SUPERIOR COURT OF NEW JERSEY
LAW DIVISION - MIDDLESEX COUNTY
DOCKET NO. MID-L-3284-15

WASHINGTON MUNOZ,

Plaintiff,

vs.

NEW JERSEY SPORTS & EXPOSITION AUTHORITY; NEW MEADOWLANDS RACETRACK, LLC; LP CIMINELLI, INC.; LP CIMINELLI RCCIP.; COOPER PLASTERING CORPORATION; KF MECHANICAL, LLC; PAINO ROOFING COMPANY, INC.; COUNTRY SIDE PLUMBING & HEATING; COUNTRYSIDE PLUMBING AND HEATING) COUNTRY SIDE PLUMBING; COUNTRY SIDE PLUMBING & HEATING, INC.; JOHN DOES 1-20; ABC CORPORATIONS 1-20,

Defendants.

STENOGRAPHIC TRANSCRIPT OF VIDEOTAPE DEPOSITION OF:

EDWARD M. DECTER, M.D.

Taken before LORA LANDSHOF, a Certified Shorthand Reporter of the State of New Jersey, at the offices of EXAM WORKS, 4 Becker Farm Road, Roseland, New Jersey, on Wednesday, March 1, 2017, commencing at 6:12 p.m.

Job No. CS2552892

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

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ALSO PRESENT:

MARC FRIEDMAN, Videographer
Veritext Legal Solutions

MR. DECTER
(Dr. Decter's brother)

I N D E X

E X H I B I T S

VIDEOGRAPHER: We are now on the record. Please note the microphones are sensitive and may pick up whisperings and private conversations. Please turn off all cell phones or place them away from the microphones as they can interfere with deposition audio. Recordings will continue until all parties agree to go off the record.

My name is Marc Friedman representing Veritext Legal Solutions. The date today is March 1st, 2017, and the time is approximately 6:12 p.m.

This deposition is being held at the office of ExamWorks located at 4 Becker Farm Road, Roseland, New Jersey.

The caption of this case is Washington Munoz versus New Jersey Sports & Exposition Authority, et al. This case is filed in the Superior Court of New Jersey, Law Division, Middlesex County, Docket Number MID-L-3284-15. The name of the witness is Dr. Decter.

At this time the attorneys in the room will identify themselves and the parties they represent starting with the noticing attorney, after which time our court reporter Lora Landshof representing Veritext will swear in the witness and we can proceed.

Counsel.

MR. GULINO: Joseph J. Gulino, Nicoletti,

Gonson, Spinner, LLP. I represent the Def -- all the Defendants, and I am producing the doctor today in lieu of trial testimony.

MR. BERENGUER: Lazaro Berenguer, Clark Law Firm, represents the Plaintiff Washington Munoz.

E D W A R D M. D E C T E R, M. D., 4 Becker Farm Road, Roseland, New Jersey, having been duly sworn, did testify as follows:

DIRECT EXAMINATION BY MR. GULINO:

Q. Good evening, Doctor.

A. Good evening, sir.

Q. Have we met before today?

A. We met yesterday for the first time. That was it.

Q. Was it Monday?

A. It was probably Monday, yes.

Q. Okay. And before that did we ever speak on the telephone?

A. No, sir.

Q. And when we met the other day were you told additional facts about this case?

A. I was told some additional facts,

yes.

Q. All right. Now, are you a physician licensed to practice in the State of New Jersey?

A. Yes, sir.

Q. And for how long have you been admitted?

A. I've been licensed in the State of New Jersey since 1976, 1977. When I was an intern I received my medical license.

Q. Any other states are you licensed in?

A. I'm licensed in New York and Florida right now.

Q. And do you have a specialty?

A. I specialize in orthopedic surgery which is the discipline of the musculoskeletal system where my specialty within that area where I'm the primary surgeon is knee and shoulder surgery.

Q. Could you tell the jury your educational background?

A. Yes, sir. I did my undergraduate schooling at the University of Maryland. I am a graduate of Creighton Medical School in Omaha, Nebraska. I graduated in 1975.

I then did a one-year internship in general

surgery at Temple University Hospital in Philadelphia, Pennsylvania, and then I did a four-year orthopedic residency from 1976 to 1980 at the Hospital For Joint Diseases Orthopedic Institute in Manhattan.

In 1980 July I came into private practice in the State of New Jersey, and I've been in practice since then.

Q. And are you Board Certified as an orthopedic surgeon?

A. Yes, I am Board Certified as an orthopedic surgeon.

Q. How long?

A. I believe since 1982.

Q. And can you tell the jury what it takes to -- first of all, what is board certification?

A. There are different specialty boards within the United States of which orthopedics is one of the specialty boards. There's internal medicine, there's cardiology, there's all different specialty boards, and orthopedics is one.

And in order to sit for your boards you have to do a accredited orthopedic residency, which obviously the Hospital For Joint Diseases is, and then you can sit for your orthopedic boards.

I am grandfathered. The younger doctors coming out these days have to recertify every ten years, but our class and a couple classes before me and after me did not have to recertify.

Q. What is the process of a certification? What exactly has to be done?

A. It's a written and oral examination that you take when you complete your residency.

Q. And at present do you have any hospital affiliations?

A. Yes. I'm a full attending at Saint Barnabas Medical Center in Livingston, New Jersey. I'm also the Medical Director of the Short Hills Surgical Center which is an outpatient privately owned center by about 70 doctors, and I've been the Medical Director there for approximately 11 years.

Q. Are you affiliated or have you been affiliated in your career with any professional sports teams?

A. Yes. I've been with the Under 20 United States Men's United States National Team. I've been the head team physician for the MetroStars in Red Bull. I've also been the head team physician for the New Jersey Gladiators which was a

professional arena indoor football team. I've also did the professional indoor lacrosse team until Jason Williams who owned that team got in trouble and then moved out of the state.

I've run, I've also run the Sports Medicine Program in the City of Newark from 1999 to 2002. I have traveled to Bolivia, South America with a soccer team to a tournament called the Mundialito where I would go down, and I would do knee and shoulder surgery with the Bolivian doctors, and I would teach them different techniques.

So there's also been high school and college affiliations, but those are my main affiliations at this juncture in time.

Q. Are you a member of any professional societies?

A. I am a member of the Fellow of the American College of Surgeons, Morris County Medical Society, the Arthroscopy Association of North America. It's American Medical Soccer Association. I'm not even sure if that's still in existence to be honest with you. The American College of Sports Medicine, and the International Society of Arthroscopy Knee Surgery and Sports Medicine, and the American Orthopaedic Society for Sports

Medicine.

Q. Have you ever been a member of the American Academy of Orthopaedic Surgeons?

A. I was. I resigned from that Academy, yes.

Q. What year?

A. Probably now it's, you know, you lose track of time, but it's probably about three or four years. I can't give you an exact date.

Q. Okay. Can you give us the circumstances as to which --

A. There were circumstances where I, I testified as a Plaintiff's expert in a medical malpractice case. I was testifying on behalf of the Plaintiff, and the Plaintiff won the case, and then he reported me to the Academy who then gave me a censure. This is a private organization. It's not a governmental organization.

Q. I was going to ask you about that. Is this, is this a State organization such as like a medical board or anything like that?

A. No, it's not a medical board. It's a private organization that you voluntarily join, and I voluntarily resigned after this whole incident because it was almost like, you know, you never --

they don't want you testifying against your brethren.

Q. Is it affiliated with the American Medical Association?

A. No, it's not with the American Medical Association. It has nothing to do with the American Board of Orthopaedic Surgery, the New Jersey State licensure, nothing to do with that. This was strictly --

Q. Does it have anything to do with keeping your license, awarding you a license, or anything like that to practice medicine?

A. No. It was a, basically, don't do this again. We don't want you testifying against other doctors. I was not cited for giving false testimony or anything like that.

The major grief -- gripe they had against me was that I did not provide literature, nor did anyone else provide literature, in giving my opinion. So the Judge actually did what's called a 104 Hearing, and they argued about it, and they said you can give your opinion based upon education, knowledge and experience, but the Academy has a different set of rules that, that wants you to provide literature.

So that's really the sum total of it, and it had

no bearing on my ability to practice medicine, my license or anything, my hospital privileges. It was nothing.

Q. Okay.

A. Sort of like I stayed after school one day because I was, I testified against somebody.

Q. And at present do you treat patients?

A. I do treat patients, sir. I have a private treating practice. I had my own orthopedic group for about 34 years in West Orange, New Jersey. There were five or six of us. I left that group recently because they wanted to join a health care system, and now I'm with a really good group called Tri-County Orthopedics in Cedar Knolls, New Jersey which is about 12 doctors of multi-specialty areas.

Q. Are you still -- are you still doing orthopedic surgeries?

A. I'm still operating, sir, yes, sir. I do about, probably do about 100 surgeries a year. I think in my career I, when I go back and I look at it, I think I've probably done between 3 and 4,000 shoulder surgeries and, you know, maybe 6 or 8,000 knee surgeries in my, in my professional career.

Q. So you said how many thousands of

surgeries for the shoulder?

A. Probably when I really go back and I think about it because most of my surgeries, either knee or shoulders, of which it's about 60/40 knee to shoulder, and I think I've done about 12,000 so there's probably in the neighborhood of 4,000 shoulder surgeries, sir.

Q. Have you ever done subacromial decompressions?

A. Yes, sir.

Q. Have you ever done acromioplasties?

A. Yes, sir.

Q. Have you ever repaired torn rotator cuffs?

A. Absolutely.

Q. Okay. And would it be fair to say that those have been, if not in the thousands, in the hundreds at least?

A. It's --

Q. Each of them?

A. It's pretty routine for me, yes. That's what I do.

Q. Now, do, you obviously have an income; correct? What percentage of your income is from treating patients presently?

A. Well, the way my income right now, sir, is about 60/40, medical-legal versus 40 percent of my income is from the medical practice.

Q. And what's the other 40 percent from?

A. My medical practice is about 40 and my medical-legal is about 60, 55. I haven't really given a careful breakdown, but it's about that.

Q. Okay. Are you affiliated or have you ever been affiliated with a company called CFO, all caps?

A. CFO was my medical practice called Center For Orthopaedics. That was my primary treating orthopedic practice, and then there was a company called CFO Medical Services which did medical-legal evaluations.

CFO Medical Services was sold to or made into what is now ExamWorks which is where we are today, and now I work for, I do medical-legal work for ExamWorks.

Q. What is the com -- what is the, what is the business of ExamWorks?

A. We, we do medical-legal evaluations, we do -- they do Medicare set-aside, they do bill review. They've expanded the industry to many things. I personally only do medical-legal

evaluations, sir.

Q. And when you do medical evaluations, do we call them Independent, IMEs or Independent Medical Examinations or medical examinations?

A. In New Jersey they call them IMEs.

Q. Okay.

A. That's what they call them. In Florida they call them, my friend does them, they're called Compulsory Medical Examinations so, you know, you could argue, but that's what they call them in New Jersey is IMEs.

Q. Now, have you ever given any lectures?

A. I have lectured, yes, sir.

Q. You ever lectured in front of the New Jersey Defense Association?

A. I have, sir, yes.

Q. And have you lectured on obviously medicine?

A. I've lectured on knees and shoulders. That's basically what my lectures have been on when I lectured to the, you know, when I, when I do lecture.

Q. Have you testified in court before?

A. Yes, I have.

Q. And have you ever testified for me?
A. No, sir.
Q. Have you ever testified to your knowledge for my firm?
A. To be honest with you I don't even know what firm you're with.
Q. Okay. Now, do you testify on behalf of Plaintiffs and Defendants? Is there a way you can tell the jury what the makeup would be?
A. Sure. The predominance of my medical-legal work is, is on behalf of Defendants. I would say 98 percent of my testimony is on behalf of Defendants, sir.
Q. Are you being compensated for your time today?
A. I hope so. I'm charging you for my time, yes, sir.
Q. And can you tell the jury what the rate of compensation is for your time?
A. For my time is $100 -- $500 an hour, I'm sorry.
Q. And before you -- withdrawn.
Your time, does it encompass reviewing of trans -- of medical records?
A. I was what?

