrated, means none of the actual bones in

[9]his spine were cracked or fractured; right?

[10]A According to this, yes.

[11]Q Did you find any?

[12]A No.

[13]Q No focal bone lesion, what does that

[14]mean?

[15]A That would be a term that would refer

[16]to a metabolic, or an infectious, or a cancerous

[17]process within the bones.

[18]Q Alignment is maintained. Does that

[19]mean, more or less, the spine is lined up the way

[20]it is supposed to be?

[21]A Correct. Yes.

[22]Q The conus medullaris is normal.

[23]A Yes.

[24]Q What is that?

[25]A Conus medullaris is the terminal

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[2]portion of the spinal cord. It's where the spinal

[3]cord ends within the spinal canal, and that

[4]generally happens in the upper portion of the

[5]lumbar spine and the lower portion of the thoracic

[6]spine.

[7]Q Next is discs are mildly diffusely

[8]narrowed with minimal signal loss.

[9]A Yes.

[10]Q Please tell us what that means,

[11]please.

[12]A So that means that the description of

[13]what he's looking at in terms of the spaces in

[14]between the bones where the discs are located, by

[15]his description, he is using adjectives that say

[16]they are mildly narrowed with minimal signal loss.

[17]Since an MRI is looking at water

[18]content and water signal of the discs, there are

[19]shades of gray within the MRI film, so he is using

[20]a description which indicates a slight loss or a

[21]subtle shade of gray within the disc, when he says

[22]minimal signal loss.

[23]So he's trying to give us a

[24]perception of what the disc color is based on the

[25]MRI film. When he says mildly diffusely narrowed,

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[2]he's trying to give us an idea of what he's

[3]looking at in terms of disc space height.

[4]Q So disks are filled with fluid;

[5]right?

[6]A The disc is made of cartilage. The

[7]outer ring is a heavy fibrocartilage. The inner

[8]portion of the disc is a more jelly-like

[9]cartilaginous substance. And within the substance

[10]of those cartilaginous components are water.

[11]Q As we get older, it tends to dry up?

[12]A As we get older, one of the normal

[13]processes is to lose water content within the

[14]collagen and cartilage of the disks.

[15]Q And then the disc losses disc height?

[16]A Then the disc can lose disc height

[17]over time, yes.

[18]Q Is that what he's describing here?

[19]A That is exactly what he is describing

[20]here, yes.

[21]Q He goes on to say no focal disc

[22]herniation nor neural encroachment. Let me break

[23]that down. Okay?

[24]A Yes.

[25]Q You've probably done this a thousand

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[2]times. I apologize.

[3]But could you first tell us what is a

[4]disc herniation?

[5]A So a herniation is the abnormal

[6]protrusion of disc material beyond the confines of

[7]the vertebral bodies. And for it to be a

[8]herniation, it is generally accepted that it is

[9]asymmetrical.

[10]Q Does that mean that the jelly-like

[11]substance, to some extent, extrudes out from

[12]the -- what do you call it, the cartilage?

[13]A The outer annular ring. Now,

[14]extrudes is a separate term. In order for a disc

[15]to be extruded, there has to be no contact between

[16]the actual jelly and the internal portion of the

[17]disc.

[18]But protruding would mean that the

[19]actual jelly-like material itself has made its way

[20]through an opening in the annulus, but it is still

[21]in contact with the remaining portion of

[22]jelly-like material within the disc itself.

[23]Q So in order for it to be a herniation

[24]as opposed to a bulge, you need some protrusion?

[25]A You need some asymmetrical

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[2]protrusion.

[3]Q So here he indicates no focal disc

[4]herniation. You just told us what a disc

[5]herniation is, so what is the importance or the

[6]meaning of the qualifier focal?

[7]A It's a good question. It's a bit

[8]redundant.

[9]Q He goes on to say there's no focal

[10]disk herniation nor neural encroachment.

[11]What does neural encroachment mean?

[12]A Neural refers to the nerve roots.

[13]Q So it sounds like that finding of no

[14]neural encroachment would be consistent with

[15]Dr. Bendiks reporting a negative seated straight

[16]leg raise?

[17]A Well, the MRI finding and the

[18]negative straight leg raise -- the negative

[19]straight leg raise means there's no nerve root

[20]impingement. But you can have a nerve root

[21]impingement and still have a negative straight leg

[22]raise.

[23]Q Okay. But this MRI is saying no

[24]nerve root impingement.

[25]A That's correct. This MRI report says

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[2]no neural or what we would consider nerve

[3]impingement.

[4]Q Now, I will ask you about the next

[5]sentence as it pertains to the lumbar, so I will

[6]intentionally leave out the cervical.

[7]A Honestly, I think that's

[8]typographical. I don't think that he meant to say

[9]cervical, because it is a dedicated lumbar spine

[10]MRI, and I believe that to be completely and

[11]entirely typographical.

[12]Q Okay. Let's assume that is true.

[13]That's fair enough.

[14]A That's my assumption.

[15]Q So the report goes on to say that

[16]there is degenerative hypertrophic facet

[17]arthropathy on the right side. Let me stop there.

[18]What is degenerative hypertrophic

[19]facet arthropathy?

[20]A That is a descriptive term that

[21]refers to the wear and tear process that happens

[22]to the facet joints of the lumbar spine over the

[23]course of time of your life.

[24]Q Where are the facet joints?

[25]A The facet joints are the

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[2]cartilaginously lined articulations or joints that

[3]are located on the posterior or back side portion

[4]of the vertebral bodies. They would be in the

[5]area where the spinal canal is located, and very

[6]close to the area where you could, with your

[7]fingers, touch the spinous processes in the small

[8]portion of your lower back. So they're

[9]essentially on the back side of your lower back.

[10]Q And he's describing degenerative

[11]changes, so this is wear and tear over your life

[12]as opposed to a traumatic event?

[13]A That's right, yes.

[14]Q He goes on to say that that condition

[15]is not -- does not cause neural encroachment. In

[16]other words, it's not impinging on the nerve

[17]roots; true?

[18]A Yes.

[19]Q He goes on to say that ligamentum

[20]flavum hypertrophy is part of this process. Tell

[21]us what that is.

[22]A So the ligamentum flavum is a tough

[23]fibrous ligament that is located in between the

[24]lamina of the vertebral bodies, so it is located

[25]in the area of the spinal canal. And it is

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[1]

[2]thicker than one would see in a younger person,

[3]which is also consistent with the normal aging

[4]process in the lower back.

[5]Q That's not causing any impingement of

[6]the nerve roots; true?

[7]A According to the report, yes.

[8]Q The next sentence, there's a

[9]spontaneous fusion across the rostral aspect of

[10]the right sacroiliac joint; correct?

[11]A Yes.

[12]Q What's the right sacroiliac joint?

[13]A So the sacroiliac -- they're joints.

[14]There is one on the right side and on the left

[15]side. That's the joint that exists between the

[16]sacrum and the pelvis. So the pelvic bones are

[17]the bones that contain your hips. And there is a

[18]right-sided pelvis and a left-sided pelvis, and in

[19]between both the right and left sides is the

[20]sacrum, which is the lowest-most portion of the

[21]spine. And where the sacrum meets the pelvis is

[22]called the sacroiliac joint. So there's one on

[23]the right side and one on the left side.

