Exhibit D

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF BRONX

----------x

LORRAINE ELSIE EVANS,

Plaintiff, Index No.

-against- 24968/2015E

THE NEW YORK AND PRESBYTERIAN HOSPITAL and WEILL CORNELL MEDICAL CENTER,

Defendants.

----------x

June 25, 2018

9:33 a.m.

DEPOSITION OF RADU LUCIAN SULICA, M.D., taken pursuant to Notice, at the law offices of Martin Clearwater & Bell LLP, 220 East 42nd Street, New York, New York, before Eleanor Greenhouse, a Shorthand Reporter and Notary Public within and for the State of New York.

GREENHOUSE REPORTING, INC.
236 West 30th Street - 5th Floor
New York, New York 10001
(212) 279-5108

A P P E A R A N C E S

JOSHUA E. ABRAHAM, ESQ.
Attorney for Plaintiff
477 Madison Avenue
Suite 1230
New York, New York 10022

MARTIN CLEARWATER & BELL LLP
Attorney for Defendants
220 East 42nd Street
New York, New York 10017
BY: RYAN T. FOX, ESQ.

S T I P U L A T I O N S

IT IS HEREBY STIPULATED AND AGREED by and between counsel for the respective parties hereto that all rights provided by the CPLR, including the right to object to any question except as to the form or to move to strike any testimony at this examination before trial shall not be a bar or waiver to make such a motion at, and is reserved for, the trial of this action.

IT IS FURTHER STIPULATED AND AGREED by and between counsel for the respective parties hereto that this examination may be sworn to by the witness being examined before a Notary Public other than the Notary Public before whom this examination was begun, but the failure to do so or to return the original of this examination to counsel, shall not be deemed a waiver or rights provided by the Rules 3116 and 3117 of the CPLR and shall be controlled thereby.

RADU LUCIAN SULICA, called as a witness, having been duly sworn by a Notary Public, was examined and testified as follows:

EXAMINATION BY

MR. ABRAHAM:

Q. Dr. Sulica, am I pronouncing that correctly?

A. Yes, sir.

Q. Thank you for appearing to testify today in this case. What did you do to prepare for this deposition?

A. I reviewed the in-patient medical record and my outpatient medical record.

MR. COX: Of course, he's asking you outside the context of discussions you had with your counsel.

Q. That's right. When you say in-patient medical records, what do you mean by that?

A. I'm referring to these documents here.

R. Sulica

Q. By that, what do you mean, when you refer to documents here? Be more specific.

A. I don't know what the legal -- the designation of this, but I guess the certified copy of the in-patient medical record. Does that answer the question?

Q. Yes. And you said outpatient records as well.

A. That's right.

Q. What do you mean by that?

A. Those are my office notes that I keep as I'm taking care of the patient as an outpatient.

Q. So there are times when you take in-patient records and there are times when you take outpatient records?

A. Correct.

Q. Why would you take two separate sets of records?

A. So the records -- the in-patient records are generated when the patient is actually in the hospital, even if it would be for, say, an outpatient

surgery.

Q. Okay.

A. Okay. And the outpatient records are when the patient is in my office being cared for away from the hospital environment.

Q. Thank you. So do you believe, in preparation for today's deposition, that you've reviewed all the medical records relating to this specific patient and relating to this specific procedure?

A. I do.

Q. Have you ever been a defendant in any litigation before?

A. So yes. There's a case pending against me right now.

Q. Okay.

A. It has been pending for many years. I don't know the status right now. It's in Suffolk County which I'm told is glacial.

Q. That's right. Do you know the name of that case off the top of your head?

A. Not off the top of my head.

R. Sulica

Q. Do you know the name of the plaintiff in that case?

A. Again, not off the top of my head. I haven't looked at those charts in three years and I kid you not.

MR. COX: Off the record.

(Discussion off the record.)

Q. Do you recall when that case was filed?

A. I don't.

Q. What is the subject of that case?

A. A delay in diagnosis.

Q. Have you ever been deposed before?

A. Yes.

Q. When was that?

A. I've been deposed multiple times as an expert witness and we had a deposition for that case as well.

Q. How many times have you been deposed as an expert witness?

A. More than half a dozen, less than a dozen.

R. Sulica

Q. Have you ever provided trial testimony as an expert?

A. I have, on two occasions.

Q. What do you recall about those occasions? When were they?

A. One was maybe about ten years ago in Rochester for defense, and the other one was earlier this year and last year on Staten Island. It was a mistrial so I went twice.

Q. What is your area of expertise for purposes of testimony?

A. Care of laryngeal disorders.

Q. Tell me about your educational history.

A. I went to college at Dartmouth College. After I got my bachelors there, I went to medical school at Georgetown University School of Medicine. I stayed at Georgetown after my medical degree to complete a residency in oral otolaryngology - head and neck surgery. That's the medical name for ear, nose and throat. Two years is just on that of the residency.

Q. So you had a residency?

A. In otolaryngology - head and neck surgery, followed by a supplementary optional year of training in care of laryngeal disorders here in New York at the former Roosevelt Hospital, and then I went into practice.

Q. And you're in private practice now?

A. No. I'm faculty at Weill Cornell Medical College which is the medical college of Cornell. I'm a full professor. I hold an endowed chair in laryngology and voice disorders. I'm the inaugural holder of that chair which means --

Q. It was started for you?

A. It was created for the care of voice disorders and I'm director of the Sean Parker Institute for Voice Disorders which is an institute within the college that devotes itself to the care of voice disorders.

Q. Who is your employer?

A. The medical college.

Q. What is the specific name of it?

A. Weill Cornell Medical College.

Q. Are you employed by anyone else?

A. No.

Q. Are you in a partnership with anyone else?

A. No.

Q. So when you say patients, under what context are you seeing patients, on behalf of whom?

A. On behalf of the medical college.

Q. So the medical college provides medical services as well?

A. Yes, exactly right. There's an entity within the medical college that concerns itself with clinical services.

Q. Which entity provides support services to you, staffing, things of that nature?

A. Also the medical college as an

outpatient, and then when I work in the hospital, New York - Presbyterian Hospital is a separate entity that has credentialed me to provide patient services there.