Q. Does your time include reviewing medical records?

A. Well, what happens when I do an examination, it's, it's a one-shot fee. It depends on the size of the chart.

Q. Okay.

A. So I do review the records first before I see the individual.

Q. When, when we talk about a one, a one-time shot for an IME or an examination, then is it by the hour when you're testifying?

A. My time now for testifying or meeting with you is an hourly rate, yes, sir.

Q. Okay. And were you retained on behalf of the Defendants in this case to examine the Plaintiff Washington Munoz?

A. Yes, sir.

Q. And did you perform an examination of Mr. Munoz?

A. I did. I reviewed medical records first, which is the way I do it, and then I did a physical examination, yes, sir.

Q. Did you write a report concerning Mr. Munoz's examination and your opinion?

A. Yes, sir. I've written four

reports.

Q. And feel free, Doctor, if you need during your testimony to refresh your recollection if you need by looking at your report. Okay?

A. Sure.

Q. And before you met with him, did you have an opportunity to look at any medical records?

A. I did, sir. I have a chart here which to the best of my knowledge is the entire chart, and I reviewed approximately 12 medical records before I even saw Mr. Munoz.

Q. And what is the reason why you would review these medical records before you meet with him and examine him?

A. Because I like to get a picture, and I say like from 5,000 feet. I like to see what's going on, what part of the body I'm dealing with, you know, is it orthopedics, were there other associated injuries, what other doctors had to say about the case, and sort of get a picture, a very broad picture in the beginning, and then narrow it down and when I see the Plaintiff.

Q. When you write these reports, would it be fair to say you write them yourself?

A. Of course. I, I don't take notes. I dictate as I go.

Q. You dictate.

A. That's how I do it.

Q. And the accident date is June -- withdrawn.

From your notes or from your report -- do you have a report in front of you right now you'd like to refer to?

A. Well, I have, yeah, I have all four reports here, sir.

Q. Okay. Why don't we do this. Why don't we start with the first report, and can you tell the jury what day that report is from?

A. This was July 18, 2016.

Q. And on that did you, did you meet with Mr. Munoz that day?

A. Yes.

Q. And was anyone else with you?

A. Yes. There was a Miss Katherine Mixit who was sent to the examination by the, I believe the Plaintiff's Law Firm, and I was clocked in and clocked out of today's exam, that examination when I was there, and she took notes

throughout the examination.

Q. When, when you talk about examination, that's -- is that basically from the time he walks in the door, you meet with him, and the time he leaves?

A. Well, that's basically where she clocked me in and clocked me out. She didn't clock me because, you know, I was reviewing the records because she wasn't in the room watching me review the records so, basically, it's just the examination that she's clocking me in and clocking me out of. That's all.

Q. Did you know her to be a medical professional?

A. I, I believe she was a nurse. That's my understanding.

Q. Now, why don't we do this. Before we get to your examination of Mr. Munoz, why don't you tell the jury the records that you reviewed before you looked at him?

A. Sure. I reviewed a legal document which are called interrogatories that are answers to questions about the case, how did you get hurt, when did you get hurt, what injuries did you sustain.

Then I reviewed records from LP Ciminelli, a

Non-Employee Incident Report dated 6/25/13, an Employee Claim Petition dated 6/25/13 noting a fall while at work.

Q. Let me, let me ask you, and I'm sorry, I should have, I should have asked you this before. Have you ever read or reviewed interrogatories before before you've done an IME of a potential -- or of a Plaintiff?

A. If they're there, I always review them beforehand.

Q. Okay. And what is your understanding of what an interrogatory is?

A. My understanding as a non-lawyer is that someone is, is, are, are, they're questions, and there's, they're giving truthful answers as to what happened to them at the time of the accident, what did they injure, you know, if there's been a wage loss and things of that sort.

Q. Did your review of the interrogatories reveal what it was claimed by Mr. Munoz how the accident happened?

Is that in your report or in the interrogatories?

A. Yeah, I'm just going to get the interrogatories in front of me, sir.

Yeah. The interrogatories do state that on June

25, 2013, he was working and performing plastering work, and he allegedly fell through a hole/depression on a roof which Defendants created and allowed to exist.

So what he told me and the interrogatories state is that he fell, and I'm reading this correctly, he fell through a hole/depression in a roof. So that is my vision, visual, of what happened to this gentleman as a result of this accident.

MR. BERENGUER: We're going to object to that question. Go ahead.

MR. GULINO: Okay. That's fine.

Q. Can you -- how about one of the, any other records, there was something I think you said from -- did you read an Employee Claim Petition?

A. Yes. That was number 3 in my July 18, 2016, report noting a fall while working.

Then there was an operative report, the first operative report from Dr. Thomas Helbig dated 10/21/13. I reviewed that operative report.

Q. Let me ask you something about Dr. Helbig. Are you familiar with his work? Withdrawn. Withdrawn. Why don't I ask you this question.

Is Dr. Helbig an orthopedist?

A. Dr. Helbig is an orthopedist.

Q. Does Dr. Helbig as far as you know have a specialty in orthopedics that he concentrates in more than any other part of the body?

A. Well, I think he did a fellowship in spine surgery if I'm not correct. I've known Dr. Helbig for many years.

Q. Okay. So why don't we continue. You, you were referencing his operative report?

A. Well, the first operative report of 10/21/13 which was four months after the accident.

Then there was a second operation that Dr. Helbig did on 7/24/15 which was two years later.

Then there were records noted as work-related injury dated 6/26/13 and 6/28/13 from Center For Occupational Medicine.

And then --

Q. Let me, let me interrupt you for a second. So, so you've read -- as far as you know there were two surgeries done to Mr. Munoz by Dr. Helbig?

A. Yes.

Q. And you read the operative reports; correct?

A. Yes, sir.

Q. And can you explain to the jury what

is an operative report?

A. An operative report is a mandated record that when a surgeon does an operation technically within 24 hours you're to dictate that record, and it's a record of what happened at the time of the operation.

Q. As far as you know, would it be fair to say that there is a, a requirement that that operative report be exact as to what the surgeon performed during the operation?

A. Well, that would be the whole point of the operative report, but Dr. Helbig even took intraoperative photographs which I was able to see that allows me the vision of what he sees in the arthroscopy.

Otherwise, you're just believing whatever anyone says, but he took photographs of his first operation so it enables me to see it and see what he saw in his operation.

Q. Now -- all right. Continue, and then I'll come back to later what an arthroscopy is and things like that.

Any other records that you looked at, that you, before you saw Mr. Munoz?

A. Yeah. There were the records from

Dr. Helbig narratives from 7/11/13, 8/9/13, chart notes from 8/13 to 1/19/16. He indicated that the Plaintiff had a neck sprain, lumbar back sprain, contusion to the right elbow, sprain of the right shoulder, rule out rotator cuff tear and right proximal biceps tendon tear.

Then there were records from a Dr. Jennifer Yanow from New Jersey Pain Management Institute of 10/29/13 and 12/10/13. Then there were x-rays done of the thoracic spine; that's the middle part of your back, not your neck, not your lower back, the mid portion, dated 6/26/13 from Hackensack University Hospital which was read as showing no evidence of a fracture.

MR. BERENGUER: Objection.

MR. GULINO: Okay.

Q. Why don't we do this, Doc. Would it be fair to say that the spine is divided up into different parts?

A. Yes.

Q. And could you describe for the jury what those different parts are?

A. The neck would be the cervical spine. Between your neck and your lower back is the thoracic spine which houses the ribs that go around

and protect your --

Q. Abdomen up to the chin, around there?

A. Yes. Chest.

Q. Or the chest, I mean?

A. Chest, yes. And then the lower back would be the lumbar spine.

Q. Is that near your belt line, down around there?

A. Down by your lower back, yes.

Q. All right. Continue.

A. And then I reviewed the MRI report of 7/9/13 of the right shoulder, and then there was another MRI report of 1/12/15 of the right shoulder which is several years later, and then, then there were physical therapy records from Kessler Rehabilitation.

Q. What's an MRI?

A. An MRI stands for magnetic resonance imaging, and it's an imaging study that allows us to visualize not only bone, but soft tissue, ligaments, tendons, and it gives us a more detailed description of the anatomy of the part of the body that we're, we're looking at.

Q. Would it be fair to say that you

would use an MRI in the hopes of examining a person's softer tissue part of the body, a tendon, a ligament, as you said, something like that, a disc, things like that?

A. Yes. When you're looking for other things besides bone, an MRI is a valuable test. I send out about 1000 MRIs a year in my private treating practice, and what I do is I have an MRI conference.

Now, I'm not a radiologist, but as an orthopedic surgeon it's part of our continuing medical education to know how to read MRIs, x-rays, CT scans, bone scans. It's all part of it because if we're the surgeon, you know, the buck sort of stops with us so we have to be able to integrate and correlate the imaging findings and see if they make sense.

Q. Let me ask you this then. You perform surgeries; correct?

A. Yes.

Q. And many times your patients are sent to a, a facility to have MRIs performed on them; right?

A. Yes.

Q. And those MRIs are read by radiologists; correct?

A. Yes.
Q. But would it be fair to say that you and pretty much all orthopedic surgeons, before they cut a person open, they're going to look at their films themselves?
A. I would think that's a fair statement that what should be done is you should review films.
Q. And I'm sorry to use the term cut, but to perform surgery on somebody would it be fair to say that just about every orthopedic surgeon is going to look at the films themselves?
A. I would think they should, yes.
Q. Okay.
A. So those are the main records that I reviewed the first go around so that was the first report that I rendered.
Q. All right. Now, did you look at any imaging studies?
A. On that date on July 18, 2016, I looked at x-rays of the thoracic spine done on 6/26/13, and I personally reviewed the MRI of the right shoulder done on 1/12/15.
So what happened in this case I was provided with the second MRI first, and I needed to see the first

MRI so I requested it so I did see --

Q. Well, now, when you say the second MRI, is that -- was that the MRI that was taken before his second surgery?

A. That was the MRI before his second surgery --

Q. And --

A. -- where Dr. Helbig said he found a torn rotator cuff.

Q. Before his first surgery he had an MRI?

A. Yes.

Q. Okay. And you read that one at some point; correct?

A. Yes, not at that particular point in time.

Q. All right. Now, did you, after looking at that and you looked at the MRI of the right shoulder, did you put in your report any of your findings on reviewing that MRI of the right shoulder of 1/12/15 which was approximately, what is it, a year and a half, 18 months after the accident?

A. Yes, I did put my, my impression and interpretation of the films.

Q. And what was your interpretation at that time?

A. My interpretation was he had arthritis of his acromioclavicular joint. This is a model of a right shoulder, and where the clavicle, where the clavicle -- this is the clavicle, and this is the acromion. Where the clavicle --

Q. Let me stop you for one second. Is that the right shoulder?

A. This is a right shoulder, yes.

Q. Okay. So, so, okay. Fine.

A. We're looking at it from the front.

Q. All right.

A. So where the clavicle and the acromion come together, I'm going to flip the muscle back out of the way, there was arthritis there. What happens is bone overgrows. This was his dominant hand. It is a very common phenomena to see arthritis of the acromioclavicular joint.

Q. Let me ask you about the shoulder. Would it be fair to say that the shoulder is probably one of the most movable joints in the body? It can do more things than any other joint?

A. Well, it's one of the most unstable joints of the body because the socket is very

shallow, and it has the greatest arc of global motion so because the socket, not, not like the hip that's very deep, is a very unstable joint.

Q. Is that what gives it its mobility as well, though, that it can do push and pull and twist and turn and things like that?

A. Yeah. It's a very mobile joint. I mean, there's circumduction, there's elevation, there's abduction, there's internal and external rotation, you know, there's all different motions of the shoulder, whereas, say the knee is a hinge joint, it just bends forward and backwards, and --

Q. Now, when you said you found arthritis, what does arthritis look like on an MRI?

A. Arthritis looks like an overgrowth of bone, in this joint we're talking about?

Q. Yes.

A. In this particular joint, the acromioclavicular joint, which is on the top of your shoulder, there, the bone becomes heaped up, and then what happens the tendon goes underneath the arc of the acromioclavicular joint, and there is rubbing on the tendon from the overgrowth of the bone, and --

Q. What does the tendon do?
A. Well, the tendon is, there's, there's four parts to the rotator cuff, and the main one, the supraspinatus, goes right under that arc, and that helps elevate the initial 30 degrees of rotation and helps with some external rotation.
Q. Is, is it a muscle, a tendon? Is it considered a muscle?
A. Well, the muscle then becomes a tendon which attaches to bone. A tendon attaches the muscle to the bone. So you have a muscle, a tendon, and it attaches into the bone which helps, as the muscle contracts, move the arm up or rotate the arm, but what's significant here is that there was encroachment on the musculotendinous unit of the overgrowth of the arthritis. Okay. That's what impingement is, overgrowth of bone.
Q. Is that what Dr. Helbig said that, if we can go back to his, and we'll get to it again later, but I notice when you looked at his operative report, number 4 in your report, he noted the diagnosis of impingement syndrome. Is that consistent with what you found on the MRI?
A. Yes.
Q. And the impingement means what, it's

pinching that tendon?

