

Exhibit D

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

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

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

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.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

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.

1 R. Sulica

2 R A D U L U C I A N S U L I C A, called
3 as a witness, having been duly sworn
4 by a Notary Public, was examined and
5 testified as follows:

6 EXAMINATION BY

7 MR. ABRAHAM:

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

10 A. Yes, sir.

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

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

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

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

24 A. I'm referring to these
25 documents here.

1 R. Sulica

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

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

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

11 A. That's right.

12 Q. What do you mean by that?

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

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

19 A. Correct.

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

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

1 R. Sulica

2 surgery.

3 Q. Okay.

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

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

13 A. I do.

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

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

18 Q. Okay.

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

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

25 A. Not off the top of my head.

1 R. Sulica

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

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

7 MR. COX: Off the record.

8 (Discussion off the record.)

9 Q. Do you recall when that case
10 was filed?

11 A. I don't.

12 Q. What is the subject of that
13 case?

14 A. A delay in diagnosis.

15 Q. Have you ever been deposed
16 before?

17 A. Yes.

18 Q. When was that?

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

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

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

1 R. Sulica

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

4 A. I have, on two occasions.

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

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

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

14 A. Care of laryngeal disorders.

15 Q. Tell me about your educational
16 history.

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

1 R. Sulica

2 Q. So you had a residency?

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

9 Q. And you're in private practice
10 now?

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

18 Q. It was started for you?

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

25 Q. Who is your employer?

1 R. Sulica

2 A. The medical college.

3 Q. What is the specific name of
4 it?

5 A. Weill Cornell Medical College.

6 Q. Are you employed by anyone
7 else?

8 A. No.

9 Q. Are you in a partnership with
10 anyone else?

11 A. No.

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

15 A. On behalf of the medical
16 college.

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

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

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

25 A. Also the medical college as an

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

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

9 A. I'm a credentialed physician
10 with them.

11 Q. So you're an attending?

12 A. Yes, correct.

13 Q. Which entity provides your
14 malpractice coverage?

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

18 MR. ABRAHAM: Why?

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

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

1 R. Sulica

2 (Discussion off the record.)

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

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

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

11 A. That's correct.

12 Q. Okay.

13 A. As far as I know.

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

17 A. Yes.

18 Q. Do you have any board
19 certifications?

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

24 Q. What is otolaryngology?

25 A. Ear, nose and throat medicine.

1 R. Sulica

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

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

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

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

17 Q. That's a lot; right?

18 MR. COX: Note my objection.

19 You can answer.

20 A. Yeah. It keeps me out of
21 trouble.

22 Q. And you also teach?

23 A. I do.

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

1 R. Sulica

2 practice?

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

19 Q. Just because it's small and
20 intimate?

21 A. Exactly.

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

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

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

7 Q. Do you travel a lot?

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

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

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

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

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

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

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

25 Q. Why is that?

1 R. Sulica

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

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

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

10 MR. COX: Is this the hospital
11 chart?

12 MR. ABRAHAM: Off the record.
13 (Discussion off the record.)

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

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

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

23 A. I reviewed it on Saturday
24 morning.

25 Q. Sorry to take your time on a

1 R. Sulica

2 Saturday.

3 And you're familiar with Elsie
4 Lorraine Evans?

5 A. Yes.

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

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

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

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

1 R. Sulica

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

4 A. I think because she was hoarse.

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

9 A. Two or three times.

10 Q. What was the purpose of those
11 meetings?

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

17 Q. What was atypical about it if
18 you recall?

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

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

1 R. Sulica

2 mass?

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

7 Q. What do you mean by that?

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

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

18 Q. Why not?

19 A. Because she was elderly.

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

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

1 R. Sulica

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

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

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

10 Q. But it was unusually large?

11 A. It was a mass that was growing.

12 Q. It was growing?

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

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

18 A. I don't.

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

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

1 R. Sulica
2 to specify it by date when things are
3 happening. If you want him to refer
4 to the chart, that would be helpful
5 just in terms of him being able to
6 review what specific dates of
7 treatment there are, and to the
8 extent maybe you have more specific
9 questions regarding different aspects
10 of what happened, I think that would
11 be more appropriate.

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

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

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

1 R. Sulica

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

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

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

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

22 A. No.

23 MR. COX: Just note my
24 objection.

25 Q. Did the fact that she was, as

1 R. Sulica
2 we said, an elderly woman, did that cause
3 you to vary the way you explained any
4 information or the way that you expected
5 her to process any information?

6 MR. COX: From a mental aspect?

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

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

19 MR. ABRAHAM: Yes, exactly.

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

1 R. Sulica
2 whatever. I can't recreate for you
3 verbatim how I discussed things with
4 Ms. Evans, but we had a normal interaction
5 throughout the entire visit.

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

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

13 A. Yes, I did.

14 Q. Outpatient notes?

15 A. That's correct.

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

19 A. That is true.

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

25 A. It occurs concurrently with the

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

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

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

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

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

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

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

13 A. The technology is different.

14 Q. What is the name of this
15 procedure?

16 A. It's called a laryngoscopy.

17 Q. How would you define a
18 laryngoscopy?

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

1 R. Sulica

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

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

12 Q. Was there a video in this
13 case?

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

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

19 A. Yes.

20 Q. Of your preoperative
21 examinations?

22 A. Yes.

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

25 A. Well, the same reason you might

1 R. Sulica

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

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

8 A. For a comparison.

9 Q. Before and after?

10 A. Right.

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

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

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

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

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

1 R. Sulica

2 that these videos are still on the
3 server?

4 THE WITNESS: Yes.

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

8 A. No.

9 Q. Why not?

10 A. Because that's a different
11 context.

12 Q. Different place, different
13 procedures?

14 A. Yeah, right.

15 Q. Okay.

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

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

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

25 Q. So just that aspect of checking

1 R. Sulica

2 the larynx, that's what is video recorded?

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

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

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

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

1 R. Sulica

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

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

8 A. In this specific case or in
9 general?

10 Q. In general.

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

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

15 A. Yes.

16 Q. Through the mouth can be used
17 for biopsy?

18 A. Yes.

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

23 A. May I look at the chart?

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

1 R. Sulica

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

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

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

8 A. I genuinely don't recall.

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

11 (Discussion off the record.)

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

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

19 For operative evaluation, you
20 only have one route.

21 Q. What is that route?

22 A. Through the mouth.

23 Q. Why is that?

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

1 R. Sulica

2 so you need direct access to the larynx.

3 You need line of sight access to the

4 larynx.

5 Q. Okay. Previously I asked you

6 whether the larynx could be biopsied

7 through the nose.

8 A. That's correct.

9 Q. Okay. Do you want --

10 A. So I answered -- I asked you in

11 return, do you mean in this specific case

12 or do you mean generally?

13 Q. Generally.

14 A. And I answered generally. In

15 this specific case, I cannot biopsy her

16 through the nose because the tumor is deep

17 in the larynx. It's not anywhere that I

18 can see it and I can't enter the tissue of

19 the larynx in a situation that I can't

20 control bleeding, like the office.

21 Q. Have you ever biopsied patients

22 in this procedure through the nose before

23 during your career?

24 A. Yes, I have.

25 Q. What percentage of the time is

1 R. Sulica

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

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

9 Q. What do you mean by that?

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

13 Q. Why not?

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

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

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

11 MR. ABRAHAM: Thanks.

12 MR. COX: What is the question?

13 (The record was read.)

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

22 Q. By treating, do you mean
23 removing?

24 A. That's right.

25 Q. Not administering any other

1 R. Sulica

2 medication at that specific time?

3 A. No.

4 Q. So go ahead. Sorry.

5 A. That's my answer.

6 Q. Oh, that's your answer. Okay.

7 I just wanted to make sure you had
8 completed your answer. So in this
9 particular case, it had to be done through
10 the mouth you said?