Q. How would you describe your affiliation with the New York - Presbyterian Hospital?

A. I'm a credentialed physician with them.

Q. So you're an attending?

A. Yes, correct.

Q. Which entity provides your malpractice coverage?

MR. COX: Note my objection. I'm going to instruct the witness would not to answer.

MR. ABRAHAM: Why?

MR. COX: It's relevant to his testimony here today and I think we've already provided disclosure in terms of what his coverage situation is.

MR. ABRAHAM: I think -- off the record.

(Discussion off the record.)

MR. COX: We will go back on the record. If you know the answer to the question, you can answer over objection.

A. My malpractice insurance is provided as part of my employment.

Q. So it's provided by Weill Cornell, the college?

A. That's correct.

Q. Okay.

A. As far as I know.

Q. Okay. Thank you. Do you have an understanding of what this present case is about?

A. Yes.

Q. Do you have any board certifications?

A. Yes, I'm board certified in otolaryngology - head and neck surgery. There is no board certification in my subspecialty.

Q. What is otolaryngology?

A. Ear, nose and throat medicine.

Q. If you had to describe to a lay person on the street exactly what you do, what would that be?

A. Well, so even though I'm board certified in ear, nose and throat medicine, I'm basically just a T. All I deal with is throat disorders, specifically, disorders of the larynx, which is the voice box. Those have to do with voice disorders, swallowing disorders, breathing disorders, tumors of the larynx.

Q. How many patients would you say you see on a weekly basis?

A. I would say probably, say, about 60 out-patients.

Q. That's a lot; right?

MR. COX: Note my objection. You can answer.

A. Yeah. It keeps me out of trouble.

Q. And you also teach?

A. I do.

Q. So on a given day, how much time do you teach and how much time do you

practice?

A. So many times it's concurrent, because the -- in my little corner of medicine, it's not something that every doctor necessarily needs to know so I'm not going to fill a lecture hall. So what will happen is trainees at various levels will rotate with me in the office and as we see patients, as they see the process of getting information from patients and examining patients and making our treatment plans, they'll learn. And then there's teaching points that you make throughout that, and they ask questions and that's typically how it works. It looks more like an apprenticeship than a typical college lecturer.

Q. Just because it's small and intimate?

A. Exactly.

Q. How many students would you estimate you have at any given time?

A. Oh, it varies so much. You know, for example, I have a fellow right

now. There are 12 residents in the department who are not always rotating with me, but one of them is usually around the office. We have a visiting doctor from overseas. It's a constantly changing cast.

Q. Do you travel a lot?

A. I travel as often as I'm invited to.

Q. How often would you estimate in any given year, conferences?

A. Three or four times a year, not including our national conferences in the U.S.

Q. So when you say three to four times a year, that would be internationally?

A. Internationally or if I get invited to be a visiting professor at another university.

Q. And on top of all that, you also provide expert witness services?

A. As little as I possibly can, to be honest.

Q. Why is that?

R. Sulica

A. I just don't enjoy the experience, but I feel it's my obligation to ensure quality in the care of patients.

MR. ABRAHAM: Okay. Fair enough. Just mark this as Exhibit 1.

(Plaintiff's Exhibit 1, inpatient medical records, marked for identification.)

MR. COX: Is this the hospital chart?

MR. ABRAHAM: Off the record.

(Discussion off the record.)

Q. So I've placed before you what has been marked Plaintiff's Exhibit 1. If you could just take a moment and leaf through it and let me know if you're familiar with it.

A. Yes. This looks like the inpatient medical record that I reviewed.

Q. When did you review it specifically in preparation for today.

A. I reviewed it on Saturday morning.

Q. Sorry to take your time on a

Saturday.

And you're familiar with Elsie Lorraine Evans?

A. Yes.

Q. What do you know about her as you sit here today?

A. Well, I recall that she was a very nice, elderly African-American lady who was sent to me by my colleague, David Cutler, who is a head and neck cancer doctor in our department to whom she was originally sent from the outside. I don't recall where she came from.

The matter was a mass that was seen in her larynx by a CT scan done outside and he handed her off to me because I was a laryngeal specialist.

After a few visits and a repeat scan to establish the nature of the disorder, I took Ms. Evans to the operating room to perform a biopsy and in the operating room, this incident happened, and then I communicated one more time with her and that was it.

Q. Do you know why she had that original CT scan?

A. I think because she was hoarse.

Q. Prior to what you referred to as the incident or the procedure, do you recall how many times you met with her pre-op?

A. Two or three times.

Q. What was the purpose of those meetings?

A. Well, the purpose of those meetings was to decide whether she really needed a biopsy. She was an elderly lady with a very, very atypical finding on her CT scan, and --

Q. What was atypical about it if you recall?

A. So most tumors in the larynx are superficial. They occur on the surface of the larynx and typically you can see those when you examine the patient in the office.

Q. So you can look in the patient's mouth and observe the actual

mass?

A. That's exactly right, and 99.5 percent of laryngeal tumors are like that. The CT scan suggested she had a tumor deep in the larynx.

Q. What do you mean by that?

A. Not visible from the outside, buried in the muscle. These things exist, but they're extremely rare, and you don't know what type of tumor it is so there can be benign tumors or malignant tumors. A malignant tumor is a potentially life threatening entity and it wasn't clear which it was from the CT scan.

I wasn't eager to expose Ms. Evans to a general anesthetic.

Q. Why not?

A. Because she was elderly.

Q. What sort of complications can occur from general anesthesia?

A. As we say in our phraseology, including but not limited to death, stroke, myocardial infarction, life threatening things, not trivial things. But a repeat

CT scan showed that the mass was growing and under those circumstances, I decided that we, in fact, did need to do a biopsy.