A. It's rubbing on the tendon because the, the bone overgrows, there's a narrow space that the tendon goes through, and it encroaches on it and impinges on it, yes.

Q. And what's the effect of the impingement? What happens to the person? Does it --

A. Well, it can thicken the bursa; it can create pain. You know, there's lots of things it can do. It just depends on, on what the symptomatology is.

Q. And, and would it be fair to say that impingement syndromes many times are not caused by trauma, but caused by congenital issues or --

A. Well, there's, there's --

Q. -- or overuse or?

A. Well, there's congenital where you can have an acromion that, which is a top bone here on your shoulder --

Q. Uh-huh.

A. -- that can be straight, it can be slightly sloped, and it can be hooked. So there's different variations of the acromion. So if you have a hooked acromion or a downsloping acromion,

this can create a mechanical impingement.

If you have arthritis of the acromioclavicular joint, that can create impingement.

Now, that can be caused by repetitive use of your arm, if you've played sports when you were younger. I mean, there's a myriad of things. It's more common than not to see that area of the shoulder calcify and form bone than not.

Q. What else did you find?

Oh, by the way, would it be fair to say when you were talking about that sports, baseball pitchers get this sometimes?

A. Any, any throwing athlete can get it. It can be baseball, it can be football.

Q. Swimming?

A. It could be --

Q. Overhead?

A. -- swimmers, any type of overhand-type repetitive motion can happen.

Q. And what about, what about a person's occupation? If a person does the same occupation over and over, overhead repetitive use or things like that, is that the kind of thing that someone like that could develop?

A. It could, sure.

Q. And if I were to tell you -- withdrawn.

Did, did -- and I know I'm jumping ahead, but did Mr. Munoz tell you what he did for a living?

A. He was a painter.

MR. BERENGUER: Objection.

Q. Okay. And did, did he indicate how long he was a painter?

A. No.

Q. But was that something now that you would think about and say, Look, he's a painter, maybe this comes from that?

A. Well --

Q. Maybe?

A. Maybe, sure. I mean, repetitive motion of any kind.

MR. BERENGUER: Objection.

MR. GULINO: Okay.

A. I mean, it could be, you know, people get, using the mouse now, we see repetitive motion of the shoulder. I mean, it's, it's endless as to what it could be.

Q. I thought it was the wrist. Okay.

A. Yeah.

Q. All right.

A. It can be the wrist. It can be the shoulder, too, moving your mouse around.

Q. So now you also looked at the -- so you looked at the, the MRI of that right shoulder which was taken about I guess two and a half years or 18 months after the accident, you, there -- you found tendinosis. What is tendinosis?

A. Tendinosis is a roughening and wear of the bursal surface, the top surface of his rotator cuff. The rotator cuff has two surfaces. It's got a top surfaces which is called the bursal or subacromial surface, and the other is the articular surface of the rotator cuff underneath the cuff.

So if you look at this as a cuff, and the bone on top, you have one surface on top and one surface on the bottom so you can have two, you know, you can have a full thickness tear, a partial tear, a tendinitis. You know, sometimes it's difficult to distinguish between tendinitis and a partial tear. You know, it can be very variable on an MRI.

Q. Now, when you're talking about a tear, what's torn?

A. Part of the rotator cuff, the supraspinatus tendon which is one of the tendons of

the rotator cuff.

Q. Now, the supraspinatus tendon the one that comes on top of your shoulder?

A. It comes from the top, yeah, on top of the spine so that's why it's called supra --

Q. Now we're looking at the back of the shoulder; right?

A. Now we're looking at the back. That's why it's called supraspinatus because it's on top, and then there's infraspinatus. Then there's the teres minor. Then there's a muscle that comes from the inside called the subscapularis --

Q. Now when --

A. -- which is the internal rotator.

Q. When you use those terms, for example, supra and infra, supra always means above?

A. Above the spine of the scapula and infra is below the spine.

Q. And what about teres and --

A. Teres minor is below the spine also. It's right underneath the infraspinatus.

Q. Okay. Oh, all right. So you also found the biceps tendon appears absent?

A. Yes. I, I believe that this

gentleman had a biceps tendon tear. As I've learned more about this case --

Q. Can you tell the jury or show the jury where would the biceps tendon be?

A. Okay. Biceps means two. Okay. Bi means two. So there's two parts. There's a long head of the biceps and a short head of the biceps. He tore the long head of the biceps that comes up on top of the, the shoulder socket, and it inserts on what's called the glenoid tubercle so it comes up the front of the shoulder, and it inserts inside in the labrum here, and that's what gave him what's called the Popeye arm or part of the muscle dropped down.

Q. Now, did, did, did, based upon your review of the records so far and looking at the films, this tear, is it from the bottom near the elbow or sit up near the top near the shoulder?

A. No. Because it's a Popeye, meaning that the muscle is dropped down, it's up on the top. If the muscle had retracted the other way and retracted up, then it would be torn at the distal portion or the end portion which inserts in the below the elbow.

Q. And then the muscle would have gone

up?

A. Gone up, yes.

Q. Okay. Now, did you take a history of the gentleman?

A. I did.

Q. And what did you learn from the history that you took from Mr. Munoz?

A. It said that he fell over while working on a roof. He states that -- he also told me he had seven to eight months ago he had additional right shoulder surgery, and his, his complaints at that time -- he told me he's not employed right at that time. He wasn't working.

Q. All right. Let me ask you again about the history. See, he said here that he fell over while working?

MR. BERENGUER: We're going to object to that.

Q. What did you take that to mean when a person tells you he fell over?

A. You know, it's hard to give you a specific answer. I would go more towards the interrogatories where he said he fell through a hole, you know, something like that so I'm sort of had that vision in my mind when he says that so, you

know. You know, I, I can only take the facts that are given to me and use them to formulate an opinion.

Q. I understand that. What I'm trying to get at is your impression at the time. Was it something that he fell to the ground or --

MR. BERENGUER: I'm going to object to that.

Q. -- something he tripped over something or what?

A. It's hard to answer that question to be honest with you, sir.

Q. Okay. So he made any complaints to you at that time?

A. He did make complaints, and I asked him, I said, could you point to me with one finger to the area of pain in the right shoulder, and he pointed just over the proximal deltoid, the muscle up here. He states his right shoulder bothers him at night when he sleeps. He says that he -- I saw that he was holding his shoulder towards his chest.

Q. And, and indicating that he was -- okay. Go ahead. We're on the --

A. He was just holding his shoulder --

Q. -- on video.

A. -- in towards his chest. This was an observation, and I observed that he did have the Popeye deformity from the torn biceps tendon, and I noted that he had scarification from the open second surgery that Dr. Helbig did.

He also complained of pain in his low back, and I said that it was around the L3 area. So if you feel your crests of your, of your, of your pelvis, that's about L4. Okay. So he was complaining pain a little higher around L3, and he said, he showed me where he had decreased sensation which would have been in the, in the distribution of the right L4 nerve root.

Q. Let me, let me ask you this now. So, so the spine itself is divided up into three different parts as far as we know, the cervical, lumbar, and thoracic; correct?

A. Yes.

Q. And would it be fair to say at least from the cervical part and the lumbar part that you have nerve endings that come out?

A. Yeah. There's nerve endings that come out from different parts of the spine which the nice thing of orthopedics, as opposed to being a cardiologist, anatomy doesn't change.

Q. So for --
A. So certain nerve roots go to certain anatomical locations.
Q. And when we talk about L3, that mean lumbar 3rd level?
A. 3rd-4th.
Q. 3rd-4th.
A. It's either L2-3 or L3-4, depending on where you're talking about.
Q. So, for example, in L3 and L4, the nerve root comes out, does that control a certain part of the lower limbs?
A. Yeah, that's more the L4 nerve root which would be more quadriceps and things of that sort.
Q. What is a quadricep? That's your thigh in the front?
A. Yes, sir.
Q. Okay. And L2-L3s control another part?
A. Yeah, up a little higher, and like L5, for example, controls your foot, your movement of your foot up and down which is a common thing to see or your big toe. Then S1 would be more stepping up on your tippy toes, things of that sort.

Q. So would it be fair to say that when you go from Lumbar 1 is the highest and 5 is the lowest, as you can down, you're affecting the lower, lower, and lower parts of your body?

A. Well, really S1 is the lowest.

Q. Okay. Sure.

A. Because it's L5-S1. So as you're, you're going from say your hip flexor down to the bottom of your foot so it's going from top to bottom.

Q. Now, did you do a physical exam of the gentleman? Oh, wait. Withdrawn. Withdrawn. Let me ask you this.

If I were to tell you that there has been testimony at depositions by Mr. Munoz, which you did not read, I assume, and that he was a stucco painter who regularly carries heavy buckets of compound or paint, and that he uses a roller, brush, et cetera, is that something that you would take into consideration when making, when giving an opinion at some point?

MR. BERENGUER: Objection.

A. It's just something that he would, you know, take into consideration in what he did as a daily, you know, occupation.

Q. Okay. All right. Now, so why don't

we -- you did a physical exam. What did you, what did you find?

A. I found him to be very pleasant. He was cooperative. He was not in acute distress. He walked around the examining room without difficulty, but noted some pain with standing on his heels. When I asked him to stand on his heels, he complained of pain.

Q. Okay. So, so what, what is the difference there? What, what, what did that mean to you?

A. It's very nonspecific at that point in time.

Q. What is nonspecific?

A. It just didn't give me any real information at that point in time. It was just an observation that he said he had pain when he walked on his heels.

Q. Okay.

A. That's all.

Q. Go ahead. Continue.

A. I examined his right shoulder. He had well-healed scarification over the front of his shoulder. He lacked 10 degrees of forward elevation when I asked him to elevate.

Q. So when he lacks 10 degrees, what's, what's full elevation?

A. 170, 180 degrees, depending on the age of the patient.

Q. All right.

A. If you're older, it could even be less what could be normal.

He complained of pain. He complained of pain diffusely around the shoulder. Okay. He didn't have pain like totally isolation where he should have pain over say the, the acromion or the rotator cuff. It was diffuse. Everywhere in his right shoulder was touched he complained of pain.

Q. And this is pain one year after his second surgery approximately?

A. Well, this is what he complained of. Pain is a subjective complaint.

Q. No, I understand that. And it -- what is subjective and what is objective?

A. Subjective is what someone tells you. Objective is if I touch you here, that's not where your rotator cuff pain should be. It should be up here.

Okay. So he just complained of diffuse pain everywhere you touched him so it was nonspecific

complaints of pain in my opinion. Okay.

Q. All right.

A. So I said everywhere I touched his right shoulder he complained of pain. He had no instability of his right shoulder --

Q. What does that mean? Now, what is instability?

A. Instability is where I checked him to see if his shoulder was unstable or could pop out of socket. There's certain signs that, to see if there's instability.

Q. And you found him to be stable?

A. He was not unstable.

Q. Okay.

A. He had this Popeye deformity which is consistent with a proximal rotator cuff or on top of the -- I'm sorry, of the, of the biceps tendon, and he had some mild weakness of supination.

You see, there's, there's a misconception that if you tear your biceps tendon that you're going to have weakness of flexion. That's not true. Okay. Because the main function of the biceps muscle is to supinate, to turn your hand up like this. That's supination. This is pronation. Okay.

So what happens is when you tear your biceps

tendon, you can lose some strength in supination, and that's really what it is.