11 A. That's right.

12 Q. Why?

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

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

20 A. Treated or evaluated?

21 Q. Evaluated and treated.

22 A. Evaluated, yes; treated, no.

23 Q. Let's look at Exhibit 1.

24 Eventually the patient was treated on
25 January 9th, 2015, I believe, but let's

1 R. Sulica

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

4 MR. COX: Is that the question?

5 MR. ABRAHAM: We will confirm
6 that but I'd like you to turn to page
7 102 of the document in front of you.

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

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

14 A. I believe it is.

15 Q. And you reviewed these medical
16 records before today?

17 A. Yes.

18 Q. Do you recall reviewing this
19 page before today?

20 A. I do.

21 Q. So what happened on January 9,
22 2015?

23 MR. COX: What do you mean what
24 happened?

25 Q. What happened during the

1 R. Sulica
2 procedure? Walk me through it to the best
3 of your recollection and based on what
4 you've read.

5 A. Okay.

6 Q. From the morning to the
7 evening.

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

16 Q. What do you recall happened
17 during the procedure?

18 A. Okay.

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

1 R. Sulica

2 format.

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

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

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

17 MR. COX: It's an improper
18 question.

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

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

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

9 MR. ABRAHAM: Ryan, this is
10 highly disruptive.

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

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

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

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

19 MR. COX: The same objection.

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

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

24 Q. She --

25 MR. COX: Again, I'm not going

1 R. Sulica

2 to have him give a narrative.

3 MR. ABRAHAM: Ryan, please
4 stop.

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

14 MR. ABRAHAM: I'm fine with
15 that.

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

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

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

1 R. Sulica

2 present a proper question. That's
3 perfectly fine.

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

6 MR. COX: No.

7 MR. ABRAHAM: Then let's move
8 on.

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

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

18 MR. COX: You said what
19 happened on the day of January 9,
20 2015? Obviously an entire surgery
21 happened. There were things that
22 happened before the procedure, during
23 the procedure, after the procedure.

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

1 R. Sulica

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

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

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

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

18 MR. ABRAHAM: Let's move on.

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

22 A. So what I recall is largely --

23 MR. COX: Note my objection.

24 You can answer over objection.

25 A. What I recall is largely

1 R. Sulica

2 contained within this operative report.

3 Q. Thank you.

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

8 Q. Okay.

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

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

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

1 R. Sulica
2 approach to the vocal cords.

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

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

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

25 Q. Okay.

1 R. Sulica

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

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

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

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

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

1 R. Sulica

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

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

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

11 A. Yes.

12 Q. What do you mean by that?

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

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

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

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

1 R. Sulica

2 that.

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

11 So --

12 Q. The biopsy instruments?

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

15 Q. Okay.

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

20 Q. How much space is there between
21 them?

22 MR. COX: How much is -- wait.

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

25 A. So I couldn't tell you exactly,

1 R. Sulica

2 but I would say whatever this space is.

3 Q. Six inches, eight inches?

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

11 Q. Yes, something like that.

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

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

22 A. No. I think --

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

25 A. No.

1 R. Sulica

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

4 A. No.

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

10 A. Correct.

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

13 A. No. So --

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

16 (Discussion off the record.)

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

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

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

25 A. Do you want a quantitative

1 R. Sulica

2 answer?

3 Q. If you know.

4 A. I do not know.

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

7 A. Yes.

8 Q. What would cause that load to
9 vary?

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

14 Q. Do you have any control over
15 the load?

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

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

22 MR. COX: Note my objection.

23 You can answer if you understand the
24 question.

25 A. Well, I'm not sure I understand

1 R. Sulica

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

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

8 A. Yes.

9 Q. How is the patient placed? How
10 is that accomplished? How does the
11 placement of the patient accomplish that
12 goal?

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

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

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

1 R. Sulica

2 Q. Okay.

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

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

9 A. Yes.

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

13 A. No.

14 Q. Did the patient move suddenly
15 during the procedure?

16 A. No.

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

19 MR. COX: Which equipment?

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

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

1 R. Sulica

2 laryngoscope, I placed the Lewy arm.

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

5 A. That's right.

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

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

14 Q. So this is sort of a freak
15 accident?

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

19 MR. ABRAHAM: Fair enough.

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

23 Q. This is an unusual
24 complication; correct?

25 A. So in general terms, dental

1 R. Sulica
2 injury is a known complication of
3 microlaryngoscopy. Something this severe,
4 I've never encountered in my career, nor
5 read about.

6 Q. So this is unusual?

7 A. Yes.

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

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

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

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

20 THE WITNESS: That is correct.

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

25 A. Yes.

1 R. Sulica

2 Q. Describe what those were again.

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

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

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

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

20 A. No.

21 MR. COX: Other than the scope.

22 MR. ABRAHAM: Other than the
23 scope.

24 THE WITNESS: Right.

25 Q. I had an endoscopy once, and

1 R. Sulica

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

5 MR. COX: What is your
6 question?

7 Q. Does that prompt any additional
8 testimony?

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

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

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

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

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

1 R. Sulica

2 anything extra. It's a question of
3 efficiency.

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

8 MR. COX: To protect the
9 maxillary dental arch?

10 MR. ABRAHAM: Yes.

11 A. Not to my knowledge.

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

16 A. Yes.

17 Q. How often has that happened?

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

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

1 R. Sulica

2 A. Part of quality control.

3 Q. Was that prompted by this
4 lawsuit?

5 A. No. It was many years before
6 this.

7 Q. Okay.

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

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

14 A. That is correct.

15 Q. And you check teeth prior to
16 this procedure?

17 A. Yes.

18 Q. Both inpatient and outpatient?

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

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

25 A. I did.

1 R. Sulica

2 Q. When do you recall doing that?

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

5 Q. That would be reflected in
6 these medical records?

7 A. Yes, sir.

8 Q. The outpatient medical records?

9 A. Yes, sir.

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

12 A. I do.

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

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

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

20 A. Yes.

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

23 A. Nothing unusual.

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

1 R. Sulica

2 the patient's mouth prior to this
3 procedure?

4 A. Not on the operating table.

5 Q. How about prior to the
6 procedure?

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

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

13 A. Yes.

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

16 A. Yes.

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

19 A. I know what revised means.

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

22 A. I don't know.

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

1 R. Sulica

2 A. Not in this particular case.

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

5 MR. COX: Just note my
6 objection.

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

10 Q. If you could turn to page 93 --

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

15 MR. ABRAHAM: Off the record.

16 (Discussion off the record.)

17 Q. Actually before we get to page
18 94 of Exhibit 1, you testified earlier --

19 MR. COX: 93 or 94?

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

22 MR. COX: Sorry, go ahead.

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

1 R. Sulica
2 of approximately 1 percent of your patients
3 get broken during this procedure and you
4 testified that prior to the procedure, you
5 disclose that risk or that possible
6 complication to your patients. Correct?

7 A. Yes.

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

11 A. No.

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

14 MR. COX: Note my objection.

15 You can answer.

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

1 R. Sulica

2 Q. Okay. So is that your personal
3 practice?

4 A. That is my personal practice.

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

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

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

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

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

20 A. Yes.

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

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

1 R. Sulica

2 (Witness and counsel confer.)

3 MR. ABRAHAM: Welcome back,
4 gentlemen.

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

7 A. Yes.

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

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

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

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

19 A. No. I warned her about dental
20 injury.

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

25 A. Yes.

1 R. Sulica

2 Q. What is this?

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

7 MR. COX: Just to be clear for
8 the record, you're referring to pages
9 93 through 96?

10 MR. ABRAHAM: Yes, thanks.

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

13 A. That's right.

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

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

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

25 A. I did not.

1 R. Sulica

2 Q. Do you know who did?

3 A. I don't.

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

7 A. That's my understanding.

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

11 A. That looks to be correct.

12 Q. Do you know why that is?

13 MR. COX: Note my objection.

14 You can answer.

15 A. No.

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

18 A. Correct.

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

21 A. No.

22 Q. Who administers this typically?

23 A. Somebody from the department of
24 anesthesia.

25 Q. In this case, do you know who

1 R. Sulica

2 administered this evaluation?

