In The Matter Of:

McGill vs.

Whitney Museum of American Art, et al.

September 24, 2024

NY County Supreme Court

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SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK: CIVIL TERM: PART 5
----------X
RICHARD MCGILL,

Plaintiff,

-against- INDEX NO: 158766/2015

WHITNEY MUSEUM OF AMERICAN ART and TURNER CONSTRUCTION COMPANY,

Defendants.
----------X
New York Supreme Courthouse
80 Centre Street
New York, New York 10007
September 24, 2024

B E F O R E:
THE HONORABLE HASA A. KINGO,
J U S T I C E

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

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Karen Mangano, CSR
Anne Brown, CSR
Senior Court Reporter

MR. THOMAS: Judge, I'm going to premark some exhibits.

THE COURT: Okay. Sounds good.

(Whereupon, the aforementioned documents and disk were marked as Plaintiff's Exhibits 18 through 20A in evidence as of this date by the Reporter.)

THE COURT: Counsel, you're ready?

MR. SARDINO: Judge, I want to put one thing on the record real quick with regard to exhibits.

THE COURT: Sure.

MR. SARDINO: I believe Plaintiff is offering Exhibit 20, Dr. Merola's records.

We had previously objected to the admission of those records pursuant to the 3122(a) objection. Your Honor has previously ruled on that, but for purposes of the record, we maintain our objection.

THE COURT: Okay. All right. Understood.

MR. THOMAS: Your Honor --

MR. SARDINO: The others are stipulated.

MR. THOMAS: -- in light of that, your Honor, out of the presence of the jury, your Honor has made very specific rulings that the defense may not mention, let alone get into substantive subject matter with regard to the third-party action or the additional litigation involving

Dr. Merola.

I would ask that counsel again be guided accordingly and not do through the back door what they are not allowed to do through the front door. I believe that counsel will abide by your Honor's ruling. But again, I just want to let you know before we start that I am going to be very sensitive to this issue.

As well, I want to point out to the Court -- excuse me. Before I do that, your Honor, in the courtroom we have Moe Fodeman who is Dr. Merola's personal counsel who is present. He is not going to speak. He is not going to address the Court or the jury in any way.

I want to bring it to your attention, but I want to make sure that counsel does not ask the doctor during this cross-examination who is this gentleman sitting here or giving any inference or appearance at all that the doctor has an attorney even in this courtroom. It would be highly prejudicial and subject to not just reversible error, but I would ask potential sanctions if they tried to do that.

Again, I trust Mr. Sardino, but in an effort for total transparency and complete openness, I want to make sure that that's clear and understood.

THE COURT: Understood. Mr. Sardino.

MR. SARDINO: Judge, I don't think there is any case law or statute that precludes me from asking the

witness why he has an attorney present with him in court.

MR. THOMAS: Your Honor, again, it's another way of --

MR. SARDINO: To have a purely sterilized courtroom that, you know, why Mr. Fodeman needs to be here. Apparently, the witness feels he needs an attorney. I think that's fair game.

He's testified in hundreds of other cases without an attorney present. Why is this case any different from the hundreds of other cases that he's testified in?

THE COURT: The attorney is not aiding him in representation. The attorney is merely observing the proceeding which any person who walks into this courtroom can do. I don't see any issue or why reference needs to be made to it. Anyone is able to be an observer in this courtroom.

MR. SARDINO: So is Mr. Fodeman going to be precluded from discussing the testimony with the witness until his entire testimony is completed.

THE COURT: He is not representing him in connection with the proceedings, so he can question him about his testimony.

MR. SARDINO: All right.

THE COURT: Again, I don't know what else --

MR. SARDINO: Well, Mr. Fodeman is not here because

Proceedings. Page 467

he didn't have anything else to do here today. He is here representing Dr. Merola as the plaintiff just said.

MR. THOMAS: He is not representing him in the McGill case. He is here as an observer. This is a public courtroom. He is entitled to be present during the course of the proceeding.

I don't want to distract this jury with counsel's pointing out that there is somebody in the audience who could give them the belief or the possibility, any inference at all which would violate your Honor's order.

THE COURT: Understood. And we know who the individual is outside the presence of the jury, so there is no need to inquire with respect to it while the jury's present. So that is my ruling on that issue.

And separately, of course, the Court's in limine rulings are clear as to what counsel may or may not go into during the course of this witness' testimony. So I will also be keeping a close eye on the rulings that I've made with respect to what can and can not be included during the course of the testimony.

MR. THOMAS: Thank you, your Honor.

MR. SARDINO: So Judge, just for further clarification then, I'm going to object to the witness getting into his qualifications without us being allowed to get into matters that affect those qualifications.

Proceedings. Page 468

THE COURT: What matters affect his qualifications? His qualification are his qualifications.

MR. SARDINO: The fact that several physicians have testified or given statements under oath to various courts that he performed procedures that he did not perform independent of any RICO, any other lawsuit. These are other cases pending in the courts of the City of New York.

MR. THOMAS: Your Honor, this is again another attempt at back-dooring in what your Honor has already said they can not do. And these are -- as far as I know, as counsel just said, they are allegations. There is no findings. So again --

THE COURT: Any allegations are not to be referenced during the course of this witness' testimony. I believe my in limine ruling is clear on this issue.

MR. SARDINO: So can I question the witness about malpractice actions?

THE COURT: Malpractice actions against this witness?

MR. SARDINO: Yes.

THE COURT: What malpractice actions are you talking about?

MR. SARDINO: Whatever malpractice actions are out there, Judge.

MR. THOMAS: Once again --

Proceedings. Page 469

MR. SARDINO: Judge, there is black letter case law --

THE COURT: If you have not made an application about this, Mr. Sardino, before today, my in limine rulings are clear. We are sticking to the facts of this case; okay. So no malpractice issue is going to be raised in any lawsuit. Nothing of that sort. I made my in limine ruling, and you didn't make a motion in limine with respect to any other lawsuits but the RICO lawsuit.

MR. SARDINO: Judge, we did it in motion number 15 that we could argue, and your Honor was here for one of the arguments, but Mr. Singer from Sacks and Sacks argued many times to the Court including to your Honor during the motion hearing on motion 15 that we get into that, and we could have free reign on that. Those are his words.

MR. THOMAS: My understanding is that what counsel just referenced was denied.

So again, I -- my concern, Judge --

THE COURT: Right.

MR. THOMAS: -- is trying to back door in what they can't do through the front door.

THE COURT: Right. It was denied.

MR. SARDINO: I didn't see that, Judge, but can I -- rather -- can we -- do you want me to do it now or can I preserve the record after the witness?

Proceedings. Page 470

THE COURT: To preserve what?

MR. SARDINO: So Judge, I would ask for a voir dire of the witness outside the presence of the jury.

MR. BERGER: The witness is in the courtroom.

THE COURT: I just asked, Counsel, before we started that no witness be present in the courtroom.

MR. THOMAS: Judge, there is an attorney in the courtroom. He is a very handsome gentleman, and he could easily be mistaken for Dr. Merola, but I can assure you as handsome as he is, he is not Dr. Merola.

THE COURT: Okay. So Counsel, what are you speaking to? Who is a witness? Who is in the room?

MR. BERGER: I don't know who he is, your Honor.

THE COURT: And as I mentioned earlier, I asked before we got started whether or not there were any witnesses in the room. The answer was no. I suspect that that continues to be the case.

MR. SARDINO: Thank you, Judge.

Just for the record, Judge, I would ask that I would be allowed to voir dire Dr. Merola on the matter your Honor previously ruled on that we could not get into it in the presence of the jury so as to preserve the record as well as I just mentioned to make an offer of proof -- if the Court does not allow a voir dire, alternatively, to allow me to make an offer of proof as to the other cases where

Proceedings. Page 471

physicians have challenged Dr. Merola's surgery.
THE COURT: Okay. As with Dr. Touliopolous, I am denying that request at this time.
MR. SARDINO: Thank you, Judge.
THE COURT: One item I wanted to bring to everyone's attention. I mentioned this, this is just a housekeeping issue with respect to scheduling.
I had mentioned earlier that the Court, although previously did not have availability tomorrow morning now does have availability to have testimony heard during the morning.
I don't know if, Mr. Thomas, you would have a witness available in the event that we can exercise that time or if there is anything that will prohibit any counsel from being able to use -- do an earlier start to the day tomorrow morning.
MR. THOMAS: Judge, if I may, has there been an inquiry from the jurors whether or not they would be --
THE COURT: I have not inquired of them first because I wanted to first inquire of counsel. I will separately inquire of the jury because I know that might also be an issue.
MR. THOMAS: Judge, I don't -- I mean, I have some photos from my trip to South Africa. I am very happy to show that to the jury to make up the time in the morning;

Proceedings. Page 472

however, we don't have a witness based on the previous schedule.
If something happens between now and the end of the day and the jurors are told or if the jurors tell you that they are available, we will see what we can do, but right now, I did inquire and we don't have anything.
THE COURT: Very well. Thank you.
All right. Counsel, you may call your next witness.
MR. THOMAS: Did you want to get the jury first?
THE COURT: Okay. Let's get the jury first.
THE COURT OFFICER: All rise. Jurors entering.
(Whereupon, at this time the jury entered the courtroom.)
THE COURT OFFICER: You may be seated.
THE COURT: Okay. Good afternoon, members of the jury, and thank you for your patience. We are now ready to commence with today's testimony.
Mr. Thomas.
MR. THOMAS: Thank you, your Honor.
Your Honor, at this time we call spine surgeon Andrew -- Dr. Andrew Merola to the witness stand.
THE COURT: Okay. My officer will get Dr. Merola.
THE CLERK: Good afternoon. Please raise your right hand.

Dr. Merola - by Plaintiff - Direct Page 473

A N D R E W M E R O L A, a witness called on behalf of the Plaintiff, after having been first duly sworn, took the witness stand and testified as follows:
THE CLERK: Please state your name and business address slowly for the record.
THE WITNESS: Andrew Merola, M-E-R-O-L-A, 5672 First Street, Brooklyn, New York.
THE CLERK: And the zip?
THE WITNESS: 11215.
THE CLERK: Thank you.
THE COURT: Please be seated, Doctor. Please be seated, everyone else.
Doctor, I'm going to ask that you adjust the microphone and just speak clearly into the microphone when you are giving your responses to any questions asked.
If there is an objection to any question, wait for my ruling before answering the question. If the objection is sustained, you may be directed not to answer the question. If it's overruled, I may then instruct you to answer the question. Okay?
THE WITNESS: Yes.
THE COURT: Mr. Thomas, your witness.
MR. THOMAS: Thank you, Judge.
DIRECT EXAMINATION
BY MR. THOMAS:

Dr. Merola - by Plaintiff - Direct Page 474

Q Good afternoon, Doctor.
A Good afternoon.
Q Dr. Merola, please tell the jury what kind of medical doctor are you.
A I'm an orthopedic spinal surgeon.
Q And orthopedics spinal surgery, tell us a little bit about that.
A So orthopedics typically deal with the musculoskeletal system. That's everything that you need to have working so that you can be up and about and moving. It's your muscles, your tendons, your bone, your ligament, your nerves, all those things.
The spinal surgery aspect of it deals specifically with the neck and back as a subcomponent of the other orthopedic portions of the body.
Q Are you a practicing physician?
A Yes, I am.
Q Tell the jury what does it mean to be a practicing physician.
A It means that I have a private practice where I see patients and take care of people.
Q Do you still perform surgery?
A Yes.
Q How often do you perform surgery?
A On a weekly basis.

Q And are you being compensated for your time away from your surgical schedule and other obligations and responsibilities to be here this afternoon?
A Yes.
Q What rate are you being compensated at?
A $650 per hour for time away from the office.
Q Can you just tell the jury a little bit about your educational background, your work experience.
A So I graduated from NYU with a degree in chemistry. I then went to Howard University, College of Medicine, graduated with a medical degree thereafter.
I then came to SUNY Downstate Medical Center, Kings County Hospital where I did an internship in general surgery and then a residency in orthopedic surgery.
After I finished my internship and my residency, I went to the University of Colorado in Denver where I did some extra training in spinal surgery.
Q Have you ever testified in court before?
A Yes, I have.
Q Have you been qualified as an expert in the field of spinal surgery?
A Yes, I have.
MR. THOMAS: All right. At this point I ask that the Court recognize Dr. Merola as an expert specializing in the field of spinal surgery.

THE COURT: Any objection?
MR. SCARDINO: Subject to prior objections, Judge.
THE COURT: Okay. Thank you, Counsel. The doctor is qualified as such at this time.
MR. THOMAS: Thank you.
Your Honor, may we show the witness Exhibits 18, 19, 20?
THE COURT: Yes. Please identify what those exhibits are.
MR. THOMAS: Exhibit 18 are the records from Complete Care. 19 are records from Universal Pain Management, and 20 are the records for Dr. Merola.
THE COURT: Okay.
The witness is being shown what has been marked and received in evidence at this time.
Q And Doctor, have you seen these records before?
A Yes, I have.
Q Okay. And among those records, Plaintiff's Exhibit 20 in evidence is a copy of your notes and records?
A Yes, it is.
MR. THOMAS: If during the course of your testimony, you need to refresh your recollection or refer to those notes, your Honor, with the Court's permission, can Dr. Merola use those records to refresh his recollection?
THE COURT: Any objection?

MR. SARDINO: No, your Honor.
THE COURT: Okay. The Court will allow that.
Q Now, you were a treating physician for Richard McGill?
A Yes.
Q Please tell us when you first -- withdrawn. When did you first meet Richard McGill?
A I first met Mr. McGill on April 29 of 2019.
Q And 2019 was almost six years post-accident?
A Yes.
Q Did you take a history for Mr. McGill?
A I did.
Q Tell the jury what you learned when you took a history from Mr. McGill.
A That Mr. McGill was working on August 16 of 2013 and there was an incident where he sustained injuries while in a scissor lift. He had shoulder problem as a consequence of the accident, and he had undergone a shoulder surgery with a Dr. Scilaris. He had been out of work for about eight days and then tried to work return to work as best as he could. He worked for about two months and then began to stop, went into a lighter duty work after that. At which point in time he indicated that in about January of 2016, he really couldn't tolerate working anymore, had the shoulder repair but continued to have persistent predominantly neck-related symptoms.
Q And did he have a course of conservative therapy before

he was referred to you?
A Yes.
Q Do you know what that conservative therapy was?
A So that treatment included therapy, medications, of course, and he had also had some what we call epidural steroid injections.
Q And so this therapy that he had, was this course of treatment successful?
A No. He continued to have symptoms in his neck.
Q When a person goes through a course of therapy like Mr. McGill, has trigger point injections or steroid injections to address pain and they have still pain complex that he was describing, what's the next step?
A Well, to get an idea of where the pain is coming from and what his particular problem is to address his concerns, so we do a physical examination and then we look at some diagnostics.
Q Based on the diagnostics and the world of information that you were provided, was he a surgical candidate by the time he was referred to you?
A Yes.
Q And for someone to be a surgical -- withdrawn.
The patients that you see in this realm, meaning, having had prior treatment, conservative therapy, and then becomes a surgical candidate, how often do you encounter

situations like that?
A So, you know, having been in practice for quite some time, you encounter these folks quite often, and typically that's why you're seeing them for surgical consultations.
Q And after all your review of the information that was provided, did you discuss with Mr. McGill the type of surgery that he was a candidate for and that you were going to perform?
A Sure. I actually had updated some of his diagnostics when I first saw him and then saw him back in the office once again to go over his symptoms, re-examine him and then discuss some options and alternatives with him.
Q Did you take a past medical history?
A Yes.
Q And tell us what you learned by taking a past medical history for Mr. McGill specifically with regard to his neck?
A Specifically, with respect to his neck, as I had indicated, he had conservative treatment including injections which weren't helpful, and because of his persistent complaints and symptoms that were interfering with his activities of daily living and his quality of life, that's why he had come in to see me.
Q Doctor, if you can with the Court's permission, I have my friend Bones here who doesn't talk much, but he is a good listener. But if you can use this model to demonstrate some portions of the anatomy if that will help the jury to understand

a little bit about the procedure that you performed on Mr. McGill.
Can you do that?
THE COURT: That's okay with the Court. Counsel?
MR. SARDINO: No objection.
THE COURT: Okay.
MR. THOMAS: We can ask the doctor to stand in front of the jury if that's possible.
THE COURT: You may, Doctor.
MR. THOMAS: As well, Doctor, I also have this if you feel it's appropriate.
THE COURT: And Doctor, I'm just going to ask that you speak at a higher tone because you're away from the microphone at the moment.
A So this is a plastic model of the spinal column. The top of the model is the base of your skull. So this is the back of your head here.
Your front side is right here, and your back side is on this side.
Your pelvis is connected to the bottom of your spinal column. And then, of course, you have your hip joints in both your right and left sides.
The top of the column is what we call cervical spine or our neck, and it contains seven bones.

Middle portion of your spine is your thoracic spine or upper back, and it contains 12 bones, and the lower portion of your spine or your lumbar spine contains five bones and then that meets at this triangular-shaped back here which sits in your pelvis is called your sacrum.
Each one of those bones lined up on top of each other to form the column. And in between each bone, there is a cartilaginous disc that sits in between the bones to help glue the bones together, provide proper motion for the way the bones themselves are working. They provides some shock absorption, so when you're walking around, you can distribute load and stress throughout your spine normally, and they help with the way your spine is supposed to typically move.
Additionally, not only is the spinal column supporting your head over your pelvis normally, but it also contain your spinal cord which is the yellow structure that runs through an opening in the spinal column called the spinal canal, and that's the continuation of your brain that has all of these little things that look like wires or nerves which are responsible for how your arms and your hands move and how your legs and your feet move around as well as other organ systems in your body so your brain is able to send all of its information through your spinal cord and your nerves to various parts of your body. And your spine is there to protect those areas and also to make sure that they travel normally into your arms and hands and legs and

feet.
Each bone itself is also responsible for not only maintaining the way you would have normal structure and normal function, but those bones themselves are also intimately involved where your cord and nerves are at the disc because in the spinal canal region itself, you have an opening that's bounded by or bordered by the bones and the discs.
Your cord or your actual brain tissue, remnants of your brain tissue travel through your cervical spine and your thoracic spine. They kind of end in your lower back area, and your lumbar spine sits mostly just nerve roots and not cord itself.
Cord is a highly sensitive structure that's very, very sensitive to pressure, trauma and other types of diseases or problems and so the cervical and thoracic regions are often times some of the more important or critical regions in your spine with respect to protecting neurological function.
Q And Doctor, you said there were some diagnostic tests that were done. MRIs?
A Yes.
Q The findings on those MRIs suggested what?
A So the MRI finding when we looked at them show that there were areas where there were disc protrusions occurring throughout the cervical region and there were several areas where the disc and the bone themselves were causing what we call

Dr. Merola - by Plaintiff - Direct Page 483

compression. Compression means pressure on the cord and on the nerve roots.