Q. Do you recall how big the mass was as we sit here today?

A. I don't recall the numbers, but if you let me look at that chart, I can tell you from the CT scan.

Q. But it was unusually large?

A. It was a mass that was growing.

Q. It was growing?

A. The size was not part of my decision-making. This is a lady with a growing mass in her larynx.

Q. As we sit here today, do you know if that mass has ever been removed?

A. I don't.

Q. What discussions do you recall with Ms. Evans in those two or three meetings -- your attorney is gesturing as if he may be objecting so why don't we --

MR. COX: I'm just going to put my objection on the record, just in terms of I don't know if it's easier

to specify it by date when things are happening. If you want him to refer to the chart, that would be helpful just in terms of him being able to review what specific dates of treatment there are, and to the extent maybe you have more specific questions regarding different aspects of what happened, I think that would be more appropriate.

MR. ABRAHAM: Okay. We will get there. I appreciate that.

Q. As we sit here today, based on your recollection, what do you recall in these discussions in these meetings prior to the operation?

A. You know, they would have been very similar to what you and I just discussed. I'm usually very straightforward with my patients. I lay out my thinking process. I explain to them why we're getting another CT scan, why I've decided to -- why I'm recommending that they undergo a biopsy.

I would have explained to her that we have a mass. We're going to watch it for a little while to make sure the biopsy is necessary. We're going to get a repeat CT scan. The repeat CT scan comes back. I would have explained to her that it looks like the mass is growing and I think we need to understand what it is.

Q. To your recollection, what was her demeanor like during these preoperative meetings?

A. I remember her as an extremely nice lady who -- I mean, I don't remember very much about the interaction other than she listened, she thought about it, and she agreed.

Q. Did you notice any sort of cognitive issues or issues related to the fact that she is an elderly woman in terms of processing information?

A. No.

MR. COX: Just note my objection.

Q. Did the fact that she was, as

we said, an elderly woman, did that cause you to vary the way you explained any information or the way that you expected her to process any information?

MR. COX: From a mental aspect?

MR. ABRAHAM: From a mental aspect, from an age aspect, from a cognitive aspect.

MR. COX: My objection is only related to because he previously gave testimony about the age being a consideration in terms of whether to proceed with the biopsy in having an elderly patient undergo anesthesia, so if you're asking specifically about the cognitive aspect, that's fine.

MR. ABRAHAM: Yes, exactly.

A. So everybody brings something different to a medical appointment and you definitely have to adjust your explanations to what the patient brings in terms of education level, in terms of their experience with the medical field and

whatever. I can't recreate for you verbatim how I discussed things with Ms. Evans, but we had a normal interaction throughout the entire visit.

She asked appropriate questions and I explained the situation to her on each occasion more or less as I felt she was capable of understanding it.

Q. Okay. And after these preoperative examinations, did you take notes?

A. Yes, I did.

Q. Outpatient notes?

A. That's correct.

Q. That's possibly what this is, and I'm pointing to the documents that you brought today.

A. That is true.

Q. What is your practice of taking outpatient notes in terms of the timing? Does that occur immediately after you see a patient? Does that occur later in the day? Talk about that.

A. It occurs concurrently with the

patient. So, for example, when the visit starts, the patient is in the examination chair. I'm seated at the computer. We all have electronic medical records now and I take the history from the patient, and I write that down as I take it.

Then I get up and perform a physical examination on the patient and prepare them for whatever endoscopy I think they need, so in order to look at the larynx, you need to use an endoscope to look through the mouth or the nose, and I'll make that judgment based on the patient's history and my physical examination.

Q. What determines whether you go through the mouth or the nose?

A. So that's an essay question. It depends -- the first thing is what the patient can tolerate. The second thing is what type of a disorder I think they have. So, for example, if I believe that a patient has a movement disorder like a paralyzed vocal cord or something like

that, I might use a flexible scope through the nose. These are not hard and fast rules. There are exceptions in each case.

Whereas if the patient has a lump or bump on their vocal cord, I might try to use the scope through the mouth because the optics are just slightly better.

Q. Why are the optics better if you go through the mouth or through the nose?

A. The technology is different.

Q. What is the name of this procedure?

A. It's called a laryngoscopy.

Q. How would you define a laryngoscopy?

A. A laryngoscopy is a look at the larynx. So a laryngoscopy is a very broad term for having a look at the larynx. It can be done in one of three ways. It can be done with a dental mirror if you recall the Norman Rockwell pictures of the doctors with the head mirror. That's what that is

for, so you can reflect a light off the head mirror into the patient's mouth and you can use a laryngeal mirror at the back of the tongue to look at the larynx.

You put a laryngeal mirror at the back of the tongue and you look down at the larynx and the vocal cords. We don't do that very much because it doesn't allow us to record the examination and sometimes we like to look at the video.

Q. Was there a video in this case?

A. There was video at the time that I saw her.

Q. When you say that, what do you mean? In the preoperative examination, there was a video taken?

A. Yes.

Q. Of your preoperative examinations?

A. Yes.

Q. Why is there a video taken in the preoperative examinations?

A. Well, the same reason you might

document what you see on any type of examination so you can compare it with an exam later. You know, my memory isn't good enough to keep all these larynxes in mind.

Q. So video would be for you to refer back to at a later time?

A. For a comparison.

Q. Before and after?

A. Right.

Q. Can you produce copies of these videos? Do you still maintain them? Do you still maintain these videos?

A. The answer is maybe. If they're still on the server, I can produce them.

REQ MR. ABRAHAM: Would you be able to look at the server and see if you still have videos?

MR. COX: I don't know how to look onto a server, but if you send me a document request, I'll absolutely respond to it.

MR. ABRAHAM: But for purposes of today, you're saying it's possible

that these videos are still on the server?

THE WITNESS: Yes.