3 A. I do not.

4 Q. Does your handwriting appear
5 anywhere in this document?

6 A. No.

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

9 MR. ABRAHAM: Yes. Thanks.

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

12 A. Okay. Yes.

13 Q. Do you know who that is?

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

16 Q. Do you believe that she
17 administered this evaluation?

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

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

22 A. That is correct.

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

25 A. No.

1 R. Sulica

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

4 A. She did not.

5 Q. How do you know that?

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

8 Q. How did you test her dental
9 arch?

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

12 Q. And it was stable?

13 A. Yes.

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

18 A. Yes.

19 Q. You said you called someone?

20 A. Yes.

21 Q. Who did you call?

22 A. I called the oral maxillofacial
23 surgery service.

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

1 R. Sulica

2 A. Not at that point.

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

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

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

13 A. She was.

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

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

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

21 A. Correct.

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

24 A. Yes.

25 Q. What did you tell her?

1 R. Sulica

2 A. I told her what had happened.

3 MR. COX: Note my objection.

4 Asked and answered. You can answer
5 again.

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

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

17 A. I explained what the plan was.

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

21 A. She agreed to the plan.

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

25 A. I don't recall.

1 R. Sulica

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

5 A. That was my understanding, yes.

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

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

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

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

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

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

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

23 A. Yes.

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

1 R. Sulica

2 conversation?

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

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

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

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

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

19 Q. Did there come a point at which
20 you saw Ms. Evans again after January 9,
21 2015?

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

24 Q. And when was that?

25 A. I don't recall exactly the

1 R. Sulica

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

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

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

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

13 (Recess taken.)

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

17 MR. COX: Thank you.

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

19

20

21

22

23

24

25

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

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.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

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

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

I N D E X

WITNESS	EXAMINATION BY	PAGE
RADU LUCIAN SULICA	MR. ABRAHAM	4

E X H I B I T S

PLAINTIFF'S	EXHIBIT	PAGE	LINE
Exhibit 1, inpatient medical records		16	7
(Exhibits retained by Counsel.)			

DOCUMENT AND/OR INFORMATION REQUESTS

PAGE	LINE
28	17

<u>A</u>				
a.m 1:14 74:18	45:14	39:3,5,8,15,24	best 38:2 39:5	carried 30:15
able 21:5 28:17	analysis 62:25	41:25 42:15	71:12 74:5,9	case 4:12 6:16,24
ABRAHAM 2:4	anatomy 53:5	43:14 54:12 72:7	better 26:9,10 31:3	7:3,9,13,21 12:15
4:7 11:18,24 16:5	AND/OR 77:12	asleep 44:9 53:7	big 20:5	26:4 27:13 31:8
16:12 21:12 23:7	anesthesia 19:21	aspect 23:6,8,8,9	biopsied 33:6,21	32:12 33:11,15
23:19 28:17,24	23:15 44:7 54:11	23:17 29:25	34:2	36:9 41:20 42:5
32:6,9 35:11 37:5	54:12 61:7 67:24	aspects 21:9 38:21	biopsy 17:22 18:14	45:9 49:7 52:5
39:3,12,19 40:9	anesthesiologist	43:10	20:4 21:25 22:5	60:18 62:2 67:25
40:13,20 41:3,14	68:15	assess 44:15	23:14 31:7,12,14	cases 58:22
41:19 42:4,7,12	anesthetic 19:17	attach 45:6	31:17 33:15	cast 15:6
42:24 43:6,18	35:17	attached 45:17	35:19,20 46:18	cause 23:2 51:8
53:20 54:19	angled 30:23	75:6	48:12 71:11	caused 50:18 55:14
56:22 58:10	answer 5:8 11:17	attending 11:11	bleeding 33:20	ceiling 63:19
62:15,20 64:24	12:4,5 13:19	46:12 68:14	blood 76:16	CENTER 1:10
65:3 66:10 68:9	28:14 32:4 36:5,6	attention 46:15	board 12:18,20,22	certain 43:10 50:21
74:11,14 77:4	36:8 42:10 43:11	attorney 2:5,12	13:5	55:23
absolutely 28:23	43:24 51:2,23	20:21 47:25	bone 50:22	certainly 46:15
access 33:2,3	63:15 65:18	atypical 18:15,17	box 13:9 61:12,14	certification 12:22
accident 54:15	66:17 67:14 71:4	authorization	break 35:9 39:11	certifications 12:19
accomplish 52:11	answered 33:10,14	71:16,19	39:23 40:6 41:10	certified 5:7 12:20
accomplished	49:23 71:4	authorized 72:12	55:15	13:6
52:10	answering 35:8	Avenue 2:6	breaking 65:9,15	certify 75:4 76:8,14
action 3:12 47:3	anybody 50:3	awake 73:8	breathing 13:11	chair 9:14,16 25:4
72:3 76:16	70:14	axial 50:20 55:17	bring 35:10 45:20	changing 15:6
actual 18:25 29:5	anymore 49:14		47:17	chart 16:11 20:8
31:20	anyway 35:18	<u>B</u>	brings 23:20,23	21:4 31:23,25
addition 44:16	appear 68:4	B 77:6	broad 26:20	charts 7:5
additional 35:3	appearing 4:11	bachelors 8:18	broke 46:21 70:7	check 59:15
56:9 57:7	appears 61:15,24	back 12:3 22:7 27:4	70:22	checking 29:25
adequate 45:10	apply 44:15,17	27:7 28:7 30:5,13	broken 63:3,10	circumstances 20:3
adjust 23:22	appointment 23:21	46:12 47:5,16	BRONX 1:3	71:12
administered 66:3	appreciate 21:13	65:3 69:14	brought 24:18 44:5	clear 19:14 66:7
66:11,12,14	74:16	bar 3:10	built 52:5	68:7
67:20 68:2,17,19	apprenticeship	barrel 48:17	bump 26:6	Clearwater 1:18
administering	14:17	based 21:14 25:14	buried 19:9	2:11
35:25	approach 45:2	35:4 38:3 51:10		clinical 10:21
administers 67:22	appropriate 21:11	51:12 60:22	<u>C</u>	cognitive 22:19
admissible 43:5	24:6	basically 13:7	C 2:2 4:2,2 76:2,2	23:9,17
affiliation 11:7	approximately 63:2	52:14	call 62:14 69:21,24	colleague 17:10
African-American	arch 56:14 58:9	basis 13:14	70:3	college 8:17,18 9:12
17:9	69:7,9 72:12	bed 44:11,13	called 4:2 26:16	9:13,22 10:2,5,16
against- 1:7	area 8:12 45:13	beeping 54:11	44:20 45:6,16	10:17,20,25
age 23:8,12	61:8	begun 3:20	46:7 47:14 52:19	12:10 14:17
ago 8:8 58:20	arm 45:7,18 47:15	behalf 10:14,15	69:19,22 70:14	come 42:14,25 56:6
agree 71:23 72:8,8	50:19,24 53:22	belief 67:4	cancer 17:11 34:7	72:21 73:19
agreed 3:4,14	54:2	believe 6:8 25:23	34:10,20 35:15	comes 22:6
22:17 47:4 71:21	asked 24:6 31:2	36:25 37:14	35:16,21	communicated
72:3	33:5,10 40:16	50:11 58:5 60:11	capable 24:9	17:24
ahead 36:4 62:22	71:4,7,22	62:3 68:16	care 5:14 8:14 9:5	compare 28:3
allow 27:9 35:7	asking 4:18 23:16	believed 50:8	9:19,23 16:4	comparison 28:8
	35:2 38:8,15,23	Bell 1:18 2:11	cared 6:6	complete 8:22
		benign 19:12	career 33:23 55:4	