For your spinal cord, your nerves to work properly, they have to have a normal blood supply and a normal spinal fluid supply, and if they are in areas that are being what we call compressed where they have pressure on them, there could be a disruption in normal blood flow, and there can be a disruption in what we call cerebrospinal fluid flow, and those disruptions can lead to nerve or cord damage over time.

So there were several areas where there was a significant amount of compression or pressure on the spinal cord and the nerves in the lower portion of the cervical spine.

Q And that pressure, does it cause pain?

A Yes.

Q What do you do to relieve pressure when you -- as you just indicated, when there are these abnormalities?

A So if there is persistent pressure causing persistent pain and/or neurological findings that have not gotten better over the course of time, you need to think about doing things to decompress, take pressure away from those cord and nerve roots and to reconstruct or stabilize the area in order to prevent that area continuing to cause any more pressure or problem with the nerves or cord.

Q Anything else you want to show us with the spine other than the brief anatomy lesson you just showed us?

Dr. Merola - by Plaintiff - Direct Page 484

A No.

Q I'm going to leave this up there in case during the course of your testimony you want to use this, it will be there for you.

A Thank you.

Q Did you do a physical examination on Mr. McGill?

A Yes.

Q Tell the jury your findings on physical examination.

A On the examination, he had palpable spasm in his neck with restrictions in his range of motion. So his ability to bend backwards, forwards or side to side or to rotate were restricted with palpable spasm.

Additionally, he had what's known as a positive Compression Distraction Maneuver and a positive Spurling's Maneuver which produce pain traveling down in the arms and hands. That's a test where you are actually increasing the pressure in the neck by pushing down on the head and rotating. So if there are any areas within the spinal column in the neck area that are touching or compressing nerves and you increase pressure in those regions, patient will have an increased symptom traveling down into their arms and hands along the course of those nerves.

And so his Spurling's Maneuver was positive, and it went down into the lower nerve roots of the arms and hands including the fifth, sixth and seventh nerve roots.

Dr. Merola - by Plaintiff - Direct Page 485

He also had a decrease in what we call pinprick and tactile sensation.

Pinprick, you typically test with a blunt instrument like a paperclip because you don't want to draw blood, so you're testing for pinprick which is a specific kind of sensation that your nerve has. And tactile sensation is a lighter type of sensation that our nerves are also responsible for, but they are mediated by different portions of your spinal cord.

So he had a decrease in those areas in the lower nerve roots of his neck as well. We have two other problems. Something called a Hoffman's Sign which is an indication of spinal cord irritation.

Hoffman Sign is if you take the relaxed hand of a patient and then you take their third finger right at the top of the third finger and flick the third finger. You are looking for a response where the hand involuntarily contracts, and that's called a Hoffman Sign. It's a sign of irritation. That typically shouldn't happen unless there is irritation in the cord that's controlling the hand and the fingers.

And then one more abnormal reflex is something called an Inverted Flexor Response, and that happens when you tap on the tendon that traverses your wrist here that goes through -- toward to your thumb and wrist area. If you tap that tendon, the normal response is for the muscle to contract, and you see your elbow contract.

Dr. Merola - by Plaintiff - Direct Page 486

The abnormal response is when you tap that tendon, if your hand flexors and your wrist flexors contract, that's an abnormal or pathological reflex indicative of cord or nerve irritation, mostly cord irritation. So he had an example of that as well.

(Continued on the following page.)

CONTINUED DIRECT EXAMINATION
BY MR. THOMAS:
Q. Doctor, can you tell the jury if he did not have the surgical procedure that you performed, would his condition have gotten better, gotten worse, stayed the same, something else?
A. So the patient, Mr. McGill, has a combination of what we call a radiculopathy, which is a nerve root irritation problem, and he also has what we call a myelopathy, which is a spinal cord-related problem. And typically, patients who have these types of problems, slowly, over the course of time, in a stepwise manner, continue to get worse unless you decompress and stabilize their spinal cord and their nerves.
Q. Did you discuss with Mr. McGill the surgical procedure that you were going to perform on him?
A. Yes.
Q. And what was the surgical procedure that you recommended and ultimately performed on Mr. McGill?
A. So the procedure is -- is known as -- it's a decompression and a spinal fusion. A decompression means removing pressure from the cord and nerve roots, and spinal fusion means stabilizing and basically gluing the bones together so they don't continue to collapse or move or cause any more damage.
Q. When did you perform this surgery?
A. So that surgery was done on May 26th of 2021.

Q. Where was it performed?
A. Presbyterian Hospital.
Q. And I assume he was under anesthesia at the time?
A. Correct.
Q. Okay. And again, you've performed this procedure many times before?
A. Yes, I have.
Q. How long does the procedure take?
A. So, typically, this procedure from start to finish takes several hours with a general anesthetic. And then the procedure itself and then the wake-up period thereafter.
Q. And so can you tell us -- take us through the procedure that you performed on Mr. McGill.
A. Sure. So the procedure itself, if I -- I'm going to use the --
Q. I have another small model. I don't know if this will help you.
A. Yes.
Q. So this is only the cervical spine and the cervical bones. And in this model you're actually looking at a plate with some screws attached to it, and then some carbon fiber, what we call spacers or cages, placed in between the bones.
So this procedure, this particular -- this particular procedure that we're talking about involves approaching the neck from the front side of the neck.

So this is essentially sitting inside you, here. If you push your finger in between where your voice box and your muscles that hold up your head are, you can feel something very hard at your fingertip. And what you're feeling is the front part of your cervical spine. And so you would be feeling the bones and the discs.
So we approach through the front. We make an incision, typically along the left side of the neck. We move your trachea and your esophagus to one side. We move your vessels and your muscles to the other side. And then we can directly look at your discs and your bones.
We then localize the area so we know where we're working by taking an X-ray. And we next remove the actual disc that sits in between, and in this case, between C5 and C6, with some very special tools.
We remove that disc to the level where it enters the spinal canal and we do this with what we call loop magnification. So they're glasses that have magnifiers on them attached to a headlight so that you can -- it's almost like a portable microscope. You can look directly at what you're supposed to be operating on and it magnifies it.
So we removed that disc all the way to the level of the spinal cord, and thereby clear out the area where the cord is. And we do that in this case in two levels, between C5 and C6 and between C6 and C7.

After those are removed, in order to make sure that the cord itself and the nerves have been fully and completely decompressed, we start to remove as much bone as we possibly can in between the area that we're fusing, and in this case, it's the C6 vertebral body.
So we're taking off -- or if you could picture us scooping out the internal portion of the vertebral body to the point where we can see the cord and the nerve roots, and pass small little tools along the area where the cord and the nerve roots are to make sure that there's no significant pressure there. And we do that on both the top and the bottom of the vertebral body that's directly in the middle of the area that we're operating on. Now that we've done that, we've basically taken everything apart and taken pressure off the cord and the nerves. That's the decompression portion of the procedure.
The fusion portion of the procedure involves inserting these carbon fiber devices in between the bones, which we pack with bone graft. So the area that we've scooped away, we pack that in with bone graft. And bone graft is two kinds. We use bone that we removed and we grind it up into a little paste, and then we also have what's called cyropreserved bone cells, which are frozen, living, human bone cells that we mix in with the patient's own bone. And then we pack in the areas that we've removed so that all of those bones eventually fuse together as one bone.

To make sure that this does not collapse, we have to lock it in place with a titanium plate, that we put screws into the vertebral body so that it's locking that section in place, so that after the surgery is over the patient can wake up, walk, eat, drink, take a shower, and do their normal activities without worrying about that area falling apart. And it holds everything together throughout entire healing process.

MR. THOMAS: Your Honor, with the Court's permission, may we publish the model that the doctor was just talking about to the jury? Because I'm not sure that -- because it's so small -- so that everybody can see it. And then once we're done, I'll have some more questions for the doctor.

THE COURT: You may do so.

MR. THOMAS: Thank you.

(Whereupon, the model was published to the jury.)

COURT OFFICER: The model has been published to the jurors.

Q. As well, Doctor, so we're clear, this is not a former patient of yours, correct?

A. Correct.

Q. This is just a model?

A. Yes.

Q. But the actual plate and screws, are those the type that you used in this procedure?

A. Yes.

Q. Now, you described two portions of the procedure. And if I may, you said you took out, you took out the disc?

A. Yes.

Q. If you took out the disc and -- to decompress the disc which was pushing on the nerve, and you left it like that, you just took out the disc, what would happen?

A. You'd have collapse of the bones on top of each other and the bones, because the disc really holds the bones together. You would always have the bones sliding around on top of each other, so you'd have collapse and abnormal motion.

Q. And if you had that and it affected the nerve roots or even the spinal cord, what could happen?

A. You'd have more nerve damage. In other words, those areas you just cleared out would become progressively damaged.

Q. So once you do the decompression where you remove the disc, you said you put in another -- what do you put in to occupy that space?

A. So, two things. One, we're taking bone we've removed and we're grinding it up and we're mixing it with these preserved bone cells which are known as allograft, which makes kind of a bony glue. So we need to get that into the area that we've decompressed or taken apart.

And then we also insert -- we slide this thing called the mechanical device or "cage" in there in order to kind of

press-fit that region in order to prevent those bones from sliding around or moving. And it also holds the bone graft in place.

Q. So once the cage with the bone that was grinded, the person's own bone -- correct?

A. Yes.

Q. -- was grinded up and put in this to help through healing. And then you have this cage. You said the next portion was to fuse or fix the vertebrae?

A. Correct. So we fix the vertebrae together with a plate. So that plate spans the three bones that are involved, and they're fixed to each bone with a screw. So that basically locks that entire area together to stabilize it so that the fusion can eventually occur. Fusion actually means the entire process of having all of the bones themselves grow together to be one area of bone.

Q. Does it matter the size of the cage or the height differential between the bones?

A. So you typically want to be able to make it so that there's no more pressure on the roots and the spinal cord. So when you're doing that, you're holding those bones apart. You're passing tools into the areas to make sure that there's no pressure. And then you're sizing the cage so that you could slide it into the area so that it fits properly.

Q. And once these vertebrae, bones, are screwed in with a

plate to hold it in position, how does that affect the movement or ability of motion at that level?

A. So if you look at, for example, the spinal model, you can see that there's motion which is going to occur above the area that's fused, and to and a certain extent, to a little bit below the area that's fused. It's as though if you took a garden hose and you held onto it very tightly with your fist, the area that you're holding with your fist is not going to be flexible or move, but the area above the hose and the area below the hose will still be flexible and move.

Q. Is this a temporary procedure that you performed?

A. So that's a permanent procedure to make sure that that area no longer continues to cause any damage.

Q. Doctor, after the surgery was performed, did you do any diagnostic testing?

A. So afterwards, he had had some diagnostic X-rays and MRIs done.

Q. And I have in evidence Plaintiff's Exhibit 20A, a disc, which if I could put it up on the screen. And I'd like you to tell us what we're looking at.

MR. THOMAS: And once again, with the Court's permission, if the doctor needs to step down.

THE COURT: You may do so at the appropriate time, Doctor.

MR. THOMAS: Judge, is there a remote control?

Can you put it on HDMI 1? You know what it is, Judge? Sometimes the signal is degraded because of the length of the cable. So let me do it this way.

Q. Sorry, Doctor. This might be the best way to do this. What is this? What is this that we're looking at here?

A. So this particular exam is a magnetic resonance imaging scan of the cervical spine.

Q. And just tell us how the MRI works.

A. Sure. So the way an MRI works and how it's different from a regular X-ray is, if you think about an X-ray as being a very bright flashlight that you can look through body parts with, an MRI is a very powerful magnet. Why a magnet? Because you're mostly made up out of water and your water molecules can be magnetized. And depending upon the way the water molecule is magnetized and the amount of water that exists in your specific internal structures, that will generate a black-and-white image that you can then reconstruct to have an MRI.

In fact, the math that was involved in that actually won the Noble Prize. The man who invented the MRI was actually from Downstate Medical Center. His name was Damadian. He was researching cancer and looking at the way cancer tumors were magnetized and he came up with this idea for MRIs. The math involved to convert the way a water signal is converted to an image was extremely complicated, and as I say, actually won the Noble Prize.

So an MRI is basically a body placed into a very powerful magnet that magnetizes the water molecules in your body, and depending upon how those molecules are magnetized, they signal -- and we call them "signals" -- a signal is generated that is translated to a black-and-white image.

Q. And what's the difference between a sagittal image and an axial image?

A. Sagittal. Any time you see "sagittal, think of the "S" in sagittal as "side view." Sagittal is side view.

Axial means you're looking at something top, down or bottom, up. So if you're looking at a two-dimensional projection, you don't know if it's bottom, up or top, down, but either way, it's axial. Side view is sagittal.

Q. I have up right now a sagittal image, sagittal T1 image. And again, these are images that are taken of Mr. McGill after the surgery, correct?

A. Yes.

MR. SARDINO: Judge, if we could just get a date of what is being shown?

MR. THOMAS: Sure. This is December 5th, 2023. Your Honor, if the witness can step down to the screen, maybe that might be a little better.

THE COURT: You can do so, Doctor.

THE WITNESS: Thank you.

Q. I'm going to scroll through -- there are 15 slices on this film. So I'm just going to scroll through first the whole thing and then you tell me when to stop when it's something that you want to point out to the jury.

First, let me go through the whole series. Okay. That's the 15 slices. I'm going to go back to one.

THE COURT: One moment, Counselor. Mr. Sardino, can you see from where you're at?

MR. SARDINO: No. I'll move over, Judge.

THE COURT: Okay.

MR. SARDINO: Thank you.

THE COURT: Okay.

Q. Slide 2, slide 3, slide 3, slide 5, 6 --

A. I would stop right there, if you could.

Q. Just nice and loud, please.

A. Yeah. And if you may, stop there.

Q. I stopped.

A. Okay. Thank you.

MR. SARDINO: Objection, Judge. I don't know if there's a question pending.

THE COURT: No.

MR. THOMAS: He asked me to stop. I stopped with this --

THE COURT: Okay. So what's the question?

Q. Please show us what we're looking at in image 6 of 15.

MR. SARDINO: Objection. Leading.

THE COURT: Sustained as to form.

Q. What are we looking at here, Doctor?

MR. SARDINO: Same objection.

THE COURT: Overruled. You can answer.

A. So this is a side-view image of a post-operative, after-surgery, MRI of Mr. McGill. And at the top of the image we're looking at the base of the skull, the brain. We're looking at this gray line here, which is the spinal canal containing the spinal cord area.

To the left of this image, we're looking at these bright squares, which are the vertebral bodies. And you can see that in the middle of this image, there are certain dark areas.

The primary dark area itself is the area where the plate is. So there's no magnetic signal coming from the plate because it's a piece of titanium. The vertebral body themselves, you can see how they do light up here. They light up because they contain bone.

So the C5 vertebral body is in its normal position, containing its normal bone.

You can see that the C6 vertebral body is missing portions of its vertebral body because it's part of the area that has been taken away or decompressed.

And then you can see the C7 vertebral body, which is also maintaining its normal alignment with a good decompression of the area where the spinal cord and the nerve roots are.

Plaintiff - Merola - Direct/Mr. Thomas Page 499

If you can advance one more slide, please.
Q. Sure.
A. In this area here, you can also see an area where, in the middle of the area, C5-C6 here, and C7, you can see that there's a bright signal kind of in the middle portion of this vertebral body. That bright signal is an area where there is still bony healing occurring where bone graft has been packed inside that vertebral body zone, which goes along with the area that we're trying to fuse. So we can assess this zone as fusing and being stable with taking a good look at the spinal cord, a good decompression of the spinal cord and the nerve roots.
Q. The T2 image, which is the next image, also 15 slides, shows the same thing?
A. Yes. Correct. And if you could back up a bit.
Q. Sure.
A. And one more, back up. One more. Right there. Stop. Great.
A little bit different contrast. MRIs have different gradations to them, if you will, depending upon how the magnet is working. And you can see that here we have a little more contrast. In other words, we can see a little bit clearer the images between gray and black and white.
And so here, we can see the spinal cord region quite nicely. We can see the vertebral body themselves quite nicely. And once again, we can see the areas where the bone graft is

Plaintiff - Merola - Direct/Mr. Thomas Page 500

healing in between all these bones, particularly on top of and on the bottom of the middle bone, and on top of the bottom bone and on the bottom of the top bone. So we know that the areas where we bone-grafted are incorporating themselves into that fusion process.
Q. I want you to look at another view here. Sorry. That's not the image. I apologize. I showed you the MRIs. I want to show you the X-ray, if we can. This is not coming out good.
MR. THOMAS: You know what, maybe we should use the computer in front of the jury.
MR. SARDINO: Judge, may I stand on the other side?
THE COURT: You may, Counsel.
A. So this is a side view, post-operative X-ray showing the screws and the plate fixed into the area where the bones are being held together.
MR. SARDINO: Can we get a date for that X-ray?
MR. THOMAS: 9/15.
THE WITNESS: 9/15/21.
Q. And again, the difference between the X-ray and the MRI?
A. So the MRI will show you more of the internal structure of the bones. As we see, there are many more slices. So it's like you put your body in a boloney slicer and you got all these different slices so you can look the at different levels or

Plaintiff - Merola - Direct/Mr. Thomas Page 501

depths, depths of the vertebral bodies. And the X-ray is just kind of like a -- it's just a little bit rougher, you know. You don't get all of the internal heeling detail.
Q. And while you got that, do you know what adjacent segment syndrome is?
A. So when we talk about -- so we're talking about segments that are adjacent to or touching a segment that has been fused. So if we go back to the garden hose example.
Q. And again, thank you.
A. If we go back to the garden hose example. If you're holding onto that garden hose, that fused area is not moving, but you got motion coming out on top and motion going on the bottom. So these are adjacent segments.
Q. And if you could just -- I'm sorry, Doctor. Just again, looking at this image. So when the jury has it, if the jury wants to take a look at it, there appears to be little dots?
A. Yeah.
Q. This is an X-ray?
A. So this -- this is an X-ray, but it's a different image. It's not a sagittal image. This is something called a coronal image. A coronal image is a front to back image, so it's as though we were looking at the patient like this, front-on.
So you can see the plate is here in the middle. And

Plaintiff - Merola - Direct/Mr. Thomas Page 502

you can see these little tiny little ball bearings or these type little dots. They're buried inside of those implants. And so here on this image, you can see the area where the middle vertebrae is, the bottom vertebra, and the top. And you can see that the plate and screws are basically still holding everything together.
Q. Thank you. I just wanted the jury to see that image as well. You can have a seat.
MR. SARDINO: May I just inquire, was that also September 15th of '21?
MR. THOMAS: That was September 15, 2021, correct.
Q. And, Doctor, using the model, just that ligament segment that you have there, once again, maybe you can just illustrate for the jury the adjacent segment; the concerns that you have as a surgeon when you do this procedure with the level above and the level below.
A. So looking at this, if we moved the neck up and down or side to side, or rotate it from side to side, you'll notice that the area that's held together with the plate and screws remains stable and does not move. But the areas that are adjacent have the only motion that's available in the cervical spine because they're not fixed to anything.
Q. And does that make him a candidate for potential future surgery?
A. So that's something that when you do a -- when you do a

Plaintiff - Merola - Direct/Mr. Thomas Page 503

mechanical reconstruction, not unlike you would do a mechanical reconstruction in a hip or a knee, you are always now subject to mechanical wear and tear over the course of time. So that's something that we always monitor, yes.