Q. If you were using a screwdriver, and you were screwing a clock watch --

A. Yeah, if you --

Q. -- is that supination?

A. -- were doing some kind of rotatory movement that required repetitive supination, you might have a fatigue factor there because of what the function of the biceps tendon is. It's a supinator.

Q. What if you used a roller or a paint brush?

A. No, it's not a flexor. That does not, you know, that does not affect that type of motion. It's a supinator. That's what the biceps --

Q. So this biceps, torn biceps, should not have an effect as his livelihood as a painter?

MR. BERENGUER: Objection.

A. In my opinion, in my opinion it shouldn't.

Q. Okay. So, all right. So did you look at anything else during the examination?

A. Yeah. I examined his lumbar spine.

He said when he, when he went to forward flex at 70 degrees that he complained, he said it hurt him. He noted pain at about 5 to 10 degrees of extension of his lumbar spine meaning leaning backwards. He had no pain on lateral bending.

He stated it hurt on the right of his paraspinal muscles in the lumbar spine. He said it hurt him there. Again, this is subjective complaints meaning what he tells me.

Then straight leg raising in a seated position, meaning he's sitting on a table, and I straighten out his leg at 90 degrees, and that did not create any back or leg pain. If you have a positive straight leg raising test to see if there's compression on the nerve, then, then that should either cause back pain or pain radiating down the entire leg.

Q. When we talk about in medical terms positive, that doesn't mean it's a good thing, does it? That just means it's a sign of something?

A. Well, it's a sign that leads you to someplace else so.

Q. If a person has negative signs --

A. Right.

Q. -- is that generally a good thing?

A. I'd rather have negative sign than

positive signs personally.

Q. Okay. So when you found -- did you found no positive signs on the leg raising you, you said?

A. It said here straight leg raising in a seated position was 90 degrees. That's normal.

Q. Normal.

A. Meaning that his leg could be lifted to 90 degrees to the axis of his body which did not create back or leg pain so that's a, that's a negative straight leg raising.

Q. What significance did that have to you?

A. It's significant that it didn't have any, in stretching the sciatic nerve, it didn't create any pain radiating down his leg.

Q. Did that also mean that there's no injury?

MR. BERENGUER: Objection.

A. All it meant to me was that he had a negative straight leg raising at that point in time. Okay.

Q. Was it a normal finding?

A. Yes.

Q. Okay. All right. Now --

A. Then I checked his knee jerks and ankle jerks. They were normal. I did hip strength tes -- I did strength, strength testing of different muscle groups. They were normal. They were, all strength was normal. He noted a sensory deprivation on the right at L4.

Q. Okay. Now, a sensory deprivation on the right at L4. In plain English what's that?

A. That means that he complained of numbness in his shin. Okay. Now, the significance to me is that he did have a small protrusion at L5-S1. That should not give sensory deprivation of the L4 nerve root. So that's where you talk about the pieces of the puzzle coming together, that's significant because that should not be L4.

Q. When you talked about a small protrusion, if that was affecting him, where would he have a sensory deprivation --

A. It would either be --

Q. -- normally?

A. -- in the L5 or S1 nerve root depending on where, where the disc was.

Q. What part of the body would that correspond to?

A. That would correspond to the top of

his foot or the big toe or the bottom of his foot.

Q. And he's making a complaint up higher?

A. He made -- he says it was numb, there was decreased sensation in his shin.

Q. In his shin. Okay. So they don't match up?

A. No, it's not consistent.

Q. Okay. Now, at the end of this -- oh. At the end of this -- wait. Now, I'm sorry.

Did you read, and I think you made reference to it, I think it's number 6 in the report, is the records noted as work-related injury from the Center For Occupational Medicine?

A. Yes.

Q. Okay. Do you have a copy of that in front of you?

A. I'll get it out.

Q. I have another clean copy here if you don't mind.

A. That's okay.

MR. GULINO: I don't know, Mr. Berenguer, do you want to have these marked or, for the record?

MR. BERENGUER: Yes, let's have them marked.

MR. GULINO: If you don't mind, sir? We need to have this marked.

Oh, wrong person, huh?

(Whereupon the medical record entitled Initial Visit: Work-Related Injury from Center for Occupational Medicine dated 6/26/13 and 6/28/13 is marked Decter-1, and there is conversation off the steno record while exhibit is being marked.)

Q. All right. Now, Doctor, I have, we have marked as Decter-1 for today's date a, for the record, it is one, two, three, four, five pages, from the, and I believe these are subpoenaed to the courthouse, the Center for Occupational Medicine, and they're records dated 6/26 and 6/28 of 2013.

Did you have a chance to review those before your report?

A. Yes.

Q. Okay. And I want to address your attention to the first page.

A. The date is 6/26/13; correct?

Q. Okay. And if we go down about halfway, and Patient Description of Illness, do you see where it says, I don't know if you can read the

word instead of me before the word back, pen back?

A. Oh. Patient Description, yeah.

Q. Yes.

A. It says, probably says pain. I would think --

Q. Oh.

A. -- that word is, I mean, it looks like pen, but hurt back, stepped on roof that was not stable. He stepped in a hole, upper and lower back.

Q. All right. Now, the diagnosis if you go down there about one-third of the way down the page, can you read that for us?

A. Yeah. It says, upper back strain and right biceps tear.

Q. Now, what's a diagnosis in medical terminology?

MR. BERENGUER: We're going to object to this line of questioning.

MR. GULINO: What was that? Okay. Yeah.

Q. What is a medical diagnosis? What is diagnosis in medical terminology? What does it mean?

A. It's what someone saw when they examined the patient and made a diagnosis of what

they thought was wrong with the patient.

Q. And if we, if we look at the bottom of the page, do you see that there's a physician's name for the record?

A. Yes. Dr --

Q. L. --

A. Yeah, Dr. Gatchalian.

MR. GULINO: For the record, it's G-a-t-c-h-a-l-i-n (sic) M. D.

Q. And would that have his medical number behind that or license number underneath that? Do you see that number?

A. I'm not sure what that number is to be honest with you. I mean, that could be his employee number there. I don't know.

Q. Is there any mention there on that day of right shoulder pain?

A. Well, it said right biceps tear.

Q. Okay.

A. So it didn't say anything more than that. So that's the right shoulder area.

Q. And how about lower back problems?

A. Well, when the patient described the illness, it was upper back and lower back, but in the diagnosis -- they took thoracic x-rays, not

lumbar x-rays, and, and they diagnosed him with upper back strain and right biceps tear.

MR. BERENGUER: Note a continuing objection to that lining questioning.

Q. Is the thoracic x-rays, would that be considered an x-ray of the upper back?

A. It's really the mid back because the upper back we'll call the neck, the lower back will be lumbar, so we'll say the mid back will be thoracic.

Q. Now, if we go to some progress notes on the third page?

A. Yep.

Q. Do you see that -- no, never mind. Let me -- all right. So let me get back to this.

We got to your medical opinion. All right. Now, after you review these medical records and after you reviewed the interrogatories and learned the history as you knew it at that time, did you come to some type of an opinion as to his condition and its cause?

A. Well, first of all, before I even got to an opinion, I say, I will need to review the original MRI films after the accident because, remember, in this report I had the subsequent MRI where he had the second surgery. So I requested

that you please send me the MRIs of the right shoulder done on 7/9/13 as well as any MRIs of the thoracic and lumbar spine so I said to send those to me.

Q. So would it be fair to say that if you gave an opinion at the end of the first report, you gave it, but you didn't have everything you really needed?

A. Yeah, it was a, a preliminary opinion. You know, sometimes I say this is a draft report or whatever, but I, based upon the information provided to me and the medical records that I had at that time --

Q. Uh-huh.

A. -- I rendered an opinion.

Q. And what was your opinion at that time?

A. My opinion was is that this individual sustained a subac -- had a subacromial decompression which means he shaved down some of the bone under the acromion. That's all it means. He shaved down bone. Then I said that he had torn right biceps tendon, and what I said, I said in the absence of any preexisting problems, I would causally relate this to the 6/25/13 incident, and

then I said at that point in time that I would causally relate the subsequent surgery to the 6/25/13 accident as well.

Q. Now, let me ask you something. You went through Dr. Helbig's operative report?

A. I did.

Q. And you were talking about that, the subacromial, he shaved down part of the acromion; right?

A. Correct.

Q. Okay. Now, did the doctor, according to his report, do an acromioplasty?

A. Well, it's called an acromioplasty when you shave it down. That's what you call it.

Q. Okay. Now, when you say shave it down, I mean, this is arthroscopic surgery?

A. Yes.

Q. Can you describe for the jury what, what do you do to do an arthroscopic surgery?

A. What you do in this case is you have an arthroscope which is a camera device that, that you can look in his shoulder, and then you put a burr in, in this particular case, and it rotates, and you shave down some of the, the bone to open up the space.

Q. Let me ask you this just so we can have it in context. Are there three holes made in a person's shoulder in arthroscopic surgery?

A. Usually three holes or could be four, there could be five, but for doing this type of surgery, usual three. One's for the arthroscope, one's for a cannula where water flows through, and the other is for the operating instruments.

Q. Now, when we talk about these holes, what kind of size are we talking about?

A. You're talking about maybe 2 centimeters, a centimeter and a half. It's a thin blade you put in to make this and put the instruments in.

Q. About the size of a straw? A little bit thicker maybe?

A. More or less, something like that, yes.

Q. All right. So it wasn't a full-blown cut-him-wide-open kind of operation. They're taking these instruments and they're putting it in his shoulder; correct?

A. Well, the second surgery he made an incision --

Q. A larger incision.

A. -- a larger incision.
Q. I'm talking about the first one. Let's just deal with the first one.
A. The first one, yeah. The first one was an arthroscopic procedure.
Q. Now, sir, you said a burr. What is a burr?
A. It's a machine that rotates that has a little knob on the end of it that, that can shave bone down.
Q. And, and the bone that they shaved, what bone did the doctor shave in his, in his operation?
A. He shaved the undersurface of the acromion which is this bone right here.
Q. Was that the one where he had arthritis?
A. Well, that's where he had arthritis in the acromioclavicular joint where the two bones come together.
Q. Okay. So the part that he shaved underneath, what was the purpose of that?
A. I guess he wanted to open the space where the rotator cuff because he was causing this, calling this an impingement so he felt that the bone

was rubbing, and he also took out some of the bursa. What is the bursa? The bursa is a soft tissue that overlies between tendon and bone.

Q. Generally, that type of surgery, if you open it up, should the impingement syndrome go away?

A. If you adequately decompress it, it should, yeah.

Q. What does decompression mean?

A. That means you shave down enough bone to open up the space so that the tendon can go freely through it and not have any pressure on it.

Q. Does decompression mean open things up? Is that what it means?

A. Yeah. Decompress something, you open it up.

Q. And then compress it, you're going to close it; right?

A. Yes.

Q. Okay. All right. What else did you have on there?

A. Well, then he did a, he said he did a synovectomy which is the lining of the joint, but I, I'm not quite certain how he did a synovectomy in the subacromial space so I'm not sure about that,

and he did a bursectomy where he removed some of the bursa.

Q. And a synovectomy, is that, is that the synovium?

A. Well, that, synovium is the lining of the joint, and I'm not sure because he really --

Q. Is that tissue?

A. -- he really doesn't describe that he was in the joint taking out the synovium.

Q. Does the synovium on top, does it touch bone?

A. Not really. That's the bursa that, that overlies the bone.

Q. What does the synovium do?

A. That's the lining of a joint, the inner part of a capsule.

Q. Okay.

A. So he also said that the biceps tendon was absent which I am going to agree that there was a biceps tendon injury. I'm not disputing that.

Q. Did he do any work on the biceps tendon?

A. No, he didn't. He didn't repair it. He just left it alone. He -- you can do two things

with a biceps tendon. Number one, you can do what's called a tenodesis where you cut it or if it's torn, and you can reattach it into the humeral head. That's called a tenodesis, and you put a screw in it, and it helps prevent the Popeye deformity, and you put tension back on the, on the muscle and you reattach it to the bone.

Q. Is the doctor actually pulling it back up again from the elbow area up to the shoulder area?

A. Well, you're pulling it back up here and reattaching it into the bone.

Q. And you would get rid of the Popeye effect, hopefully, if it worked?

A. Yeah, you'd get rid of the Popeye effect.

Q. And Dr. Helbig did not do any of that here?

A. No. Then you can do what's called a tenotomy where you just cut the tendon, and say it's partially torn, you can cut it, and then you have the Popeye deformity. So he, he just left it alone. He said it was torn, and he didn't do anything about it.