[24]Q Dr. Fuller reports a spontaneous

[25]fusion --

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[2]A Yes.

[3]Q -- of that joint, which means what?

[4]A Since it is a joint, it means that in

[5]an area where the two bones come together, there

[6]is a cartilage covering to the bones. So those

[7]two bones should be separated from each other and

[8]should be able to slide on each other where they

[9]come together, just as any other joint does.

[10]These particular joints have

[11]extremely limited motion, as you can imagine,

[12]because if your spine was sliding around in your

[13]pelvis, you would be a squid.

[14]Be that as it may, when he says

[15]spontaneous fusion, this is a description of the

[16]fact that the topmost portion of the joint appears

[17]to be actually joined in a bony way with the

[18]pelvis.

[19]So it appears as though there is a

[20]lack of a continuity in the joint on the right

[21]side at the topmost portion of the joint.

[22]Q And again, is that something caused

[23]by age as opposed to trauma?

[24]A That may likely be something that is

[25]just congenital in origin and based upon the way

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[2]his pelvis and sacrum were made at birth.

[3]Q What kind of symptoms or limitations

[4]will that cause?

[5]A Often sometimes, if it is congenital,

[6]none.

[7]Q If it does cause any, what would the

[8]problems be?

[9]A If it were a -- if it were a

[10]degenerative process over the course of time, it

[11]could cause pain localized to the sacroiliac

[12]joint.

[13]Q Which would be low back?

[14]A Which would be in the crease -- what

[15]we would call the gluteal fold or the crease of

[16]where your gluteus maximus meets the other gluteus

[17]maximus.

[18]Q Okay. So the way he's referring to

[19]the MRI report number 4 -- so the way these work

[20]is Dr. Fuller is the radiologist. He notes his

[21]findings that we've been talking about and then

[22]renders his opinion at the end of the report?

[23]A Yes.

[24]Q Okay. So his first opinion is

[25]chronic alterations. What does that mean?

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[2]A Chronic means that there are things

[3]that have been there for some time. Alterations

[4]means -- I guess the best way to describe that is

[5]findings outside what one would consider, quote,

[6]unquote, normal anatomy.

[7]Q He goes on to say no acute lesion is

[8]detected.

[9]A Yes.

[10]Q What does that mean?

[11]A It means that once again, there is no

[12]evidence of a fracture, a tumor, metabolic bone

[13]disease, a dislocation or any -- any of the other

[14]processes that he went on to describe in his

[15]initial findings section.

[16]Q I know when you looked at the film,

[17]you had some different findings and different

[18]conclusions; right?

[19]A Yes.

[20]Q I don't want you to think I'm cutting

[21]you off. We'll get to those.

[22]A Sure.

[23]Q As Dr. Fuller read the study, is it

[24]fair to say that his opinion was that the changes

[25]he saw were due to the aging process as opposed to

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[1]

[2]trauma?

[3]A That is one interpretation of the way

[4]this report is written in terms of the way he has

[5]worded it, yes.

[6]Q And he notes no neural encroachment,

[7]meaning none of the nerve roots are being

[8]impinged; correct?

[9]A Yes.

[10]Q At least as he read the film, "he"

[11]being Dr. Fuller, he did not find any herniations

[12]or bulges; correct?

[13]A Yes.

[14]Q Based on the findings as reported

[15]here, there's nothing that you would operate on;

[16]is that also fair?

[17]A Well, not so much, because it

[18]depends -- this is the problem. Herein lies the

[19]problem with a radiology report versus a -- versus

[20]looking at the films yourself and doing an

[21]examination, because facet arthropathy can be an

[22]indication for surgery, just based on the report.

[23]I'm not even talking about the disc herniations.

[24]So based on the report itself, the

[25]answer to that question would be not necessarily,

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[2]if all we were looking at is the report itself.

[3]Q Correct me if I'm wrong, because I

[4]don't mean to oversimplify things.

[5]Was the primary reason that you did

[6]surgery because of the herniations you found at

[7]L4-5?

[8]A No.

[9]Q What was the primary reason for your

[10]surgery?

[11]A To prevent further neural

[12]deterioration into the lower extremities from

[13]neurological compression.

[14]Q Was that compression caused by

[15]herniations at L4/5?

[16]A That was part of the problem, yes.

[17]Q The rest of the problem you talk

[18]about in your report; right?

[19]A Yes.

[20]Q Just taking one final look at

[21]Dr. Fuller's report here. So he does not note any

[22]alterations, or in layman's terms call it

[23]problems, at L4-5 in his report; is that true?

[24]A No. He does note a problem at L4-5

[25]which he describes as degenerative hypertrophic

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[2]facet arthropathy, bilaterally mild at what he

[3]says C4-C5, which I take to be L4-L5. That's my

[4]assumption based on what he's written on his

[5]report.

[6]Q All right. I generally do things

[7]chronologically, but since we're in the weeds on

[8]MRI, let's go ahead and finish it. Okay?

[9]A Sure.

[10]Q Now, you did not write a separate

[11]"MRI report," you commented on the MRI in your

[12]initial report of December 2, 2013; right?

[13]A Yes.

[14]Q And that's Exhibit 10?

[15]A Yes.

[16]Q You did surgery at L4-5; right?

[17]A Yes.

[18]Q Let's focus on that.

[19]What did you find at L4-L5 which is

[20]different from what Dr. Fuller found, at least

[21]according to his MRI report?

[22]A Sure. I'm going to refer to the

[23]operative report for the operative findings.

[24]Q Okay. That's Exhibit 12.

[25]A Correct.

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[2]Q Before you jump into the operative

[3]report, during surgery, was there any type of

[4]camera or film or recording used?

[5]A We use what's known as fluoroscopy.

[6]So what we do is we have the MRI film, which we

[7]put into the room and project it onto the screen.

[8]And then we use a fluoroscopic camera in order to

[9]make sure that what we're operating on is

[10]identical to what it is that we're seeing on the

[11]MRI films so that we can localize the level that

[12]we're operating on.

[13]So there is a fluoroscopic -- shall

[14]we say a fluoroscopic film taken intra-operatively

[15]for the procedure.

[16]Q Is it snapshots or more of a running

[17]video?

[18]A They're snapshots. So once the

[19]level -- so there are several snapshots that

[20]happened. The first snapshot is a positioning

[21]snapshot in order to be able to mark the surgical

[22]area so that you know where your incision will be

[23]made.

[24]The second snapshot is to confirm

[25]that you've exposed the area that you intend to

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[2]operate upon. And then the third snapshot is

[3]after you have operated upon the area, to

[4]ascertain that you're truly 100 percent certain

[5]that that's the area that you were decompressing

[6]and operating upon.

[7]Q Have you seen those snapshots?

[8]A Those are taken intra-operatively.