Q. And based on the fact that Mr. McGill -- he's now in his -- I think he's 59 now. Can he anticipate potential future intervention, surgical intervention in his neck?

A. So it's always something that, you know -- so if we say 60 years old, and he's got potential for another -- I mean, if you're just eyeballing or, you know -- he's got at least another 15. Well, I'm 62, so we're looking at maybe another 20 summers if we're lucky, right?

Q. People are living longer, Doctor.

A. Yeah, you know. I don't know.

So, you know, over the course of that time, wear and tear occurs to those areas. It's definitely a concern. Far more of a concern when you're younger because you have more life to live. When you're older, decreasing stress and decreasing motion and wear and tear gives you a little bit more road to travel. But it's certainly something that we're always concerned about going ahead in the future.

Q. Doctor, do you have an opinion within a reasonable degree of medical certainty whether the accident of August 16, 2013 was a competent producing cause of his symptoms and complaints with regard to his neck?

Plaintiff - Merola - Direct/Mr. Thomas Page 504

A. Yes, I do.

Q. What is that opinion?

A. That the accident was a cause for his symptoms in his neck.

Q. Once again, the basis for that opinion?

A. So I had an opportunity to review his medical records, treatment, and care before he came to see me; my treatment of the patient; and of course my subsequent treatment with him as well and, you know, my years of being able to treat folks.

Q. And do you have an opinion within a reasonable degree of medical certainty whether any complaints and symptoms that he's described to you and is exhibited as a result of the injuries from this accident are permanent in nature?

A. Yes.

Q. Can you tell us, what is your opinion?

A. They are permanent.

Q. And once again, the basis?

A. Well, we've -- he had neurological deficits when we first saw him, which we were able to stabilize with surgery. And we have done something now that has changed the mechanics of his neck in order to maintain his stability.

Q. And just so we're clear, will these screws and plates ever come out?

A. Typically, we like to leave them in there without taking them out if we don't have to. So more likely than not, those will always be there.

Q. And do you have an opinion within a reasonable degree of medical certainty whether Mr. McGill will continue to experience some level of pain, discomfort, restriction, and limitation as a result of the injuries from this accident, even though you've performed this surgical procedure on his neck?

A. So based on my treatment of the patient and my post-operative follow-ups with him, once again, he was stabilized. And in that sense, it was helpful, but it's not something that's relieved all of his complaints or symptoms.

MR. THOMAS: Doctor, thank you very much. I have no further questions for you. Counsel may have some questions for you.

THE COURT: Okay. Mr. Sardino.

(Whereupon, Senior Court Reporter Anne Brown was relieved by Senior Court Reporter Karen Mangano.)

Dr. Merola - by Plaintiff - Cross/Mr. Sardino Page 506

CROSS-EXAMINATION

BY MR. SARDINO:

Q Good afternoon, Doctor.

A Good afternoon.

Q The MRI and the x-rays that you just reviewed, you don't keep those in your office; do you?

A Correct.

Q Where are they kept?

A They are kept on the server for the location in which they were done.

Q And did you bring them with you today at the request of plaintiff's attorney?

A No, I did not.

Q Did you bring them with you today?

A No.

Q Doctor, when you dictate your notes, do you do that immediately after seeing the patient?

A Yes.

Q Always?

A Yes.

Q How about your operative reports? Do you do that immediately after the procedure is finished?

A Yes.

Q Always?

A Yes.

Q Doctor, your opinion is that Mr. McGill is able to do some work; correct?
A Yes.
Q What kind of work can Mr. McGill do?
A I think he is able to do work in a sedentary light capacity.
Q In your -- when did you last see Mr. McGill?
A My last visit was on December 28 of 2023.
Q Okay. Do you have plans to see him again in the future?
A Yeah. Typically what I tell patients is once they are at least a year or more post-op, I'm happy to see them every several years or so or earlier if they are having problems.
Q Do you know whether he has an appointment to see you in the future?
A I do not know.
Q Doctor, with regard to Mr. McGill's ability to work, you indicate in your note of December 28 of 2023 that he can only occasionally sit.
Do you see that?
A Yes.
Q Why is that?
A So this particular note is looking at the -- what we call the New York State Worker's Compensation guidelines for non-scheduled permanency, so it's a specific question asked

based on a -- essentially a guideline book, and then they have definitions for what each one of those means.
"Occasionally" means up to one third of the day. So if you look at a full eight-hour day, "occasionally" would mean that he can sit pretty much continuously up to one third of the day. So he should be able to alternate sitting and standing if he is in an eight-hour day.
Q So it's an eight-hour workday.
A That's correct, yes.
Q And what about the cervical spine that makes it so that he can only sit up to a third of a eight-hour day?
A Yeah. The only consideration for that is because you have to maintain your head and neck in a given position.
For example, if you're evaluating sitting for a working patient, you would be talking about some kind of either supervisory or sedentary type of activity. Perhaps working in a computer screen or something like that. So they should have the ability to be able to more than two thirds of the day get up and about, so they can essentially relieve any pain or stiffness they have in their head or neck.
Q But the physical act of sitting, there is no restriction because of the cervical spine.
A Only in terms of the pain and stiffness so that they can work out and move their head and neck around from time to time and just to move their spine and extremities.

Q And that's the same with standing?
A Correct.
Q Same with walking?
A Yes.
Q You find that he could never reach overhead.
A So "never" is one of those interesting definitions as well. So that would mean less than one third of the day. So "never" in this scenario wouldn't mean he can't ever do that, but it would mean on a repetitive basis up to one third of the day should be avoided.
Q And he can drive a vehicle?
A Yes.
Q Can he kneel?
A Sure.
Q Bend?
A Yes.
Q Stoop?
A Yes.
Q Squat?
A Yes.
Q In your experience, Doctor, do patients who work have better outcomes than patients that don't work?
MR. THOMAS: Objection.
THE COURT: Sustained.
Q Doctor, did you make any recommendations to Mr. McGill

of whether he should go back to work?
A We did -- I believe I put that in my note where we discussed. Yeah, it says have you discussed patient's returning to work and your limitations with patient. I put down yes.
Q Okay; and the patient -- Mr. McGill indicated to you that he wanted to return to work?
A I do not completely recall what he said, but I don't remember him saying that he didn't want to.
Q And Doctor, you also indicated in your note that the patient would not benefit or the benefit from vocational rehabilitation was not applicable.
What did you mean by that?
A I'm not a vocational specialist, so I wouldn't be able to assess his educational level or his vocational potential. I just commented on his musculoskeletal condition.
Q Doctor, when you see a patient for the first time, patient fills out an intake sheet; correct?
A Yes.
Q Can you point out that to us in your records, please?
A I don't see a copy of it in here.
Q Did you bring records with you independent of that exhibit that you are look at?
A No. I was told everything was in evidence.
Q But there is an intake sheet somewhere?
A Yeah, there is typically an intake sheet. Sometimes --

you know, we have been trying to go paperless, so sometimes those sheets are available, sometimes they get shredded, and I went through a couple of different medical records of people. So I don't see it in this particular record.

Q How was Mr. McGill referred to you?

A So if I look at my first note, I don't have a referral source listed.

Q Wouldn't that be on the intake sheet?

A It can be, yes.

Q There is a line that says "How were you referred to my office;" isn't there?

A I don't think I have "How were you referred." I have a line that says "Who are you accompanied with" and then a line for "Other contact information."

I don't -- I don't -- I mean, I have to look at my intake sheet again, but I don't specifically recall that question.

Q Was he referred to you by plaintiff's attorney?

A I do not know.

Q Now, Doctor, you were shown some MRIs earlier. I think in your report, you indicated that there were normal age-related changes in the cervical spine that you observed on the MRI; is that correct?

A Yes.

Q Which MRI was that?

A So that would be the first MRI that he had come in with when I saw him initially, and I have copies of -- let's see -- so there was an MRI of the cervical spine from April 7, 2015, and there was also a July 7, 2020 MRI as well.

Q What were those normal age-related changes in the cervical spine that you observed on the MRI?

A So typical normal age-related changes refer to loss of disc signal.

Once again, signal being hydration and/or water contents to the bones, and in some cases it could also refer to what looked like -- there are joints within the cervical spine called the facet joints which can also undergo some changes where they either develop a little bit of swelling or a little bit of a structural abnormality we call spondylosis.

Q Hypertrophy indicative of degeneration?

A Sure.

Q Is arthropathy indicative of degeneration?

A Yes. Specifically referring to a joint; correct.

Q Is spurring indicative of degeneration?

A Yes.

Q Is disc osteophyte complex indicative of degeneration?

A Yes.

Q All of those were present on the MRI of April 7, 2015, and July 7 of 2020; correct?

A Yes.

Q What was the acute part of the injury that Mr. McGill sustained on August 16 of 2013?

A I'm not sure I understand that question.

Q Well, there is degeneration in the spine; right?

A Yes.

Q That occurs over a period of time?

A Correct.

Q Okay. And then there's acute injury; isn't there?

A Yeah. "Acute" means sudden onset.

Q Sure. So what was the acute injury that Mr. McGill sustained on August 16 of 2013?

A It would be symptoms.

Q What else?

A Well, I wasn't -- I wasn't there when he sustained the actual acute injury. So other than the fact that he was symptomatic with respect to his neck, I'm not sure I understand the question.

Q There were disc herniations?

A Yes.

Q Were those present in his spine before August 16 of 2013?

A There is no way to know because I don't think we have an MRI prior to the accident.

Q Were they present on the MRI of April 7 of 2015?

A So there were -- yes, there were discs that were

herniated on the April 7, 2015 MRI, yes.

Q If a herniation occurred acutely, you would expect that person to be in a significant amount of pain; wouldn't you?

A It would depend on the size of the herniation.

Q How about the herniations in this case?

A These herniations themselves, I mean, at this particular point in time were hard to tell whether or not they were acute or not because I don't see any evidence of structures or dislocations or anything like that

Q Right. If they were acute, you would expect to see other indications on MRIs or x-rays at around the time of the accident that would show things like swelling.

A There can sometimes be, yes, depending -- I'm sorry.

Q I interrupted you, Doctor.

A Yeah. So it depends on the amount of disc disruption that occurs.

Q How about in this case?

A In terms of the -- I'm sorry. In terms of the disc disruption?

Q Yes.

A I didn't see any increase swelling or any of those issues on the MRI, no.

Q Wouldn't you expect to see that with the herniations that were incurred as is alleged by the plaintiff in this case?

MR. THOMAS: Objection, your Honor.

THE COURT: Overruled. You can answer.
A So you know it's the MRI itself doesn't have a time stamp on it, so we don't know when those herniations occurred. The only thing we can say for sure that he did become symptomatic after the accident happened.
Q And are you aware that this did not become symptomatic until some time in November of 2013?
MR. THOMAS: Objection.
THE COURT: Overruled.
A Now, I don't have the chart memorized, but I do recall having looked at some medical records that had indicated some neurological numbness and tingling, if I'm not mistaken that he presented with to his treating physicians before he had seen me.
Q What about the pain? Did you see anything where he was complaining of neck pain before November of 2013?
A I know he was having a significant amount of shoulder pain and there was some neurological complaints and symptoms; but once again, I don't have the chart completely memorized, so I don't recall when neck pain first arose.
Q Well, can you look at it?
A I don't have the Scilaris record or I believe he was also being treated by a pain management doctor and a rehab doctor, so I don't see those documents.
Q What documents did you review at or near the time of your first visit with Mr. McGill?

A So when I first saw him, I was -- let's see what I saw document-wise.
I went over the history with him. So he had given me his entire history in terms of his neck problems and then I did indicate that medical records were reviewed.
One thing that I pointed out from the medical records were the cervical epidural steroid injections because they pointed to him having been symptomatic with respect to his neck and having taken the step, that to me is significant in terms of treating his radiculopathy. So that's one of the specific ones that I pointed out.
I would have seen his conservative treatment records and those other records, but as I say, I don't have them memorialized, so I can't off the top of my head recall what those all said other than that the gestalt was that his neck had been symptomatic for some time.
Q You didn't bring your file with you today?
A No, I did not.
MR. SARDINO: Judge, if I could have this marked for identification as Defense Exhibit A.
THE COURT: Okay.
(Whereupon, the aforementioned document was marked as Defendant's Exhibit A for identification as of this date by the Reporter.)
THE COURT: Okay. The witness is being shown what

was marked as Defense Exhibit A.
Q Doctor, have you seen Exhibit A before today?
A Yes.
Q Did you bring any of the documents -- well, tell us what that is first.
A It's a request for documents to my office.
Q Okay. And did you bring documents with you in response to that subpoena today?
A No. I was told that they would be here.
Q Who were you told that by?
A Trial counsel.
Q Who is that?
A Mr. Thomas.
Q Were you told that all documents and communications including emails and attachments concerning the medical treatment that you completed on the plaintiff would be here in court today?
MR. THOMAS: Objection. Reading from a document not in evidence.
THE COURT: The witness may not read from the document not yet admitted in evidence; however, counsel can ask the question.
MR. THOMAS: Your Honor, I believe he was reading from a document once again that's not in evidence.
THE COURT: Counsel, I'll sustain the objection.

You can ask questions.
SARDINO: Judge, at this time I will offer Exhibit A into evidence.
MR. THOMAS: Your Honor, may we approach?
THE COURT: Okay.
(Whereupon, an off-the-record discussion was held.)
MR. SARDINO: Judge I'd like to have this marked as Defense Exhibit B.
THE COURT: Okay.
(Whereupon, the aforementioned document was marked as Defendant's Exhibit B for identification as of this date by the Reporter.)
Q Doctor, Exhibit 20 are your office records?
A Yes.
Q And we have already talked about the intake sheet. That's not present in Exhibit 20; correct?
A Yes. Correct.
Q That would be part of your office records?
A As I say, typically unless it was shredded and scanned or just dictated into the report. It depends.
Q Well, if something was scanned, you would be able to print it out.
A Yeah. Yeah, you're right. Correct.
Q Is there any correspondence that you have in

Exhibit 20?
A No.
Q Do you generally keep correspondence on patient matters?
A Not typically, no.
Q Well, Doctor, if you have to refer a patient somewhere or you have to request another diagnostic imaging or something like that, wouldn't there be some written record of that?
A So two different things.
If I was going to refer the patient to someone, I typically just give the patient a prescription pad and then say call this particular doctor or give them the number, so I put that on a little piece of paper for them. And then if I was going to request, for example -- a test, did you say or something like that?
Q Yes.
A I would just write it on a script pad and then hand it to the patient.
Q All right. Wouldn't you keep a copy of that?
A It depends on who my secretary is at the front desk.
Q So there may be other records such as we have just talked about that are at your office that aren't present in Exhibit 20.
MR. THOMAS: Objection.
THE COURT: I am going to sustain it.

Q You wrote scripts for Mr. McGill to have diagnostic tests elsewhere?
A I had sent him for diagnostics, yes.
Q You would expect there to be a copy of that in your file?
A Like I said, not necessarily, no.
Q Depending upon who was at your office?
A Yes.
Q You would want that as part of your file; right?
MR. THOMAS: Objection, your Honor. He's answered the question.
THE COURT: Sustained.
Q If a doctor referred a patient to you, you would want that referral in your records?
MR. THOMAS: Same objection.
THE COURT: Sustained.
Q Are your billing records contained in Exhibit 20?
A No.
Q Do you keep billing records?
MR. THOMAS: Objection, your Honor. Beyond the scope.
THE COURT: Overruled.
A So billing is outsourced, so I have an outsource company that does the billing.
Q Doctor, I'm going to show you part of -- well, I would

offer Defendant's Exhibit B into evidence, Judge.
THE COURT: Any objection?
MR. THOMAS: Judge, he may show it to the witness.
THE COURT: I don't know that the witness hasn't been referred to -- referring to his own file. So subject to a proper foundation.
Q Doctor, in front of you, you have just been handed what's been marked for identification as Defendant's Exhibit B. Do you recognize that?
A This looks like my office notes.
Q And there is a subpoena contained within there; correct?
A Yes.
Q And were those records produced pursuant to the subpoena that's contained in there?
A As far as I know, yes.
Q Okay.
MR. SARDINO: Judge, I'd offer Exhibit B.
MR. THOMAS: Your Honor, may we approach?
THE COURT: Yes.
(Whereupon, an off-the-record discussion was held.)
THE COURT: Okay. After a bench conference, the Court is not receiving the full content of Defense Exhibit B in evidence at this time, but Counsel, based on my

instruction, you may question the witness accordingly.
Q Did you bring your billing records with you, Doctor, in response to that subpoena?
A No.
Q And you were directed not to do that by the plaintiff's attorney?
MR. THOMAS: Objection. Move to strike, your Honor. Totally improper.
THE COURT: I'm going to sustain the objection. I'll going to strike that.
Q Why didn't you bring your billing records?
A They are outsourced.
Q To who?
A To the billing company.
Q Who is the billing company?
A I have it listed on this piece of paper right here, and it gives their office telephone number and contact information.
Q Do you ever go back and look at your billing records?
A No, I typically don't.
Q You have perhaps telephone notes in your file; correct?
A No, not typically.
Q Any other things that aren't in Exhibit 20 you have in front of you that you would expect to see?
MR. THOMAS: Objection to the form of the question, Judge.

THE COURT: Sustained as to form.
Q So Doctor, you still have Exhibit 20 now?
A Yes.
MR. THOMAS: Judge, can we take away Defendant's B so there is no confusion?
THE COURT: All right.
(Continued on the following page.)