34:25
completed 36:8
 70:17
complication 54:21
 54:24 55:2 63:6
complications
 19:20 59:11,22
comprehended
 60:11
computer 25:4
concerns 10:21
concurrent 14:3
concurrently 24:25
condition 36:19
confer 65:2
conference 65:6,6
conferences 15:11
 15:13
confirm 37:2,5
 67:10
consent 59:9
consideration
 23:13
constantly 15:6
consult 71:8
consulted 46:11
contact 56:7
contained 44:2
context 4:18 10:13
 29:11
control 33:20 34:16
 51:14,16,20
 53:11,17 54:3
 59:2
controlled 3:24
conversation 72:11
 72:25 73:2,6,8,18
copies 28:11
copy 5:7
cord 25:25 26:6
cords 27:8 45:2
 47:16 49:14
 57:18
Cornell 1:9 9:12,13
 10:5 12:10
corner 14:4 61:11
correct 5:19 11:12
 12:11 24:15
 32:14 33:8 50:5
 50:10 54:24
 55:19,20 59:14
 63:6 67:11,18
 68:21,22 70:21
 75:4
corrections 75:5
correctly 4:9
counsel 3:5,15,22
 4:20 65:2 77:9
County 1:3 6:21
 76:5
course 4:17 47:3
 72:3
COURT 1:2
coverage 11:14,22
COX 4:17 7:7
 11:15,19 12:3
 13:18 16:10
 20:23 22:23 23:6
 23:10 28:20 32:4
 34:21 35:12 37:4
 37:23 38:8,19
 39:10,17,21
 40:11,15,19,25
 41:5,16,24 42:6,9
 42:18 43:4,9,23
 48:22 49:23
 50:14 51:22
 53:19 54:16,20
 55:10,16 56:21
 57:5 58:8 62:5,11
 62:19,22 63:14
 64:21 65:17 66:7
 67:13 68:7 71:3
 74:17
CPLR 3:7,24
create 56:9
created 9:19
credentialed 11:4,9
cross-sectional
 45:13
crowding 44:25
CT 17:16 18:3,16
 19:5,15 20:2,9
 21:23 22:6,6
 36:16
cure 34:20
cushion 56:9
cut 34:15 43:10
Cutler 17:11
cutting 34:22

D
D 4:2 77:2
Daphne 68:15
Dartmouth 8:17
date 21:2 37:11
 74:2
dates 21:6
David 17:10
day 13:24 24:23
 29:17 38:14 39:9
 39:25 42:19
 43:21 75:18
 76:20
deal 13:7
death 19:23
decide 18:13
decided 20:3 21:24
 46:17
decision 32:13
decision-making
 20:14
deemed 3:22
deep 19:5 33:16
 36:14
defendant 6:14
Defendants 1:11
 2:12
defense 8:8
define 26:17
definitely 23:22
degree 8:21
delay 7:14
demeanor 22:11
demonstrated
 36:15
dental 26:23 46:6
 54:25 56:14 58:9
 65:13,19 69:6,8
 74:8
department 15:3
 17:12 67:23
depends 25:20
 30:18
deployed 53:12
deposed 7:15,19,23
deposition 1:16
 4:13 6:9 7:21
 38:25 42:13
 76:10,12
describe 11:6 13:2
 39:9 56:2
designation 5:6
detailed 73:18
detect 49:19 50:2
deterioration 31:2
determines 25:17
detour 30:7
device 47:14 48:6
 57:9
devotes 9:23
diagnosing 34:8
diagnosis 7:14
dialogue 54:12
different 21:9 23:21
 26:13 29:10,12
 29:12 31:4 44:21
 45:14
difficulty 45:10
digital 30:25
direct 33:2
director 9:20
disagree 39:20
disclose 63:5,23
disclosure 11:21
discuss 70:9
discussed 21:20
 24:3 32:16,18
 74:4
discussing 30:6
discussion 7:8 12:2
 16:13 32:11
 50:16 59:9 62:16
 64:13 71:14
discussions 4:19
 20:19 21:16 40:5
 43:17
disease 34:17
dislodged 58:14
 59:13
disorder 17:21
 25:22,24
disorders 8:14 9:6
 9:15,20,21,24
 13:8,8,10,11,11
displaced 55:14
 69:17
disruptive 40:10
distance 49:4
doctor 14:6 15:5
 17:12 39:8 42:15
doctor's 39:6
doctors 26:24
document 28:2,22
 37:7 66:3 68:5,24
 77:12
documents 4:25 5:3
 24:17
dog 52:22
doing 60:2,19 74:3
 74:5
downstairs 46:22
dozen 7:24,25
DPP 68:11
Dr 4:8 40:17 74:15
drafting 66:23
drape 44:11
drapes 44:12
draw 47:23
duly 4:3 76:11

E
E 2:2,2,4 76:2,2
 77:2,6
eager 19:16
ear 8:24 12:25 13:6
earlier 8:9 62:18,24
easier 20:25 39:22
East 1:18 2:13
education 23:24
educational 8:15
efficiency 58:3
eight 49:3
elderly 17:9 18:14
 19:19 22:20 23:2
 23:15
Eleanor 1:19 76:6
 76:24
electronic 25:5
 30:16
electronically 30:17
Elsie 1:5 17:3
employed 10:6
employer 9:25
employment 12:8
encountered 55:4
endoscope 25:12
 30:11,22,22
 55:22 57:17
endoscopy 25:10
 30:8 56:25
endowed 9:14
enjoy 16:2
ensure 16:4
enter 33:18
entered 37:10
entire 24:5 34:11

34:17 38:14 41:7
 42:20 49:4 52:4
entity 10:20,22
 11:4,13 19:14
environment 6:7
equipment 30:19
 49:20 53:11,18
 53:19,20 54:4,13
 55:22 56:7
ESQ 2:4,15
essay 25:19
essentially 44:23
 45:7 73:10
establish 17:20
estimate 14:23
 15:10
evaluated 36:20,21
 36:22 47:2 70:6
evaluation 32:18,19
 67:17,20 68:2,17
Evans 1:5 17:4,21
 19:17 20:20 24:4
 59:21 65:15 69:2
 72:22 73:7,14,16
 73:20
Evans' 69:17,24
 70:9
evening 38:7
Eventually 36:24
everybody 23:20
exactly 10:19 13:3
 14:21 19:3 23:19
 48:25 73:25
exam 28:4
examination 3:10
 3:16,19,21 4:6
 25:3,9,16 27:10
 27:17 28:3 29:21
 30:20 31:22
 60:14,22,25 77:3
examinations 24:11
 27:21,24 31:19
examine 18:22
examined 3:17 4:4
examining 14:12
 31:20
example 14:25 25:2
 25:23 41:9 63:18
exceptions 26:4
exclusively 29:18
Exhibit 16:6,7,15

32:10 36:23
 61:10 62:18
 65:22 77:7,8
Exhibits 77:9
exist 19:9
expected 23:4
experience 16:3
 23:25 34:4 36:18
 65:8,11
expert 7:20,23 8:3
 15:22
expertise 8:12
explain 21:22 48:3
 73:9
explained 22:2,7
 23:3 24:7 46:14
 46:23,24 60:10
 71:17
explanation 55:8
 55:13
explanations 23:22
expose 19:16
exposure 45:11,16
 51:12 52:4
extend 52:17
extended 52:21
extent 21:8
extra 44:17 57:20
 58:2
extremely 19:10
 22:13
eyes 48:17 49:5

F

F 76:2
fact 20:4 22:20,25
faculty 9:11
failure 3:20
Fair 16:5 54:19
fall 63:19
familiar 16:18 17:3
 65:23
family 46:22
fans 54:10
far 12:13
fast 26:3
feel 16:3
fellow 14:25
felt 24:8
fibers 30:15
field 23:25
file 42:13

filed 7:10
fill 14:7
finally 45:15
finding 18:15
fine 23:18 38:12,22
 39:14 41:10,14
 42:3 49:24 54:22
finish 35:7
first 25:20 30:9
 56:3 72:25
five-minute 74:12
flex 52:17
flexible 26:2 30:11
 57:11
Floor 1:24
flow 43:2
focal 49:6,8
follow 74:2
followed 9:4
following 62:24
follows 4:5
football 56:5
foregoing 75:3
form 3:8 39:14
format 38:10 39:2
 39:23 42:11
former 9:7
forth 76:10
forward 71:19
four 15:12,15
FOX 2:15
fractured 72:18
frame 40:7 41:11
freak 54:14
free 45:8
front 37:7
full 9:13 35:8 43:13
further 3:14 46:15
 73:12 76:14

G

gastroenterologists
 57:10
general 19:17,21
 29:24 31:9,10,11
 35:17 54:25 67:6
generally 33:12,13
 33:14
generated 5:23
gentlemen 65:4
genuinely 32:8
Georgetown 8:19