Q. Okay. Now, the work that was done --

A. One other important point to his operation.

Q. Sure.

A. That he makes a reference, he says there was no full thickness tear of the rotator cuff.

Why is that significant? It is significant because in the subsequent operation he found a full thickness tear of the rotator cuff, and that's when he did the open surgery, you know, I believe it was like a year and a half later, so, but in the first operation that was closest to the date of the accident, he said there is no full thickness tear of the rotator cuff.

Q. Now, let me ask you about this so, and I know we're jumping ahead a little bit, but at the time of the first surgery the surgeon is using a camera, is he not, he or she not; right?

A. Yes.

Q. And, and so when, when they are looking at the rotator cuff with this camera, would it be fair to say that they're basically eyeballing the rotator cuff?

A. Yeah, it's direct visualization. You're seeing it in two ways. You're seeing the top of the cuff, and you're seeing the bottom of the

cuff.

Q. Now, we can take film studies and look to see whether rotator cuffs are torn or worn away, right, like an MRI?

A. You can do an MRI, yes.

Q. Okay. And we can also use a camera during an arthroscopic procedure to do the same thing; correct?

A. Sure.

Q. Would it be fair to say that the camera used during the arthroscopic surgery is going to be more accurate than the MRI?

A. Well, it's direct visualization as opposed to, you know, shadows and, and signals from an MRI.

Q. And at that point there was no known, there was no seen rotator cuff. It was intact.

A. Well, he says there was no full thickness rotator cuff. He says, he makes a point about it in his operative report.

Q. Now, does that have any significance to you that he made a point of saying that in his report?

A. Well, it wasn't torn. That's what he said. I mean, he's just reporting, you know,

hopefully honestly of what he found, and he said he did not find a rotator cuff tear. That's all.

Q. Okay. Did you have an opinion at that time based upon your understanding that Mr. Munoz fell --

MR. BERENGUER: Objection.

Q. -- as to whether or not the surgery performed on him was causally connected to the accident he had on June 25, 2013?

A. Yes. From what I was told and what I knew at that particular point in time, it was my opinion that the subsequent surgery was causally related and that he did a decompression, and he found torn biceps tendon, but didn't find a torn rotator cuff.

Q. Now, and, and when we're talking about the synovectomy he performed and the acromioplasty and the subacromial decompression, are they repairs?

A. No. You're not putting stitches into anything. You're sort of giving something a haircut. That's what you're doing. You're shaving some bone. You're removing some of the bursal tissue. You're not putting stitches into anything. He didn't have to repair the labrum. He didn't

repair the biceps tendon, and he didn't repair the rotator cuff because he says it wasn't torn.

Q. Except for your understanding or your belief at that time that he fell, looking at the operative report and looking at the MRI, do you see any signs of trauma to his right shoulder?

A. Well, the only thing you can say is the biceps tendon was absent. That's all you can say that, that it was absent biceps tendon and there was no biceps tendon appreciated on the MRI. It was absent. That's all.

Q. Okay. All right. Now --

MR. BERENGUER: Note an objection to that last question.

Q. Okay. Now, you reviewed -- let me just get something straight here. I notice that you reviewed -- no, we're good. I think we'll move on to the, to the second time you saw him, but, you know, you had read his operative report, correct, Dr. Helbig's report?

A. Yes.

Q. And you looked at the MRI of January 12, 2015? You actually looked at the -- did you look at the film at that time?

A. I did.

Q. Yeah. Yeah.
A. I read it. It was in my report, in the four corners of my report, yes.
Q. You know what? I didn't ask you about that I don't think. So what, what did you find in your review -- oh, you did, didn't you. You talked about arthritis of the AC joint?
A. I think, I think I did --
Q. We did.
A. -- talk about it, yes.
Q. We did. You're right.
The glenoid labrum wasn't torn?
A. No.
Q. Things like that?
Okay. And you found a partial tear; right? I'm looking at the MR --
A. I thought there was some tendinitis and a partial tear of the rotator cuff, yes.
Q. Now, did you do a second report?
A. I did a second report, and just for accuracy purposes, I only saw him one time. My other reports were based upon records that were provided to me.
Q. Thank you. I forgot to ask you that. So in the second report dated October 4, 2016?

A. Yes.

Q. And if you need to refer to it, please do. That was approximately three years four months after the accident. Now, what records did you review at that time?

A. I had, I was provided with the report from Dr. Helbig from South Mountain Orthopaedic Associates. It said Dr. Helbig performed surgery on the right shoulder on 10/21/13. It's pretty much the same thing I said before where he did an acromioplasty, subacromial decompression, debridement and bursectomy, and I state, I note that he did, did not do a Mumford procedure. What's a Mumford procedure?

Q. Thank you. I was ready to ask you that.

A. A Mumford procedure is where you take out a portion of the clavicle, maybe about a centimeter of the clavicle. You resect it which also helps open up the subacromial space.

Q. Now, let me ask you. In layman's term, when you say you resect it, what, what does that mean?

A. You take it out. You remove about a centimeter of bone, 2.5 centimeters an inch.

Q. You cut it right out and take it out of the body?

A. You shave it right out, yes, you take it right out.

Q. And what, if it works according to plan, what is supposed to happen?

A. It just helps the arthritis, the pain from the arthritis of the acromioclavicular joint, and also if there's bony projections that affect the rotator cuff, it will help decompress it and open up the space.

Q. If a person has arthritis such as that, and you take a centimeter of the bone out, will it ever grow back?

A. Shouldn't grow back, no.

Q. Okay. All right. So you reviewed more records, and it had to do with your -- let's see. You looked at the MRI of the right shoulder the first time. All right. That's 7/19/13?

A. No. The MRI of -- the first time was of the second MRI.

Q. I apologize.

A. Not the first one.

Q. The second time you looked at. Right, the second time. And what did you find when

you looked at the second time, the first MRI?

A. It showed that he had some arthritis of his acromioclavicular joint.

Q. Uh-huh?

A. Which Dr. Helbig didn't address the first time. He just did an acromioplasty. He didn't take out the clavicle, and he -- and I said there appears to be a partial thickness rotator cuff tear, and then, then it said a subsequent MRI of the right shoulder was performed which I already had seen, and then I said, I causally relate the right shoulder injury and the subsequent surgery to the 6/25/13 accident.

Q. Now, you, you didn't look at the second operative report, did you, on this time?

A. At that time I didn't see the second operative report.

Q. Okay. Now, when you said that you still causally related the injury to the accident, what was the basis of that opinion?

A. It was based upon the records that I had at that time.

Q. Okay.

A. There still were things that I didn't, you know, have. I didn't have the second

operation. I didn't, you know, see that Helbig said there was a torn rotator cuff the second time.

Q. Did you look at the first time -- I'm going to -- I'll come back to it.

You did look at the, the second MRI of the right shoulder for the first report?

A. Yes.

Q. Right? Okay. And we're going to get to that later.

Now, did you get a chance to review Dr. Decter's October 4, 2000 and -- not Dr. Decter, I apologize. Dr. Helbig, if I were to tell you that Dr. Helbig indicated that he believes that future medical costs for Mr. Munoz due to perhaps future surgery on that rotator, the right rotator cuff, and it would come to about a minimum of $25,000, would you agree with that?

A. I have no idea how Dr. Helbig is making up that number of anything. I mean, look, anything could happen.

Q. Correct.

A. The man could fall, he could have an accident, he could retear his rotator cuff, you know, anything could happen. I don't know how you can hang a number out there. So I can't say I agree or disagree. I just don't know the basis how

Dr. Helbig arrived at that.

Q. Well, why don't we do this. Absent trauma to his right shoulder, if Dr. Helbig repaired the rotator cuff, would he need further surgery on that shoulder?

A. If it was repaired, and there was adequate physical therapy, and he regained his motion and his strength, unless there was something that happened, I don't see the reason why he should have subsequent surgery.

Q. Okay. So you disagree with Dr. Helbig on that?

A. I just don't understand where he's coming from. It doesn't -- there's no basis for it.

Q. Okay. Now, now, I -- did you ask for, if I'm not mistaken, on the second, your second report, you had not seen the intraoperative photos I don't think at that time, did you?

A. I haven't commented on them yet, no.

Q. Okay. You know what we can do then? We can go to the third --

A. I said here I have not been provided with the intraoperative photographs on October 4, 2016.

Q. All right. I want you to do me a favor. Can you go to the -- can you go to the MRI report of 7/19/13 for me if you don't mind? Do you have a copy of that there?

A. The report or my interpretation?

Q. The report. The report.

A. Sure, I have it.

Q. And while you're looking, may I ask you, the reports are prepared by the radiologist who review, who is responsible for the taking of the film and then they review the film; right?

A. Well, the technician takes the film, and the radiologist reviews the film.

Q. All right. And you have read many reports, I assume, in your career, thousands?

A. Yes, thousands, sir.

Q. And you've also probably looked at thousands of MRIs as well?

A. Yes, sir.

Q. Would it be fair to say that a lot of the language is very common, the medical language?

A. Sure. I mean, we, we speak in a different language so, you know, we talk about edema and we talk about different things that are, are medical jargon in reports that, that, you know, it's

our language.

Q. So I want to direct your attention if you have a copy of that July 19, 2013, MRI report of Advanced Imaging Center. For the record, the Board Certified radiologist is Robert D. Solomon, M.D., and you'll see the area where it says Findings?

MR. BERENGUER: Please note an objection to as this calls for hearsay.

MR. GULINO: Okay.

Q. I just wanted to ask you, there's a, there's a, a line there that says, This is no -- There is no subacromial/subdeltoid bursal or glenohumeral joint fluid seen.

What does -- what is that?

A. It means that there was no bursitis seen in the what's called the subacromial space or the subdeltoid, meaning below the deltoid muscle space, and there was no fluid in the joint.

If you have an injury to a joint, the lining of the joint, the synovium, produces fluid or if you tear your labrum or if you have arthritis, there's friction inside of a joint, it creates fluid. It's nature's way of trying to lubricate a joint.

Q. Is it, is it, is it also called edema?

A. No.
Q. No?
A. Edema is something different. Well, we're -- I'm going to say that that's not an interchangeable term.
Q. All right. Let's go back to the fluid for a second. If a person has trauma in the subacromial or bursal or the glenohumeral joint, would it produce fluid if there's a trauma, a hit, something like that?
A. There should be some fluid in the subdeltoid/subacromial space or if there's a tear of the rotator cuff, what happens is the fluid leaks from with inside the joint and can go up into the subacromial space. Sometimes that's one of the sine qua non or the signs of a rotator cuff tear.
Q. Well, let me ask you this then. If, if there's no fluid seen on an MRI, is that the sign of generally no trauma?
A. I think the radiologist is just reporting the facts that he does not see any fluid.
MR. BERENGUER: Note a continued objection.
Q. Okay. Now, let's go to your --

A. Then there was a second MRI, too.
Q. Yeah. We're going to do the second MRI in a little while. Okay? We're going to get to that, the 1/12/15; right?
A. Uh-huh.
Q. What I wanted to get to was -- so we are in your third report of October 31st, 2016, and we have, we finished that one; right? No. October 31st, I'm sorry, 2016. Do you have that report?
A. I do.
Q. Now, you did look at the intraoperative photographs, did you not?
A. I said, yeah, Thank you very much for sending me the intraoperative photographs of 10/21/13 to the right shoulder.
Q. And, again, I think you described them before. They were taken by the camera that's used during the arthroscopy?
A. Yeah, we have a camera that attaches to the lens so we don't have to put our eye to anything. It's magnified on a TV screen so we just push a button and we get an instant photograph.
Q. Can you tell us the intraoperative photos that you looked at, and I do have copies of them here, but I don't think we need them at this

time, what did you find when you looked at them?

A. I found that he had no full thickness rotator cuff tear identified on these films. He had some fraying of the bursal surface meaning the top of the rotator cuff had some fraying in it, and that's what, that's what he had.

Q. Now, I forgot to ask you this very important question. The intraoperative photographs, they were taken during the first operation?