CONTINUED CROSS-EXAMINATION
BY MR. SARDINO:
Q. Under oath, Doctor, that's not your full file --
MR. THOMAS: Objection, Your Honor.
Q. -- is it, Doctor?
MR. THOMAS: Objection. Move to strike. Your Honor, this is totally inappropriate and improper. I'd ask for a curative instruction to the jury. This is badgering this witness.
THE COURT: I'm going to sustain the objection, Counsel. Within the parameters of my ruling you can ask questions, but the question that you just asked is an inappropriate question and I'm giving the jury the instruction to disregard it.
Q. Doctor, is Exhibit 20 a full copy of your file?
A. To the best of my knowledge, yes.
Q. But it's not the best of your knowledge because you've already told us that the intake sheet isn't in there, correct?
MR. THOMAS: Objection, Your Honor. Argumentative.
THE COURT: Sustained as to form.
Q. Doctor, the intake sheet is part of the patient's record, right?
A. As I had said previously, there is an intake sheet, which I sometimes dictate into the actual initial visit. And in some cases it's been scanned and it's dependent on who has been

in the office at any given time, who's handling the paperwork.
Q. Did you look for it for Mr. McGill?
A. I don't specifically put all the records together myself so I wouldn't be the person actually looking for it.
Q. Doctor, you are responsible for your office, aren't you?
A. I don't know if I -- I mean, I'm not sure I understand that question.
Q. Sure. Complying with a subpoena that ultimately falls to you in your responsibility when you're coming into court to testify, isn't it?
A. And to the best of my knowledge, I have been compliant.
Q. What other records did you have, Doctor, when you first saw Mr. McGill?
A. Well I -- I referenced the cervical epidural steroid injections that he had.
Q. And those are contained in Exhibit 20?
A. Let's see.
No, I don't see those.
Q. Well, where would those be, Doctor?
A. If, if he had brought them in with him and then I had read them, I would have given those back to him. And then, as I say, they may or may not have been scanned into the chart.
Q. So would it be fair to say then, Doctor, as you sit here today, five years later, you're not sure what documents you

reviewed --
MR. THOMAS: Objection.
Q. -- when you first saw Mr. McGill?
MR. THOMAS: Objection. That's not what he said.
MR. SARDINO: Judge, it's cross-examination.
THE COURT: Overruled. I'll allow it.
A. So as I say, I did dictate a section that said I looked at records. And in the one record that I pulled out that was of significance to me was the cervical epidural steroid injections.
Q. And that's in your file, Exhibit 20?
A. I dictated that into the initial visit of the patient, yes.
Q. And then it was so significant to you, you gave it back or you trashed it or did something else with it?
A. Well, I put it into his note.
Q. Did you review the records of Dr. Kyriakides at or before the time you first saw Mr. McGill?
A. I don't recall.
Q. What about Dr. Scilaris' records?
A. I do not remember.
Q. Do you remember any records other than the cervical epidural steroid injections records?
A. Not specifically, no.
Q. Were you aware, Doctor, that Dr. Kyriakides saw Mr. McGill a short period of time after the accident?

A. I know that Dr. Kyriakides was treating him shortly after the accident, yes.
Q. Did you ever talk to Dr. Kyriakides about his treatment of Mr. McGill?
A. No, did I not.
Q. Did you ever talk to Dr. Kyriakides about his testimony in this case?
A. No.
Q. What did you do, Doctor, in preparation for your testimony here today?
A. Reviewed my medical chart for the patient.
Q. That would be Exhibit 20?
A. Yes.
Q. Are there other things in your medical chart that you reviewed in preparation for your testimony that are not contained in Exhibit 20?
A. No.
Q. Did you speak with plaintiff's counsel about your testimony?
A. Yes.
MR. THOMAS: Objection to what he spoke to me about, Your Honor.
THE COURT: Sustained.
Q. Outside of plaintiff's counsel, did you speak to anyone else about your testimony here today?

A. No.
Q. Were you aware that Dr. Kyriakides testified in this trial that at the time he saw Mr. McGill on August 22nd, '23, just nine days after this accident, that his cervical spine was stable?
A. I am not aware of Dr. Kyriakides' testimony, no.
Q. Now, Doctor, the use of -- do you read the MRI reports? Do you read the MRI films themselves?
A. Yes.
Q. Do you also read MRI reports?
A. Yes.
Q. And generally, the MRI films are initially read by a radiologist, correct?
A. Yes.
Q. Okay. Can you explain to the jury what a radiologist is?
A. A radiologist is a person who basically reads and interprets films and then offers a dictation or a description of what it is that they saw.
Q. And that's something that's done in the regular and ordinary course of your business as an orthopedic surgeon?
A. I'm --
Q. It's not unusual that you send someone out for radiology?
A. Correct.

Q. And with regard -- did you read the MRI reports, the reports with regard to Mr. McGill's MRI of April 7th of 2015?
A. Yes.
Q. Did you agree with those reports?
A. Yeah, I don't -- I don't see anything that I have any significant disagreements with, no.
Q. Doctor, you were shown Exhibit 18 and Exhibit 19. Do you still have those in front of you?
A. Yes, I believe so.
Q. And Exhibit 18 are Dr. Hausknecht's records?
A. Yes.
Q. Did you refer Mr. McGill to Dr. Hausknecht?
A. I believe I did.
Q. Are Dr. Hausknecht's records part of your chart?
A. The only -- I have -- I have Dr. Hausknecht's EMG testing for Mr. McGill.
Q. Can you go through Exhibit 20 and point that out for us, please.
A. Sure.
MR. SARDINO: May I approach the witness real quick?
THE COURT: You may.
THE WITNESS: It's here, towards the back of the chart.
MR. THOMAS: You want to put it up?

MR. SARDINO: Yeah, I'll put it up.
MR. THOMAS: Have to turn the TV on.
MR. SARDINO: That's okay. I'll just do it this way.
Q. Doctor, I'm going to hand these back to you to look at in just a moment, Dr. Hausknecht's records and EMG study that you referenced.
You pointed out to me at the very top, it says, "Complete care electrodiagnostic laboratory," and then at the top right, page 001/010. If you could just confirm that for us, please.
A. Yes.
Q. Okay. Any other records from Dr. Hausknecht in Exhibit 20?
A. Yes.
Q. Can you tell us what those are?
A. Sure. Yeah. There's a couple of other pages.
Q. Okay.
A. So that's -- that's -- you want me to give you the numbers or what they're in reference to? I can tell what you they are, what they -- you know.
Q. Sure. Are they in order from that page, 001/010 --
A. Yes.
Q. -- right through to 10?
A. Yes. I believe they are, yes.

Q. Other than those ten pages, are there any other records within your file of Dr. Hausknecht?
A. No.
Q. So would it be fair to say that you didn't rely on any of Dr. Hausknecht's records other than the ones contained in your file?
A. I looked at -- I mean, I looked at Dr. Hausknecht's EMG in order to, you know, help get an idea of what was happening with the patient's electrodiagnostic studies, yeah.
Q. Sure. But that's contained in Exhibit 20?
A. Correct.
Q. Other than the EMG studies, looking at Exhibit 18 in front of you -- which are Dr. Hausknecht's records, correct?
A. Yes.
Q. You didn't rely on any of Dr. Hausknecht's records other than those EMG studies that you've just referenced?
MR. THOMAS: Objection, Your Honor. Relied on what for what purpose?
THE COURT: Sustained as to form.
Q. Did you ever see them before?
A. Not that I recall, no.
Q. Okay. So you couldn't -- if you've never seen them before you couldn't rely on them for any reason, correct?
MR. THOMAS: Objection.
THE COURT: Sustained.

Q. Well, you wouldn't rely on them for your treatment of the patient, correct?
MR. THOMAS: Objection. Asked and answered, Judge.
THE COURT: Overruled.
A. So in terms of the reliability of Dr. Hausknecht's records, typically, I mean -- maybe I don't understand what the question is.
Q. Sure. I'm asking you -- you were shown Dr. Hausknecht's records, Exhibit 18, correct?
A. Yes.
Q. Other than the ten pages that are contained in Exhibit 20, you didn't see any of those other dozens of records of Dr. Hausknecht, did you?
MR. THOMAS: Objection. Asked and answered.
THE COURT: Sustained.
Q. And, Doctor, with regard to Exhibit 19, the pain management records. Are any of those records that are in Exhibit 19 contained in your records, Exhibit 20?
A. No, I don't have any of those pain management records in there, other than having seen the epidural cervical record that I referenced in the initial visit.
Q. In the cervical epidural injection that you've referenced in your initial visit, what document did you actually look at? Do you have that?
A. No, I don't.

Q. So it was -- all right.
So Exhibit 20, which are the pain management records, you didn't rely on any of those records in anything -- I'm sorry, Exhibit 19, which are the pain management records. You didn't rely on any of those records for the care and treatment that you gave Mr. You go McGill, did you?
A. Which exhibit are we talking about? I'm sorry. 18?
Q. 19.
A. 19. So these are the Universal Pain Management records.
Q. Right.
A. Those, I believe, were Dr. Purpa's (phonetic) records. He's another pain management physician. I believe the pain management physician that, if I recall correctly -- once again, I don't have the chart memorized -- but I believe it was Dr. Aiden (phonetic) who had seen him before I saw him.
Q. But, Doctor, did you see those pain management records before today?
A. These are the Dr. Purpa records. No, not that I recall.
Q. Okay. You're aware that Mr. McGill prior to his treatment with you and prior to this accident had bilateral hip replacement surgery?
MR. THOMAS: Objection, Your Honor. Beyond the scope; relevance.

THE COURT: Sustained. Sustained.
MR. THOMAS: Move to strike.
THE COURT: Sustained. I'm going to strike that.
Q. So, Doctor, if you look at your note of April 29th of 2019 --
A. Yes.
Q. -- you have an indication of past surgical history, correct?
A. Yes, I do.
Q. Can you read to the jury what the past surgical history is?
MR. THOMAS: Objection, Your Honor, once again. Relevance. This doctor wasn't asked to evaluate his hip in any way, shape, or form, Judge. And it's not in issue in this case and I don't know why counsel is going down this road, but once again I would ask the Court --
THE COURT: I'm going to sustain the objection.
MR. THOMAS: Thank you.
MR. SARDINO: Doctor -- Judge, it's a document in evidence.
THE COURT: It's in evidence, but it's not relevant.
Q. Doctor, why do you take a past surgical history of a patient?
A. To get an idea of any past surgeries that they've had

and/or if they've had any difficulties with their anesthetic or procedures.
Q. It's important as part of your care and treatment of the patient, isn't it?
A. It's helpful, yes.
MR. SARDINO: Judge, at this time I would ask the witness to read the past surgical history.
MR. THOMAS: Once again, Judge, based on the objection I just made and Your Honor's ruling, I would ask that counsel abide by Your Honor's ruling.
THE COURT: I made my ruling, Counsel.
MR. SARDINO: May I lay a further foundation, Judge?
THE COURT: I made my ruling, Counsel.
Q. Now, Doctor, you've talked a little bit about Spurling's test, Hoffman tests, inverted flexor responses. Do you recall that testimony?
A. Yes.
Q. And did you test the Spurling -- did you do the Spurling test on every visit for Mr. McGill?
A. I had -- so I did it on my initial visit. My second visit was actually a telemed so I couldn't physically examine him. I had another telemed in there, so that wasn't a physical exam.
It looks like I did it preop. First postop, I didn't

do a Spurling's because it was his first post-operative visit.
I did it second post-op visit, and I did it after that follow-up on December 28th of 2023 as well.
Q. Did the results of the Spurling test change at any time from April 29th of 2019 to December of 2023?
A. Yes.
Q. Can you tell the jury?
A. Sure. They had become negative.
Q. Meaning, what?
A. That the decompressing those segments was helpful.
Q. Okay. Was the -- prior to your surgery, how many times did you see him?
A. Let's see. Three physical exams, but five visits. So two telemeds and three in-person, not counting the day of the surgery, which there's another visit with an H&P just to preoperatively get him going.
Q. Would you expect the Spurling test results to be consistent presurgery?
MR. THOMAS: Objection to the form of the question, Judge.
THE COURT: Sustained as to form.
Q. Doctor, you indicated earlier what the Spurling test was. And how many times did you do it presurgery?
A. Let's see. Initial evaluation. Not on the telemed. July 13, 2020, so that's two. Then there was another telemed,

so no. And April 26, 2021, so that was another one. Preop. So they were positive on his preop visits.
Q. Sure. And that's one of the things you're looking for when you're doing the Spurling's maneuver or Spurling's test is to see if it's consistent over time, the results?
A. I mean, in part, sure.
Q. Doctor, if someone had a negative Spurling test and then a positive one and then a negative one, that doesn't give you much clinical correlation that there's a nerve root problem, does it?
A. Depends on the circumstances of the test.
Q. If there was a nerve root problem, you would expect the Spurling's test to be positive?
A. It's typically positive when you have nerve root compression unless you have some kind of ameliorating factor. I mean, some patients are on medications. Some patients are on patches. Some patients -- you can put patients on steroids and then it can make the Spurling's get better. So it depends on the circumstances of the test and when it's done.
Q. How about in Mr. McGill's case?
A. No. He had pretty consistent on those visits.
Q. And you would expect that across all medical records?
MR. THOMAS: Once again, objection to the form of the question, Judge.
THE COURT: Sustained as to form.

Q. That was not a surprise to you that that was consistently positive throughout your preoperative treatment of Mr. McGill?
MR. THOMAS: Same objection.
THE COURT: Sustained.
Q. So you have a positive treatment -- a positive Spurling's on April 29th of 2019, correct?
A. Correct.
Q. And when was your next positive Spurling test?
A. July 13th, 2020.
Q. Were you surprised that there was a positive Spurling test on July 13th of 2020?
MR. THOMAS: Same objection.
THE COURT: Sustained.
Q. Did you expect to find a positive Spurling sign on that second visit in July?
MR. THOMAS: Same objection.
THE COURT: Counsel, approach for a moment.
(Whereupon, a side-bar discussion was held amongst the Court and counsel.)
(Open court.)
THE COURT: Okay. Counsel, after a brief bench conference, did you want to ask the question?
MR. SARDINO: Judge, perhaps, I will take the time to better formulate my questions.

THE COURT: Very well. So, members of the jury, we're going to break at this time. But before we do, Doctor, Mr. Thomas indicated that he's going to confer with you about bringing you back for the remainder of your testimony. I understand that we're not complete with your testimony yet, so I'm going to excuse you at this time and you could wait outside and he'll speak to you afterwards. I'm just going to remind you that you are under oath in this case and not to discuss your testimony with anyone else, including anywhere where the jury may be found. Okay?

THE WITNESS: Very good.

THE COURT: Thank you very much.

MR. THOMAS: Your Honor, may we approach again briefly? I'm sorry.

THE COURT: While the witness is here?

MR. THOMAS: The witness is going to be excused.

THE COURT: All right.

(Whereupon, a side-bar discussion was held amongst the Court and counsel.)

(Open court.)

THE COURT: Members of the jury, we had previously indicated that tomorrow we would, just as we did today, resume our testimony at 2:15, because we're not complete with this witness' testimony. But I understand that based on my conversations with counsel, that we have a little bit

more before we can get to the end of it. And I also want to be considerate of the witness' schedule. Just, is it at all an imposition for any of you to come in earlier tomorrow morning? Okay. It would be?

JUROR: Yes.

THE COURT: Okay. All right. So then we'll keep the schedule as is and you'll report here tomorrow at 2:15. Okay. All right. Thank you very much.

COURT OFFICER: All rise. Jurors exiting.

(Whereupon, the jury exited the courtroom.)

THE COURT: Okay. Mr. Thomas, please be seated if you wish. Mr. Thomas, did you -- do you know of Dr. Merola's availability beyond asking about tomorrow?

MR. THOMAS: Judge, I believe Thursday afternoon he can come back.

THE COURT: Okay. Very well. Then we could do it at that time. Give me a moment.

So I know that we also had discussed on Thursday having the continuation of --

MR. THOMAS: Mr. Thomann.

THE COURT: -- Mr. Thomann's testimony. Mr. Thomann's available for Thursday as well?

MR. SARDINO: 9:30.

THE COURT: 9:30 on Thursday. Okay. Okay. So then we would expect to continue Mr. Thomann's testimony and

Dr. Merola's testimony on Thursday in the morning and afternoon, respectively.

And then for tomorrow, Mr. Thomas, who do you anticipate?

MR. THOMAS: Dr. Barry Root, R-O-O-T.

THE COURT: Okay. Okay. Very well. Anything else to discuss before we break for the day?

MR. THOMAS: Not on the record, Judge.

THE COURT: Okay. All right. Thank you very much, everyone. So we will reconvene tomorrow for Dr. Root's testimony at 2:15.

MR. THOMAS: Thank you.

MR. SARDINO: Thank you, Your Honor.

(Whereupon, the trial was adjourned to Wednesday, September 25, 2024, at 2:15 p.m.)