8:21
gesturing 20:21
getting 14:11 21:23
 30:5 45:10 64:9
give 31:25 41:2
given 13:24 14:23
 15:11 76:13
gives 47:15
glacial 6:22
glass 30:25
glottiscope 45:17
go 12:3 25:17 26:11
 32:15 36:4 40:21
 51:18 62:22
goal 52:12
going 11:16 14:7
 20:23 22:3,5
 34:24 35:16
 38:24 40:25
 41:12 42:9 43:2,4
 43:9,12 47:24
 48:13 50:15
 71:10,19
good 28:4 35:15
 45:5,15,19 52:25
gray 61:12
greater 63:24
Greenhouse 1:20
 1:23 76:6,24
growing 20:2,11,12
 20:15 22:8
guard 44:16,17
 46:5 49:16 56:4
 56:14,16 69:7
guess 5:6
guidance 64:10
guide 45:4
guys 65:5

H

H 77:6
half 7:24
hall 14:7
hand 76:20
handed 17:17
handling 51:17
hands 45:8
handwriting 68:4
hangs 48:6
happen 14:8 63:21
happened 17:23
 21:10 37:21,24

37:25 38:13,16
 39:5,9,25 40:8,17
 41:8 42:15,19,21
 42:22 45:24
 46:10,24 55:9,12
 58:17 64:15 71:2
 71:6 73:9
happening 21:3
happens 48:5 58:18
 63:23
hard 26:3
hardware 57:20,22
head 6:24,25 7:5
 8:23 9:3 12:21
 17:11 26:25 27:3
 44:11,13 47:18
 52:18,18
hear 54:6
help 40:12,13 57:21
helpful 21:4
hereinbefore 76:10
hereto 3:6,16
hereunto 76:19
highly 40:10
history 8:16 25:6
 25:15
hit 63:19
hoarse 18:4
hold 9:14
holder 9:16 45:7
holding 61:8
hole 57:3
hollow 44:23
honest 15:24
hospital 1:9 5:24
 6:7 9:7 11:3,3,8
 16:10 29:6 66:5

I

idea 35:15
identification 16:9
image 30:14,16,24
 31:2,3
immediately 24:22
 60:16 66:5
improper 38:9 39:7
 39:17,20 40:16
 41:16,21
in-patient 4:14,22
 5:7,17,23
inappropriate
 38:25 41:23,25

inaugural 9:16 37:10,21 42:19 **larynx** 13:9,12 25:11,13 26:19 64:12
inches 49:3,3,10 43:20 73:20 17:16 18:19,21 26:21 27:5,7,11 **means** 9:17 61:18
incidence 63:24 **jaw** 55:15 63:9 65:9 19:6 20:15 25:12 28:18,21 30:14 61:19
incident 17:23 18:6 65:16 26:20,21 27:5,8 30:17 31:23 **meant** 52:3
43:19 **JOSHUA** 2:4 29:24 30:2,14 36:23 46:8 65:23 **medical** 1:9 4:15,15
incidents 58:23 32:25 33:2,4,6,17 **looked** 7:5 73:11 4:22 5:7 6:10
including 3:7 15:13 33:19 36:15 45:5 **looking** 32:25 45:4 8:19,21,24 9:12
19:23 **July** 76:20 45:15 48:14 49:5 45:21 50:6 61:10 9:13 10:2,5,15,17
index 1:6 69:10 **June** 1:13 50:8 51:12 **looks** 14:16 16:19 10:18,20,25 16:8
industry 64:6,8,18 **K** **larynxes** 28:5 22:8 30:22 52:22 16:20 23:21,25
infarction 19:24 **keep** 5:14 28:5 **law** 1:17 52:23 61:7 67:11 25:5 37:15 54:17
information 14:11 42:25 44:24 **lawsuit** 59:4 68:10 60:6,8 65:22 77:8
22:21 23:4,5 57:15 **lay** 13:2 21:21 **loose** 46:6 49:18 **medication** 36:2
77:12 **keeps** 13:20 **leading** 41:8 68:20 69:2 **medicine** 8:20
informed 59:9 **kid** 7:6 56:4 **Lorraine** 1:5 17:4 12:25 13:6 14:5
informs 59:8 **kind** 50:23 52:19 **lot** 13:17 15:7 **meetings** 18:11,13
injury 41:9 47:2 30:23 52:19 **LUCIAN** 1:16 20:21 21:16
55:2 58:7 65:13 7:2 12:4,13 14:6 **lump** 26:6 22:12
65:20 74:8 14:25 16:17 17:6 **M**
inpatient 16:8,20 18:2 19:11 20:17 **M.D** 1:16 **memory** 28:4
59:18 77:8 **length** 49:7,8 **machine** 54:11 **mental** 23:6,7
insert 44:19 45:3 28:20 29:18 30:3 **Madison** 2:6 **mentioned** 53:21
48:10 59:19 35:6 37:11 49:6,9 **maintain** 28:12,13 **met** 18:7 46:23
inserted 53:25 54:17 56:4 61:19 43:18,19 65:21 **metal** 44:24 45:3
inserting 60:16 61:20,22 62:7,7,8 67:16 69:14 **method** 30:9,10
insertion 55:21 63:18 67:2,12,25 74:11 **making** 14:12 31:21
instance 58:12 68:13,18 69:5 **malignant** 19:12,13 **methods** 30:7 31:5
institute 9:21,22 72:15 **malpractice** 11:14 31:6,11
instruct 11:16 42:9 **levels** 14:8 12:7 **microlaryngoscopy**
instructed 64:13 **Lewy** 45:7,18 47:15 **man** 42:25 **55:3**
instrument 32:25 **known** 55:2 **manually** 72:18 **microscope** 45:20
44:20 **L** **margins** 34:16 45:21 46:3 47:18
instruments 45:22 **life** 19:13,24 **mark** 16:6 32:9 48:6,8,16,24 49:7
48:10,12 **light** 27:2 63:18 **marked** 16:8,15 49:12,14 50:6
insurance 12:7 **limited** 19:23 **marriage** 76:16 **middle** 35:5
interaction 22:15 20:14 22:14 **Martin** 1:18 2:11 **millimeters** 49:5
24:4 **line** 33:3 47:18,20 52:15,16 62:12 **mind** 28:5
interested 76:17 77:7,13 **lined** 48:17 49:12 **minimize** 52:3,7
internationally 15:17,18 **listened** 22:16 **mass** 17:15 19:2 20:2,5,11,15,17
15:17,18 **litigation** 6:15 **matter** 17:15 76:18 22:3,8
interrupt 62:12 **little** 14:4 15:23 **maxillary** 46:6 17:15 76:18
intimate 14:20 22:4 56:9 63:21 50:21 55:18 **maxillofacial** 46:8
invited 15:9,19 69:11 73:16 56:14 58:9 46:25 47:6 69:22
involving 30:9 **LLP** 1:18 2:11 70:5 71:8 72:14
Island 8:10 **load** 50:20 51:5,8 51:10,11,15,16,20 **mean** 4:23 5:2,12
issue 38:20 39:11 52:7 19:7 22:14 27:17
issues 22:19,19 53:21 54:2 57:18 30:3 33:11,12
34:22 **laryngeal** 8:14 9:6 34:9 35:22 37:23
items 55:23 **laryngeal** 8:14 9:6 38:20 47:12

J **laryngology** 9:15 **laryngoscopy** 18:24 20:8
January 36:25 **laryngology** 9:15 44:22 56:11 63:17
laryngoscope 44:20 45:12,22 46:4
47:13,19 48:4,5,7
48:9,18,24 49:15
50:20 51:13,17
53:21 54:2 57:18
laryngoscopes
44:22
laryngoscopy
26:16,18,19,20

27:3 30:21 31:16
 32:22 34:3 36:10
 44:14,15,21,25
 46:4 52:16 55:22
 55:24 56:19 57:3
 57:20,23 58:5,6
 59:20 60:17 61:2
move 3:9 42:7,17
 43:3,18 44:12
 53:14
movement 25:24
 50:3
multiple 7:19 45:11
muscle 19:9
myocardial 19:24