[9]They're saved to the PAC system. Then both myself

[10]and my partner, who are doing the surgery, confirm

[11]the snapshots realtime as we're doing the

[12]procedure. So yes, intra-operatively, absolutely.

[13]Q Maybe they've been produced in

[14]discovery. Maybe they haven't. If they haven't,

[15]I want to get them. Would I get them from you or

[16]the hospital?

[17]A You would get them from the hospital.

[18]I believe when you make a hospital request for

[19]medical records, what they're going to give you

[20]medical record-wise is the paper chart.

[21]Q Correct.

[22]A You would have to make sure that you

[23]request what are known as the PACs images. The

[24]PACs images are the images that are downloaded

[25]from the fluoroscopic machine intra-operatively.

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[2]So that machine is actually plugged into a

[3]computer in the hospital.

[4]Then after the technician takes the

[5]images, it's his duty to make sure that those

[6]images are downloaded into the mainframe imaging

[7]system.

[8]Q So they exist digitally?

[9]A Correct.

[10]Q So I would want to get them on a

[11]disk?

[12]A Yes. When you make the request, I

[13]would make a specific request for those particular

[14]images.

[15]And then the other thing we also do,

[16]just in terms of monitoring, we do something

[17]called neurological monitoring during the actual

[18]surgical procedure ourself. So we are wiring the

[19]patient's brain, spinal cord and nerve roots to a

[20]computer system, and then that computer system is

[21]monitoring the nerves as we operate upon them,

[22]just as another way of imaging. It's another

[23]form. It's electronically imaging the nervous

[24]system as we're doing the surgery.

[25]Q Okay. With your operative report,

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[1]

[2]Exhibit 12 --

[3]A Yes.

[4]Q -- there is a pre-op diagnosis and a

[5]post-op diagnosis; correct?

[6]A Yes.

[7]Q I assume that happens on occasion,

[8]that based on an MRI, you think you're looking at

[9]one thing going in, and it turns out to be a

[10]little different when you get in there; right?

[11]A That's correct, yes.

[12]Q That difference would be reflected in

[13]those two diagnoses; right?

[14]A Yes.

[15]Q Here they're the same; right?

[16]A Yes.

[17]Q So what you expected going in is just

[18]what you found; right?

[19]A Yes.

[20]Q So going back to my question, what

[21]did you find at L4-5 that was different from what

[22]Dr. Fuller reported in his MRI report?

[23]A So, there's a portion of the

[24]operative report that's noted to be intraoperative

[25]findings where we'll give a verbal description of

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[2]what it was that we found. What was there was a

[3]disc herniation of L4-L5, and a torn annulus at

[4]L4-L5, the herniation of which was removed and

[5]sent to pathology.

[6]Q Taking it in order, the first thing

[7]you found was a herniation at L4-L5; correct?

[8]A Yes.

[9]Q You go on to say bilateral

[10]neuroforaminal inpingement; correct?

[11]A Yes. So the jelly in the middle,

[12]it's coming out from two different directions

[13]affecting both the left and the right nerve roots.

[14]The jelly in the middle is herniating centrally,

[15]so what happens is the annulus that is responsible

[16]for containing that jelly-like substance should

[17]be -- it's like -- think of it as a belt wrapped

[18]around your waist.

[19]If you've eaten, if you have a really

[20]big meal and your belly is swollen, and you've

[21]eaten a lot, your belly is going to protrude in

[22]the middle. It also causes the edges of your belt

[23]to protrude. So not only do you have a central

[24]protrusion, but your waist on both the right and

[25]left sides get larger as well.

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[2]So as that jelly-like substance makes

[3]its way out, the center portion where the

[4]herniation is, the annulus, or that fibrous ring

[5]on both the right and left sides also expand into

[6]the area where the neuroforamina are causing

[7]compression.

[8]Also, as the jelly-like material

[9]makes it way out of the disc, the disc is no

[10]longer able to maintain its disc height, and so

[11]there's also compression so that the bones are

[12]coming closer to each other. And when the bones

[13]come closer to each other, because the never root

[14]openings are dependent on the spacing between the

[15]bones, the nerve root openings are also

[16]secondarily being compressed.

[17]Q So the condition you described here

[18]in your report, bilateral neuroforaminal

[19]inpingement, would you expect pain radiating down

[20]both legs?

[21]A Yes.

[22]Q That's what you wanted to describe

[23]there, impinging upon exiting L4 and descending

[24]L-5 roots; correct?

[25]A Yes.

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[2]Q You say there is an annular tear. I

[3]apologize if you've already described it, but what

[4]is an annular tear?

[5]A So an annular tear -- the outer

[6]annulus or ring of the disk is made of interwoven

[7]and interlocking fibers of collagen. A tear means

[8]that there is a defect in those fibers, and

[9]through that defect is the area where the actual

[10]disc herniation itself is making its way into the

[11]canal.

[12]Q These conditions that you're

[13]describing here can occur sometimes from the aging

[14]process, sometimes from trauma; is that true?

[15]A They can, yes.

[16]Q Doctor, have we now covered --

[17]because it's an important question, so I want to

[18]make sure you covered everything, the differences

[19]in what you found at L4-5 versus what Dr. Fuller

[20]reported?

[21]A In terms of the reports, yes. I

[22]think the operative report -- I mean the operative

[23]report is really the best way of showing what it

[24]was on the inside. The only other way to look at

[25]it is to actually look at films. But based on my

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[2]operative report comparing and contrasting it to

[3]the written radiographic report, I believe we've

[4]hit the highlights.

[5]Q So I will try and get back to my

[6]chronology here.

[7]Dr. Bendiks sent Mr. Hunt for the MRI

[8]on June 4, and then saw Mr. Hunt after that on

[9]June 11, 2013, which is Exhibit 5.

[10]Do you see that one?

[11]A Yes.

[12]Q And he looks at the MRI and

[13]recommends epidural steroid injections; correct?

[14]A Yes.

[15]Q Do you agree with that

[16]recommendation?

[17]A Yes.

[18]Q He also notes at the bottom of page

[19]1, the top of page 2, that if the injections do

[20]not provide relief of pain, then the pain is

[21]possibly coming from his hips and will require

[22]further evaluation.

[23]Were you provided with any kind of

[24]medical history about Mr. Hunt's hips?

[25]A Yes. It was actually in Dr. Bendiks'

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[2]first note.

[3]Q Exhibit 3?

[4]A Yes.

[5]Q Go ahead and tell us where that is.

[6]A Sure. On the first page under Roman

[7]numeral II, examination, the last sentence under

[8]objective where it says lumbar spine x-ray,

[9]degenerative changes of right hip.

[10]Q It seems what Dr. Bendiks is

[11]indicating here is the kind of pain he's

[12]experiencing, low back maybe with some light pain,

[13]that could also potentially be caused by a bad

[14]hip; is that right?

[15]A Hip pain can cause back pain, yes,

[16]but there are some differentiating factors.

[17]Q What are those?

[18]A Well, it depends on whether or not

[19]the pain radiates below the knees and whether or

[20]not there are any neurological associated

[21]findings.

[22]Q Such as?