A. Yes.

Q. That was October 21st, 2013; right?

A. Yes.

Q. Okay. And so the photographs basically showed no full thickness tear of the rotator cuff, and what is a full thickness tear?

A. It means it did not go from the top surface, the bursal surface, to the articular surface so it didn't go all the way through, the fraying. It was just sort of like some fraying on the top of the cuff.

Q. And is that, the findings that you found in reviewing the intraoperative photographs, consistent with Dr. Helbig's report which says it was intact and no tear; correct?

A. Correct.

Q. All right. Now, anything else that you looked at during your October 31st report?

A. Yes. I looked at the MRI of the lumbar spine, and I said there are some straightening of the curvature, and there was a small central disc protrusion without mass effect at L5-S1. What does mass effect mean? Means there was no compression on the neural elements. Okay.

Q. No squeezing of something?

A. No, there was, there was a small little protrusion there, but it did not encroach upon or impress on the neural elements. That's all.

Q. All things being equal, would that mean that someone shouldn't have weakness or pain?

A. Well, it certainly shouldn't be weakness and there shouldn't be decreased sensation at L4.

Q. Okay.

A. Okay. That's without, I can say that without a doubt. When you start talking about pain because pain is subjective. Okay. And we all know that 28 to 35 percent of asymptomatic patients have discal herniations which is referenced in my February 9, 2017, report which was documented in the Orthopaedic Basic Science textbook, Second Edition,

written by Dr. Joseph Buckwalter and Dr. Einhorn and Dr. Sheldon Simon.

Q. Let me ask you --

A. So we know a certain percentage of people that are asymptomatic have discal herniations.

Q. Let me ask you another layman's question. When you say asymptomatic, means nothing?

A. Means if you take 100 people, and you do an MRI on them, 28 to 35 percent of these people will have discal herniations that are asymptomatic. That's all that means.

Q. My, my question to you is, because I didn't do well in biology, asymptomatic means you have no pain, you have no weakness, there's no effect on the person?

A. There's no symptoms, that's correct.

Q. No symptoms. Okay. All right.

A. Asymptomatic, without symptoms.

Q. So if we get back to it, it's a 28 to 30 percent or whatever, the people who have MRIs at a certain age, it may show they have a herniated or bulging disc, but it's not going to have any

symptoms nor will it have any effect on them?

A. Correct.

Q. Okay. Now, did you have an opinion at the end of that report after looking at those records?

A. I just want to reference something.

Q. Yes, please.

A. Because what I said is incorrect. In my October 31st report I reference the report that the radiologist said. It is my February 9, 2017, report that I looked at the actual MRI films myself so I just wanted to make that clear.

Q. Okay. Thank you. I see that, and you made reference to that in your report. All right.

Now, at the end of that third report dated October 31st, 2016, did you have an opinion concerning the need or -- withdrawn, the connection between the second surgery which is the torn rotator cuff repair and his accident which occurred about 18 months before?

A. Okay. Could I just ask you to please repeat the question?

Q. Sure. I will, I'll rephrase the question because I was confused. How's that?

A. Okay.

Q. All right. In your October 31st, 2016, report did you come to an opinion as to whether or not the need -- withdrawn.

Did you come to an opinion in your October 31st, 2016, report as to whether or not the second surgery performed by Dr. Helbig in January of 2015 was causally connected to the accident that he had back in June of 2013?

A. Yes. I've changed my opinion with more information that was provided to me based upon the fact that --

Q. Well, we're just talking about the second surgery, the rotator cuff --

A. Yeah, I'm talking -- I'm going to get to that, yeah.

Q. Okay.

A. My opinion is is that the second surgery was not causally related to the accident because --

Q. Now I'm going to ask you what's the basis of your opinion?

A. -- Dr. Helbig, Dr. Helbig found a torn rotator cuff which he clearly did not find the first time. That's number 1.

Number 2, I believe that he did sustain a biceps

tendon tear. I just want to make that clear, and I said that the subsequent surgery is, is elective surgery and not causally related.

Then there's further substantiation that I have in coming to that conclusion. The substantiation that I have in coming to that conclusion is the second MRI that was done on 1/12/15.

Q. Now, that was done before the second surgery; correct?

A. Correct.

Q. And the MRI was taken of the same right shoulder in January of 2015; correct?

A. Correct.

Q. And I'm going to ask you, I have it in front of me here. Let me ask you some questions about it.

MR. BERENGUER: Please note an objection to this line of questioning as it calls for hearsay.

MR. GULINO: Okay.

Q. Let me ask you this, Doctor. Did you use the MRI report and the films that you reviewed of January 12, 2015, to come to your opinion?

A. It was part of my process in formulating opinion. Okay.

Q. But you did review --

A. I looked at them myself.
Q. You reviewed both the report and the film studies; correct?
A. Yes.
Q. Okay. And I'm looking at this MRI report, and it says, there is moderate to severe acromioclavicular joint arthrosis with capsular, I pronounce it hypertrophy, hyper --
A. Hypertrophy.
Q. Hypertrophy.
A. Overgrowth it means of the bone.
Q. Okay. Can you tell the jury what that, what that means in English?
A. It means that there was arthritis of the acromioclavicular joint that was not addressed on the first operation because he only did an acromioplasty. He didn't take out the distal end of the clavicle, but I think what's more telling in this MRI is now there's edema at the end of the distal clavicle.
Q. I'm going to ask you about that next. So the next sentence is, edema of the distal clavicle is identified. First of all, show the jury what's the distal clavicle? Where is that?
A. It's at the end of your shoulder

here.

Q. Distal is towards the front?

A. No.

Q. Or side?

A. Towards the side.

Q. Okay. Now, it says edema, and for the record, it's e-d-m-a (sic). What is edema?

A. It means that the bone has some -- there's been some kind of event that created, it could be a little microfracture at the end of the collar bone, but there's, there's an abnormal signal at the end of the collar bone.

Q. Is it generally the result of a trauma?

A. That is usually due to trauma when you see edema like that, but you don't see this edema from a year and a half later.

Q. That was my next question. So, so the edema that was seen on the MRI report and I believe also in your review of the film studies was not there in the MRI taken in July of 2013, 18 months or 16 months before this one?

A. The edema was not present on the first MRI.

Q. Does that have any significance to

you?

A. Well, it also raises the question as to how he may have torn his rotator cuff because there's something else that's significant in that they talk about a Hill-Sachs deformity.

Q. I'm going to get to that in a little while. So I'm going to ask you, if we get back to the edema of the distal clavicle which wasn't there 18 months before, do you have an opinion within a reasonable degree of medical certainty whether something happened between the time of the first MRI and January of 2015?

A. Within a reasonable degree of medical probability something may have happened.

MR. BERENGUER: Please note a continuing objection.

A. The radiologist says that the edema is most likely posttraumatic with narrowing of the subacromial space.

Q. And then when we talk about posttraumatic, do we mean an accident traumatic?

A. It means some kind of trauma, whatever it is, you know.

Q. Trauma could be a fall, it could be an overuse of something, it could be a whole bunch

of things, right, but it's not just sitting there?

A. No, it's not just sitting there.

Q. You have to have movement or impact; right?

A. You have to have something that repetitively injuries that part of the body, yes.

Q. Now, they found a high grade partial tear of the supraspinatus tendon; correct?

A. Well, that's what they say. Helbig says he found a full thickness tear.

Q. Okay. And there's another part on the third line there, it says, the subscapularis tendon is thickened. First of all, what is a subscapularis tendon?

A. The subscap is one of the internal rotators of the rotator cuff. It's the muscle in front that comes from the front of the scapula to the, to here.

Q. And if the MRI report and the interpretation of the radiologist that it says it is thickened, what does the medical significance?

A. I don't know what it means to be honest with you.

Q. Okay.

A. I don't know. It's just a, he's

saying it, and I can't put any -- I can't give you an answer to that.

Q. How about there's a part of the report down in the next line, it says, mild atrophy of the subscapularis muscle superiorly is identified?

A. Just shows that there's been disuse of that muscle and there's atrophy, meaning shrinkage, of the muscle. You can get fatty infiltration.

Q. Now, there's --

A. It's a sign of chronicity.

Q. There was small joint effusion. What is that?

A. That there's fluid in the joint now.

Q. And fluid, again, comes generally from what?

A. It can come from trauma. It can come from arthritis. It can come from a torn labrum. It's something that wasn't there before.

Q. No. The next line is a possible small Hill, cap H-i-l-l - Sachs, S-a-c-h-s, deformity. What is that?

MR. BERENGUER: Please note my continuing

objection.

A. That's a defect in the humeral head. When the shoulder has instability and comes out of socket, it creates a little notch in the humeral head, and that's what's called a Hill-Sachs deformity.

Q. Hill-Sachs deformity, how is it caused?

A. Usually from some sort of subluxation where the shoulder can sublux out or dislocation of the shoulder.

Q. You don't get it just by sitting there watching television; correct?

A. Not unless you have an inherently unstable shoulder. I mean, some people have dislocated their shoulder in bed that have an inherently unstable shoulder.

Q. Okay.

A. So it can come out, you know, if it's very loosy goosy.

Q. In your reading of all the medical records from Mr. Munoz's treatment, have you found that he has an unstable shoulder?

A. No.

Q. Okay. Now, the impression at the MRI

was acromioclavicular joint arthrosis. What's arthrosis?

A. Arthritis.

Q. Arthritis. With bone marrow edema likely posttraumatic with narrowing of the sum -- subacromial space. In plain English what is that?

A. The arthritis is narrowing the space. Like I said, in the first operation there was no removal of the, of the end of the clavicle so, and that's all I can say about that.

Q. And in the second surgery that Dr. Helbig performed after this MRI did he remove some of the bone?

A. He did.

Q. Is that what we're talking about? Did he get rid of some of this problem?

A. Well, he took out part of that bone.

Q. And did he also go back in and do part of the subacromial decompression again?

A. Yes.

Q. And he did it the first time, though, about 18 months before, didn't he?

A. That's what he said he did, yes.

Q. Okay. I'm sure he did. So, so is it

growing or did it need to be done more?

A. It may have needed more of a haircut.

Q. And, basically, except for the partial tear repair in the second operation, and were sutures used in the second operation, do you know?

A. Your, your terminology is wrong.

Q. I have his report.

A. Yes, I know that, but you said partial tear.

Q. Oh.

A. Helbig said it was a full thickness tear.

Q. A full tear. Okay. So if it was a full tear, he would have used sutures?

A. Yeah, he, I mean, the first time he didn't use any sutures. He just kind of trimmed things down.

Q. Except for the use of the sutures in the second surgery, if you take the two surgeries, one in July of '13 -- not July, October of '13 and one in January of '15, except for the sutures on the rotator cuff, was any repair done?

A. The only other thing he did was take out part of the clavicle on the second operation.

Q. And that was removing of the bone; correct?

A. Correct, yes.

Q. All right. And that's because it had arthritis?

A. Yes.

Q. Which is not traumatically induced; is it?

A. Well, it can be from repetitive motion.

Q. Okay.

A. Let's say you break your clavicle as a kid, and you have a incongruous area, that can be posttraumatic arthritis, too.

Q. I think what I'm, what I'm, I'm, it's my fault. I keep talking about trauma and traumatic. How about this? Generally, it's not removed, this part of the shoulder, the bone, as a result of an impact?

A. I think you got to repeat that question again.

Q. Okay. I'll try to rephrase it. The removal of the bone in the second surgery --

A. The removal of the bone is from arthritis. Okay. But if someone has, say, a

severely distal clavicle fracture let's just say. You break your collar bone, it's out there on the end, and you can't repair it, and you can't put a plate on it, you can't put screws in it, then you can remove it, so you can remove a clavicle. There's no evidence of any fracture here so.

Q. So why don't we do this. Just at the end of your third report, it is -- was it -- and correct me if I'm wrong, it's still your opinion that the surgery for the first time may have been connected based upon your understanding of Mr. Munoz's claim as to how the accident happened, but you don't believe that the second surgery was connected to the accident?

A. I don't believe the second surgery, after the information that was provided to me and that what Dr. Helbig said that he found a torn rotator cuff -- had this individual sustained a torn rotator cuff after the first accident and he found it, my opinion might be different.

Q. Correct.

A. But it was, he made a point of saying there was no full thickness tear of the rotator cuff. To me that's just very basic. That's what he found. There's no tear.