N

N 2:2 3:2 4:2 77:2
name 6:24 7:2 8:24
 10:3 26:14
named 68:11
narrative 38:9,15
 38:24 39:4 40:2
 40:23 41:2,18
 43:15
narratives 43:16
national 15:13
nature 10:24 17:20
 71:13
necessarily 14:6
necessary 22:5
neck 8:23 9:4 12:21
 17:11 52:17,18
 52:21
need 20:4 22:9
 25:11,12 32:25
 33:2,3 34:14,15
 46:15 48:10
 57:17,25
needed 18:14 73:11
needs 14:6 34:14
never 55:4 73:22
New 1:2,8,19,19,21
 1:24,24 2:8,8,14
 2:14 9:6 11:3,7
 76:3,5,8
nice 17:9 22:14
niece 46:23 70:9
 73:4
noisy 54:10
normal 24:4
Norman 26:24
nose 8:24 12:25
 13:6 25:13,18
 26:3,12 30:12,12
 31:13 33:7,16,22
 34:2 36:19
Notary 1:20 3:18
 3:19 4:4 76:7
note 11:15 13:18
 22:23 42:17
 43:23 51:22
 54:16 55:10 62:5
 63:14 65:17
 67:13 71:3
noted 39:8 40:21
 43:3 74:18
notes 5:13 24:12,14
 24:21
notice 1:17 22:18
noticed 69:16
numbers 20:7
nurse 54:13 66:4,12

O

O 3:2
object 3:7 39:14
 57:15
objecting 20:22
 39:12
objection 11:15
 12:6 13:18 20:24
 22:24 23:10 39:7
 39:13 40:19,20
 42:16 43:23,24
 51:22 54:16
 55:11 62:6 63:14
 65:17 67:13 71:3
objections 43:2
obligation 16:3
observe 18:25
observing 31:6
 60:21
obstructing 57:16
obstructive 57:23
obvious 52:20 53:6
obviously 42:20
 74:8
occasion 24:8
occasions 8:4,6
occur 18:20 19:21
 24:22,23
occurred 43:20
 65:10 72:20,22
occurs 24:25
offhand 32:2
office 5:13 6:6 14:9
 15:5 18:23 29:19
 32:18 33:20
 34:12,18,20
 35:19 36:14
 44:23
offices 1:17
Oh 14:24 36:6
Okay 6:3,4,18
 12:12,14 16:5
 21:12 24:10
 29:15 33:5,9 36:6
 38:5,18 43:7,9
 44:8 45:25 47:13
 48:15 53:2 59:7
 64:2,17 68:12
 73:5
once 45:5,19 51:18
 56:25 64:13 70:5
ones 56:6
open 44:14
operate 45:8,20
operated 37:12
operating 17:21,23
 29:16 35:20 44:6
 47:5 60:25 61:4
 63:18,22 70:8
operation 21:17
operative 32:19
 37:9 44:2
opinion 50:17
opposed 34:3
optical 30:15
optics 26:8,10
optimize 52:4
optional 9:5
oral 8:22 46:7,25
 47:6 69:22 70:5
 71:7 72:14
order 25:11 34:10
original 3:21 18:3
originally 17:13
 31:2 35:2
otolaryngology
 8:22 9:3 12:21,24
out-patients 13:16
outcome 76:17
outpatient 4:15 5:9
 5:15,18,25 6:4
 11:2 24:14,21
 59:18 60:4,8
outside 4:18 17:13
 17:17 19:8 64:22
overseas 15:6
overwhelmed 73:17

P

P 2:2,2 3:2
page 37:6,9,19 61:9
 61:10,20,25 62:4
 62:9,10,17,23
 65:21 67:16
 68:10,20 75:6
 77:3,7,13
pages 62:24 66:8
 68:8
paralyzed 25:25
Parker 9:21
part 12:8 20:13
 59:2
particular 32:12
 36:9 37:12 45:9
 60:18 62:2
parties 3:6,16
 76:15
partnership 10:9
passes 30:12
passing 57:11
patient 5:14,24 6:5
 6:11 11:5 18:22
 23:15,23 24:23
 25:2,3,6,9,21,24
 26:5 29:21 31:21
 34:2 35:16,18
 36:24 37:13 44:5
 44:9,11 50:3 52:2
 52:6,9,11 53:4,7
 53:10,14 56:12
 59:10 63:20 66:4
 66:21
patient's 18:25
 25:15 27:3 30:12
 44:14,15,21 46:4
 46:22 55:22
 56:18 58:6,13
 59:20 60:17 61:2
 65:9
patients 10:12,13
 13:13 14:10,11
 14:12 16:4 21:21
 33:21 51:6 63:2,6
 63:9
pending 6:16,19
percent 19:4 34:5
 58:18 59:13 63:2
 63:17,24 64:14
 64:19
percentage 33:25
perfectly 38:12,22
 41:10 42:3 54:22
perform 17:22 25:8
person 13:3 70:10
personal 64:2,4
phone 62:13
phraseology 19:22
physical 25:9,15
 60:13
physician 11:9
pictures 26:24
piece 34:19
Pierre-Paul 68:15
pixilated 30:17
place 29:6,12 37:3
 54:10 72:19
placed 16:14 52:6,9
 54:2 56:18 57:2
placement 51:21
 52:11
placing 54:4
plaintiff 1:6 2:5 7:3
Plaintiff's 16:7,15
 77:7
plan 71:17,20,21,23
plans 14:13
plastic 57:2
plays 56:5
please 40:14 41:3
 41:21
point 29:22 32:14
 35:10 45:23,23
 46:7,17 47:4,16
 50:22 53:4,23
 57:19 60:14
 61:21 69:15 70:2
 70:3 72:16,21
 73:18,19
pointing 24:17
points 14:14
position 52:2,19,20
 64:15
positioning 53:4
possible 28:25 63:5

65:16
possibly 15:23
 24:16
pot 52:24
potentially 19:13
power 51:19
practice 9:8,9 14:2
 24:20 36:17 64:3
 64:4,11,18
pre-anesthesia
 67:17
pre-op 18:8 40:4
 44:5 61:8
precipitated 50:12
precision 34:18
 58:20
preoperative 22:11
 24:11 27:17,20
 27:24 29:21
 65:22
preparation 6:9
 16:22
prepare 4:13 25:10
preparing 66:23
Presbyterian 1:8
 11:3,8
present 12:15 42:2
 73:4
presents 66:4
pressure 50:24
pretty 35:15 46:9
previously 23:11
 33:5
prior 18:5 21:16
 31:19 43:16
 51:21 54:7 55:21
 59:15 60:4,14,16
 61:2,5 63:4 65:14
 66:5
prisms 30:25
private 9:9
probably 13:15
problem 43:8 74:9
problematic 43:12
procedure 6:12
 18:6 26:15 29:5
 31:20 32:14
 33:22 37:2 38:2
 38:17,22 40:18
 41:7 42:22,23,23
 43:21 47:8,10
 52:4 53:8,15,18
 54:7 57:24 59:16
 59:24 60:15 61:3
 61:6 63:3,4 65:10
 65:14 66:15,19
 68:24 69:3,15,16
 72:20
procedures 29:13
 58:15
proceed 23:14
 46:18 71:11
process 14:10
 21:22 23:5
processing 22:21
produce 28:11,15
professor 9:14
 15:19
prominent 51:11
prompt 57:7
prompted 59:3
promptly 46:9
pronouncing 4:8
proper 42:2
protect 58:6,8
protection 44:18
provide 11:5 15:22
 43:13
provided 3:6,23 8:2
 11:21 12:8,9
provides 10:17,22
 11:13
Public 1:21 3:18,19
 4:4 76:7
purpose 18:10,12
 57:19
purposes 8:13
 28:24 57:24
pursuant 1:17
pushed 49:14
put 20:23 27:6 44:6
 55:23 56:3,8
 57:22 58:5 69:7
 69:10
puts 50:20,24
putting 35:18 45:21
 56:13,15 57:20

Q

quality 16:4 30:18
 59:2
quantitative 50:25
question 3:8 5:8
 12:5 25:19 32:7
 35:4,8,12 37:4
 38:11 39:7,16,18
 40:15 41:21 42:2
 43:14 49:24
 51:24 52:2 53:5,7
 54:18 57:6 58:2
 64:22,23
questioning 62:12
questionnaire
 65:23 66:17,21
 66:23 67:5,9
questions 14:15
 21:9 24:6 34:25
 40:6 41:6 67:8
quick 64:22
quite 62:20
quote 59:10,12