[23]A Sensation, reflexes, weakness,

[24]positive provocative signs.

[25]Q Are there indications in the medical

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[2]records of any of those distinguishing

[3]characteristics you just talked about that makes

[4]back pain different than leg pain?

[5]A That makes radiating pain different

[6]from -- well, we saw in the chiropractic initial

[7]exam that there was radiating below the knee. Hip

[8]pain generally radiates into the groin.

[9]Sacroiliac pain is often times only

[10]confined to the sacroiliac joint. So pain

[11]traveling below the knee is a radiculopathic issue

[12]versus a hip-related issue.

[13]Q Then Exhibits 6, 7 and 8 are simply

[14]the reports from the lumbar injections. They all

[15]seem to go fine; correct?

[16]A Yes.

[17]Q Is it an epidural, is it a steroid;

[18]what is it?

[19]A So epidural refers to the location of

[20]the injection. The medication that's injected is

[21]a steroid, and a steroid is an anti-inflammatory

[22]medication used to decrease inflammation and

[23]swelling in the roots and in the nerve area within

[24]the canal, within the spinal canal in order to

[25]decrease pain and systems.

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[2]Q I skipped one question. Could you

[3]put Exhibit 5 in front of you.

[4]A Sure.

[5]Q So Dr. Bendiks sends him for the MRI.

[6]He comes back on June 11, 2013, and Dr. Bendiks

[7]offers his thoughts on the MRI at the top of the

[8]page; correct?

[9]A Yes.

[10]Q His finding is L4-5 disc bulge

[11]central?

[12]A Yes.

[13]Q You found disc herniation central;

[14]correct?

[15]A Correct.

[16]Q Is there a clear line distinction

[17]between the two?

[18]A Well, if we look at the basic

[19]definition of bulge versus herniation, bulge will

[20]be symmetric. So when you see a bulge, that

[21]bulge, like the bulge around my waist, should go

[22]completely and entirely around my waist, versus a

[23]hernia, which would be sticking out in one

[24]specific area.

[25]So interestingly enough, Dr. Bendiks

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says disc bulge, but he offers a location, which

is central. Because there is a location offered,

it makes it, by definition, eccentric, which by

definition then makes it a herniation.

Q We talked about the jelly protruding

from the outer annular ring; correct?

A Yes.

Q That's part of what's required for a

herniation; right?

A Right, protruding into and out of the

annular ring, yes.

Q If the entire annular ring is intact,

that's not a herniation?

A If the entire annular ring is intact,

but you have jelly protruding in one specific

portion of the ring, you still have a herniation,

but you have a herniation without a -- you have a

herniation without the jelly-like material in the

canal.

So there are actually different

gradations of herniation based upon the amount of

material that is protruding into or out of the

annulus. And, in fact, one of the ones that you

had mentioned beforehand I said was the special

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condition of extrusion, which is where that

material has gone so far out of the annulus that

it's no longer in contact with the rest of the

nucleus.

[6]Q Then Exhibit 9 is Dr. Bendiks' next

[7]and last report for your surgery.

[8]A Yes.

[9]Q On September 10, 2013; right?

[10]A Yes.

[11]Q In a subjective section at the top,

[12]he's indicating that Mr. Hunt is feeling 80

[13]percent better, pain 3 out of 10, and he can live

[14]with the pain; correct?

[15]A Yes.

[16]Q Towards the bottom on the treatment

[17]plan, Dr. Bendiks indicates that if Mr. Hunt were

[18]to consider surgery, and then he goes on to

[19]mention a particular type of surgery; correct?

[20]A Yes.

[21]Q But at least in this report,

[22]Dr. Bendiks is not himself recommending surgery;

[23]is that fair?

[24]A Technically he's offered him surgery

[25]because he's actually gone into a description of

[78]

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[2]what the surgery is that he offered him. So he's

[3]actually given the patient the choice of whether

[4]or not he wants to or not proceed forward with an

[5]operation.

[6]Q It seems in the beginning of the

[7]report he starts out by telling Mr. Hunt -- he

[8]says I'm 80 percent better and I can live with the

[9]pain; right?

[10]A Yes.

[11]Q If a patient tells you that, as a

[12]doctor you're typically not recommending surgery?

[13]A Correct.

[14]Q I see what you're saying, but his

[15]wording here is if Mr. Hunt is to consider

[16]surgery, this is what the surgery should be.

[17]But is it fair enough that

[18]Dr. Bendiks never comes out in this report and

[19]says I'm recommending surgery?

[20]A It's under his treatment plan. I

[21]can't -- I don't want to opine as to what he's

[22]thinking about, but as a surgeon, if I were not

[23]recommending surgery, my treatment plan would be

[24]continue conservative treatment and management,

[25]activities as tolerated, and then return to me on

79

[1]

[2]an as-needed basis. That would be my treatment

[3]plan for a nonsurgical candidate or a nonsurgical

[4]offering.

[5]Q Now, in that same sentence there, the

[6]type of surgery Dr. Bendiks describes is different

[7]than the surgery you did; right?

[8]A Yes.

[9]Q So what surgery did he describe, what

[10]did you do, and why did you do what you did?

[11]A Fantastic question. So, there are

[12]different ways to address Mr. Hunt's particular

[13]problem, and I guess that's why we can obtain

[14]different opinions from different surgeons,

[15]because we all have a certain preference as to why

[16]we would do certain things.

[17]My thinking on the condition is that

[18]Mr. Hunt's, when I saw him, primary issue is nerve

[19]root compression with radiculopathy. That is a

[20]problem with the nerve roots with compression most

[21]significant at L4-L5, that compression coming from

[22]the herniation.

[23]Directly addressing the herniation

[24]itself through a posterior or back-sided approach

[25]is safe and effective in being able to prevent

80

[1]

[2]further nerve root compression and deterioration.

[3]So if you look at it from a safety

[4]and efficacy perspective, addressing it from the

[5]area where the compression is maximal through the

[6]back side offers less potential for complications

[7]and the benefit of actually making more room for

[8]the nerves.

[9]Whereas addressing the condition from

[10]the front side, which would mean going through the

[11]abdomen in a patient who weighs in excess of

[12]300 pounds, would be the type of procedure that

[13]indirectly addresses the nerve roots, because

[14]you're coming through the front. The herniation

[15]is in the back, but you're coming through the

[16]front.

[17]The decompression, when you do it

[18]from the front side, would involve removing the

[19]entire disc and then having to, for lack of a

[20]better term, jack up the bones with a

[21]biomechanical device, what we call a cage or an

[22]implant, so that you now have a secondary

[23]decompression of the nerves by increasing nerve

[24]root opening by increasing disc space height, by

[25]jacking the bones up.

[81]

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[2]That involves coming through the

[3]abdomen, which means not only an abdominal surgery

[4]with a general anesthetic in a patient who weighs

[5]300 pounds, but also an increased risk of

[6]potential vascular complications because you need

[7]to move the great vessels out of the way in order

[8]to get to that area.