Q. Now, you wrote your last report February 9, 2017, and you, you reviewed the report and the MRI films of 2/4/16; right? And we had just discussed that of the lumbar spine. We didn't review, we didn't talk about those.

Okay. Why don't we talk about them. You had an MRI of the lumbar spine done about two and a half years after his accident. The accident occurred in June of 2013. You have your February 9th report?

A. I do, yes.

Q. Okay. And the MRI of the lumbar spine --

A. Right.

Q. -- was done on February 4th?

A. 2016.

Q. '16, correct.

A. Almost three years after the accident.

Q. Almost three years. Okay.

A. Little under three, two, little under three years.

Q. Okay. So and you looked at the MRI yourself?

A. I did, yes.

Q. Now, would it be fair to say you're

not a spine surgeon generally; right?

A. I've never been a primary spine surgeon. When I've done spine work, I mean, I see spine patients in my practice every day. You can't not in a community that I live in and work in so it's not like you don't see backs.

Q. Uh-huh.

A. Okay. I don't operate on them. I'm never a primary surgeon. I could be a secondary or assistant. That's been my world of spine.

Q. Now, let me ask you this, though. Even though you may not have been the primary spinal surgeon, you've read MRIs of the lumbar spine of the back?

A. Every day.

Q. Okay. And it would be fair to say you've probably read hundreds, if not thousands, of these MRIs of the lumbar?

A. Probably thousands, yeah.

Q. Okay. So you read the one of February 4, 2016, and did you have, come to an interpretation of it?

MR. BERENGUER: Objection. Calls for hearsay.

A. I personally reviewed the MRI of

2/4/16. I believe there was degeneration, meaning loss of fluid content, in the L4-L5 disc space, at L5-S1.

Q. Can I stop you there for a second?

A. Sure.

Q. By its very medical definition degeneration means something has to take place over a long period of time?

A. It means in this particular case, when I talk about a disc degeneration, a disc has fluid in it.

Q. Uh-huh?

A. The most mobile segment is L5-S1, the lowest segment and the level above have the most movement when we bend and twist. Okay. So there's loss of fluid content meaning, if you look at the films, there's a dark disc, and it's not nice and bright because it's lost fluid content. That's what degeneration means. Then I said --

Q. Well, can you tell from looking at an MRI whether or not it's traumatic in nature, a person has an accident and you can tell right away or can you tell that it took place over a long period of time?

A. Well, first of all, you can't say

that an MRI done say two and a half years after the an accident is reflective of what happened at the time of the accident.

Q. Okay.

A. We do not live in a vacuum. We move, we walk, we bend, we twist, and there's a certain percentage of people that have asymptomatic discal herniations. So all I can say is you have an MRI that was done close to three years after the accident. You can't sit here and say within a reasonable degree of medical certainty that what you see there is caused by that accident two and a half years ago. Okay. That's all I'm saying.

MR. BERENGUER: Please note my continuing objection to this line of questions.

Q. Okay. Now, can you, can you go to the next line because I have a question for you about that?

A. Sure.

Q. What is that next line?

A. What, about Schmorl's nodes --

Q. Yes.

A. -- at the superior endplate?

Q. And for the record can you, can we spell that?

A. Yeah. Schmorl's is spelled S-c-h-m-o-r-l-s. That's just an indentation of the endplate, the top of the vertebrae, okay, that, that collapses down. It's usually an embryological remnant. Now, in the absence of marrow edema, okay, you cannot say that that's an acute protrusion of the disc into the vertebral body. Okay. That's just, there's no marrow edema there.

Q. All right. Marrow edema is indicative of what?

A. Of, of an acute event.

Q. An acute event means something happened quick?

A. Yes.

Q. All right. So when you see the Schmorl's node, that tells you that whatever this is happened over a long period of time and not from --

A. I'm just referencing it.

Q. Yeah.

A. You know, we see Schmorl's nodes all the time. It's an incidental finding.

Q. Okay.

A. You know, I have Schmorl's nodes in my own back so it is what it is.

Q. All right.

A. And then I found that there was degeneration of the disc space and narrowing of the disc space. I said the nerve roots were not compressed. Okay. They were wide.

Q. What is the significance of nerve roots not compressed?

A. That that should not give you any type of radiating pain down your leg.

Q. So this is what we're talk --

A. Or weakness, yeah.

Q. Is it consistent with what you were talking before about the 28 to 30 percent of the population could have a herniated disc, but they are asymptomatic, and one of the reasons would be that there's no compression?

A. Correct.

Q. All right. Go ahead.

A. Then I said, there's no narrowing or stenosis. That's important. Meaning narrowing of that would affect the nerve roots and encroach upon them.

Q. Well, when you say narrowing on the spine, do you mean from top-to-bottom narrowing or do you mean side-to-side narrowing?

A. I mean of the canal.

Q. Okay.
A. That there's nothing pushing back there that's narrowing the nerve roots.
Q. Something coming from the side?
A. Either on the side called laterally or from centrally. So there was no central stenosis or lateral recess stenosis. Okay.
Then I said that there was a minscule central protrusion which looks degenerative on the spine. Now I want to explain that.
Q. Uh-huh.
A. If you have a basketball, let's say, and you pump it up full, and you sit on it, the basketball is not going to displace. It's going to maintain its shape and form. If you take a basketball, and you take half of the air out of it, and you sit on it, what's going to happen? You sit on it, the ball's going to displace.
It's the same thing with a disc. When a disc narrows down and is degenerated, the disc can displace both in the front and the back area, and that's what I felt that this was a degenerative protrusion at I believe was L5-S1, and that's what I read it as.
Q. Now, and did you have an impression at the end of your report, of the February 9, 2017,

report?

A. I said this individual had subjective, meaning what he told me, complaints of mechanical findings on my physical examination. The objective portion of the examination, meaning the neurological portion, had some sensory deprivation on the right at L4 which would not be consistent with this MRI because the protrusion and the degeneration was at L5-S1.

Q. When you looked at the films, did you then look at the MRI report of the radiologist?

A. I'd like to see it because I have it referenced here, but if you have a copy of it, it might just make it easier here.

Q. I have a copy. I don't know if you do.

A. Let me just see. I'm not sure where it is, but I -- okay.

Q. Okay. Is your interpretation consistent with the interpretation of the radiologist?

MR. BERENGUER: Objection. Calls for hearsay.

A. Yes.

Q. Okay. Now, at this time after your

fourth report and reviewing all these records, concerning the first surgery, was it still your opinion that the first surgery, based upon what you learned from the Plaintiff as to how the accident happened and your review of the records and the interrogatories served by his lawyer, that the first surgery was, the necessity of that first surgery --

A. He complained --

Q. -- was caused by his accident?

A. He complained of pain to Dr. Helbig. He had a torn biceps tendon. Dr. Helbig chose to operate on him, not repair the biceps tendon, and just do a decompression.

Q. Okay.

A. So if all the information about how he fell and everything like that is correct, then I'm causally relating it to the accident.

Q. Okay. Now, when you looked at the lumbar MRI, and you talked about sensory losses, there was a inconsistency between what he told you in his examination and what was seen later?

A. Yes.

Q. And, and what was, just because it's been quite sometime, and I apologize for dragging this out, what is the inconsistencies that you found

on your exam that was shown on his MRI?

A. I found a non-compressive protrusion of a disc that was degenerated at L5-S1 that should not give you sensory deprivation in the L4 nerve root area.

MR. BERENGUER: Objection to that question and answer.

Q. The lumbar MRI was taken as we talked about two and a half, three years later after the accident, and he had an x-ray of the thoracic spine, higher, the day after the accident. That have any significance to you when someone tells you that I hurt my lower back as a result of this accident?

A. I think the doctor he saw the next day felt that the pain was coming from his thoracic spine because that's where he took the x-ray of. That's all I can say about that is the x-ray was taken of the thoracic, not the lumbar spine.

MR. BERENGUER: Objection to that question and answer as well.

Q. Now, I have -- we met two days ago; right?

A. Yeah, it seems like --

Q. Monday. Okay. Monday the 27th for the record. Okay. And I'm going to ask you this,

and we're going, we're going to wrap it up, okay, so I'm sure the jury is ready to wrap it up themselves.

At present if I were to tell you that there has been deposition testimony of a witness who is going to come in to testify under oath that at the time of the accident Mr. Munoz did not fall.

MR. BERENGUER: Objection.

Q. But rather Mr. Munoz was walking five feet ahead of him, he had either one or two buckets in hand, one in one hand and one in another, and a tool belt over his right shoulder, and that as he stepped into the inch and a half depression, he lurched, but he didn't fall, would that have an effect on your opinion as to whether or not the first surgery was necessitated by this accident?

MR. BERENGUER: Objection.

A. It was still my opinion that he tore his biceps tendon by carrying a bucket. I, I will say this over and over again.

Q. Why don't we do this.

A. Dr. Helbig --

Q. Let me break it down because you're correct, and it's my fault. The surgery had a few components to it; right?

A. Yes.

Q. Would it be fair to say that based upon the fact that I've just told you, even that lurching and the biceps tear, would you say that the biceps tear probably was caused by the, the accident that day?

A. In the absence of any documentation --

MR. BERENGUER: Objection again.

A. -- that he hurt himself before, I would say the biceps tendon was torn as a result of that, but Dr. Helbig didn't do anything about it, and he chose to do something else at the time of the operation.

Q. That's the part I'm going to ask you now. All right. A subacromial depression --

A. Decompression.

Q. -- decompression and an acromioplasty which is basically using a burr to cut away arthritic bone; right?

A. It's to cut away bone that is allegedly pressing on the tendon and creating an impingement.

Q. Now, based upon the fact that if I were to tell you then that someone is going to come in and testify under oath that they were five feet

behind the Plaintiff at the time of this accident --

MR. BERENGUER: Objection.

Q. -- and that the Plaintiff did not fall, but rather lurched?

A. Right.

Q. Do you have an opinion within a reasonable degree of orthopedic or medical certainty whether or not the subacromial decompression and the acromioplasty were needed because of that first accident?

A. No, I don't believe that the decompression and bursectomy is causally related if he did not fall. If he fell on an outstretched arm and had a thickened bursa, then my opinion's different, but not falling does cast a different opinion as to the, to the need for a subacromial decompression.

Q. Okay. And the second surgery we've already established was not related to the first accident?

A. In my opinion the fact that he went in to repair a rotator cuff and take out some arthritis of the AC joint, I'm not causally relating this to this accident, sir.

Q. And, obviously, the rotator cuff tear

repair, there was edema before the second accident. That's an indication --

A. Well, there was edema in the distal clavicle.

Q. Distal clavicle. Okay. And do you have an opinion within a reasonable degree of medical certainty whether or not the lower back claim that Mr. Munoz is claiming now was caused by his accident of June 25, 2013?

A. No, I don't think it was. I think there was some degenerative discogenic disease. His physical examination was inconsistent. Therefore, I do not believe he sustained a loss of bodily function or permanent orthopedic injury to his lumbar spine as a result of this accident.

MR. GULINO: Thank you, Doctor.

THE WITNESS: Thank you.

MR. GULINO: Do you want to take a break?

MR. BERENGUER: Let's take a break.

VIDEOGRAPHER: Stand by. The time is 7:55 --

MR. GULINO: I'm sorry I took so long. I should have gotten through this.

VIDEOGRAPHER: Excuse me. Excuse me. The time is 7:55. We're going off the record. This will end

media unit number one.

(Whereupon there is a break)

VIDEOGRAPHER: Stand by to go back on the record. The time is 8:04. We are back on the record. This will be the start of media unit number two.

Counsel.