R

R 2:2 4:1,2 5:1 6:1
 7:1 8:1 9:1 10:1
 11:1 12:1 13:1
 14:1 15:1 16:1
 17:1 18:1 19:1
 20:1 21:1 22:1
 23:1 24:1 25:1
 26:1 27:1 28:1
 29:1 30:1 31:1
 32:1 33:1 34:1
 35:1 36:1 37:1
 38:1 39:1 40:1
 41:1 42:1 43:1
 44:1 45:1 46:1
 47:1 48:1 49:1
 50:1 51:1 52:1
 53:1 54:1 55:1
 56:1 57:1 58:1
 59:1 60:1 61:1
 62:1 63:1 64:1
 65:1 66:1 67:1
 68:1 69:1 70:1
 71:1 72:1 73:1
 74:1 76:2
RADU 1:16 75:12
 76:9 77:4
rare 19:10
rate 59:10,12
react 73:15
read 35:13 38:4
 55:5 75:3
realized 45:24 50:7
really 18:13 41:22
 47:22
reason 27:25
reasonable 65:16
reasons 52:20
recall 7:9 8:5 17:8
 17:14 18:7,18
 20:5,7,19 21:15
 26:23 31:24 32:8
 37:18 38:16
 43:21,22,25 60:2
 60:19,21 64:9,12
 71:24,25 72:6,7
 72:24 73:5,8,17
 73:25 74:10
recess 74:12,13
recollection 21:15
 22:10 38:3 39:6
 71:13,24 74:6
recommendation
 46:13 70:7 71:9
 72:13
recommended 47:3
 72:4
recommending
 21:24
record 4:15,16 5:8
 7:7,8 11:25 12:2
 12:4 16:12,13,20
 20:24 27:10
 32:11 35:13
 50:15,16 62:15
 62:16 64:25 66:8
 76:12
recorded 29:7 30:2
records 4:22 5:10
 5:17,18,21,22,23
 6:5,10 16:8 25:5
 37:16 60:6,8 77:8
recovery 73:3
recreate 24:2
refer 5:3 21:3 28:7
referred 18:5
referring 4:24 66:8
 68:8
reflect 27:2
reflected 30:24
 60:5
regarding 21:9
related 22:19 23:11
 76:15
relating 6:11,12
relatives 69:25 70:4
relevant 11:19
reliably 34:20
remember 22:13,14
 56:12
remove 34:11
 46:19
removed 20:17
 46:3
removing 35:23
repeat 17:19 19:25
 22:6,6
replaced 72:18
report 37:9 44:2
Reporter 1:20 76:7
REPORTING 1:23
REQ 28:17
request 28:22
REQUESTS 77:12
reserved 3:12
residency 8:22,25
 9:2
resident 58:24
residents 15:2
 58:21
resolution 30:18
respect 59:23 71:19
respectfully 39:15
 39:20 43:8
respective 3:5,15
respond 28:23
response 35:5 43:5
 43:13
responses 34:25
result 59:23 65:9
retained 77:9
return 3:21 33:11
review 16:21 21:6
 58:25
reviewed 4:14 6:10
 16:20,23 37:15
 58:21 68:23
reviewing 37:18
revised 61:15,19,21
 61:24 62:4,9
ridge 46:6,13
ridiculous 42:14
right 3:7 4:21 5:11
 6:17,20,23 10:19
 13:17 14:25 19:3

28:10 29:14
30:10 35:24
36:11 54:5 56:24
59:19 61:11,14
62:21 63:17
66:13
rights 3:6,23
rigid 30:22,22
risk 63:5,12,16
65:16
Rochester 8:8
Rockwell 26:24
rod 30:23
role 66:22
room 17:22,23
29:16 35:20 44:6
46:12 47:5 63:18
63:22 70:8,11,15
70:20 73:3
Roosevelt 9:7
rotate 14:9
rotating 15:3
route 32:20,21
routes 32:15,17
rules 3:23 26:4
Ryan 2:15 40:9
41:3

S

S 2:2 3:2,2 4:2 77:6
Saturday 16:23
17:2
saw 27:15 46:5
73:20,22
saying 28:25 38:13
41:17
says 65:22 68:20
scan 17:16,20 18:3
18:16 19:5,15
20:2,9 21:23 22:6
22:6 36:16
school 8:19,20
scope 26:2,7 56:21
56:23 57:11
scrub 44:12 46:21
70:7,22
Sean 9:21
seated 25:4
second 25:21 30:10
see 13:14 14:9,10
18:21 24:22 28:2
28:18 33:18
35:14 36:13 48:3
49:13,17,19 50:7
56:17,17
seeing 10:13
seen 17:16 44:4
segment 46:20
72:18
self-retaining 47:14
53:24
send 28:21
sense 35:7
sent 17:10,13
separate 5:20 11:4
48:6
series 58:22
server 28:15,18,21
29:3
serves 57:18
service 69:23 70:6
services 10:18,21
10:23 11:5 15:22
set 29:17 49:6
76:10,20
sets 5:21
severe 55:3 65:13
shake 69:11
shape 45:13
shift 49:20 50:9,12
50:18
shifted 45:23 47:10
54:8
Shorthand 1:20
76:6
shoulders 52:17
showed 20:2
shown 75:6
shut 42:13
sight 33:3
signed 68:11,19
similar 21:19 36:18
simple 41:5
sir 4:10 60:7,9
sit 17:7 20:6,16
21:14
sits 47:13
situation 11:22
24:7 33:19 36:19
57:12 63:8 70:9
situations 63:13
six 49:3,10
size 20:13
sleep 44:6
slightly 26:8
small 14:19
smell 52:25
smelling 52:24
sniffing 52:20,22
soft 57:16
Somebody 67:23
sorry 16:25 36:4
56:11 62:22
sort 19:20 22:18
49:20 50:9 54:14
56:12 57:2 67:6
sound 54:6
source 64:10
space 48:9,20,23
49:2
speak 73:23
speaking 41:13
specialist 17:18
specific 5:4 6:11,12
10:3 21:6,8 31:8
33:11,15 36:2
38:11,21 39:23
52:3
specifically 13:8
16:22 23:16 52:7
66:15,18 72:7
specify 21:2
spoke 70:23 72:21
sponge 44:17 49:16
56:8,15
stabilization 72:12
stabilized 46:14
48:4 72:19
stabilizing 71:10
stable 47:15 69:12
staffing 10:23
stand 53:25
standard 63:16,22
64:5,8,10
start 29:22
started 9:18
starts 25:3
state 1:2,21 59:21
76:3,8
Staten 8:10
status 6:20
stayed 8:20
steel 30:23
steps 51:20
sterile 44:12
STIPULATED 3:4
3:14
stop 41:4
straight 52:16
straightforward
21:21
street 1:19,24 2:13
13:3
strike 3:9
stroke 19:23
structures 52:15
students 14:22
subject 7:12 75:5
Subscribed 75:17
subspecialty 12:23
sudden 49:20 50:2
suddenly 49:13
53:14
Suffolk 6:21
suggest 40:5
suggested 19:5
Suite 2:7
Sulica 1:16 4:1,8
5:1 6:1 7:1 8:1
9:1 10:1 11:1
12:1 13:1 14:1
15:1 16:1 17:1
18:1 19:1 20:1
21:1 22:1 23:1
24:1 25:1 26:1
27:1 28:1 29:1
30:1 31:1 32:1
33:1 34:1 35:1
36:1 37:1 38:1
39:1 40:1,17 41:1
42:1 43:1 44:1
45:1 46:1 47:1
48:1 49:1 50:1
51:1 52:1 53:1
54:1 55:1 56:1
57:1 58:1 59:1
60:1 61:1 62:1
63:1 64:1 65:1
66:1 67:1 68:1
69:1 70:1 71:1
72:1 73:1 74:1,15
75:12 76:9 77:4
superficial 18:20
supplementary 9:4
support 10:22
SUPREME 1:2
sure 22:4 34:16
36:7 51:25
surface 18:20
surgeon 46:8 70:6
surgeons 46:25
47:6 71:8 72:14
72:15
surgery 6:2 8:23
9:4 12:21 42:20
60:4 66:6 67:6
69:23 70:17,19
surgical 45:5,10
surprised 54:9
suspending 50:19
swallower 52:14
swallowing 13:11
sword 52:14
sworn 3:17 4:3
75:17 76:11