[9]So in this particular patient, that,

[10]in my opinion, would be a very -- would be not

[11]very -- I don't want to use the term very, but

[12]would offer an indirect method of decompression

[13]with potential higher postsurgical morbidity or

[14]potential complications versus a more minimally

[15]invasive direct approach with less risk of

[16]postoperative complications.

[17]So I think, you know, you can address

[18]the condition either way. But when looking at the

[19]surgery, you need to weigh relative risk versus

[20]benefit of procedure and tailor it to the patient.

[21]So that's why I chose a posterior

[22]approach with a decompression alone versus an

[23]anterior/posterior approach with a decompression,

[24]biomechanical device placement and spinal fusion

[25]with facet screws, which is what Dr. Bendiks

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[1]

[2]chose.

[3]Q You certainly talked about the

[4]potential -- not the potential, but the additional

[5]risks of what Dr. Bendiks talked about. I'm sure

[6]there's pros and cons.

[7]What are the pros of what Dr. Bendiks

[8]described?

[9]A The advantage is -- so the advantage

[10]of that would be a more anatomical restoration of

[11]vertebral body height with a stabilization of the

[12]L4-L5 segment to prevent that segment from further

[13]collapse.

[14]So the advantage would be more

[15]anatomical, so you would be rebuilding it in a --

[16]it would be like tearing down -- it would be like

[17]putting in a new floor rather than just buffing

[18]and polishing. But buffing and polishing may

[19]suffice if tearing out the floor is going to put

[20]holes in your house that are then going to cause

[21]leaks.

[22]So there are advantages to his

[23]approach, but those advantages come with certain

[24]potential complications.

[25]Q If we go to Exhibit 10, which is your

83

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[2]first report, do you have any idea how Mr. Hunt

[3]got to you, how he found you and came to be your

[4]patient?

[5]A I know he came in for a second

[6]opinion because he had been offered an opinion

[7]regarding surgery if his condition had

[8]deteriorated. I didn't specifically list how he

[9]came in to see me, but I did read Mr. Hunt's

[10]deposition that he gave.

[11]According to what he said in his

[12]deposition, he had, I guess, looked me up on the

[13]Internet to see whether or not I offered some

[14]alternatives for him.

[15]Q You say in your report he came in for

[16]a second opinion?

[17]A Yes.

[18]Q Did he come in specifically and ask

[19]you, hey, Doctor, do I need surgery or do I not

[20]need surgery, or was it more I need surgery and I

[21]want your opinion as to what kind of surgery it

[22]should be?

[23]A If I can go to my first note. He

[24]said to me he had a conversation with Dr. Bendiks

[25]whereby he did say if his pain got worse, he would

84

[1]

[2]need an operation. So his specific question to me

[3]was would surgery benefit him. So that was my

[4]understanding when I initially saw him.

[5]Q As reported in your first paragraph,

[6]by then he was reporting radiating pain, both

[7]legs?

[8]A Yes.

[9]Q His reported symptoms also included

[10]sexual function at that time?

[11]A Yes.

[12]Q This is the first note of that I saw.

[13]What in particular was he telling you?

[14]A In general when I talk to patients

[15]about lower-back conditions, I ask them whether or

[16]not they have difficulty with sexual function, and

[17]he reported to me that he did. So I put it into

[18]the history section.

[19]Q Nothing else?

[20]A Correct.

[21]Q We've talked about nerves and where

[22]they go.

[23]Is there anything about L4-L5 that

[24]would cause sexual dysfunction?

[25]A Oftentimes when you see -- when you

85

[1]

[2]have a patient who has low back pain and radiating

[3]pain into the legs and feet, it's that they have

[4]difficulty with sexual function as a consequence

[5]of the pain, not so much as a consequence of the

[6]actual nerve roots themselves, because it's a much

[7]more complicated neurological cascade of events

[8]that are involved with sexual function than only

[9]the nerves themselves.

[10]Q All right. On your physical

[11]examination, what there, Doctor, is most important

[12]for our case? We're here today talking about the

[13]low back and your ultimate surgery.

[14]Of your physical exam, rather than

[15]have me go through everything and ask you what

[16]every word means, tell me what was most important

[17]in your physical exam as it relates to his low

[18]back?

[19]A So, number 1 was his gait, which

[20]means the way he was walking. And he was walking

[21]with what I described as a kyphotic gate pattern,

[22]which is a pitched forward, low back posture.

[23]Pitched forward, low back postures

[24]are generally seen with low back nerve root

[25]compression. He had a positive spinal Phalen's

86

[1]

[2]test, and a spinal Phalen's test is forcibly

[3]extending the lumbar spine to reproduce symptoms

[4]into the lower extremities. That was positive.

[5]Q Bending --

[6]A Backwards bending, correct, the 4th

[7]and 5th root distribution, sensory abnormalities

[8]where I described a decrease in both pinprick and

[9]tactile sensation in the 4th and 5th roots with an

[10]absence of the quad reflexes.

[11]Q What's that one all about?

[12]A So that you're basically testing the

[13]nerve roots. So you test the roots in the lower

[14]abdomen, the groin and the thighs, the front part

[15]of the legs, the back part of the legs, and the

[16]side of the legs. And you're testing side to side

[17]and in between nerve roots.

[18]And if there is a decrease in the

[19]ability to feel either a pinprick or tactile

[20]sensation in the specific roots, it means that

[21]those roots are not -- basically are not working

[22]properly, and they're basically the 4th and 5th

[23]roots.

[24]Q How do you know?

[25]A A pinprick is a paper clip, and

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[2]tactile is just using your hands.

[3]Q You're asking the patient do you feel

[4]this, do you feel that?

[5]A Well, yes. You compare root to root.

[6]So, for example, L3 roots bilaterally, no problem.

[7]S1 roots bilaterally, no problem. L4 roots, L5

[8]roots, we check the anterior thigh and the knees

[9]in the front of the shins, and in the dorsal of

[10]the feet, and the anterior thighs were the major

[11]problem.

[12]Q The MRI we covered, so we can skip

[13]that.

[14]A Yes.

[15]Q Based on sort of the same question I

[16]was asking you about with Dr. Bendiks, so now

[17]you've seen Mr. Hunt and examined him.

[18]At that time, I know it's, of course,

[19]always the patient's choose, but was it your

[20]recommendation that he undergo this surgery, or

[21]was it more a scenario where if you want surgery,

[22]this is the one I would recommend?

[23]A So as a surgeon, I never tell a

[24]patient they need surgery unless it's a life or

[25]death or life or limb-related problem. What I do

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[1]

[2]tell a patient is surgery can be offered to you

[3]based on your symptoms and your physical findings

[4]with the advantages of decreasing some of the

[5]radiating pain that you have and preventing those

[6]nerves from getting worse as an advantage of

[7]surgery.

[8]And the disadvantages of the surgery

[9]would be it's an operation. You have to have a

[10]general anesthetic, you have to have an incision,

[11]which then needs to heal, so there's a risk of

[12]infection. And then discuss with him the

[13]anesthetic risk, the infection risk, the bleeding

[14]risk, the potential medical complications, et

[15]cetera, and basically put it into their court.