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$650 (1)
475:6

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***s (1)**
541:16

A

abide (2)
465:5;535:10
ability (4)
484:10;494:2;
507:17;508:18
able (12)
466:15;471:15;
481:22;493:19;504:9,
19;507:1,5;508:6,18;
510:13;518:22
abnormal (4)
485:20;486:1,3;
492:11
abnormalities (1)
483:16
abnormality (1)
512:14
above (3)
494:4,9;502:16
absorption (1)
481:10
accident (12)
477:17;503:23;
504:3,13;505:5;
513:23;514:12;515:5;
526:25;527:2;528:4;
533:22
accompanied (1)
511:13
accordingly (2)
465:3;522:1
across (1)
537:22
act (1)
508:21
action (1)
464:25
actions (4)
468:17,18,21,23
activities (2)
479:19;491:5
activity (1)
508:16
actual (5)
482:8;489:13;
491:24;513:15;524:24
actually (10)
479:8;484:16;
488:20;493:14;495:18,
19,24;525:4;532:23;
535:22
acute (7)
513:1,8,9,10,15;
514:8,10
acutely (1)
514:2
additional (1)
464:25
Additionally (2)
481:14;484:13
address (4)
465:12;473:5;
478:12,15
adjacent (5)
501:4,7,13;502:14,
20
adjourned (1)
541:14
adjust (1)
473:13
admission (1)
464:14
admitted (1)
517:21
advance (1)
499:1
affect (3)
467:25;468:1;494:1
affected (1)
492:12
aforementioned (3)
464:4;516:22;518:11
Africa (1)
471:24
afternoon (9)
472:16,24;474:1,2;
475:3;506:3,4;540:14;
541:2
after-surgery (1)
498:6
afterwards (2)
494:16;539:7
again (32)
465:2,5,20;466:2,24;
468:8,12,25;469:18;
479:10;488:5;494:21;
496:15;499:25;500:20;
501:9,15;502:13;
504:5,17;505:8;507:9;
511:16;512:9;515:18;
517:24;533:14;534:12,
16;535:8;537:23;
539:13
against (1)
468:18
against- (1)
463:4.5
age-related (3)
511:22;512:5,7
agree (1)
529:4
ahead (1)
503:21
Aiden (1)
533:16
aiding (1)
466:11
alignment (1)
498:24
allegations (2)
468:11,13
alleged (1)
514:24
allograft (1)
492:21
allow (4)
470:24,24;477:2;
526:6
allowed (3)
465:4;467:24;470:20
almost (2)
477:8;489:19
alone (1)
464:23
along (4)
484:21;489:8;490:9;
499:8
alternate (1)
508:6
alternatively (1)
470:24
alternatives (1)
479:11
although (1)
471:8
always (8)
492:10;503:2,4,8,20;
505:1;506:19,24
ameliorating (1)
537:15
AMERICAN (1)
463:5.5
among (1)
476:18
amongst (2)
538:19;539:18
amount (5)
483:11;495:15;
514:3,15;515:16
anatomy (2)
479:25;483:25
and/or (3)
483:18;512:9;535:1
Andrew (3)
472:22,22;473:6
anesthesia (1)
488:3
anesthetic (2)
488:10;535:1
Anne (2)
463:24;505:15
answered (3)
520:10;532:3,14
anticipate (2)
503:6;541:4
anymore (1)
477:23
apart (4)
490:14;491:6;
492:23;493:21
apologize (1)
500:7
Apparently (1)
466:6
appearance (1)
465:16
appears (1)
501:16
applicable (1)
510:11
application (1)
469:3
appointment (1)
507:14
approach (6)
489:7;518:4;521:19;
529:20;538:18;539:13
approaching (1)
488:24
appropriate (2)
480:12;494:23
April (10)
477:7;512:3,23;
513:24;514:1;529:2;
534:4;536:5;537:1;
538:7
area (36)
482:10;483:21,22;
484:19;485:23;489:12,
23;490:4,9,12,18;
491:6;492:22;493:13,
16,24;494:5,6,8,9,9,13;
498:9,13,13,21,25;
499:3,3,4,6,8;500:15;
501:11;502:3,19
areas (15)
481:24;482:23,24;
483:5,10;484:18;
485:9;490:23;492:15;
493:22;498:12;499:25;
500:3;502:20;503:16
argue (1)
469:11
argued (1)
469:12
Argumentative (1)
524:19
arguments (1)
469:12
arms (5)
481:20,25;484:15,
21,24
arose (1)
515:19
around (6)
481:11,21;492:10;
493:2;508:24;514:11
ART (1)
463:5.5
arthropathy (1)
512:17
aspect (1)
474:13
assess (2)
499:9;510:14
assume (1)
488:3
assure (1)
470:9
attached (2)
488:21;489:19
attachments (1)
517:15
attempt (1)
468:9
attention (2)
465:13;471:6
Attorney (12)
463:14,17.5;465:17;
466:1,6,9,11,12;470:7;
506:12;511:18;522:6
audience (1)
467:8
August (6)
477:14;503:23;
513:2,11,20;528:3
availability (3)
471:9,10;540:13
available (5)
471:13;472:5;
502:21;511:2;540:22
avoided (1)
509:10
aware (5)
515:6;526:24;528:2,
6;533:21
away (7)
475:1,6;480:14;
483:20;490:18;498:22;
523:4
axial (3)
496:7,10,13

B

back (23)
465:3;469:20;
474:14;479:9;480:17,
19;481:2,4;482:10;
497:5;499:14,16;
501:8,10,22;510:1;
522:18;525:22;526:13;
529:23;530:5;539:4;
540:15
back-dooring (1)
468:9
background (1)
475:8
backwards (1)
484:11
badgering (1)
524:8

ball (1)
502:1
Barry (1)
541:5
base (2)
480:17;498:7
based (8)
472:1;478:18;503:5;505:7;508:1;521:25;535:8;539:24
basically (6)
487:21;490:13;493:12;496:1;502:5;528:17
basis (4)
474:25;504:5,17;509:9
bearings (1)
502:1
become (4)
492:15;515:4,6;536:8
becomes (1)
478:25
began (1)
477:20
behalf (1)
473:2
belief (1)
467:9
below (3)
494:6,9;502:16
bench (2)
521:23;538:22
bend (2)
484:11;509:15
benefit (2)
510:10,10
BERGER (3)
463:19.5;470:4,13
best (5)
477:19;495:4;524:16,17;525:12
better (6)
483:18;487:5;496:22;509:22;537:18;538:25
Beyond (3)
520:20;533:24;540:13
bilateral (1)
533:22
billing (9)
520:17,19,23,24;522:2,11,14,15,18
bit (13)
474:6;475:7;480:1;494:5;499:14,18,21;501:2;503:19;512:13,14;535:15;539:25
black (2)
469:1;499:22
black-and-white (2)
495:16;496:5
blood (3)
483:4,7;485:4
blunt (1)
485:3
bodies (2)
498:11;501:1
body (19)
474:15;481:21,23;490:5,7,12;491:3;495:11;496:1,3;498:15,18,20,21,23;499:6,8,24;500:24
boloney (1)
500:24
bone (27)
474:11;481:7;482:2,25;490:3,18,19,19,20,21,22,23,25;492:19,21;493:2,4,5,12,16;498:17,19;499:7,25;500:2,2,3
bone-grafted (1)
500:4
Bones (31)
479:23;480:25;481:2,3,6,8,9,9;482:4,7;487:21;488:20,22;489:6,11;490:17,24;492:8,9,9,10;493:1,11,15,18,21,25;500:1,15,23;512:10
bony (2)
492:22;499:7
book (1)
508:1
bordered (1)
482:7
both (2)
480:22;490:11
bottom (9)
480:21;490:11;496:11,12;500:2,2,3;501:13;502:4
Boulevard (1)
463:14.5
bounded (1)
482:7
box (1)
489:2
brain (5)
481:18,22;482:8,9;498:7
break (2)
539:2;541:7
brief (2)
483:25;538:22
briefly (1)
539:14
bright (4)
495:11;498:11;499:5,6
bring (10)
465:13;471:5;506:11,14;510:21;516:17;517:4,7;522:2,11
bringing (1)
539:4
Broadway (1)
463:18
Brooklyn (1)
473:7
brought (1)
525:21
Brown (2)
463:24;505:15
buried (1)
502:2
business (2)
473:4;528:21

C

C5 (3)
489:14,24;498:18
C5-C6 (1)
499:4
C6 (5)
489:14,24,25;490:5;498:20
C7 (3)
489:25;498:23;499:4
cable (1)
495:3
cage (5)
492:25;493:4,8,17,23
cages (1)
488:22
call (16)
472:8,21;478:5;480:24;482:25;483:6,8;485:1;487:7,8;488:22;489:17;496:4;507:24;512:14;519:12
called (10)
473:1;481:5,17;485:11,17,20;490:21;492:24;501:21;512:12
came (3)
475:12;495:22;504:7
can (95)
466:14,21;467:19,19;468:10,16;469:23,24,24;470:9;471:13;472:5;474:10;475:7;476:23;479:22,24;480:3,8;481:11;483:7,9;487:3;488:12;489:3,10,19,20;490:3,8;491:4,11;493:14;494:4;495:1,11,13,17;496:21,23;497:7;498:4,11,16,20,23;499:1,3,4,9,20,21,23,24,25;500:8,17,25;501:25;502:1,3,4,8,13;503:6;504:15;507:4,18;508:5,11,19,24;509:11,13;510:19;511:9;512:12;514:13;515:1,4,20;517:21;518:1;523:4;524:11;528:15;529:17;530:16,20;534:10;536:7;537:17,18;540:1,15
canal (4)
481:17;482:6;489:17;498:8
cancer (2)
495:21,21
candidate (4)
478:19,25;479:7;502:23
capacity (1)
507:6
carbon (2)
488:21;490:17
care (6)
474:21;476:11;504:7;530:9;533:5;535:3
cartilaginous (1)
481:8
case (17)
465:25;466:9;467:4;469:1,5;470:17;484:2;489:14,24;490:4;514:5,17,24;527:7;534:15;537:20;539:9
cases (6)
466:8,10;468:7;470:25;512:10;524:25
cause (6)
483:13,22;487:22;494:13;503:24;504:3
causing (2)
482:25;483:17
cells (3)
490:21,22;492:21
Center (2)
475:12;495:20
Centre (1)
463:8
cerebrospinal (1)
483:8
certain (2)
494:5;498:12
certainly (1)
503:20
certainty (3)
503:23;504:11;505:3
cervical (23)
480:24;482:9,15,24;483:12;488:19,19;489:5;495:7;502:21;508:10,22;511:22;512:3,6,11;516:7;525:15;526:9,21;528:4;532:20,22
challenged (1)
471:1
change (1)
536:4
changed (1)
504:20
changes (4)
511:22;512:5,7,12
chart (8)
515:10,18;525:23;527:11,14;529:14,24;533:15
chemistry (1)
475:9
circumstances (2)
537:11,19
City (1)
468:7
CIVIL (1)
463:1.5
clarification (1)
467:23
clear (7)
465:22;467:16;468:15;469:5;489:23;491:19;504:22
cleared (1)
492:15
clearer (1)
499:21
clearly (1)
473:14
CLERK (4)
472:24;473:4,8,10
clinical (1)
537:9
close (1)
467:18
collapse (4)
487:22;491:1;492:8,11
College (1)
475:10
Colorado (1)
475:16
column (7)
480:16,22,24;481:7,14,17;484:18
combination (1)
487:6
coming (5)
478:14;498:14;500:8;501:12;525:10
commence (1)
472:18
commented (1)
510:15
communications (1)
517:14
COMPANY (4)
463:5.5;520:24;

522:14,15
compensated (2)
475:1,5
Compensation (1)
507:24
competent (1)
503:24
complaining (1)
515:15
complaints (5)
479:18;503:25;
504:11;505:10;515:17
complete (5)
465:21;476:11;
530:9;539:5,23
completed (2)
466:19;517:16
completely (3)
490:2;510:7;515:18
complex (2)
478:12;512:21
compliant (1)
525:12
complicated (1)
495:24
Complying (1)
525:9
compressed (1)
483:6
compressing (1)
484:19
Compression (5)
483:1,1,11;484:14;
537:15
computer (2)
500:11;508:17
concern (3)
469:18;503:16,17
concerned (1)
503:21
concerning (1)
517:15
concerns (2)
478:15;502:14
condition (2)
487:4;510:15
confer (1)
539:3
conference (2)
521:23;538:23
confirm (1)
530:10
confusion (1)
523:5
connected (1)
480:21
connection (1)
466:21
consequence (1)
477:16
conservative (5)
477:25;478:3,24;
479:17;516:12
considerate (1)
540:2
consideration (1)
508:12
consistent (3)
536:18;537:5,21
consistently (1)
538:2
CONSTRUCTION (1)
463:5.5
consultations (1)
479:4
contact (2)
511:14;522:17
contain (2)
481:15;498:17
contained (9)
520:17;521:11,15;
525:17;527:16;531:5,
10;532:11,18
containing (2)
498:9,19
contains (3)
480:25;481:2,3
content (1)
521:24
contents (1)
512:10
continuation (2)
481:18;540:19
continue (4)
487:11,22;505:3;
540:25
continued (6)
477:23;478:9;486:6;
487:1;523:7;524:1
continues (2)
470:17;494:13
continuing (1)
483:22
continuously (1)
508:5
contract (3)
485:24,25;486:2
contracts (1)
485:16
contrast (2)
499:18,21
control (1)
494:25
controlling (1)
485:19
conversations (1)
539:25
convert (1)
495:23
converted (1)
495:23
copies (1)
512:2
copy (5)
476:19;510:20;
519:19;520:4;524:15
cord (32)
481:16,23;482:5,8,
11,13;483:1,3,9,11,20,
23;485:8,12,19;486:3,
4;487:12,20;489:23,
23;490:2,8,9,14;
492:13;493:20;498:9,
25;499:10,11,23
cord-related (1)
487:9
coronal (2)
501:22,22
correctly (1)
533:14
correlation (1)
537:9
correspondence (2)
518:25;519:3
Counsel (33)
464:8;465:2,5,10,14;
467:16;468:11;469:16;
470:5,11;471:14,20;
472:8;476:3;480:5;
500:13;505:12;517:11,
21,25;521:25;524:11;
527:18,24;534:15;
535:10,11,14;538:18,
20,22;539:19,25
Counselor (1)
497:6
counsel's (1)
467:7
counting (1)
536:14
COUNTY (2)
463:1.5;475:13
couple (2)
511:3;530:17
course (19)
467:5,15,17,20;
468:14;476:21;477:25;
478:5,7,10;480:22;
483:19;484:3,22;
487:10;503:3,15;
504:8;528:21
COURT (130)
463:1,24.5;464:3,8,
11,18;465:8,12,23;
466:1,11,20,24;467:11;
468:1,13,18,21;469:3,
13,19,22;470:1,5,11,
14,24;471:2,5,8,19;
472:7,11,12,15,16,23;
473:11,22;475:18,24;
476:1,3,8,13,25;477:2,
2;480:4,4,7,10,13;
491:14,17;494:23;
496:23;497:6,9,11,20,
23;498:1,4;500:13;
505:14,15,16;509:24;
515:1,9;516:21,25;
517:17,20,25;518:5,10;
519:25;520:12,16,22;
521:2,4,20,23,24;
522:9;523:1,6;524:10,
20;525:10;526:6;
527:23;529:22;531:19,
25;532:4,15;534:1,3,
16,17,21;535:11,14;
536:21;537:25;538:5,
14,18,20,21,22;539:1,
12,15,17,19,20,21;
540:6,9,11,16,21,24;
541:6,9
Courthouse (1)
463:7.5
courtroom (11)
465:9,17;466:4,13,
16;467:5;470:4,6,8;
472:14;540:10
courts (2)
468:4,7
Court's (5)
467:15;476:23;
479:22;491:8;494:21
COZEN (1)
463:17
critical (1)
482:16
cross-examination (4)
465:15;506:1;524:1;
526:5
CSR (2)
463:23.5,24
curative (1)
524:8
cyropreserved (1)
490:21

D

daily (1)
479:19
Damadian (1)
495:20
damage (4)
483:9;487:23;
492:14;494:13
damaged (1)
492:15
dark (2)
498:12,13
date (5)
464:6;496:18;
500:17;516:24;518:13
day (12)
471:15;472:4;508:3,
4,6,7,11,18;509:7,10;
536:14;541:7
days (2)
477:18;528:4
deal (1)
474:8
deals (1)
474:13
December (5)
496:20;507:8,18;
536:3,5
decompress (3)
483:20;487:11;492:5
decompressed (3)
490:3;492:23;498:22
decompressing (1)
536:10
decompression (6)
487:19,19;490:15;
492:16;498:24;499:11
decrease (2)
485:1,9
decreasing (2)
503:18,18
Defendant (1)
463:17.5
Defendants (1)
463:6.5
Defendant's (5)
516:23;518:12;
521:1,8;523:4
defense (5)
464:23;516:20;
517:1;518:9;521:24
deficits (1)
504:18
definitely (1)
503:16
definitions (2)
508:2;509:6
degeneration (5)
512:15,17,19,21;
513:4
degraded (1)
495:2
degree (5)
475:9,11;503:23;
504:10;505:2
demonstrate (1)
479:24
denied (2)
469:17,22
Denver (1)
475:16
denying (1)
471:3
depend (1)
514:4
dependent (1)
524:25
depending (5)
495:14;496:3;
499:19;514:13;520:7
depends (5)
514:15;518:21;
519:20;537:11,18
depths (2)
501:1,1
described (2)
492:2;504:12
describing (1)
478:13

description (1)
528:18
desk (1)
519:20
detail (1)
501:3
develop (1)
512:13
device (1)
492:25
devices (1)
490:17
diagnostic (5)
482:18;494:15,16;
519:7;520:1
diagnostics (4)
478:17,18;479:8;
520:3
dictate (3)
506:16;524:24;526:7
dictated (2)
518:21;526:11
dictation (1)
528:18
difference (2)
496:6;500:20
different (10)
466:9;485:8;495:9;
499:18,18;500:25,25;
501:20;511:3;519:9
differential (1)
493:18
difficulties (1)
535:1
dire (3)
470:2,20,24
DIRECT (2)
473:24;487:1
directed (2)
473:18;522:5
directly (3)
489:10,20;490:12
disagreements (1)
529:6
disc (19)
481:8;482:5,23,25;
489:13,16,22;492:3,5,
5,7,9,17;494:18;512:8,
21;513:18;514:15,18
discomfort (1)
505:4
discs (4)
482:7;489:6,11;
513:25
discuss (5)
479:6,10;487:13;
539:9;541:7
discussed (3)
510:3,3;540:18
discussing (1)
466:18
discussion (4)
518:6;521:21;
538:19;539:18
diseases (1)
482:14
disk (1)
464:5
dislocations (1)
514:9
disregard (1)
524:14
disruption (4)
483:7,7;514:15,19
disruptions (1)
483:8
distract (1)
467:7
Distraction (1)
484:14
distribute (1)
481:11
doctor (73)
465:14,16;473:11,
13;474:1,4;476:3,16;
479:22;480:8,10,11,13;
482:18;487:3;491:9,
13,19;494:14,22,24;
495:4;496:23;498:2;
501:14;502:12;503:13,
22;505:11;506:3,16;
507:1,17;509:21,25;
510:9,16;511:20;
514:14;515:22,23;
517:2;518:14;519:6,
12;520:13,25;521:7;
522:2;523:2;524:3,5,
15,21;525:5,13,20,24;
526:24;527:9;528:7;
529:7;530:5;532:16;
533:17;534:4,13,19,23;
535:15;536:22;537:7;
539:3
document (7)
516:22;517:18,21,
24;518:11;532:23;
534:19
documents (8)
464:4;515:23,24;
517:4,6,7,14;525:25
document-wise (1)
516:2
done (9)
482:19;487:25;
490:13;491:12;494:17;
504:20;506:10;528:20;
537:19
door (4)
465:3,4;469:20,21
dots (2)
501:17;502:2
down (11)
484:15,17,21,24;
494:22;496:10,12,21;
502:17;510:4;534:15
Downstate (2)
475:12;495:20
dozens (1)
532:12
Dr (45)
464:13;465:1,10;
467:2;470:9,10,20;
471:1,2;472:22,23;
474:3;475:24;476:12,
23;477:17;526:16,19,
24;527:1,3,6;528:2,6;
529:10,12,14,15;530:6,
13;531:2,5,7,13,15;
532:5,8,13;533:12,15,
19;540:12;541:1,5,10
draw (1)
485:4
drink (1)
491:5
drive (1)
509:11
duly (1)
473:2
during (9)
465:14;467:5,17,19;
468:14;469:13;471:10;
476:21;484:2
duty (1)
477:21