T

T 2:15 3:2,2 13:7
76:2,2 77:6
table 44:10 47:17
60:25 61:4
tailored 66:18
take 5:17,18,20
16:16,25 24:11
25:6,7 34:19
35:19 38:21
41:22 49:15,16
49:16 51:20
67:10 74:11
taken 1:16 27:18,23
74:13
talk 24:24 43:19
talking 30:8 39:13
66:16
task 52:13,14
teach 13:22,25
teaching 14:14
team 44:7 54:12
technology 26:13
31:4
teeth 44:18 49:17
50:21 51:11
55:14,18 56:6
58:13 59:13,15
59:23 60:14
62:25 67:9 68:21
69:3,17 70:6

telephone 73:23
tell 8:15 20:9 48:25
58:19 63:20
64:15 70:25
tells 41:20
ten 8:7 34:5 41:22
ten-page 38:23
39:4
term 26:21
terms 11:22 20:25
21:5 22:20 23:13
23:23,24 24:21
32:13,14 40:7
41:6,11 54:25
test 69:8
tested 69:6
testified 4:5 47:9
55:11,16,23
62:18,24 63:4
testify 4:12 55:19
testimony 3:9 8:3
8:13 11:20 23:12
57:8 75:3 76:13
Thank 4:11 6:8
12:14 44:3 74:14
74:17
thanks 35:11 66:10
68:9
thing 25:20,21 45:6
56:3 57:2 63:21
things 10:23 19:9
19:25,25 21:2
24:3 42:21 45:14
think 11:20,24 18:4
21:10 22:9 25:10
25:22 34:21,22
38:8 39:19 47:25
49:22 50:14,21
55:11,16 62:8
73:16
thinking 21:22
thought 22:16
threaded 47:21
threatening 19:14
19:24
three 7:6 15:12,15
18:9 20:20 26:22
30:7 31:5,6 32:15
32:17 58:22
three-minute 62:13
threshold 64:19
throat 8:24 12:25
13:6,8 30:13
thumb 69:10
time 13:25,25 14:23
16:25 17:24
27:14 28:7 33:25
34:6,7 35:21 36:2
40:7 41:8,11
49:21 50:11
58:19 70:12
73:14 74:6,15,18
times 5:16,17 7:20
7:22 14:3 15:12
15:16 18:7,9
timing 24:21
tissue 33:18 34:15
36:14 57:16
tissues 44:24
titled 37:9
today 4:12 11:20
16:22 17:7 20:6
20:16 21:14
24:18 28:25
37:16,19 74:15
today's 6:9
told 6:21 46:9
64:16 71:2,6,7
73:10
tolerate 25:21
tongue 27:5,7 44:25
tooth 44:16,17 46:5
49:16 56:4,13,15
69:7
top 6:24,25 7:4
15:21 37:8 56:8
56:10,15 61:11
61:11
trainees 14:8
training 9:5
transcript 34:24
75:5
transmitted 30:16
travel 15:7,8
treat 34:6,10 35:21
treated 36:18,20,21
36:22,24
treating 35:22
treatment 14:12
21:7
trial 3:10,12 8:2
43:7
trick 32:6
trivial 19:25
trouble 13:21
true 24:19 75:4
76:12
try 26:7
trying 40:11
tube 44:24 45:3
tumor 19:5,11,13
33:16 34:11
tumors 13:12 18:19
19:4,12,12
turn 37:6 61:9
62:10 65:21
67:16
turned 44:10
twice 8:11
two 5:20 8:4,24
18:9 20:20 31:11
45:8
type 19:11 25:22
28:2 38:10 51:13
57:13 58:7 66:15
66:18
types 58:14 63:12
typical 14:17
typically 14:16
18:21 30:3,4
67:22

U

U 3:2 4:2,2,2
U.S 15:14
undergo 21:25
23:15 35:17
understand 22:9
51:23,25
understanding
12:15 24:9 61:17
61:23 63:25 64:7
66:20 67:5,7
70:18 72:2,5,17
undertake 58:24
60:13,25
university 8:20
15:20
unpacked 46:2
unusual 54:21,23
55:6 60:23
unusually 20:10
65:12,13
upper 56:5
upside 56:13
use 25:12 26:2,7
27:4 29:17 30:11
31:21 44:22
51:13 56:5 57:10
57:13
usually 15:4 21:20
34:5,6 35:14 61:7

V

variations 53:5
varies 14:24
various 14:8
vary 23:3 45:12
51:6,9,10,11,20
verbatim 24:3
video 27:11,12,14
27:18,23 28:6
29:6,20,22 30:2
videos 28:12,13,19
29:2
view 29:23 45:6,19
45:23 47:10,15
48:19 53:4 54:7
visible 19:8
visit 24:5 25:2 60:4
visiting 15:5,19
visits 17:19
vocal 25:25 26:6
27:8 45:2 47:16
49:13 57:18
voice 9:15,20,21,23
13:9,10

W

wait 42:4 48:22
waited 73:7
waiting 70:11,15,16
70:19,20
waits 46:22
waiver 3:11,22
Walk 38:2
want 21:3 32:2 33:9
34:6 35:3 38:10
38:20 40:22
41:19 42:5,12
43:15 47:22
50:25 54:20
55:18 62:11 67:9
wanted 35:10 36:7
74:2
warn 65:15
warned 65:19
wasn't 19:14,16
watch 22:3
way 23:3,4 29:19
30:14 31:4 40:15
49:15 50:22 52:3
76:17
ways 26:22
we're 21:23 22:3,5
45:4 61:9 64:24
66:16
we've 11:21
week 29:17
weekly 13:14
Weill 1:9 9:11 10:5
12:9
Welcome 65:3
went 8:10,17,19 9:7
45:11 46:21 47:5
70:8,22 73:9
West 1:24
wet 44:17 56:8,15
WHEREOF 76:19
witness 3:17 4:3
7:20,23 11:16
15:22 29:4 39:22
42:10 55:20
56:24 65:2 75:2
76:9,13,19 77:3
woman 22:20 23:2
word 61:15,24
words 66:16 72:10
work 11:2
works 14:16
worry 43:6
wouldn't 57:13
write 25:7

X

x 1:4,12 77:2,6

Y

Yeah 13:20 29:14
year 8:9,9 9:5
15:11,12,16
years 6:20 7:6 8:7
8:25 58:20 59:5
York 1:2,8,19,19
1:21,24,24 2:8,8
2:14,14 9:6 11:3
11:7 76:3,5,8

<hr/> Z <hr/>	5th 1:24
<hr/> 0 <hr/>	<hr/> 6 <hr/>
	60 13:16
<hr/> 1 <hr/>	<hr/> 7 <hr/>
1 16:6,7,15 36:23	7 77:8
58:18 59:12	
61:10 62:18 63:2	<hr/> 8 <hr/>
63:17,24 64:14	<hr/> 9 <hr/>
64:18 65:22 77:8	
10:51 74:18	9 37:10,21 42:19
10001 1:24	43:20 73:20
10017 2:14	9:33 1:14
10022 2:8	93 62:10,19,20,23
102 37:7 61:10	65:21 66:9
11th 76:20	94 62:18,19
12 15:2	96 66:9
1230 2:7	97 67:16 68:8,20
15 41:13	98 68:8,10
16 77:8	99.5 19:3
17 77:14	9th 36:25
<hr/> 2 <hr/>	
2 32:10	
20-page 40:2	
2015 36:25 37:10	
37:22 42:20	
43:20 73:21	
2018 1:13 75:19	
76:20	
212 1:25	
220 1:18 2:13	
236 1:24	
24968/2015E 1:7	
25 1:13	
279-5108 1:25	
28 77:14	
<hr/> 3 <hr/>	
300 58:22	
30th 1:24	
3116 3:23	
3117 3:23	
<hr/> 4 <hr/>	
4 77:4	
400 49:5	
400-millimeter 49:8	
42nd 1:18 2:13	
477 2:6	
<hr/> 5 <hr/>	