[16]But in general, and specifically, you

[17]know, it is an elective operation to be done, to

[18]decrease some symptoms and to prevent those

[19]symptoms from getting worse based on how that

[20]patient feels.

[21]Q Okay. Your addendum to that report

[22]is Exhibit 11?

[23]A Yes.

[24]Q It looks like you wrote it to make a

[25]note that Mr. Hunt showed signs of chronic venous

[89]

[1]

[2]stasis.

[3]A Correct.

[4]Q What is that?

[5]A That just means that he has a

[6]vascular condition of the lower legs that results

[7]in swelling of the lower legs with some skin

[8]changes in the lower legs bilaterally.

[9]Q He described it as that, and I saw

[10]some notes in the medicals about cellulitis.

[11]A Correct. Cellulitis specifically

[12]refers to -- so chronic venous stasis means that

[13]the return blood flow in the legs, in other words

[14]the blood flow that's coming out of the legs back

[15]up into the rest of the body, is not as efficient

[16]as it should be.

[17]And because it's not as efficient as

[18]it should be, it leads to an increase in swelling

[19]of the lower legs. That increase in swelling of

[20]the lower legs makes you more susceptible to

[21]cellulitis, cellulitis specifically being an

[22]inflammation of the skin.

[23]So it's a superficial inflammation

[24]and infection of the skin which can oftentimes and

[25]oftentimes does occur in patients with venous
90

[1]

[2]stasis.

[3]As an aside, this is one of the other

[4]reasons why I considered the posterior approach

[5]over the anterior approach for this man, because

[6]the anterior approach has a higher incidence of

[7]postoperative venous thrombosis in the right

[8]vessels that need to be moved out of the way.

[9]So if you have a patient that has

[10]this particular condition, the anterior

[11]approach -- I don't want to say is

[12]contraindicated, but would be relatively

[13]contraindicated in this patient.

[14]Q Doctor, Exhibit 12 is your operative

[15]report; correct?

[16]A Yes.

[17]Q I would say without a need for you to

[18]go into every detail, can you give us a layman's

[19]description of your operation? In other words, we

[20]know you went in through the back. What did you

[21]do?

[22]A So it's a midline incision in the

[23]lower back. If you make the incision, you

[24]basically move the muscles out of the way so you

[25]can expose the bones, and localize the area with

[91]

[1]

[2]the intraoperative fluoroscopy so that you know

[3]you are at the specific segment that you need to

[4]be at.

[5]Once you're there, the next portion

[6]of the procedure is to remove a portion of the

[7]covering of the spinal canal, that is the lamina,

[8]so that you can then remove portions of the facet

[9]joints which are covering the nerve opening,

[10]visualize the neurological structures, that's the

[11]nerve roots and the covering of the nerves,

[12]mobilize them, that is to move them out of the way

[13]of the disc, explore and visualize the disc, and

[14]then remove whatever disc material may be there.

[15]Q Not the entire disc?

[16]A Not the entire disc, no.

[17]Q You were removing just the portion

[18]that's protruded?

[19]A Correct. Exactly. A removal of the

[20]entire disc would entail having to fuse the

[21]patient with that inter-body spacer and then

[22]screws and rods.

[23]So this would be a removal of a

[24]portion of the disc, that portion of the disc that

[25]is in the canal area in order to make sure that

[92]

[1]

[2]the nerves now have no pressure on them that would

[3]be continuing to cause further deterioration.

[4]Q So now here the herniation was

[5]central?

[6]A Correct.

[7]Q So a central protrusion; right?

[8]A Yes.

[9]Q So you removed that?

[10]A Yes.

[11]Q Then how does that address the

[12]bulging that we talked about earlier on either

[13]side?

[14]A So the opening of the canal -- you

[15]make -- you remove the lamina of the spinal canal.

[16]Not the entire lamina, but you remove a portion of

[17]the lamina of the canal. You resect or remove the

[18]flavum, which is that ligament in between the

[19]lamina.

[20]So by doing these things, you are

[21]increasing the size of the spinal canal. You're

[22]also resecting portions of the actual facet joints

[23]themselves.

[24]So by removing these portions of bone

[25]and ligaments, you are creating more room within

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[1]

[2]the canal. So by combining a removal of the

[3]herniated material with a removal of the flavum,

[4]the lamina and the facet joints, you've now opened

[5]the space available for the nerves and have,

[6]therefore, now decompressed those nerves.

[7]Q Were there any complications?

[8]A No.

[9]Q Overall, this surgery went well?

[10]A Yes.

[11]Q Doctor, Exhibit 13 is some of the

[12]hospital records.

[13]A Yes.

[14]Q So the record is clear, it is not all

[15]of them. It's just some stuff I wanted to ask you

[16]about.

[17]A Yes.

[18]Q One thing I know at the top of the

[19]first page there, the chief complaint is described

[20]as pain radiating down the left leg.

[21]A Yes.

[22]Q I think what we've now seen is early

[23]on he was describing only the right leg, then

[24]there was no radiating pain. Here it's the left

[25]leg. When he was with you he was describing both

94

[1]

[2]legs.

[3]Isn't there some inconsistency here?

[4]A No. This was a note that was written

[5]by a PA. It doesn't look like I had an

[6]opportunity to go over the note with the PA, and I

[7]would say that it was transcribed by the PA as

[8]told to the PA by the patient.

[9]It's not unusual for patients to have

[10]symptoms that can wax and wane depending upon the

[11]day. But in the history section, it also says he

[12]also complains of right forward/left leg swelling,

[13]left greater than right. So I don't know if the

[14]PA was confusing the swelling with the radicular

[15]neurogenic symptoms or not, because this is not a

[16]straightforward patient.

[17]Q I will follow up on the next page.

[18]About three-quarters of the way down, physical

[19]exam, it notes an irregular heart rhythm; correct?

[20]A Correct.

[21]Q You will see on the next report there

[22]it says patient results, and it's a three-page

[23]document, all part of the same exhibit. Do you

[24]see that?

[25]A Yes.

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[2]Q At the conclusion section on page 3,

[3]it notes aortic sclerosis without stenosis.

[4]A Yes.

[5]Q Is there something going on with his

[6]heart?

[7]A Yeah. According to this, he has --

[8]sclerosis means a hardening of. So this

[9]particular echocardiogram -- so an echo is a test.

[10]It's like an ultrasound of the heart. So it sends

[11]sound waves into the heart, and then the sound

[12]waves are recorded on a computer. They then

[13]generate an image.

[14]When they're describing aortic

[15]sclerosis without stenosis, what they mean to say

[16]is that the aorta itself is -- I want to give the

[17]right descriptive term for it. It is harder.

[18]It's more -- it's more echogenic than a

[19]non-sclerotic vessel.

[20]So it's hardened. There is a

[21]hardening of that particular artery, but that

[22]particular artery is not narrowed.

[23]Q Okay.

[24]MR. HANLON: Off the record.

[25](Discussion held off the

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[1]

[2]record.)