CROSS EXAMINATION BY MR. BERENGUER:

Q. Good evening, Doctor. My name is Lazaro Berenguer. I'm the attorney for the Plaintiff in this case Washington Munoz.

A. Good evening.

Q. Doctor, you examined Washington on July 18, 2016, a little over three years after his June 2013 incident; correct?

A. Yes, sir.

Q. You examined Washington at the request of the defense attorney; correct?

A. Yes, sir.

Q. And you are aware that Dr. Helbig is his treating orthopedist. You are aware of that, aren't you?

A. Yes, sir.
Q. And you are aware that Dr. Helbig has been the treating orthopedist for Washington since about two weeks after his injury in 2013. You're aware of that; right?
A. Absolutely.
Q. And you are aware that Dr. Helbig is still treating Washington and has had a doctor/patient relationship with him for about four years now. You're aware of that; right?
A. Well, I'm not aware of anything short of what I've been provided. I don't know if he saw him last week or the week before. I don't, I don't know that, sir, but I could only conclude in response to your questions that he was the treating doctor who performed two surgeries on him, and that's what I know.
Q. Now, you've drafted numerous reports and/or letters in this case; correct?
A. Four reports, yes.
Q. Prior to your drafting of any of your reports did you contact Dr. Helbig at all to get his medical viewpoint on his patient?
A. No --
MR. GULINO: Objection.

A. No, sir. That's not how it's done in the, in the IME world. I have no doctor/patient relationship with him, and I did not contact Dr. Helbig. I relied upon the medical records and reports and MRIs and things. That's what I was provided with, sir.

Q. Prior to drafting any of your reports did you contact any of Washington's physical therapists to get their medical viewpoint?

A. No, sir. That's not what's usual and customary.

Q. As you are aware, Washington underwent two surgical procedures, one in October 2013 and another in July 2015?

A. Absolutely.

Q. Now, you never examined Washington's right shoulder prior to his injury in June 2013. Isn't that right?

A. Of course.

Q. So you didn't examine his shoulder prior to his injury; correct?

A. Of course, I didn't examine his shoulder prior to the injury.

Q. Now, you never examined his right shoulder after his June 25, 2013, injury, but prior

to his first surgery in October 2013.

A. Okay. Sir --

Q. You never examined --

A. I examined him on July 18, 2016. That's the only time I examined him, sir.

Q. You were not Washington's treating physician, were you?

A. No, sir. There's no doctor/patient relationship here.

Q. You didn't prescribe any medications or, like you said, have any doctor/patient relationship?

A. Absolutely. There is no doctor/patient relationship. It's said, it's stated in my report there is no doctor/patient relationship.

Q. Doctor, in your report dated July 18, 2016, which was about three years after his injury, you found that his injuries were causally related to the June 25, 2013, incident; correct?

A. My initial assessment based upon the information that I had on July 18, 2016, were what they were, and I causally related them, and then I subsequently got more information that altered and changed my medical opinion.

Q. Now, in that same report dated July 18, 2016, you also found that his initial surgery in October 2013 was causally related to his injuries of June 2013?

A. Right. Based upon the information that I had at that time I, I stated there was a causal relationship, yes, sir.

Q. And your opinions were within a reasonable degree of medical certainty, were they not?

A. As is required by the court system, yes, sir.

Q. After his first surgery in October 2013, but prior to his second surgery in July 2015, you didn't examine Washington's right shoulder for his limitation of motion or whether there was a positive impingement sign or negative drop sign, did you?

A. No, sir. I examined him after both surgeries, sir, not in between.

Q. Now, also in your report dated July 18, 2016, you state that Washington complains of pain in his lower back. Wouldn't you agree that the person feeling the pain is the best judge of the pain?

A. Well, first of all, sir, as a physician, I can't see or feel pain. That's number one. What you tell me I have to take for face value, but also when I examine someone, the symptom complex has to be consistent with the objective tests like an MRI.

So whatever he tells me that it hurts him, and I, I have to take that for what he tells me. That's all there is to it. It's a subjective complaint that I take, and I correlate with a physical examination.

Q. After you evaluated Washington, did you have any other contact with him? Did you call him to see how he was doing?

A. No, sir. There is no doctor/patient relationship, and it would be inappropriate for me to call him. We are not even allowed to have their phone numbers here. We have to go through you, and I don't think you as the Plaintiff's attorney would want me contacting your, your client, number one.

Number two, if we were even to change an appointment in, for an examination, we'd have to call your law firm to get them to change the appointment. We couldn't call Mr. Munoz directly.

Q. Dr. Decter, if I were to show you a picture of Washington or if he were to walk in the

room, would you recognize him?

A. No. I have no specific recollection of him, sir. Maybe if he was a really good looking girl, I might have remembered him, but I don't think I remember Mr. Munoz, sir.

Q. Do you know what language Washington speaks?

A. Si.

(Whereupon the doctor responds in Spanish.)

So Mr. Munoz and I did very well communicating Spanish as I've lived in a foreign country for two years and speak the language quite nicely.

Q. Do you know what language you communicated with him on July 18?

A. I don't remember, sir. I don't have a specific recollection.

Q. If you want to review your reports, take some time to do so. Is that information found in your reports?

A. No, sir. It's not found in my reports.

Q. Do you know how much time you spent with Washington when you evaluated him in July --

A. I think if I spent --
Q. -- 2016?
A. If I spent 5 or 7 minutes examining a shoulder and a back, that probably would be about it because when you think about how much time a cardiologist spends listening to your heart or a gynecologist spends examining women, the amount of time that you spend in these cases, sir, is more in evaluating the records.
Okay. The actual physical examination is the smallest amount of time. So it didn't take very long to examine his shoulder which I've probably done I can't tell you how many thousands of shoulders and how many thousands of backs I've examined, but I can only tell you it was not very long, sir.
Q. Now, the information of how long you spent examining Mr. Munoz, is it found in any of your reports?
A. No, sir. I don't, I don't put that in. You sent a nurse in who clocked me in and clocked me out so you have that information. I, I don't live with a time capsule. I do what I have to do. I examine him, and I leave. That's it.
Q. Dr. Decter, as an orthopedist you want your reports to be as complete and as accurate

as possible; correct?

A. I try my best, sir. I'm not perfect. None of us are perfect. We're all human beings.

Q. In addition to your medical practice, you have owned or organized or formed some companies; correct?

A. Well, I, I had a medical practice which I explained before that it was CFO -- CFO, that now is CFO Medical Service was a separate company, and we separated it because one of the partners in that company's father-in-law was an accountant. He wanted it separate. So CFO Medical Services was formed, and then CFO Medical Services was sold and now has become ExamWorks.

Q. CFO Medical Services performed medical-legal evaluations; correct?

A. Yes.

Q. Approximately what percent of your work while working for CFO Medical Services was on behalf of Defendants?

A. I said already that it was 98 percent of defense work. That's, that's my balance, sir.

Q. And in the beginning days of CFO Medical Services you were trying to build up your practice and business, and you solicited business

from law firms who represent insurance companies. Is that correct?

A. Yes. I gave lectures to law firms, and the lectures were medical lectures so that they would understand what they would do.

As a matter of fact what I even did one year, sir, is I did live surgery from my operating room of a knee and a shoulder, and I did an anterior cruciate ligament reconstruction and a labral repair, and I, I telecommunicated it into a conference room so that people could understand the medicine that they were talking about.

So I have done live surgery from the operating room into a conference room where there were attorneys to learn about knees and shoulders.

Q. And aside from the live surgeries, you also gave seminars and taught other doctors how to be more effective witnesses for insurance companies?

A. Well, that, I don't really remember doing that. That keeps coming up on, on the -- I don't have a specific recollection that I have actually done that to be honest with you, but maybe I have, maybe I haven't. I don't have a specific recollection of that.

Q. And you sold CFO Medical Services like you said earlier to a company which is now called ExamWorks; correct?

A. Yes, sir.

Q. How much money did you make off of the sale of this company?

A. The total --

MR. GULINO: Objection.

A. The total sale was $14 million of which Dr. Robbins had half, and so each one of us got about $7 million of which 3 and a half million was in cash and 3 and a half million went into stock so I gambled that everything was going to turn out okay.

Q. Now, Doctor, you continue to do work for ExamWorks; correct?

A. I do, yes. I'm not retired, sir. I still work. I still have an active orthopedic practice. I still operate, and I work for ExamWorks, that's correct.

Q. What is your yearly income?

A. My yearly income is probably --

MR. GULINO: Objection. Objection. You can answer the question.

A. My yearly income probably is around

$850,000, maybe 900. It's about 60 percent of my gross income, sir.

Q. How much of your current income comes from testifying in cases?

A. Well, you mean like this?

Q. Yes.

A. That's all part of the ExamWorks number that I just gave you so it's, that's the number, sir. I don't break it down by how much do I make doing depositions, how much do I make doing testimony, that's the total number, sir.

Q. And that number was between 800 to 900,000. Is that correct?

A. In that range. That, I mean, it's not exact. I don't know exactly. I didn't check last year what I earned from ExamWorks. You know, I just don't know.

Q. How many times did you testify in court in 2016?

A. I think last year in 2016 I think is around 20 times, sir, maybe 22. I think that's about right so, you know.

Q. And what percentage of those times that you testified in court was on behalf of Defendants, Doctor?

A. For the third time it's 98 percent of my medical-legal work, sir, is on behalf of Defendants.

Q. Isn't it true that a grievance was filed against you alleging violations of Mandatory Standards 1, 2, 3 and 7?

A. No, not number 1, sir.

MR. GULINO: Objection.

A. That's not true. Number 1 is false testimony. I was not censured for false testimony. That's a mis, mis -- that's a misstatement. Okay. I did not use literature to support my, my testimony. When the Judge at the 104 Hearing said that you could do, testify based upon education, knowledge, and experience, so you're incorrect about number 1, sir.

MR. GULINO: I don't mean to interrupt you, Mr. Berenguer. I just want to tell you that I'm, I'm going to have a running objection to this whole line of questioning.

A. You can ask whatever you want.

MR. GULINO: Starting when you started that question and moving forward.

MR. BERENGUER: That's fine.

Q. Now, Doctor, my question was isn't it

true that a grievance was filed against you alleging violations --

A. Yes. Yes.

Q. -- of Mandatory Standards 1, 2, 3 and 7 --

A. Yes.

Q. -- of the --

A. But that, but number 1 was not found to be a, they did not censure me for number 1. So you can, you can send a grievance, and you can do anything you want, but it was not, it was not acknowledged by the Academy.

Q. So you were censured for violating Mandatory Standards 2, 3, and 7 of the standards of professionalism for orthopedic expert witness testimony. Isn't that true?

A. Yes, based upon the American Academy of Orthopedic Surgeons which I no longer am a member of and I resigned from the Academy. I could have stayed. They, they were -- I was not suspended. I received a censure. A censure is a smack on the back of your hand, and don't testify against your brethren. That's all it means, sir.

Q. Isn't it true that this grievance arose from statements made by you in a case

involving a work-related injury. Isn't that true?

A. Yes. It was, it was an old patient of mine that was injured and had a herniated disc in her back and had a foot drop, and the doctor kept sending her back to work, and I would sit here today, and I would testify against this doctor today as I did then because he mistreated her, and this doctor had been sued 25 times, even to the point where he went to the Superior Court or Supreme Court of the State of New Jersey, and he really ruined this woman's life.

Okay. And this woman flew out to Chicago for, on my behalf, to give an opinion as to what happened, and the American Academy of Orthopaedic Surgeons would not let her speak. Okay. So this woman flew out to Chicago on her own dime because of what was done to her, and the Academy Board would not even let her talk. So you can see what type of, of hearing this was.

Q. Now, isn't it true that the Judiciary Committee found that you had been provided with due process and that the clear weight of evidence supported the panel's recommendations. Isn't that true?

A. Well, that's what they said, that it was due process. How can there be due process if

the woman who was injured and flew out there on her own dime that they wouldn't let her talk so their opinion is that I was provided with due process.

MR. BERENGUER: I have nothing further.

MR. GULINO: Nothing further?

MR. BERENGUER: No.

VIDEOGRAPHER: Stand by the time is 8:20. We're going off the record. This will end media unit number two and today's deposition.

(Whereupon the deposition is concluded at 8:20 p.m.)

* * * *

C E R T I F I C A T E

I, LORA LANDSHOF, a Certified Court Reporter of the State of New Jersey, hereby certify that EDWARD M. DECTER, M.D. was duly sworn by me according to law.

I do further certify that the foregoing is a true and accurate transcript of the testimony and proceedings in the above-entitled matter as reported by me stenographically at the time, place and on the date hereinbefore set forth.

LORA LANDSHOF, C.C.R.
License Number 30XI00131800

New Jersey Rules Governing Civil Practice

Part IV, Rule 4:14

Depositions Upon Oral Examination

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