Q. When the actual procedure took place in the hospital, was that video recorded as well?

A. No.

Q. Why not?

A. Because that's a different context.

Q. Different place, different procedures?

A. Yeah, right.

Q. Okay.

A. It's an operating room that I use one day a week. It's not set up, you know, by me for me, exclusively for me, the way my office is.

Q. When you're taking a video of a patient in a preoperative examination, at what point do you start the video?

A. When we have a view of the larynx in general.

Q. So just that aspect of checking

the larynx, that's what is video recorded?

A. Typically. I mean, you know, typically.

Q. So getting back to what we were discussing before, before we took that detour, you said there are three methods of endoscopy, so you were talking about the first method involving a mirror.

A. Right. The second method is to use a flexible endoscope through the patient's nose that passes through the nose down the back of the throat and let's us look at the larynx that way. That image is carried by optical fibers and it's an electronic image that is transmitted electronically. It's a pixilated look, and the resolution depends on the quality of the equipment.

Then there's an examination through the mouth which is done with a rigid endoscope. A rigid endoscope looks like a steel rod that has an angled mirror on the end, and it's just a reflected image through glass prisms so there's no digital

image deterioration. You asked originally why is that image better. Because the technology is different in that way.

Q. All three methods, is that just for observing or can all three methods be used for biopsy as well?

A. In this specific case or in general?

Q. In general.

A. In general, the two methods can be used for biopsy.

Q. So through the nose can be used for biopsy?

A. Yes.

Q. Through the mouth can be used for biopsy?

A. Yes.

Q. During your examinations prior to the actual procedure, in examining the patient, what method did you use just for the examination?

A. May I look at the chart?

Q. If you recall. And then I can give you the chart.

A. I don't want to say offhand and be mistaken.

MR. COX: If you can't answer without --

MR. ABRAHAM: It's not a trick question.

A. I genuinely don't recall.

MR. ABRAHAM: Let's mark this as Exhibit 2.

(Discussion off the record.)

Q. In this particular case, a decision was made in terms of how to do the procedure at some point, correct, in terms of whether you go one of these three routes that we discussed?

A. The three routes that I discussed are for office evaluation.

For operative evaluation, you only have one route.

Q. What is that route?

A. Through the mouth.

Q. Why is that?

A. Because you're not just looking. You need to instrument the larynx

so you need direct access to the larynx. You need line of sight access to the larynx.

Q. Okay. Previously I asked you whether the larynx could be biopsied through the nose.

A. That's correct.

Q. Okay. Do you want --

A. So I answered -- I asked you in return, do you mean in this specific case or do you mean generally?

Q. Generally.

A. And I answered generally. In this specific case, I cannot biopsy her through the nose because the tumor is deep in the larynx. It's not anywhere that I can see it and I can't enter the tissue of the larynx in a situation that I can't control bleeding, like the office.

Q. Have you ever biopsied patients in this procedure through the nose before during your career?

A. Yes, I have.

Q. What percentage of the time is

a patient biopsied through the nose as opposed to through the mouth in your experience?

A. Usually about ten percent of the time because you usually want to treat a cancer at the same time that you're diagnosing it.

Q. What do you mean by that?

A. So in order to treat a cancer, you've got to remove the entire tumor. I can't do that in the office.

Q. Why not?

A. Because it needs -- you need to cut into the tissue and you need to have control over margins to make sure you've got the entire disease and you just don't have that level of precision in the office. You can take a piece of it, but you can't reliably cure cancer in the office.

MR. COX: I think one of the issues is -- I think you're cutting him off so when you get the transcript, there's not going to be complete responses to the questions

that you originally asking, because you want to ask an additional question based on what he just said when he's in the middle of a response so I don't know if it would make sense to allow him to finish answering the full question and then break it down or to do otherwise, but I wanted to bring that point up.

MR. ABRAHAM: Thanks.

MR. COX: What is the question?

(The record was read.)

A. So usually when you see a cancer, you have a pretty good idea that it's a cancer and that patient is going to have to undergo a general anesthetic anyway. So instead of putting a patient through an office biopsy, you might take him to the operating room to do the biopsy and treat the cancer at the same time.

Q. By treating, do you mean removing?

A. That's right.

Q. Not administering any other

medication at that specific time?

A. No.

Q. So go ahead. Sorry.

A. That's my answer.

Q. Oh, that's your answer. Okay. I just wanted to make sure you had completed your answer. So in this particular case, it had to be done through the mouth you said?

A. That's right.

Q. Why?

A. Because I couldn't see it in the office. It was deep in the tissue of the larynx, which was demonstrated to me by her CT scan.

Q. Have you ever in your practice, in your experience, treated a similar condition or situation through the nose?

A. Treated or evaluated?

Q. Evaluated and treated.

A. Evaluated, yes; treated, no.

Q. Let's look at Exhibit 1. Eventually the patient was treated on January 9th, 2015, I believe, but let's

confirm that. That's when the procedure took place.

MR. COX: Is that the question?

MR. ABRAHAM: We will confirm that but I'd like you to turn to page 102 of the document in front of you.

Q. This is, at the top of the page, titled Operative Report and it's entered on January 9, 2015.

Do you know if that is the date on which you operated on this particular patient?

A. I believe it is.

Q. And you reviewed these medical records before today?

A. Yes.

Q. Do you recall reviewing this page before today?

A. I do.

Q. So what happened on January 9, 2015?

MR. COX: What do you mean what happened?

Q. What happened during the

procedure? Walk me through it to the best of your recollection and based on what you've read.

A. Okay.

Q. From the morning to the evening.

MR. COX: I think you're asking for a narrative which is improper for this type of format, so if you want to ask a more specific question, I'm perfectly fine with that, but if you're just saying what happened throughout the entire day, that's asking for a narrative.

Q. What do you recall happened during the procedure?

A. Okay.

MR. COX: Again, it's the same issue. So, I mean, if you want to take it by specific aspects of the procedure, that's perfectly fine, but if you're asking him for a ten-page narrative, then that's going to be inappropriate for a deposition

format.