[3]Q Doctor, since we've covered a lot of

[4]ground today, I will skip a number of the pages

[5]and bring your attention to the postop exam, still

[6]part of Exhibit 13, December 12, 2013. It looks

[7]like 7:17 in the morning; right?

[8]A Yes.

[9]Q Did you do the exam?

[10]A No. Freddie Verzosa, who is the

[11]in-house covering doctor for the orthopedic team

[12]did, and my associate and partner Dr. Franco

[13]Cerabona also rounded on the patient and co-signed

[14]the note. He was also the assistant at surgery.

[15]Q According to that exam, everything

[16]was good, it was positive?

[17]A Yes. Postoperatively, correct. He

[18]was doing well. There were no complications or

[19]concerns.

[20]Q His strength was 5 out of 5

[21]bilaterally. He wasn't having any issues there.

[22]A Yes.

[23]Q So no indications of any postsurgical

[24]problems in this exam; right?

[25]A Correct.

97

[1]

[2]Q So during the surgery, I imagine you

[3]felt the surgery went well, and this seems to

[4]confirm that at least as of the next day

[5]everything seems to be going well?

[6]A Yes.

[7]Q Flip just one or two pages. You're

[8]going to see the pathology order.

[9]A Yes.

[10]Q So you talk about removing a portion

[11]of the disc?

[12]A Yes.

[13]Q That is then sent out for a pathology

[14]exam?

[15]A Yes.

[16]Q What's the purpose?

[17]A In general when we remove something,

[18]you send it to pathology just to make sure that we

[19]haven't removed something we shouldn't have

[20]removed, number 1. And number 2, just to confirm

[21]what it is that you did remove.

[22]So in this case we did get a nice

[23]chunk of disc material out, which we then sent to

[24]pathology.

[25]Q And pathology comes back and says

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[1]

[2]yeah, it's a nice chunk of disc?

[3]A Pretty much.

[4]Q Nothing more to it than that?

[5]A Correct.

[6]Q Let me get to the discharge summary.

[7]So I guess he came in on day one, and he's

[8]discharged the next day; right?

[9]A Yes.

[10]Q So he came in on December 11, 2013

[11]about 10 o'clock in the morning; right?

[12]A Yes.

[13]Q And he's discharged at 5 o'clock the

[14]next day?

[15]A Yes.

[16]Q Then flip a page or two. There is a

[17]medical record inpatient abstract.

[18]A Yes.

[19]Q In the middle you see some diagnostic

[20]codes and descriptions?

[21]A Yes.

[22]Q First of all, who prepares this; is

[23]this you or the hospital? I see your name on it.

[24]A This would be a hospital coder. So

[25]what a hospital coder does is a hospital coder

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[1]

[2]takes the hospital record and then -- and there

[3]are actually people that do this, who then read

[4]through the record and then take out words from

[5]the record that correspond to codes so that they

[6]can then in a numerical way, quote, unquote, code

[7]the visit.

[8]And they do multiple things with

[9]those codes. Those codes are used for billing.

[10]They're also used for data collection. In other

[11]words, how many laminectomies were done in New

[12]York City in 2013. So when the hospital reports

[13]on the types of cases that it did, it uses those

[14]specific codes to say we did 400 722.10s.

[15]So these numbers basically translate

[16]the hospital visit into a number that corresponds

[17]to all of these things that are listed on this

[18]piece of paper.

[19]Q Okay. The first one seems to make

[20]sense. The second is 9056, late effect of

[21]dislocation.

[22]A I have no idea what that means.

[23]Q The next one is even stranger.

[24]A Yes.

[25]Q E989, late effects of injury,

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[1]

[2]undetermined if accident/purposely inflicted.

[3]A Yes. Interestingly enough, the way

[4]these codes are written, they're standard and they

[5]come in these books. So there are actually books

[6]that have what we call -- it's an ICD,

[7]international classification of disease. I think

[8]we're up to ICD 10 now. The previous ICD was 9,

[9]and so forth and so on going back in time.

[10]You see the 72210?

[11]Q Sure.

[12]A That's an ICD code. The ICD code,

[13]displacement of lumbar intervertebral disc without

[14]myelopathy. So that means lumbar disc herniation.

[15]Late effect of dislocation, 9056,

[16]honestly, not a code that I'm familiar with, so I

[17]don't know where they got that. But I can

[18]guarantee you it came out of a hospital coding

[19]book.

[20]The E codes are even further away

[21]from whatever I would potentially use. But when

[22]they're in the book, this is the way the book

[23]describes them. And in general, they're very

[24]vague, and they contain multiple -- sometimes

[25]unrelated issues, because that code number needs

101

[1]

[2]to encompass many potential issues.

[3]I don't know if you want to go off

[4]the record for a second, and I will tell you a

[5]quick aside on the ICD.

[6]MR. HANLON: Off the record.

[7](At this time, a brief recess

[8]was taken.)

[9]CONTINUED EXAMINATION

[10]BY MR. HANLON:

[11]Q A quick question on the last page of

[12]Exhibit 13. Financial information indicates self

[13]pay.

[14]A Yes.

[15]Q How were you paid and how was the

[16]hospital paid?

[17]A So as far as I know for this

[18]particular case, the patient actually paid for all

[19]the services.

[20]Q I assume you have no more information

[21]than that?

[22]A What we'll do is we'll send a bill.

[23]We see a patient, we send them a bill, and you ask

[24]them how they're going to cover the bill. You

[25]just go over it with them. Sometimes, for

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[2]example, it's a commercial plan. It could be a

[3]Workers' Comp plan. It could be no-fault. It

[4]could be a self pay. There are 20 different ways

[5]that they can pay for it. And in this case, he

[6]was a self pay.

[7]Q Then you saw him one more time on

[8]December 16, 2013, which is Exhibit 14; right?

[9]A Yes.

[10]Q It's a post-op exam; correct?

[11]A Yes.

[12]Q And everything was still in order.

[13]All signs were good at that time?

[14]A Yes.

[15]Q And post-op, your recommendation was

[16]physical therapy, which he was going to go home to

[17]Georgia and do; correct?

[18]A Correct.

[19]Q Exhibit 15, that's your prescription

[20]for the physical therapy; right?

[21]A Yes.

[22]Q And similar to what I did with the

[23]chiropractor, the physical therapy, I marked the

[24]initial evaluation and the final evaluation only.

[25]So the first one was Exhibit 16; right?

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[2]A Yes.

[3]Q December 30, 2013 he starts his

[4]post-op physical therapy?

[5]A Yes.

[6]Q That's pretty close to the surgery?

[7]A Yes.

[8]Q Let's go to 17. That's his discharge

[9]summary from the postop physical therapy on

[10]April 21 of 2014; right?

[11]A Yes.

[12]Q So he had completed a cycle of 34

[13]treatments, it looks like?

[14]A Yes.

[15]Q He was reporting good results with

[16]pain rated as a 1 on a scale of zero to 10;

[17]correct?

[18]A Yes.

[19]Q He goes on right there to say, and of

[20]his pain, it is located mainly in the right hip

[21]with no pain in the low back; right?

[22]A Yes.