E

earlier (7)
470:14;471:8,15;
507:13;511:20;536:22;
540:3
easily (1)
470:9
eat (1)
491:5
educational (2)
475:8;510:14
effort (1)
465:20
eight (1)
477:18
eight-hour (4)
508:4,7,8,11
either (3)
496:13;508:15;
512:13
elbow (1)
485:25
electrodiagnostic (2)
530:9;531:9
else (10)
466:24;467:1;
473:12;483:24;487:5;
513:13;526:14;527:25;
539:9;541:6
elsewhere (1)
520:2
emails (1)
517:15
EMG (5)
529:15;530:6;531:7,
12,16
encounter (2)
478:25;479:3
end (3)
472:3;482:10;540:1
entered (1)
472:13
entering (1)
472:12
enters (1)
489:16
entire (5)
466:19;491:7;
493:13,14;516:4
entitled (1)
467:5
epidural (7)
478:5;516:7;525:15;
526:9,22;532:20,22
ERIC (1)
463:19.5
error (1)
465:18
esophagus (1)
489:9
ESQ (3)
463:15.5,19,19.5
essentially (3)
489:1;508:1,19
evaluate (1)
534:13
evaluating (1)
508:14
evaluation (1)
536:24
even (3)
465:17;492:13;505:5
event (1)
471:13
eventually (2)
490:24;493:14
everybody (1)
491:11
everyone (2)
473:12;541:10
everyone's (1)
471:6
evidence (14)
464:6;476:15,19;
494:18;510:23;514:8;
517:19,21,24;518:3;
521:1,25;534:20,21
exam (2)
495:6;535:24
EXAMINATION (6)
473:24;478:16;
484:6,8,9;487:1
examine (1)
535:22
example (6)
486:4;494:3;501:8,
10;508:14;519:14
exams (1)
536:13
excuse (2)
465:8;539:6
excused (1)
539:16
exercise (1)
471:13
Exhibit (43)
464:13;476:10,18;
494:18;510:22;516:20,
23;517:1,2;518:2,9,12,
14,17;519:1,23;
520:17;521:1,8,18,24;
522:22;523:2;524:15;
525:17;526:10;527:12,
16;529:7,7,10,17;
530:14;531:10,12;
532:9,12,16,18,18;
533:2,4,7
exhibited (1)
504:12
exhibits (5)
464:2,5,10;476:6,9
exists (1)
495:15
exited (1)
540:10
exiting (1)
540:9
expect (10)
514:2,10,23;520:4;
522:23;536:17;537:12,
22;538:15;540:25
experience (3)
475:8;505:4;509:21
expert (2)
475:20,24
explain (1)
528:15
extent (1)
494:5
extra (1)
475:16
extremely (1)
495:24
extremities (1)
508:25
eye (1)
467:18
eyeballing (1)
503:10

F

facet (1)
512:12
fact (4)
468:3;495:18;503:5;
513:15
factor (1)
537:15

facts (1)
469:5
fair (3)
466:7;525:24;531:4
falling (1)
491:6
falls (1)
525:9
far (3)
468:10;503:16;
521:16
feel (2)
480:12;489:3
feeling (2)
489:4,5
feels (1)
466:6
feet (2)
481:21;482:1
fiber (2)
488:21;490:17
field (2)
475:20,25
fifth (1)
484:25
file (10)
516:17;520:5,9;
521:5;522:20;524:3,
15;526:10;531:2,6
fills (1)
510:17
film (1)
497:1
films (3)
528:8,12,18
find (2)
509:5;538:15
finding (1)
482:22
findings (4)
468:12;482:21;
483:18;484:8
finger (4)
485:14,15,15;489:2
fingers (1)
485:19
fingertip (1)
489:4
finish (1)
488:9
finished (2)
475:15;506:22
first (25)
471:19,20;472:10,
11;473:2,7;477:5,6,7;
479:9;497:1,4;504:19;
510:16;511:6;512:1;
515:19,25;516:1;
517:5;525:13;526:3,
17;535:25;536:1
fist (2)
494:7,8
fits (1)
493:24
five (3)
481:3;525:25;536:13
fix (2)
493:9,10
fixed (3)
493:12;500:15;
502:22
flashlight (1)
495:11
flexible (2)
494:9,10
Flexor (2)
485:21;535:16
flexors (2)
486:2,2
flick (1)
485:15
Floor (2)
463:14.5,18
flow (2)
483:7,8
fluid (2)
483:5,8
Fodeman (4)
465:10;466:5,17,25
folks (2)
479:3;504:9
following (2)
486:6;523:7
follows (1)
473:3
follow-up (1)
536:3
follow-ups (1)
505:8
Forest (1)
463:15
form (11)
481:7;498:1;522:24;
523:1;524:20;531:19;
534:14;536:19,21;
537:23,25
former (1)
491:19
formulate (1)
538:25
forwards (1)
484:11
found (1)
539:10
foundation (2)
521:6;535:12
free (1)
469:15
friend (1)
479:23
front (14)
465:4;469:21;480:9,
19;488:25;489:4,7;
500:11;501:22;519:20;
521:7;522:23;529:8;
531:13
front-on (1)
501:24
frozen (1)
490:22
full (4)
508:4;521:24;524:3,
15
fully (1)
490:2
function (2)
482:4,17
further (3)
467:22;505:12;
535:12
fuse (3)
490:24;493:9;499:9
fused (4)
494:5,6;501:8,11
fusing (2)
490:4;499:9
fusion (6)
487:19,21;490:16;
493:14,14;500:5
future (5)
502:23;503:6,21;
507:10,15

G

game (1)
466:7
garden (4)
494:7;501:8,10,11
gave (2)
526:13;533:6
general (2)
475:13;488:10
generally (2)
519:3;528:12
generate (1)
495:16
generated (1)
496:5
gentleman (2)
465:15;470:8
gestalt (1)
516:15
given (5)
468:4;508:13;516:3;
525:1,22
gives (2)
503:19;522:17
giving (3)
465:16;473:15;
524:13
glasses (1)
489:18
glue (2)
481:8;492:22
gluing (1)
487:21
goes (3)
478:10;485:22;499:8
good (13)
464:3;472:16,24;
474:1,2;479:23;
498:24;499:10,11;
500:9;506:3,4;539:11
gradations (1)
499:19
graduated (2)
475:9,10
graft (6)
490:18,19,19;493:2;
499:7,25
gray (2)
498:8;499:22
Great (1)
499:17
grind (1)
490:20
grinded (2)
493:4,7
grinding (1)
492:20
grow (1)
493:15
guided (1)
465:2
guideline (1)
508:1
guidelines (1)
507:24

H

H&P (1)
536:15
hand (7)
472:25;485:13,16,
19;486:2;519:17;530:5
handed (1)
521:7
handling (1)
525:1
hands (5)
481:20,25;484:16,
21,24
handsome (2)
470:8,10
happen (3)
485:18;492:7,13
happened (1)
515:5
happening (1)
531:8
happens (2)
472:3;485:21
happy (2)
471:24;507:12
hard (2)
489:4;514:7
HASA (1)
463:11
Hausknecht (4)
529:12;530:13;
531:2;532:13
Hausknecht's (10)
529:10,14,15;530:6;
531:5,7,13,15;532:5,9
HDMI (1)
495:1
head (8)
480:18;481:15;
484:17;489:3;508:13,
20,24;516:14
headlight (1)
489:19
healing (4)
491:7;493:8;499:7;
500:1
heard (1)
471:10
hearing (1)
469:14
heeling (1)
501:3
height (1)
493:17
held (7)
494:7;500:16;
502:19;518:7;521:22;
538:19;539:18
help (6)
479:25;481:8,12;
488:17;493:7;531:8
helpful (4)
479:18;505:9;535:5;
536:10
herniated (1)
514:1
herniation (2)
514:2,4
herniations (5)
513:18;514:5,6,23;
515:3
higher (1)
480:14
highly (2)
465:17;482:13
Hills (1)
463:15
hip (4)
480:22;503:2;
533:22;534:13
history (10)
477:10,12;479:12,
15;516:3,4;534:7,10,
23;535:7
Hoffman (3)
485:13,17;535:16
Hoffman's (1)
485:11
hold (2)
489:3;494:1
holding (4)
493:21;494:8;
501:11;502:5
holds (3)

491:6;492:9;493:2
Honor (36)
464:15,19,21,22; 465:9;466:2;467:21; 468:8,9;469:11,13; 470:13,21;472:20,21; 476:6,23;477:1;491:8; 496:21;514:25;517:23; 518:4;520:10,20; 521:19;522:8;524:4,7, 19;527:22;531:17; 533:24;534:12;539:13; 541:13
HONORABLE (1)
463:11
Honor's (4)
465:5;467:10;535:9, 10
hose (6)
494:7,9,10;501:8,10, 11
Hospital (2)
475:13;488:2
hour (1)
475:6
hours (1)
488:10
housekeeping (1)
471:7
Howard (1)
475:10
human (1)
490:22
hundreds (2)
466:8,10
hydration (1)
512:9
Hypertrophy (1)
512:15

I

idea (4)
478:14;495:22; 531:8;534:25
identification (4)
516:20,24;518:13; 521:8
identify (1)
476:8
illustrate (1)
502:14
image (23)
495:16,24;496:5,6,7, 14,15;497:24;498:5,6, 10,12;499:12,12; 500:7;501:15,21,21,22, 22,22;502:3,7
images (2)
496:15;499:22
imaging (2)
495:6;519:7
immediately (2)
506:17,22
implants (1)
502:2
important (2)
482:16;535:3
imposition (1)
540:3
improper (2)
522:8;524:7
inappropriate (2)
524:7,13
incident (1)
477:15
incision (1)
489:7
included (2)
467:19;478:4
including (5)
469:13;479:17; 484:25;517:15;539:10
incorporating (1)
500:4
increase (2)
484:19;514:21
increased (1)
484:20
increasing (1)
484:16
incurred (1)
514:24
independent (2)
468:6;510:21
INDEX (1)
463:4
indicate (2)
507:18;516:5
indicated (10)
477:21;479:17; 483:16;510:5,9; 511:21;515:11;536:22; 539:3,22
indication (2)
485:11;534:7
indications (1)
514:11
indicative (5)
486:3;512:15,17,19, 21
individual (1)
467:12
inference (2)
465:16;467:9
information (5)
478:18;479:5; 481:22;511:14;522:17
initial (6)
524:24;526:11; 532:21,23;535:21; 536:24
initially (2)
512:2;528:12
injection (1)
532:22
injections (8)
478:6,11,11;479:17; 516:7;525:16;526:9,22
injuries (3)
477:15;504:13;505:5
injury (4)
513:1,8,10,15
in-person (1)
536:14
inquire (5)
467:13;471:20,21; 472:6;502:9
inquired (1)
471:19
inquiry (1)
471:18
insert (1)
492:24
inserting (1)
490:16
inside (3)
489:1;499:8;502:2
instruct (1)
473:19
instruction (3)
522:1;524:8,14
instrument (1)
485:3
intake (9)
510:17,24,25;511:8, 16;518:16;524:18,21, 23
interesting (1)
509:6
interfering (1)
479:19
internal (4)
490:7;495:16; 500:22;501:3
internship (2)
475:13,15
interprets (1)
528:18
interrupted (1)
514:14
intervention (2)
503:7,7
intimately (1)
482:4
into (28)
464:24;466:13; 467:16,24,25;469:14; 470:21;473:14;477:20; 481:25;484:21,24; 490:20;491:2;492:22; 493:22,24;496:1; 500:4,15;518:3,21; 521:1;524:24;525:10, 23;526:11,15
invented (1)
495:19
Inverted (2)
485:21;535:16
involuntarily (1)
485:16
involved (4)
482:5;493:11; 495:18,23
involves (2)
488:24;490:16
involving (1)
464:25
irritation (6)
485:12,17,18;486:4, 4;487:7
issue (8)
465:7;466:14; 467:14;468:15;469:6; 471:7,22;534:14
issues (1)
514:22
item (1)
471:5

J

January (1)
477:22
joint (1)
512:18
joints (3)
480:22;512:11,12
Judge (44)
464:1,9;465:24; 467:22;468:24;469:1, 10,18,23;470:2,7,18, 19;471:4,17,23; 473:23;476:2;494:25; 495:2;496:18;497:8, 18;500:12;516:19; 518:2,8;521:1,3,18; 522:25;523:4;526:5; 532:3;534:14,19; 535:6,8,13;536:20; 537:24;538:24;540:14; 541:8
July (6)
512:4,24;536:25; 538:10,12,16
JUROR (1)
540:5
jurors (6)
471:18;472:4,4,12; 491:18;540:9
jury (37)
464:22;465:12; 467:7,12;470:3,22; 471:21,25;472:10,11, 13,17;474:3,18;475:7; 477:12;479:25;480:9; 484:8;487:3;491:10, 16;497:3;500:11; 501:15,16;502:7,14; 524:8,13;528:15; 534:10;536:7;539:1, 10,21;540:10
jury's (1)
467:13

K

Karen (2)
463:23.5;505:16
keep (5)
506:6;519:3,19; 520:19;540:6
keeping (1)
467:18
kept (2)
506:8,9
kind (10)
474:3;482:10;485:5; 492:22,25;499:5; 501:2;507:4;508:15; 537:15
kinds (1)
490:19
KINGO (1)
463:11
Kings (1)
475:12
knee (1)
503:2
kneel (1)
509:13
knowledge (3)
524:16,17;525:12
known (3)
484:13;487:18; 492:21
Kyriakides (6)
526:16,24;527:1,3,6; 528:2
Kyriakides' (1)
528:6

L

laboratory (1)
530:9
last (2)
507:7,8
later (1)
525:25
law (2)
465:25;469:2
lawsuit (3)
468:6;469:7,9
lawsuits (1)
469:9
lay (1)
535:12
lead (1)
483:9
Leading (1)
497:25
learned (2)
477:12;479:14
least (2)

503:10;507:12
leave (2)
484:2;504:24
left (4)
480:23;489:8;492:6;498:10
legs (2)
481:20,25
length (1)
495:3
less (1)
509:7
lesson (1)
483:25
letter (1)
469:1
level (7)
489:16,22;494:2;502:15,16;505:4;510:14
levels (2)
489:24;500:25
life (2)
479:20;503:17
lift (1)
477:16
ligament (2)
474:11;502:12
light (4)
464:21;498:16,16;507:5
lighter (2)
477:20;485:6
likely (1)
504:25
limine (5)
467:15;468:15;469:4,7,8
limitation (1)
505:5
limitations (1)
510:4
line (4)
498:8;511:10,13,13
lined (1)
481:6
listed (2)
511:7;522:16
listener (1)
479:24
litigation (1)
464:25
little (22)
474:6;475:7;480:1;481:18;490:9,20;494:5;496:22;499:18,20,21;501:2,16;502:1,1,2;503:19;512:13,13;519:13;535:15;539:25
live (1)
503:18
living (3)
479:20;490:22;503:13
load (1)
481:11
localize (1)
489:12
location (1)
506:9
lock (1)
491:2
locking (1)
491:3
locks (1)
493:13
long (1)
488:8
longer (2)
494:13;503:13
look (20)
478:16;481:19;489:10,20;494:3;495:11;499:10;500:6,25;501:16;508:4;510:22;511:6,15;515:20;522:18;525:2;530:5;532:24;534:4
looked (6)
482:22;512:11;515:11;526:7;531:7,7
looking (20)
485:15;488:20;494:20;495:5,21;496:10,11;497:24;498:2,7,8,10;501:15,23;502:17;503:11;507:23;525:4;531:12;537:3
looks (2)
521:10;535:25
loop (1)
489:17
loss (1)
512:7
loud (1)
497:14
lower (5)
481:2;482:10;483:12;484:24;485:9
lucky (1)
503:12
lumbar (2)
481:3;482:11

M

magnet (4)
495:12,12;496:2;499:19
magnetic (2)
495:6;498:14
magnetized (4)
495:14,15,22;496:3
magnetizes (1)
496:2
magnification (1)
489:18
magnifiers (1)
489:18
magnifies (1)
489:21
maintain (3)
464:17;504:21;508:13
maintaining (2)
482:3;498:24
makes (2)
492:21;508:10
malpractice (5)
468:17,18,21,23;469:6
man (1)
495:19
Management (10)
476:12;515:22;532:17,19;533:2,4,9,13,14,17
Maneuver (4)
484:14,15,23;537:4
Mangano (2)
463:23.5;505:16
manner (1)
487:11
many (5)
469:12;488:5;500:23;536:11,23
marked (8)
464:5;476:14;516:19,23;517:1;518:8,12;521:8
math (2)
495:18,22
matter (3)
464:24;470:20;493:17
matters (3)
467:25;468:1;519:4
may (33)
464:23;467:16,16;471:17;472:8,15;473:18,19;476:6;480:10;487:25;491:9,14;492:3;494:23;497:15;500:12,13;502:9;505:12;517:20;518:4;519:21;521:3,19;522:1;525:23,23;529:20,22;535:12;539:10,13
maybe (5)
496:22;500:10;502:13;503:11;532:6
MCGILL (44)
463:2.5;467:4;477:3,6,7,10,13,14;478:11;479:6,15;480:2;484:6;487:6,13,17;488:13;496:15;498:6;503:5;505:3;507:1,4,7;509:25;510:5;511:5;513:1,10;515:25;520:1;525:2,14;526:3,17,25;527:4;528:3;529:12,16;533:6,21;535:20;538:3
McGill's (3)
507:17;529:2;537:20
mean (15)
471:23;474:18;503:9;508:4;509:7,8,9;510:12;511:15;514:6;525:7;531:7;532:6;537:6,16
meaning (2)
478:23;536:9
means (9)
474:20;483:1;487:19,21;493:14;496:10;508:2,3;513:9
mechanical (4)
492:25;503:1,1,3
mechanics (1)
504:20
mediated (1)
485:8
medical (18)
474:3;475:11,12;479:12,14;495:20;503:23;504:6,11;505:3;511:3;515:11;516:5,6;517:15;527:11,14;537:22
medications (2)
478:4;537:16
Medicine (1)
475:10
meet (1)
477:6
meets (1)
481:4
members (3)
472:16;539:1,21
memorialized (1)
516:14
memorized (3)
515:10,18;533:15
mention (1)
464:23
mentioned (4)
470:14,23;471:6,8
merely (1)
466:12
Merola (12)
465:1;467:2;470:9,10,20;472:22,23;473:6;474:3;475:24;476:12,24
M-E-R-O-L-A (1)
473:6
Merola's (5)
464:13;465:10;471:1;540:13;541:1
met (1)
477:7
MICHAEL (1)
463:19
microphone (3)
473:14,14;480:15
microscope (1)
489:20
Middle (8)
481:1;490:12;498:12;499:4,5;500:2;501:25;502:3
might (3)
471:21;495:4;496:22
missing (1)
498:20
mistaken (2)
470:9;515:12
mix (1)
490:22
mixing (1)
492:20
model (11)
479:24;480:16,17;488:16,20;491:9,16,17,22;494:3;502:12
Moe (1)
465:10
molecule (1)
495:14
molecules (3)
495:13;496:2,3
moment (5)
480:15;497:6;530:6;538:18;540:17
monitor (1)
503:4
months (1)
477:20
more (20)
482:16;483:22;485:20;487:22;491:12;492:14;493:20;499:1,16,16,20;500:22,23;503:17,17,19;504:25;507:12;508:18;540:1
morning (6)
471:9,11,16,25;540:4;541:1
mostly (3)
482:11;486:4;495:13
motion (13)
469:8,10,13,14;481:9;484:10;492:11;494:2,4;501:12,12;502:21;503:19
move (15)
481:13,20,21;487:22;489:8,9;494:9,10;497:8;502:20;508:24,25;522:7;524:6;534:2

moved (1)
502:17
movement (1)
494:1
moving (3)
474:10;493:2;501:11
MRI (29)
482:22;495:8,9,12,17,19;496:1;498:6;500:21,22;506:5;511:23,25;512:1,3,4,6,23;513:23,24;514:1,22;515:2;528:7,8,10,12;529:1,2
MRIs (8)
482:19,21;494:17;495:22;499:18;500:7;511:20;514:11
much (8)
479:23;490:3;505:11;508:5;537:9;539:12;540:8;541:9
muscle (1)
485:24
muscles (3)
474:10;489:3,10
musculoskeletal (2)
474:8;510:15
MUSEUM (1)
463:5.5
myelopathy (1)
487:8
myself (1)
525:4