MR. ABRAHAM: I'm not asking for a ten-page narrative. I'm just asking what happened to the best of the doctor's recollection. It's not an improper question. Your objection is noted. So I'm asking the doctor to describe what happened that day.

MR. COX: Again, it's the same issue. Why don't you break it down.

MR. ABRAHAM: I'm objecting to this talking objection. You can object to the form, that's fine, but just respectfully, I'm asking a question.

MR. COX: It's an improper question.

MR. ABRAHAM: If you think it's improper, I respectfully disagree.

MR. COX: Why don't you just make it easier for the witness and just break it down by specific format because you're asking him what happened throughout the day. That

could be a 20-page narrative. That could be anything. So why don't you just ask, did you have pre-op discussions with her? I can suggest several questions but just break it down just in terms of the time frame. What happened --

MR. ABRAHAM: Ryan, this is highly disruptive.

MR. COX: No. I'm trying to help you out.

MR. ABRAHAM: Don't help me out, please.

MR. COX: The question the way you asked it is improper.

Q. Dr. Sulica, what happened during the procedure?

MR. COX: The same objection.

MR. ABRAHAM: Your objection is noted. Let's go.

A. So where do you want me to begin my narrative?

Q. She --

MR. COX: Again, I'm not going

to have him give a narrative.

MR. ABRAHAM: Ryan, please stop.

MR. COX: Just ask simple questions just in terms -- you have the entire procedure here, so what happened leading up to the time of the injury, for example. That's perfectly fine, but just break it down in terms of time frame because otherwise, you're going to have him speaking for 15 minutes.

MR. ABRAHAM: I'm fine with that.

MR. COX: But that's improper. That's what I'm saying. That's a narrative.

MR. ABRAHAM: If you want to get me a case that tells me that that question is improper, please, I'll take ten minutes. This is really inappropriate.

MR. COX: It's not inappropriate. I'm asking you to

present a proper question. That's perfectly fine.

MR. ABRAHAM: I'll wait. Do you want to get me a case?

MR. COX: No.

MR. ABRAHAM: Then let's move on.

MR. COX: I'm going to instruct the witness not to answer in that format.

MR. ABRAHAM: Do you want me to shut this deposition down and file a motion? Come on, this is ridiculous. I'm asking the doctor what happened. If you have an objection to that, then just note it, and let's move on.

MR. COX: You said what happened on the day of January 9, 2015? Obviously an entire surgery happened. There were things that happened before the procedure, during the procedure, after the procedure.

MR. ABRAHAM: This is not like you, man. Come on. Let's just keep

this flow going. Your objections have been noted. Let's move on.

MR. COX: You're not going to get an admissible response, though.

MR. ABRAHAM: Then I'll worry about that at trial. Okay? That's my problem, not yours, respectfully.

MR. COX: Okay. Are you going to cut him off at certain aspects of the answer? Because that when it's going to be problematic because he won't provide a full response to your question if you're asking for a narrative. If you want to ask him about narratives, about prior discussions --

MR. ABRAHAM: Let's move on.

Q. Let's talk about the incident that occurred on January 9, 2015. What do you recall about the procedure on that day?

A. So what I recall is largely --

MR. COX: Note my objection. You can answer over objection.

A. What I recall is largely

contained within this operative report.

Q. Thank you.

A. After I would have seen the patient pre-op, she was brought to the operating room and put to sleep by the anesthesia team.

Q. Okay.

A. After the patient was asleep, the table gets turned so that I'm at the head of the bed. We drape the patient with sterile drapes, I scrub, and then I move to the head of the bed.

I open the patient's mouth, I assess the patient's mouth, and apply a tooth guard, and then in addition to the tooth guard, I apply a wet sponge as extra protection for the teeth.

And then we insert an instrument called the laryngoscope through the patient's mouth. These are different from the laryngoscopes that we use in the office in that they're essentially a hollow metal tube that keep all of the tissues of the tongue and the mouth from crowding our

approach to the vocal cords.

We insert this metal tube while we're looking. We guide it down to the larynx and once we have a good surgical view, we attach it to a thing called the Lewy arm that is a holder essentially so you can have two hands free to operate.

In this particular case, I had difficulty getting adequate surgical exposure and I went through multiple models of laryngoscope. These vary in their shape, cross-sectional area, all these different things that allow us to get down to the larynx, and I finally got good laryngeal exposure with a model called the modular glottiscope and I attached that to the Lewy arm.

So once we have a good view, we bring the microscope in because we operate looking through a microscope putting our instruments into the laryngoscope. At some point, the view shifted at that point, so I realized something had happened.

Q. Okay.

A. So I unpacked all of that. I removed the microscope, took the laryngoscope out of the patient's mouth, took the tooth guard off and saw that the maxillary dental ridge was loose.

At that point I called the oral maxillofacial surgeon to have a look, who came pretty promptly, and she told me what had happened.

She consulted with her attending and came back into the room and gave me the recommendation that that ridge be stabilized. She explained to me that it would certainly need further attention after that.

I decided at that point not to proceed with the biopsy because to do so, I would have had to remove the whole -- the whole segment.

I broke scrub, I went downstairs where the patient's family waits and I met with her niece. I explained to her what had happened. I explained to her that the oral maxillofacial surgeons had

evaluated the injury and that they had recommended this course of action.

At that point, she agreed. I went back to the operating room, let the oral maxillofacial surgeons do what they had to do, and that is the end of the procedure.

Q. You testified that during the procedure, the view shifted.

A. Yes.

Q. What do you mean by that?

A. Okay. So the laryngoscope sits in the self-retaining device called the Lewy arm and it gives you a stable view of the vocal cords. At this point, I back away from the table and I bring a microscope head from above and I line it up with the laryngoscope.

Q. When you say line it up, that gets threaded through it?

A. No, no, no. I really want to draw it for you but --

Q. I was going to ask you, but I don't think your attorney will let you do

that.