[23]Q It probably makes you happy to see

[24]this. It's a good indication that your surgery

[25]and the physical therapy, and now he's reporting

104

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[2]pain free in the low back; correct?

[3]A Yes.

[4]Q And that's exactly the kind of good

[5]result you would expect from that type of surgery

[6]that you did here?

[7]A That is one of our hopeful good

[8]results, yes.

[9]Q The bottom page, again more

[10]complaints from the patient about hip mobility;

[11]right?

[12]A Yes.

[13]Q Then if you go to the assessment,

[14]again getting back to the hip, there is a

[15]reference to significant difficulty with walking

[16]is secondary to hip joint mobility limitation and

[17]weakness; right?

[18]A Yes.

[19]Q That's nothing to do with his low

[20]back and your surgery; right?

[21]A Right.

[22]MR. HANLON: Off the record for

[23]a second.

[24](At this time, a brief recess

[25]was taken.)

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[2]MR. HANLON: Off the record we

[3]cleared up some things, just because

[4]I didn't want to go into grounds

[5]unnecessarily.

[6]Mr. Wasick, I know you sent

[7]Dr. Merola some medical records

[8]post-op, but it's my understanding

[9]that you don't intend to have this

[10]doctor opine on post-op care or need

[11]for future care or future surgery,

[12]those kinds of things; correct?

[13]MR. WASICK: I sent him post-op

[14]records because I figured that would

[15]be something you might ask him about,

[16]and he figured he would be better off

[17]having an opportunity to read those

[18]things before having to sit here and

[19]you paying him by the hour.

[20]MR. HANLON: Sure.

[21]MR. WASICK: But his opinions as

[22]far as the treatment, further care of

[23]Mr. Hunt after Dr. Merola's last

[24]visit with him, that's not part of

[25]what we're -- I'm not presenting him

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[2]to give an opinion on those things.

[3]MR. HANLON: Okay. Similarly in

[4]terms of how the accident happened,

[5]what the forces were, whether they

[6]were enough to cause certain

[7]injuries, the same thing, you're not

[8]going to bring Dr. Merola into that?

[9]MR. WASICK: If we were, we

[10]would have to go through the -- you

[11]know, right now -- well, let me put

[12]it this way.

[13]I think Dr. Merola -- if you ask

[14]him questions, as most defense

[15]counsel would typically, ask

[16]questions about -- I've seen a

[17]variety of different ways defense

[18]counsel may approach the question

[19]about causation of injury and force

[20]and mechanism, and I mean I don't

[21]think you got into it very much

[22]today.

[23]fI think in his experience as an

[24]orthopedic surgeon, he's qualified to

[25]give general opinions about what he's

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[2]seen. And if we were calling

[3]Dr. Merola for trial, I don't have

[4]any expectation of getting into

[5]opinions that are outside the scope

[6]of his experience and his training

[7]as apply to the context of Mr. Hunt.

[8]Does that answer your question?

[9]I mean if you're asking me whether or

[10]not you should go into those areas

[11]with him today on cross and

[12]discovery, I mean that's your call.

[13]I feel like that's outside. I'm

[14]trying to give you some information,

[15]but honestly, it's a judgment

[16]discussion for you.

[17]MR. HANLON: Let's go off the

[18]record.

[19](Discussion held off the

[20]record.)

[21]CONTINUED EXAMINATION

[22]BY MR. HANLON:

[23]Q Doctor, I saw in some of your records

[24]and some of the records you reviewed a general

[25]description of the accident which was an

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[2]18-wheeler backing into a vehicle that was

[3]occupied by Mr. Hunt; correct?

[4]A Yes.

[5]Q Do you have any information about the

[6]accident beyond that?

[7]A No. I don't have any more specifics

[8]than that regarding the actual accident itself,

[9]no.

[10]Q Do you have any specifics about the

[11]severity of that impact and the forces it may have

[12]imparted on Mr. Hunt, including his lumbar spine?

[13]A I have not made any specific

[14]calculations with respect to force, no.

[15]Q So at least as of today, you have not

[16]yet been asked to, and you have not, rendered any

[17]opinions about the forces in the accident and what

[18]injuries they were or were not sufficient to

[19]cause; fair enough?

[20]A Correct.

[21]MR. HANLON: I have no further

[22]questions.

[23]Do you have anything?

[24]MR. WASICK: Just a couple.

[25]EXAMINATION BY
109

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[2]MR. WASICK:

[3]Q Dr. Merola, as, I guess, a segue to

[4]what Mr. Hanlon's questions were pertaining to,

[5]how many years have you been treating people as an

[6]orthopedic surgeon?

[7]A I've been treating patients as an

[8]orthopedic surgeon since 1990.

[9]Q In that time, would you say you've

[10]treated hundreds of patients?

[11]A Many, many hundreds of patients.

[12]Q Have you treated patients with

[13]subjective histories where they told you they were

[14]involved in one type of motor vehicle accident or

[15]another?

[16]A Yes.

[17]Q Have you seen motor vehicle

[18]accidents, very severe motor vehicle accidents

[19]were people reported minimal injuries?

[20]A Yes.

[21]Q Have you seen motor vehicle accidents

[22]with minimal collision damage where people had

[23]more significant injuries?

[24]A Yes.

[25]Q Would it be fair to say that the

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[2]manner in which a motor vehicle collision could

[3]affect a given individual is variable and tends to

[4]depend on that individual?

[5]A Yes.

[6]Q Everyone is a little bit different,

[7]in other words?

[8]A Correct.

[9]MR. WASICK: Mr. Hanlon, that's

[10]what I wanted to ask him about.

[11]MR. HANLON: I think we're done.

[12](Time noted: 3:47 P.M.)

[13]

[14]* * * *

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[2]ACKNOWLEDGMENT

[3]

[4]STATE OF NEW YORK

[5]ss:

[6]COUNTY OF

[7]

[8]I, Andrew Merola, M.D., hereby certify that

[9]I have read the transcript of my testimony taken

[10]under oath in my deposition of January 29, 2016,

[11]that the transcript is a true and complete record

[12]of my testimony, and that the answers on the

[13]record as given by me are true and correct.

[14]

[15]

[16]

[17]ANDREW MEROLA, M.D.

[18]

[19]

[20]Subscribed and sworn to before me

[21]This day of 2016.

[22]

[23](NOTARY PUBLIC)

[24]

[25]

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[3]CERTIFICATE

[4]

[5]I, Terri Fudens, a stenotype reporter

[6]and Notary Public within and for the State of New

[7]York, do hereby certify:

[8]That the witness whose testimony is

[9]hereinbefore set forth was duly sworn by me and

[10]that such testimony is a true record of the

[11]testimony given by such witness.

[12]I further certify that I am not related

[13]to any of the parties by blood or marriage, and

[14]that I am in no way interested in the outcome of

[15]this matter.

[16]IN WITNESS WHEREOF, I have hereunto set

[17]my hand.

[18]

[19]

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[21]

[22]/s/ [Signature]

[23]Terri Fudens

[24]

[25]

Appendix

[SEE GLOSSARY LETTER IN ORIGINAL]

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