N

name (2)
473:4;495:20
nature (1)
504:13
near (1)
515:24
necessarily (1)
520:6
neck (27)
474:14;478:9;479:15,16;480:25;484:9,17,18;485:10;488:24,25;489:8;502:17;503:7,25;504:4,21;505:6;508:13,20,24;513:16;515:15,19;516:4,8,15
neck-related (1)
477:24
need (5)
467:13;474:9;476:22;483:19;492:22
needs (4)
466:5,6,14;494:22
negative (3)
536:8;537:7,8
nerve (21)
482:11;483:2,9,20;484:24,25;485:6,9;486:3;487:7,20;490:8,9;492:6,12,14;498:25;499:11;537:9,12,14
nerves (13)
474:11;481:19,23;482:5;483:3,12,23;484:19,22;485:7;487:12;490:2,15
neurological (5)
482:17;483:18;504:18;515:12,17
NEW (11)
463:1,1.5,7.5,8.5,8.5,15,18.5,18.5;468:7;473:7;507:24
next (6)
472:8;478:13;489:13;493:8;499:12;538:9
nice (1)
497:14
nicely (2)
499:24,24
nine (1)
528:4
Noble (2)
495:19,25
non-scheduled (1)
507:25
normal (13)
482:3,3;483:4,4,7;485:24;491:5;498:18,19,24;511:22;512:5,7
normally (3)
481:12,15,25
note (7)
507:18,23;510:2,9;511:6;526:15;534:4
notes (5)
476:19,23;506:16;521:10;522:20
notice (1)
502:18
November (2)
515:7,15
number (3)
469:10;519:12;522:17
numbers (1)
530:20
numbness (1)
515:12
NYU (1)
475:9

O

oath (3)
468:4;524:3;539:8
object (1)
467:23
objected (1)
464:14
objection (43)
464:15,17;473:16,17;476:1,25;480:6;497:18,25;498:3;509:23;514:25;515:8;517:18,25;519:24;520:10,15,20;521:2;522:7,9,24;524:4,6,10,19;526:2,4;527:21;531:17,24;532:3,14;533:24;534:12,17;535:9;536:19;537:23;538:4,13,17
objections (1)
476:2
obligations (1)
475:2
observed (2)
511:23;512:6
observer (2)
466:15;467:4
observing (1)
466:12
occasionally (3)
507:19;508:3,4
occupy (1)
492:18
occur (2)
493:14;494:4
occurred (2)
514:2;515:3
occurring (2)
482:23;499:7
occurs (3)
503:16;513:6;514:16
O'CONNOR (1)
463:17
off (3)
490:6,14;516:14
offer (5)
470:23,25;518:2;521:1,18
offering (1)
464:12
offers (1)
528:18
office (13)
475:6;479:9;506:6;511:11;517:6;518:14,19;519:22;520:7;521:10;522:17;525:1,5
OFFICER (5)
472:12,15,23;491:17;540:9
off-the-record (2)
518:6;521:21
often (4)
474:24;478:25;479:3;482:15
old (1)
503:9
older (1)
503:18
Once (21)
468:25;479:9;491:12;492:16;493:4,25;494:21;499:25;502:13;504:5,17;505:8;507:11;512:9;515:18;517:24;533:14;534:12,16;535:8;537:23
one (27)
464:9;469:11;471:5;481:6;485:20;489:9;490:25;492:19;493:16;497:5,6;499:1,16,16;508:2,3,5;509:6,7,9;516:6,10;526:8;537:1,3,8,8
ones (2)
516:10;531:5
only (10)
481:14;482:2;488:19;502:21;507:19;508:11,12,23;515:4;529:15
onset (1)
513:9
onto (2)
494:7;501:11
Open (2)
538:21;539:20
opening (2)
481:17;482:6
openness (1)
465:21
operating (2)
489:21;490:13
operative (1)
506:21
opinion (7)
503:22;504:2,5,10,15;505:2;507:1
opportunity (1)
504:6
options (1)
479:11
order (8)
467:10;483:21;490:1;492:25;493:1;504:21;530:22;531:8
ordinary (1)
528:21
organ (1)
481:21
orthopedic (4)
474:5,14;475:14;528:21
orthopedics (2)
474:6,8
osteophyte (1)
512:21
others (1)
464:20
out (28)
464:21;465:8;467:8;468:23;477:18;489:23;490:7;492:3,3,5,7,15;495:13;497:3;500:8;501:12;504:23,25;508:24;510:17,19;516:6,11;518:23;526:8;528:23;529:17;530:8
outcomes (1)
509:22
outside (4)
467:12;470:3;527:24;539:7
outsource (1)
520:23
outsourced (2)
520:23;522:12
over (12)
479:10;481:15;483:9,19;487:10;491:4;497:8;503:3,15;513:6;516:3;537:5
overhead (1)
509:5
overruled (7)
473:19;498:4;515:1,9;520:22;526:6;532:4
own (3)
490:23;493:5;521:5

P

pack (3)
490:17,18,23
packed (1)
499:7
pad (2)
519:11,17
page (4)
486:6;523:7;530:10,22
pages (3)
530:17;531:1;532:11
Pain (24)
476:11;478:12,12,14;483:13,18;484:15;505:4;508:19,23;514:3;515:14,15,17,19,22;532:16,19;533:2,4,9,13,13,17
palpable (2)
484:9,12
paper (2)
519:13;522:16
paperclip (1)
485:4
paperless (1)
511:1
paperwork (1)

525:1
parameters (1)
524:11
PART (11)
463:1.5;489:5;
498:21;513:1;518:19;
520:9,25;524:21;
529:14;535:3;537:6
particular (8)
478:15;488:23,23;
495:6;507:23;511:4;
514:7;519:12
particularly (1)
500:1
parts (2)
481:23;495:11
pass (1)
490:8
passing (1)
493:22
past (7)
479:12,14;534:7,10,
23,25;535:7
paste (1)
490:20
patches (1)
537:17
pathological (1)
486:3
patience (1)
472:17
patient (26)
484:20;485:14;
487:6;491:4,20;
501:23;504:8;505:7;
506:17;508:15;510:4,
5,10,16,17;519:3,6,10,
11,18;520:13;526:11;
527:11;532:2;534:24;
535:4
patients (10)
474:21;478:23;
487:9;507:11;509:21,
22;537:16,16,17,17
patient's (4)
490:23;510:3;
524:21;531:9
pelvis (3)
480:21;481:5,15
pending (2)
468:7;497:19
people (3)
474:21;503:13;511:3
per (1)
475:6
perform (6)
468:5;474:22,24;
479:7;487:14,24
performed (10)
468:5;480:1;487:4,
17;488:1,5,13;494:11,
14;505:6
Perhaps (3)
508:16;522:20;
538:24
period (3)
488:11;513:6;526:25
permanency (1)
507:25
permanent (3)
494:12;504:13,16
permission (4)
476:23;479:22;
491:9;494:22
persistent (4)
477:24;479:18;
483:17,17
person (5)
466:13;478:10;
514:3;525:4;528:17
personal (1)
465:10
person's (1)
493:5
PETER (2)
463:13.5,15.5
phonetic (2)
533:12,16
photos (1)
471:24
physical (6)
478:16;484:6,8;
508:21;535:23;536:13
physically (1)
535:22
physician (5)
474:16,19;477:3;
533:13,14
physicians (3)
468:3;471:1;515:13
picture (1)
490:6
piece (3)
498:15;519:13;
522:16
pinprick (3)
485:1,3,5
place (3)
491:2,3;493:3
placed (2)
488:22;496:1
Plaintiff (7)
463:3.5,14;464:12;
467:2;473:2;514:24;
517:16
Plaintiff's (8)
464:5;476:18;
494:18;506:12;511:18;
522:5;527:18,24
plans (1)
507:9
plastic (1)
480:16
plate (12)
488:20;491:2,24;
493:11,11;494:1;
498:14,14;500:15;
501:25;502:5,19
plates (1)
504:22
Please (14)
472:24;473:4,11,11;
474:3;476:8;477:5;
497:14,24;499:1;
510:19;529:18;530:11;
540:11
pm (1)
541:15
point (9)
465:8;475:23;
477:21;478:11;490:8;
497:3;510:19;514:7;
529:17
pointed (4)
516:6,8,11;530:8
pointing (1)
467:8
portable (1)
489:20
portion (8)
481:1,2;483:12;
490:7,15,16;493:9;
499:5
portions (5)
474:15;479:25;
485:8;492:2;498:21
position (3)
494:1;498:18;508:13
positive (13)
484:13,14,23;537:2,
8,13,14;538:2,6,6,9,11,
15
possibility (1)
467:9
possible (1)
480:9
possibly (1)
490:3
post-accident (1)
477:8
postop (1)
535:25
post-op (2)
507:12;536:2
post-operative (4)
498:5;500:14;505:8;
536:1
potential (5)
465:19;502:23;
503:6,9;510:14
powerful (2)
495:12;496:2
practice (2)
474:20;479:2
practicing (2)
474:16,18
precluded (1)
466:18
precludes (1)
465:25
predominantly (1)
477:24
prejudicial (1)
465:18
premark (1)
464:1
preop (3)
535:25;537:1,2
preoperative (1)
538:2
preoperatively (1)
536:16
preparation (2)
527:9,15
Presbyterian (1)
488:2
prescription (1)
519:11
presence (4)
464:22;467:12;
470:3,22
present (11)
465:11;466:1,9;
467:5,14;470:6;
512:23;513:20,24;
518:17;519:22
presented (1)
515:13
preserve (3)
469:25;470:1,22
preserved (1)
492:21
press-fit (1)
493:1
pressure (16)
482:14;483:1,6,11,
13,15,17,20,22;484:17,
20;487:20;490:10,14;
493:20,23
presurgery (2)
536:18,23
pretty (2)
508:5;537:21
prevent (2)
483:21;493:1
previous (1)
472:1
previously (6)
464:14,16;470:21;
471:9;524:23;539:21
primary (1)
498:13
print (1)
518:23
prior (6)
476:2;478:24;
513:23;533:21,22;
536:11
private (1)
474:20
Prize (2)
495:19,25
problem (7)
477:16;478:15;
483:22;487:8,9;537:9,
12
problems (5)
482:15;485:10;
487:10;507:13;516:4
procedure (22)
480:1;487:4,13,16,
18;488:5,8,9,11,12,14,
23,24;490:15,16;
491:25;492:2;494:11,
12;502:15;505:6;
506:22
procedures (2)
468:5;535:2
proceeding (2)
466:13;467:6
proceedings (1)
466:21
process (3)
491:7;493:15;500:5
produce (1)
484:15
produced (1)
521:14
producing (1)
503:24
progressively (1)
492:15
prohibit (1)
471:14
projection (1)
496:12
proof (2)
470:23,25
proper (2)
481:9;521:6
properly (2)
483:3;493:24
protect (1)
481:24
protecting (1)
482:17
protrusions (1)
482:23
provide (1)
481:9
provided (2)
478:19;479:6
provides (1)
481:10
public (1)
467:4
publish (1)
491:9
published (2)
491:16,17
pulled (1)
526:8
purely (1)
466:4
Purpa (1)

533:19
Purpa's (1)
533:12
purpose (1)
531:18
purposes (1)
464:16
pursuant (2)
464:15;521:14
push (1)
489:2
pushing (2)
484:17;492:6
put (16)
464:9;491:2;492:17, 17;493:7;494:19; 495:1;500:24;510:2,4; 519:12;525:3;526:15; 529:25;530:1;537:17

Q

qualification (1)
468:2
qualifications (4)
467:24,25;468:1,2
qualified (2)
475:20;476:4
quality (1)
479:20
Queens (1)
463:14.5
quick (2)
464:10;529:21
quite (4)
479:2,3;499:23,24

R

radiculopathy (2)
487:7;516:10
radiologist (3)
528:13,15,17
radiology (1)
528:24
raise (1)
472:24
raised (1)
469:6
range (1)
484:10
rate (1)
475:5
rather (1)
469:24
reach (1)
509:5
read (9)
517:20;525:22; 528:7,8,10,12;529:1; 534:10;535:7
Reading (2)
517:18,23
reads (1)
528:17
ready (2)
464:8;472:17
real (2)
464:10;529:20
really (2)
477:22;492:9
realm (1)
478:23
reason (1)
531:23
reasonable (3)
503:22;504:10;505:2
recall (10)
510:7;511:16; 515:10,19;516:14; 526:18;531:21;533:14, 20;535:17
received (1)
476:15
receiving (1)
521:24
recognize (2)
475:24;521:9
recollection (2)
476:22,24
recommendations (1)
509:25
recommended (1)
487:17
reconstruct (2)
483:21;495:17
reconstruction (2)
503:1,2
reconvene (1)
541:10
record (13)
464:10,17;469:25; 470:19,22;473:5; 511:4;515:21;519:8; 524:22;526:8;532:20; 541:8
records (59)
464:13,15;476:10, 11,12,16,18,19,24; 504:6;510:19,21; 511:3;515:11;516:5,6, 12,13;518:14,19; 519:21;520:14,17,19; 521:14;522:2,11,18; 525:3,13;526:8,16,19, 21,22;529:10,14;530:6, 13;531:1,5,13,15; 532:6,9,12,17,17,18, 19;533:2,3,4,5,10,12, 17,19;537:22
re-examine (1)
479:10
refer (6)
476:22;512:7,10; 519:6,10;529:12
reference (2)
466:14;530:20
referenced (7)
468:14;469:17; 525:15;530:7;531:16; 532:21,23
referral (2)
511:6;520:14
referred (8)
478:1,20;511:5,10, 12,18;520:13;521:5
referring (2)
512:18;521:5
reflex (2)
485:20;486:3
refresh (2)
476:22,24
regard (8)
464:10,24;479:15; 503:25;507:17;529:1, 2;532:16
region (4)
482:6,24;493:1; 499:23
regions (3)
482:15,16;484:20
regular (2)
495:10;528:20
rehab (1)
515:22
rehabilitation (1)
510:11
reign (1)
469:15
relaxed (1)
485:13
relevance (2)
533:25;534:13
relevant (1)
534:22
reliability (1)
532:5
Relied (1)
531:17
relieve (2)
483:15;508:19
relieved (2)
505:10,16
rely (6)
531:4,15,23;532:1; 533:3,5
remainder (1)
539:4
remains (1)
502:19
remember (3)
510:8;526:20,21
remind (1)
539:8
remnants (1)
482:8
remote (1)
494:25
remove (4)
489:13,16;490:3; 492:16
removed (5)
489:22;490:1,20,24; 492:19
removing (1)
487:20
repair (1)
477:23
repetitive (1)
509:9
replacement (1)
533:23
report (3)
511:21;518:21;540:7
Reporter (6)
463:24.5;464:7; 505:15,16;516:24; 518:13
reports (6)
506:21;528:7,10; 529:1,2,4
representation (1)
466:12
representing (3)
466:20;467:2,3
request (5)
471:3;506:11;517:6; 519:7,14
researching (1)
495:21
residency (2)
475:14,15
resonance (1)
495:6
respect (8)
467:13,19;469:8; 471:7;479:16;482:17; 513:16;516:8
respectively (1)
541:2
response (6)
485:16,21,24;486:1; 517:7;522:3
responses (2)
473:15;535:16
responsibilities (1)
475:3
responsibility (1)
525:10
responsible (4)
481:19;482:2;485:7; 525:5
restricted (1)
484:12
restriction (2)
505:4;508:22
restrictions (1)
484:10
result (2)
504:12;505:5
results (3)
536:4,17;537:5
resume (1)
539:23
return (2)
477:19;510:6
returning (1)
510:3
reversible (1)
465:18
review (4)
479:5;504:6;515:24; 526:16
reviewed (5)
506:5;516:5;526:1; 527:11,15
RICHARD (3)
463:2.5;477:3,6
RICO (2)
468:6;469:9
right (31)
464:18;466:23; 469:19,22;472:5,8,25; 475:23;480:19,23; 485:14;496:14;497:13; 499:16;503:12;513:4; 514:10;518:24;519:19; 520:9;522:16;523:6; 524:22;530:10,24; 533:1,11;539:17; 540:6,8;541:9
rise (2)
472:12;540:9
road (2)
503:19;534:16
room (2)
470:12,16
root (5)
487:7;537:9,12,14; 541:5
R-O-O-T (1)
541:5
roots (13)
482:11;483:2,20; 484:24,25;485:10; 487:20;490:8,10; 492:12;493:20;498:25; 499:11
Root's (1)
541:10
rotate (2)
484:11;502:18
rotating (1)
484:17
rougher (1)
501:2
ruled (2)
464:16;470:21
ruling (10)
465:5;467:14; 468:15;469:7;473:17; 524:11;535:9,10,11,14
rulings (4)
464:23;467:16,18; 469:4