A. Let me see if I can explain it to you. So the laryngoscope is stabilized, nothing happens to the laryngoscope. The microscope is a separate device that hangs down between me and the laryngoscope, and then between the microscope and the laryngoscope, there's a space through which I would need to insert my instruments.

So --

Q. The biopsy instruments?

A. Whatever you're going to do to the larynx.

Q. Okay.

A. So a microscope is up against your eyes and it's lined up with the barrel of the laryngoscope so that you have a view.

Q. How much space is there between them?

MR. COX: How much is -- wait.

Q. How much space is there between the microscope and the laryngoscope?

A. So I couldn't tell you exactly,

but I would say whatever this space is.

Q. Six inches, eight inches?

A. The entire distance from my eyes to the larynx is 400 millimeters, so I know that because you have to set the focal length of the microscope to do the case, and that's a 400-millimeter focal length, and I would say -- I don't know what is that, six inches?

Q. Yes, something like that.

A. And I had the microscope lined up and suddenly I didn't see the vocal cords anymore. So I pushed the microscope out of the way, take out the laryngoscope, take the sponge off, take the tooth guard off, and then I see that the teeth are loose.

Q. I see. Did you detect some sort of sudden shift of equipment at that time?

A. No. I think --

MR. COX: You answered the question. That's fine.

A. No.

R. Sulica

Q. Did you detect any sudden movement by anybody around the patient?

A. No.

Q. So am I correct that you were looking through the microscope, you realized that you could no longer see the larynx and, therefore, you believed that there was some sort of shift?

A. Correct.

Q. Did you believe at that time that anything precipitated that shift?

A. No. So --

MR. COX: I think you're going -- off the record.

(Discussion off the record.)

Q. Do you have an opinion as to what caused the shift?

A. So the Lewy arm, in suspending the laryngoscope, puts an axial load on the maxillary teeth, and I think at a certain point the bone gave way.

Q. Do you know what kind of pressure the Lewy arm puts?

A. Do you want a quantitative

answer?

Q. If you know.

A. I do not know.

Q. Do you know if that load could vary between patients?

A. Yes.

Q. What would cause that load to vary?

A. The load can vary based on how prominent the teeth are. The load can vary based on the exposure of the larynx and what type of laryngoscope you use.

Q. Do you have any control over the load?

A. I have a control of the load while I'm handling the laryngoscope, but not once I've let go.

Q. Is it within your power or control to take steps to vary the load prior to its placement?

MR. COX: Note my objection. You can answer if you understand the question.

A. Well, I'm not sure I understand

the question. We position the patient in a specific way meant to minimize that and optimize exposure, and the entire procedure is built around that in every case.

Q. So the patient is placed specifically to minimize the load?

A. Yes.

Q. How is the patient placed? How is that accomplished? How does the placement of the patient accomplish that goal?

A. The task is the same as the task of a sword swallower. You basically have to line up all the structures so they're a straight line from the mouth. So we flex the neck from the shoulders, extend the head from the neck so that the head is kind of in this position. It's called a sniffing position for obvious reasons.

Q. Because the neck is extended and it looks like a dog sniffing?

A. Yes. It looks like you're just smelling a pot or something that might smell good.

Q. Okay.

A. That's all you can do from the patient positioning point of view, and then it's a question of variations in anatomy.

Q. Maybe this is an obvious question, but the patient was asleep during this procedure?

A. Yes.

Q. Did the patient have any control over the equipment that was being deployed?

A. No.

Q. Did the patient move suddenly during the procedure?

A. No.

Q. Who had control over the equipment during the procedure?

MR. COX: Which equipment?

MR. ABRAHAM: All the equipment that you mentioned, the laryngoscope, the Lewy arm.

A. So those, at that point, are self-retaining. They're on their own. They stand by themselves. I inserted the

laryngoscope, I placed the Lewy arm.

Q. So you had control over it as you were placing the equipment?

A. That's right.

Q. Did you hear any sound during the procedure prior to the view being shifted?

A. No, but you would be surprised what a noisy place the OR is with fans, the beeping from the anesthesia machine, the dialogue on the anesthesia team, asking the nurse for equipment.

Q. So this is sort of a freak accident?

MR. COX: Note my objection. I don't know if that's a medical question.

MR. ABRAHAM: Fair enough.

MR. COX: If you want to ask if this is an unusual complication, that's perfectly fine.

Q. This is an unusual complication; correct?

A. So in general terms, dental

injury is a known complication of microlaryngoscopy. Something this severe, I've never encountered in my career, nor read about.

Q. So this is unusual?

A. Yes.

Q. Do you have any explanation as to what happened?

MR. COX: Just note my objection. I think he testified as to what happened.

Q. Do you have any explanation as to what caused her teeth to be displaced and her jaw to break?

MR. COX: I think he testified about the axial loading on the maxillary teeth. I don't want to testify, but is that correct?

THE WITNESS: That is correct.

Q. Prior to the insertion of the endoscope equipment in the patient's mouth, you testified that you put certain items in her mouth.

A. Yes.

Q. Describe what those were again.

A. So the first thing we put is a tooth guard like, you know, your kid might use if he plays football, on the upper teeth because those are the ones that come into contact with the equipment. And then we put a wet sponge on top of that to create a little additional cushion.

Q. When you say on top of that, I'm sorry, what do you mean?

A. So remember the patient is sort of upside down, so I'm putting a tooth guard on the maxillary dental arch and I'm putting a wet sponge on top of the tooth guard.

Q. I see. I see. Is there anything else you placed in the patient's mouth?

A. No.

MR. COX: Other than the scope.

MR. ABRAHAM: Other than the scope.

THE WITNESS: Right.

Q. I had an endoscopy once, and

some sort of plastic thing was placed in my mouth with a hole in it. You were about to say something.

MR. COX: What is your question?

Q. Does that prompt any additional testimony?

A. No. That's a device that the gastroenterologists use when they're passing a flexible scope. Not our situation at all.

Q. Why wouldn't you use that type of --

A. The object of that is to keep the soft tissue out from obstructing the endoscope. I need to actually get down to the vocal cords so the laryngoscope serves that purpose. There's no point in me putting extra hardware in the mouth that doesn't help me.

Q. The more hardware you put in the mouth, the more obstructive it can be for purposes of the procedure?

A. Well, you just don't need to do

anything extra. It's a question of efficiency.

Q. Is there anything else you believe you could have put in her mouth, the patient's mouth, to protect it from any type of injury?

MR. COX: To protect the maxillary dental arch?

MR. ABRAHAM: Yes.

A. Not to my knowledge.

Q. Have you ever had an instance in which one of your patient's teeth have been dislodged during one of these types of procedures?

A. Yes.

Q. How often has that happened?

A. It happens about 1 percent of the time, and I can tell you that with some precision because a few years ago, one of my residents actually reviewed those, a series of 300 cases, and we had three incidents.

Q. Why did the resident undertake a review of that?

A. Part of quality control.

Q. Was that prompted by this lawsuit?

A. No. It was many years before this.

Q. Okay.

A. And it actually informs my informed consent discussion with the patient when I quote them the rate of complications.

Q. So you quote them a rate of 1 percent of teeth being dislodged?

A. That is correct.

Q. And you check teeth prior to this procedure?

A. Yes.

Q. Both inpatient and outpatient?

A. Right before we insert anything into the patient's mouth.

Q. And did you state to Ms. Evans that there could be complications with respect to her teeth as a result of this procedure?

A. I did.

Q. When do you recall doing that?

A. It would have been the last outpatient visit prior to the surgery.

Q. That would be reflected in these medical records?

A. Yes, sir.

Q. The outpatient medical records?

A. Yes, sir.

Q. And when you explained that to her, do you believe she comprehended it?

A. I do.

Q. Did you undertake a physical examination of her teeth at any point prior to the procedure?

A. Immediately prior to inserting anything into the patient's mouth.

Q. And in this particular case, do you recall doing that?

A. Yes.

Q. What do you recall observing based on that examination?

A. Nothing unusual.

Q. Did anyone else on the operating table undertake an examination of

the patient's mouth prior to this procedure?

A. Not on the operating table.

Q. How about prior to the procedure?

A. Anesthesia usually looks at them in the pre-op holding area.

Q. Before we turn the page, we're looking at page 102 of Exhibit 1. On the top right corner or on the top, there's a gray box.

A. Yes.

Q. On the right of that box, the word "Revised" appears.

A. Yes.

Q. Do you have an understanding of what that means?

A. I know what revised means.

Q. Do you know if this page was revised at any point?

A. I don't know.

Q. Do you have any understanding as to why the word "revised" appears on this page?

A. Not in this particular case.

Q. Do you believe something on this page could have been revised?

MR. COX: Just note my objection.

A. You know, I don't know. I would think that -- I don't know what was revised on this page.

Q. If you could turn to page 93 --

MR. COX: I don't want to interrupt your line of questioning. I have to make a three-minute phone call.

MR. ABRAHAM: Off the record.

(Discussion off the record.)

Q. Actually before we get to page 94 of Exhibit 1, you testified earlier --

MR. COX: 93 or 94?

MR. ABRAHAM: 93, you're quite right.

MR. COX: Sorry, go ahead.

Q. Before we get to page 93 and the following pages, you testified earlier that there was an analysis that the teeth

of approximately 1 percent of your patients get broken during this procedure and you testified that prior to the procedure, you disclose that risk or that possible complication to your patients. Correct?

A. Yes.

Q. Have you ever had a situation in which the jaw of one of your patients has been broken?

A. No.

Q. Is that a risk in these types of situations?

MR. COX: Note my objection. You can answer.

A. So our standard for risk is right around 1 percent, so I mean, you know, for example, the operating room light could fall out of the ceiling and hit you, and you can't tell a patient every last little thing that might happen in the operating room, so the standard is to disclose anything that happens in an incidence of about 1 percent or greater. That's my understanding.

Q. Okay. So is that your personal practice?

A. That is my personal practice.

Q. And that's also the standard in the industry?

A. That's my understanding of the standard in the industry.

Q. Do you recall getting any guidance on that standard from any source or that's just the practice?

A. No. I mean, I recall having a discussion once where I was instructed about this 1 percent, but I'm not in a position to tell you when that happened and who told that to me.

Q. Okay. But at the very least, that's the practice in your industry, the 1 percent threshold?

A. Yes.

MR. COX: Let me ask him a quick question outside. It's a question for me.

MR. ABRAHAM: We're not off the record.

(Witness and counsel confer.)

MR. ABRAHAM: Welcome back, gentlemen.

Q. So you guys just had a conference? Your conference is over?

A. Yes.

Q. So in your experience, a patient's jaw breaking as a result of this procedure has not occurred in your experience?

A. It would be an unusually -- no, it was an unusually severe dental injury.

Q. Prior to this procedure, did you warn Ms. Evans that the breaking of a jaw is a reasonable possible risk?

MR. COX: Note my objection. You can answer.

A. No. I warned her about dental injury.

Q. Let's turn to page 93 of Exhibit 1. It says, "Preoperative Medical Questionnaire." Does this look familiar to you?

A. Yes.

Q. What is this?

A. This is a document administered by the nurse when the patient presents to the hospital immediately prior to her surgery.

MR. COX: Just to be clear for the record, you're referring to pages 93 through 96?

MR. ABRAHAM: Yes, thanks.

Q. So this is not administered by you. This is administered by a nurse?

A. That's right.

Q. And is this administered specifically for the type of procedure that we're talking about? In other words, before you answer, is this questionnaire tailored specifically for this type of procedure?