runs (1)
481:16

S

Sacks (2)
469:12,12
sacrum (1)
481:5
sagittal (9)
496:6,8,8,9,9,13,14,14;501:21
same (9)
487:5;498:3;499:13;509:1,3;520:15;538:4,13,17
sanctions (1)
465:19
SARDINO (51)
464:9,12,20;465:20,23,24;466:4,17,23,25;467:22;468:3,16,20,23;469:1,4,10,23;470:2,18;471:4;477:1;480:6;496:18;497:7,8,10,18,25;498:3;500:12,17;502:9;505:14;506:2;516:19;518:2,8;521:18;524:2;526:5;529:20;530:1,3;534:19;535:6,12;538:24;540:23;541:13
SAVINO (1)
463:19
saw (13)
479:9,9;504:19;512:2;516:1,1;525:14;526:3,17,24;528:3,19;533:16
saying (1)
510:8
scan (1)
495:7
scanned (4)
518:20,22;524:25;525:23
SCARDINO (1)
476:2
scenario (1)
509:8
schedule (4)
472:2;475:2;540:2,7
scheduling (1)
471:7
Scilaris (2)
477:18;515:21
Scilaris' (1)
526:19
scissor (1)
477:16
scooped (1)
490:18
scooping (1)
490:7
scope (2)
520:21;533:25
screen (3)
494:19;496:22;508:17
screw (1)
493:12
screwed (1)
493:25
screws (7)
488:21;491:2,24;500:15;502:5,19;504:22
script (1)
519:17
scripts (1)
520:1
scroll (2)
496:25;497:1
seat (1)
502:8
seated (4)
472:15;473:11,12;540:11
second (3)
535:21;536:2;538:16
secretary (1)
519:20
section (2)
491:3;526:7
sedentary (2)
507:5;508:16
seeing (2)
479:4;506:17
segment (4)
501:5,7;502:13,14
segments (3)
501:7,13;536:10
send (2)
481:22;528:23
Senior (3)
463:24.5;505:15,16
sensation (4)
485:2,5,6,7
sense (1)
505:9
sensitive (3)
465:7;482:13,14
sent (1)
520:3
separately (2)
467:15;471:21
September (4)
463:9;502:10,11;541:15
series (1)
497:4
server (1)
506:9
seven (1)
480:25
seventh (1)
484:25
several (5)
468:3;482:24;483:10;488:10;507:13
shape (1)
534:14
sheet (9)
510:17,24,25;511:8,16;518:16;524:18,21,23
sheets (1)
511:2
shock (1)
481:10
short (1)
526:25
shortly (1)
527:1
shoulder (4)
477:16,17,23;515:16
show (10)
471:25;476:6;482:22;483:24;497:24;500:8,22;514:12;520:25;521:3
showed (2)
483:25;500:7
shower (1)
491:5
showing (1)
500:14
shown (6)
476:14;496:19;511:20;516:25;529:7;532:8
shows (1)
499:13
shredded (2)
511:2;518:20
side (18)
480:19,19,20;484:11,11;488:25;489:8,9,10;496:9,9,13;500:12,14;502:18,18,18,18
side-bar (2)
538:19;539:18
sides (1)
480:23
side-view (1)
498:5
Sign (5)
485:11,13,17,17;538:15
signal (9)
495:2,23;496:4,4;498:14;499:5,6;512:8,9
signals (1)
496:4
significance (1)
526:9
significant (7)
483:11;490:10;514:3;515:16;516:9;526:13;529:6
Singer (1)
469:12
sit (4)
507:19;508:5,11;525:24
sits (4)
481:4,8;482:11;489:14
sitting (5)
465:15;489:1;508:6,14,21
situations (1)
479:1
six (1)
477:8
sixth (1)
484:25
size (2)
493:17;514:4
sizing (1)
493:23
skull (2)
480:17;498:7
slicer (1)
500:24
slices (4)
496:25;497:5;500:23,25
slide (7)
492:24;493:24;497:12,12,12,12;499:1
slides (1)
499:12
sliding (2)
492:10;493:2
slowly (2)
473:5;487:10
small (3)
488:16;490:9;491:11
somebody (1)
467:8
someone (4)
478:22;519:10;528:23;537:7
Sometimes (6)
495:2;510:25;511:1,2;514:13;524:24
somewhere (2)
510:24;519:6
Sorry (8)
495:4;500:6;501:14;514:13,18;533:4,7;539:14
sort (1)
469:7
Sounds (1)
464:3
source (1)
511:7
South (1)
471:24
space (1)
492:18
spacers (1)
488:22
spans (1)
493:11
spasm (2)
484:9,12
speak (6)
465:11;473:14;480:14;527:18,24;539:7
speaking (1)
470:12
special (1)
489:15
specialist (1)
510:13
specializing (1)
475:24
specific (5)
464:23;485:5;495:15;507:25;516:10
specifically (7)
474:13;479:15,16;511:16;512:18;525:3;526:23
spinal (35)
474:5,6,13;475:17,21,25;480:16,21;481:14,16,17,17,23;482:6;483:3,4,11;484:18;485:8,12;487:9,12,19,20;489:17,23;492:13;493:20;494:3;498:8,9,25;499:10,11,23
spine (29)
472:21;480:24;481:1,1,3,3,12,13,24;482:9,10,11,17;483:12,24;488:19;489:5;495:7;502:21;508:10,22,25;511:22;512:3,6,11;513:4,20;528:4
spoke (1)
527:21
spondylosis (1)
512:14
Spurling (9)
535:19,20;536:4,17,22;537:7;538:9,11,15
Spurling's (9)
484:14,23;535:16;536:1;537:4,4,13,18;538:7
spurring (1)
512:19
squares (1)
498:11
Squat (1)
509:19

stability (1)
504:21
stabilize (4)
483:21;487:12;
493:13;504:19
stabilized (1)
505:9
stabilizing (1)
487:21
stable (3)
499:10;502:20;528:5
stamp (1)
515:3
stand (4)
472:22;473:3;480:8;
500:12
standing (2)
508:6;509:1
start (4)
465:6;471:15;488:9;
490:3
started (2)
470:6,15
STATE (3)
463:1;473:4;507:24
statements (1)
468:4
statute (1)
465:25
stayed (1)
487:5
step (4)
478:13;494:22;
496:21;516:9
stepwise (1)
487:11
sterilized (1)
466:4
steroid (6)
478:5,11;516:7;
525:15;526:9,22
steroids (1)
537:17
sticking (1)
469:5
stiffness (2)
508:19,23
still (7)
474:22;478:12;
494:10;499:7;502:5;
523:2;529:8
stipulated (1)
464:20
Stoop (1)
509:17
stop (6)
477:20;497:2,13,15,
21;499:16
stopped (2)
497:16,21
Street (2)
463:8;473:7
stress (2)
481:11;503:18
strike (5)
522:7,10;524:6;
534:2,3
structural (1)
512:14
structure (4)
481:16;482:3,13;
500:22
structures (2)
495:16;514:8
studies (3)
531:9,12,16
study (1)
530:6
subcomponent (1)
474:14
subject (5)
464:24;465:18;
476:2;503:2;521:5
subpoena (5)
517:8;521:11,15;
522:3;525:9
subsequent (1)
504:8
substantive (1)
464:24
successful (1)
478:8
sudden (1)
513:9
suggested (1)
482:21
summers (1)
503:11
SUNY (1)
475:12
supervisory (1)
508:16
supply (2)
483:4,5
supporting (1)
481:14
supposed (2)
481:13;489:21
SUPREME (2)
463:1,7.5
Sure (33)
464:11;465:14,22;
479:8;481:24;488:14;
490:1,10;491:1,10;
493:22;494:12;495:9;
496:20;499:2,15;
509:14;512:16;513:3,
10,16;515:4;525:7,9,
25;529:19;530:17,22;
531:10;532:8;536:8;
537:3,6
surgeon (4)
472:21;474:5;
502:15;528:21
surgeries (1)
534:25
surgery (22)
471:1;474:6,13,22,
24;475:13,14,17,21,25;
477:17;479:6;487:24,
25;491:4;494:14;
496:16;502:24;504:19;
533:23;536:11,15
surgical (14)
475:2;478:19,22,25;
479:4;487:4,13,16;
503:7;505:6;534:7,10,
23;535:7
surprise (1)
538:1
surprised (1)
538:11
suspect (1)
470:16
sustain (5)
517:25;519:25;
522:9;524:10;534:17
sustained (22)
473:18;477:15;
498:1;509:24;513:2,
11,14;520:12,16;
523:1;524:20;527:23;
531:19,25;532:15;
534:1,1,3;536:21;
537:25;538:5,14
swelling (3)
512:13;514:12,21
sworn (1)
473:2
symptom (1)
484:21
symptomatic (5)
513:16;515:5,6;
516:8,16
symptoms (10)
477:24;478:9;
479:10,19;503:24;
504:3,11;505:10;
513:12;515:17
syndrome (1)
501:5
system (1)
474:9
systems (1)
481:21

T

T1 (1)
496:14
T2 (1)
499:12
tactile (2)
485:2,6
talk (4)
479:23;501:6;527:3,
6
talked (3)
518:16;519:22;
535:15
talking (6)
468:22;488:24;
491:10;501:6;508:15;
533:7
tap (3)
485:21,23;486:1
tear (3)
503:3,16,19
telemed (4)
535:22,23;536:24,25
telemeds (1)
536:14
telephone (2)
522:17,20
temporary (1)
494:11
ten (2)
531:1;532:11
tendon (3)
485:22,23;486:1
tendons (1)
474:11
TERM (1)
463:1.5
terms (6)
508:23;514:18,18;
516:4,9;532:5
test (16)
484:16;485:3;
519:14;535:16,19,20;
536:4,17,22;537:4,7,
11,13,19;538:9,12
testified (6)
466:8,10;468:4;
473:3;475:18;528:2
testify (1)
525:11
testimony (26)
466:18,19,22;
467:17,20;468:14;
471:10;472:18;476:21;
484:3;527:6,10,15,19,
25;528:6;535:17;
539:5,6,9,23,24;
540:21,25;541:1,11
testing (3)
485:5;494:15;529:16
tests (3)
482:18;520:2;535:16
therapy (6)
477:25;478:3,4,7,10,
24
thereafter (2)
475:11;488:11
thereby (1)
489:23
third (8)
485:14,15,15;508:3,
5,11;509:7,9
third-party (1)
464:25
thirds (1)
508:18
Thomann (1)
540:20
Thomann's (3)
540:21,22,25
THOMAS (88)
463:13.5,15.5;464:1,
19,21;466:2;467:3,21;
468:8,25;469:16,20;
470:7;471:12,17,23;
472:10,19,20;473:22,
23,25;475:23;476:5,10,
21;480:8,11;487:2;
491:8,15;494:21,25;
496:20;497:21;500:10,
18;502:11;505:11;
509:23;514:25;515:8;
517:13,18,23;518:4;
519:24;520:10,15,20;
521:3,19;522:7,24;
523:4;524:4,6,19;
526:2,4;527:21;
529:25;530:2;531:17,
24;532:3,14;533:24;
534:2,12,18;535:8;
536:19;537:23;538:4,
13,17;539:3,13,16;
540:11,12,14,20;541:3,
5,8,12
thoracic (3)
481:1;482:10,15
though (3)
494:6;501:23;505:6
three (3)
493:11;536:13,14
throughout (4)
481:12;482:24;
491:7;538:2
thumb (1)
485:23
Thursday (5)
540:14,18,22,24;
541:1
tightly (1)
494:7
times (5)
469:13;482:16;
488:6;536:11,23
tingling (1)
515:12
tiny (1)
502:1
tissue (2)
482:8,9
titanium (2)
491:2;498:15
today (13)
467:1;469:4;506:11,
14;516:17;517:2,8,17;
525:25;527:10,25;
533:18;539:22
today's (1)
472:18

together (12)
481:9;487:21;
490:24;491:7;492:9;
493:10,13,15;500:16;
502:6,19;525:3
told (6)
472:4;510:23;517:9,
10,14;524:18
tolerate (1)
477:22
tomorrow (8)
471:9,16;539:22;
540:3,7,13;541:3,10
tone (1)
480:14
took (7)
473:3;477:12;492:3,
3,5,7;494:6
tools (3)
489:15;490:9;493:22
top (18)
480:17,24;481:6;
485:14;490:11;492:8,
10;496:10,12;498:6;
500:1,2,3;501:12;
502:4;516:14;530:8,10
total (1)
465:21
Totally (2)
522:8;524:7
touching (2)
484:19;501:7
Touliopolous (1)
471:2
toward (1)
485:23
towards (1)
529:23
trachea (1)
489:8
training (1)
475:17
translated (1)
496:5
transparency (1)
465:21
trashed (1)
526:14
trauma (1)
482:14
travel (3)
481:25;482:9;503:20
traveling (2)
484:15,21
traverses (1)
485:22
treat (1)
504:9
treated (1)
515:22
treating (4)
477:3;515:13;
516:10;527:1
treatment (17)
478:4,8,24;479:17;
504:7,7,8;505:7;
516:12;517:16;527:3;
532:1;533:5,22;535:3;
538:2,6
Trial (3)
517:11;528:3;541:14
triangular-shaped (1)
481:4
tried (2)
465:19;477:19
trigger (1)
478:11
trip (1)
471:24
trust (1)
465:20
trying (3)
469:20;499:9;511:1
tumors (1)
495:21
turn (1)
530:2
TURNER (1)
463:5.5
TV (1)
530:2
two (10)
477:20;485:10;
489:24;490:19;492:2,
19;508:18;519:9;
536:14,25
two-dimensional (1)
496:11
type (5)
479:6;485:6;491:24;
502:1;508:16
types (2)
482:14;487:10
typical (1)
512:7
typically (19)
474:8;479:3;481:13;
485:3,18;487:9;488:9;
489:8;493:19;504:24;
507:11;510:25;518:20;
519:5,11;522:19,21;
532:6;537:14

U

ultimately (2)
487:17;525:9
under (4)
468:4;488:3;524:3;
539:8
undergo (1)
512:12
undergone (1)
477:17
Understood (4)
464:18;465:22,23;
467:11
Universal (2)
476:11;533:9
University (2)
475:10,16
unless (4)
485:18;487:11;
518:20;537:15
unlike (1)
503:1
unusual (1)
528:23
up (27)
471:25;474:10;
481:6;484:2;489:3;
490:20;491:4;492:20;
493:7;494:19;495:13,
22;496:11,12,14;
498:16,17;499:14,16;
502:17;508:3,5,11,18;
509:9;529:25;530:1
updated (1)
479:8
upon (4)
495:14;496:3;
499:19;520:7
upper (1)
481:2
use (8)
471:15;476:24;
479:24;484:3;488:15;
490:19;500:10;528:7
used (1)
491:25
using (1)
502:12

V

various (2)
468:4;481:23
vehicle (1)
509:11
vertebra (1)
502:4
vertebrae (4)
493:9,10,25;502:4
vertebral (14)
490:5,7,12;491:3;
498:11,15,18,20,21,23;
499:6,8,24;501:1
vessels (1)
489:9
view (5)
496:9,9,13;500:6,14
violate (1)
467:10
visit (13)
507:8;515:25;
524:24;526:11;532:21,
23;535:20,21,22;536:1,
2,15;538:16
visits (3)
536:13;537:2,21
vocational (3)
510:10,13,14
voice (1)
489:2
voir (3)
470:2,20,24

W

wait (2)
473:16;539:7
wake (1)
491:4
wake-up (1)
488:11
walk (1)
491:4
walking (2)
481:11;509:3
walks (1)
466:13
wants (1)
501:16
water (7)
495:13,13,14,15,23;
496:2;512:9
way (16)
465:12;466:2;481:9,
12;482:3;489:22;
495:3,4,9,14,21,23;
496:13;513:22;530:4;
534:14
wear (3)
503:3,15,19
Wednesday (1)
541:14
weekly (1)
474:25
weren't (1)
479:18
what's (6)
478:13;484:13;
490:21;496:6;497:23;
521:8
Whereupon (12)
464:4;472:13;
491:16;505:15;516:22;
518:6,11;521:21;
538:19;539:18;540:10;
541:14
white (1)
499:22
WHITNEY (1)
463:5.5
whole (2)
497:1,4
who's (1)
525:1
wires (1)
481:19
wish (1)
540:12
withdrawn (2)
477:5;478:22
within (8)
484:18;503:22;
504:10;505:2;512:11;
521:11;524:11;531:2
without (4)
466:8;467:24;491:6;
504:24
witness (38)
466:1,6,18;467:23;
468:16,19;469:25;
470:3,4,6,12;471:13;
472:1,9,22;473:1,3,6,9,
21,22;476:6,14;496:21,
24;500:19;516:25;
517:20;521:3,4;522:1;
524:9;529:20,23;
535:7;539:11,15,16
witness' (4)
467:17;468:14;
539:24;540:2
witnesses (1)
470:16
won (2)
495:19,24
words (3)
469:15;492:14;
499:21
work (16)
475:8;477:18,19,19,
21;483:3;507:2,4,5,17;
508:24;509:21,22;
510:1,4,6
workday (1)
508:8
worked (1)
477:19
Worker's (1)
507:24
working (8)
474:9;477:14,22;
481:10;489:13;499:20;
508:14,16
works (2)
495:8,9
world (1)
478:18
worrying (1)
491:6
worse (2)
487:5,11
wrist (3)
485:22,23;486:2
write (1)
519:17
written (1)
519:8
wrote (1)
520:1

X

X-ray (10)
489:13;495:10,10;
500:8,14,17,20;501:1,
19,20
X-rays (3)
494:16;506:5;514:11

Y

year (1)
507:12
years (5)
477:8;503:9;504:9;
507:13;525:25
yellow (1)
481:16
YORK (11)
463:1,1.5,7.5,8.5,8.5,
15,18.5,18.5;468:7;
473:7;507:24
younger (1)
503:17

Z

zip (1)
473:8
zone (2)
499:8,9

0

001/010 (2)
530:10,22

1

1 (1)
495:1
10 (1)
530:24
10006 (1)
463:18.5
10007 (1)
463:8.5
108-18 (1)
463:14.5
11215 (1)
473:9
11375 (1)
463:15
12 (1)
481:2
13 (1)
536:25
13th (2)
538:10,12
15 (8)
469:10,14;496:25;
497:5,24;499:12;
502:11;503:11
158766/2015 (1)
463:4.5
15th (1)
502:10
16 (5)
477:14;503:23;
513:2,11,20
16th (1)
463:18
18 (8)
464:5;476:6,10;
529:7,10;531:12;
532:9;533:7
19 (8)
476:7,11;529:7;
532:16,18;533:4,8,9

2

2 (1)
497:12
2:15 (4)
539:23;540:7;
541:11,15
20 (23)
464:13;476:7,12,18;
503:11;518:14,17;
519:1,23;520:17;
522:22;523:2;524:15;
525:17;526:10;527:12,
16;529:17;530:14;
531:10;532:12,18;
533:2
2013 (7)
477:14;503:24;
513:2,11,21;515:7,15
2015 (5)
512:3,23;513:24;
514:1;529:2
2016 (1)
477:22
2019 (5)
477:7,8;534:5;536:5;
538:7
2020 (5)
512:4,24;536:25;
538:10,12
2021 (3)
487:25;502:11;537:1
2023 (5)
496:20;507:8,18;
536:3,5
2024 (2)
463:9;541:15
20A (2)
464:6;494:18
21 (1)
502:10
22nd (1)
528:3
23 (1)
528:3
24 (1)
463:9
25 (1)
541:15
26 (1)
537:1
26th (1)
487:25
28 (2)
507:8,18
28th (1)
536:3
29 (1)
477:7
29th (3)
534:4;536:5;538:7

3

3 (2)
497:12,12
3122a (1)
464:15

4

45 (1)
463:18

5

5 (2)
463:1.5;497:12
5672 (1)
473:6
59 (1)
503:6
5th (2)
463:14.5;496:20

6

6 (2)
497:12,24
60 (1)
503:9
62 (1)
503:11

7

7 (6)
512:3,4,23,24;
513:24;514:1
7th (1)
529:2

8

80 (1)
463:8

9

9/15 (1)
500:18
9/15/21 (1)
500:19
9:30 (2)
540:23,24