A. It is not. My understanding is that every patient gets this questionnaire.

Q. And did you have any role in preparing this questionnaire, in drafting it?

A. I did not.

Q. Do you know who did?

A. I don't.

Q. Is it your belief or understanding that this questionnaire is for any sort of general surgery?

A. That's my understanding.

Q. There are no questions about teeth in this questionnaire, if you want to take a moment to confirm that.

A. That looks to be correct.

Q. Do you know why that is?

MR. COX: Note my objection. You can answer.

A. No.

Q. Let's turn to page 97. This is a pre-anesthesia evaluation.

A. Correct.

Q. Is this something that you administered, this evaluation?

A. No.

Q. Who administers this typically?

A. Somebody from the department of anesthesia.

Q. In this case, do you know who

administered this evaluation?

A. I do not.

Q. Does your handwriting appear anywhere in this document?

A. No.

MR. COX: Just to be clear, you're referring to pages 97 and 98?

MR. ABRAHAM: Yes. Thanks.

Q. On page 98, it looks like it's signed by someone named DPP?

A. Okay. Yes.

Q. Do you know who that is?

A. That is the attending anesthesiologist, Daphne Pierre-Paul.

Q. Do you believe that she administered this evaluation?

A. I don't know if she administered it or just signed it.

Q. On page 97 it says "No loose teeth." Is that correct?

A. That is correct.

Q. Would you have reviewed this document before your procedure?

A. No.

Q. Did Ms. Evans have any loose teeth before the procedure?

A. She did not.

Q. How do you know that?

A. Because I tested her dental arch before I put the tooth guard on.

Q. How did you test her dental arch?

A. I put my index and thumb and gave it a little shake.

Q. And it was stable?

A. Yes.

Q. Let's get back to the procedure, itself. There came a point in the procedure where you noticed that Ms. Evans' teeth were displaced.

A. Yes.

Q. You said you called someone?

A. Yes.

Q. Who did you call?

A. I called the oral maxillofacial surgery service.

Q. Did you call any of Ms. Evans' relatives?

A. Not at that point.

Q. At what point did you call one of her relatives?

A. Once the oral maxillofacial surgeon service had evaluated the teeth and made a recommendation, I broke scrub, I left the operating room, and I went to discuss the situation with Ms. Evans' niece in person.

Q. Was she in the waiting room at the time?

A. She was.

Q. Had she been called by anybody to -- why was she in the waiting room?

A. Because she was waiting for the surgery to be completed.

Q. So it's your understanding that during the surgery, she was waiting in the waiting room?

A. Correct.

Q. So you broke scrub, you went out, and you spoke to her?

A. Yes.

Q. What did you tell her?

A. I told her what had happened.

MR. COX: Note my objection. Asked and answered. You can answer again.

A. I told her what had happened. I told her that we had asked the oral maxillofacial surgeons to consult. That they made a recommendation about stabilizing it, that I was not going to proceed with the biopsy under the circumstances, and to the best of my recollection, that's the nature of the discussion.

Q. Did you ask her for any authorization for anything?

A. I explained what the plan was.

Q. Did you ask for her authorization with respect to going forward with that plan?

A. She agreed to the plan.

Q. So, therefore, you asked her if she would agree to the plan; is that your recollection, if you recall?

A. I don't recall.

Q. But it was your understanding that she agreed with the course of action you recommended?

A. That was my understanding, yes.

Q. Do you recall -- but you don't recall specifically asking her whether she does agree or does not agree?

A. I did not ask her in so many words.

Q. After that conversation, you authorized the stabilization of her arch?

A. Yes. I took the recommendation from the oral maxillofacial surgeons.

Q. Do you know what those surgeons did at that point?

A. My understanding is that they manually replaced the fractured segment and stabilized it in place.

Q. After that procedure occurred, did there come a point at which you spoke to Ms. Evans about what had occurred?

A. Yes.

Q. What do you recall about that conversation? First of all, when was that

conversation?

A. It was in the recovery room with her niece present.

Q. Okay. What do you recall about that conversation?

A. I waited for Ms. Evans to be awake enough to recall the conversation and I went to explain to her what had happened. And that was essentially -- and I told her that this needed to be looked after further.

Q. Did she say anything, Ms. Evans, at that time? How did she react?

A. I think Ms. Evans was a little overwhelmed by the moment. I don't recall any detailed conversation at that point.

Q. Did there come a point at which you saw Ms. Evans again after January 9, 2015?

A. No, I never saw her again. I did speak to her on the telephone.

Q. And when was that?

A. I don't recall exactly the

date, but I wanted to follow up with her and ask her how she was doing, and that's what we discussed.

Q. How was she doing to the best of your recollection as of that time?

A. Well, she was -- she had had a dental injury and obviously it was a problem for her, and that was the best that I can recall.

MR. ABRAHAM: Let's take a five-minute recess.

(Recess taken.)

MR. ABRAHAM: Thank you for your time today, Dr. Sulica. I appreciate it.

MR. COX: Thank you.

(Time noted: 10:51 a.m.)

I, the witness herein, having read the foregoing testimony, do hereby certify it to be a true and correct transcript, subject to the corrections, if any, shown on the attached page.

_____

RADU LUCIAN SULICA

Subscribed and sworn to
before me this ____ day
of _____ 2018.

_____

C E R T I F I C A T E

STATE OF NEW YORK)
:
COUNTY OF NEW YORK)

I, ELEANOR GREENHOUSE, a Shorthand Reporter and Notary Public within and for the State of New York, do hereby certify:

That, RADU LUCIAN SULICA, the witness whose deposition is hereinbefore set forth, was duly sworn by me and that such deposition is a true record of the testimony given by such witness.

I further certify that I am not related to any of the parties to this action by blood or marriage, and that I am in no way interested in the outcome of this matter.

IN WITNESS WHEREOF, I have hereunto set my hand this 11th day of July, 2018.

_____

ELEANOR GREENHOUSE

I N D E X

E X H I B I T S

(Exhibits retained by Counsel.)

DOCUMENT AND/OR INFORMATION REQUESTS