SUPERIOR COURT OF NEW JERSEY
LAW DIVISION, CIVIL PART
MIDDLESEX COUNTY
DOCKET NO. L-3284-15
A.D.#_____

WASHINGTON MUNOZ,	)	
	)	
Plaintiff,	)	TRANSCRIPT
	)	OF
v.	)	TRIAL
	)	
L.P. CIMINELLI, and	)	
PAINO ROOFING CO., INC.,	)	
	)	
Defendant.	)	

Place: Middlesex County Courthouse
56 Paterson Street
New Brunswick, New Jersey 08903

Date: July 12, 2017
Volume 2 of 2
Pages 201 - 286

BEFORE:

HONORABLE ANDREA G. CARTER, J.S.C., AND JURY

TRANSCRIPT ORDERED BY:

JOSEPH J. GULINO, ESQ. (Nicoletti Gonson Spinner LLP)

APPEARANCES:

GERALD H. CLARK, ESQ.
LAZARO BERENGUER, ESQ.
(Clark Law Firm)
Attorneys for the Plaintiff

JOSEPH J. GULINO, ESQ.
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Sound Recorded
Recording Operator,

(Continuation of Volume 1 of 2)

MR. CLARK: Correct.

THE COURT: So to the extent that he's not allowed to, then the jury's verdict will have to be molded accordingly.

MR. GULINO: Then I'm going to want each and every one of the medical care providers who provided you with those numbers to come in and testify.

THE COURT: Well, -- anything else that I have to address?

MR. CLARK: Judge, I've never had -- I've never -- just for the record, the medical bills are here. The doctors reviewed them. I expect he will testify they're reasonable, necessary, and related. Ordinarily, in my experience, the parties just stipulate to the number.

THE COURT: That's normally the case, but go ahead.

MR. CLARK: The collateral source rule prevents the double recovery. It requires post-verdict that the parties submit to the Court things that are relevant to that. I've never had a situation where I've been required or -- to bring in a records custodian or a person from each provider and say, yes, yes, yes, and that --

THE COURT: You try your case, and he can make the appropriate motion that he feels is appropriate and then I'll rule on it. But the fact of the matter is, a lot of the issues that you're raising are issues that are addressed by way of post-verdict molding. So you can make that argument that the bills aren't reasonable and necessary and make your arguments accordingly. But you can require whatever you feel you need to require, but it's his case to prove and if you don't think he's proven it, then you make the motion when it's time to make the motion.

MR. GULINO: Those expenses were not incurred.

THE COURT: Okay.

MR. GULINO: 56--

THE COURT: Sir, you're telling -- listen, I didn't go to any of those doctors. I don't know whether they were incurred or not. So you're telling me this means nothing to me.

MR. GULINO: Then he said to me that he didn't want to be forced to bring in each of the medical care providers and I said, okay, we'll do this. Now, if he wants to do that, then let him lay the foundation for each individual medical care provider to say, yes, these are the bills. Do it.

THE COURT: It seems to me that part of the discussion included the fact that you indicated that while you were stipulating to an amount, you were not stipulating to the fact that the bills were reasonable and necessary.

MR. GULINO: To the 56,000 that was owed on the medical.

THE COURT: Okay. Then to the extent that that's your stipulation, he'll prove whatever he needs to prove with respect to the --

MR. GULINO: Oh, Judge.

THE COURT: You're doing it again. You are doing it again. You don't like my ruling and the record should reflect, the hands go up, oh, Jesus. None of this is necessary. It's very disrespectful. I am not disrespectful to you, and I don't have to tolerate it from you, sir. You do it again and be prepared to take out your checkbook. I'm tired of it.

MR. GULINO: I apologize, again. I am sorry. But I thought this was an agreement we had the other day in front of you. That's why. To me, and maybe I'm wrong, he's changing the rules. He said, I don't want to have to bring everybody in. I said, fine. Then I will agree to the 56. I don't agree to the necessity of it. That's what I thought, and I apologize if I

upset you, Judge, and it's my fault. It's not yours. That's what I thought, and it seems to me as if Mr. Clark is changing the rules and the agreement that we had the other day in front of you.

MR. CLARK: I just have to correct the record. There was no such agreement, and the record speaks for itself on that. That's just not the case.

THE COURT: Okay. Let's bring in the jury.

COURT OFFICER: Jury is entering.

(Jury present in courtroom)

THE COURT: Thank you. Please be seated. Mr. Clark, your next witness.

MR. CLARK: Yes, Judge Carter. At this time, we would like to call Dr. Thomas Helbig.

COURT OFFICER: Place your left hand on the Bible, lift your right, state your full name for the record.

DR. HELBIG: Thomas Edward Helbig, M.D.

COURT OFFICER: Spell your last name.

DR. HELBIG: H-e-l-b-i-g.

T H O M A S E D W A R D H E L B I G, M. D., PLAINTIFF'S WITNESS, SWORN

COURT OFFICER: Thank you, sir. Please be seated and answer all questions.

VOIR DIRE DIRECT EXAMINATION BY MR. CLARK:

Q Dr. Helbig, could you just give us your -- the short -- the short version of your CV or resume, your education, that sort of thing?

A Sure. I attended college at Rutgers University, graduated with a Bachelor's degree in Chemistry in 1977. I attended New Jersey Medical School, graduated with my M.D. degree in 1981. I did post-graduate training in surgery and orthopedic surgery at New Jersey Medical School in Newark, which I completed in 1986. I did a fellowship in spinal surgery at Upstate Medical Center in Syracuse in New York, which I completed in 1987. I've been in practice in orthopedic surgery in South Orange in New Jersey up until now, and I have been Board certified by the American Board of Orthopedic Surgeons as a Board certified orthopedist since 1989.

MR. CLARK: Doctor, at this time, I would like to ask the Court to allow Dr. Helbig to testify as an expert in the field of orthopedic surgery. Thank you.

THE COURT: Any voir dire?

MR. GULINO: No objection.

THE COURT: Okay. Members of the jury, this witness is being offered to you as an expert in the field of orthopedic surgery. I'm satisfied that based

on his qualifications, he's able to offer you such an opinion. What weight you will give it will still be left to you. All right? Your witness.

MR. CLARK: Your Honor, may I ask that the witness keep his voice up, please?

THE COURT: Sure.

DIRECT EXAMINATION BY MR. CLARK:

Q Dr. Helbig, I have your reports and I just want to go through that. Why don't you just tell us how you came to, you know, -- just tell us your relationship with Washington Munoz in terms of treating him, that sort of thing.

A Sure. I started treating and taking care of Mr. Munoz July 11th, 2013. It was regards to an injury from June 25th, 2013. He reported to me that there was an injury at work. He had stepped into a hole and landed on his right arm while carrying a heavy bucket, and he had sustained injuries to his neck and his back, his right shoulder, and his right arm at that time.

Q Okay. And, doctor, I'm going to ask you to give expert conclusions. Will all the conclusions you give in the case and your opinions be within a reasonable degree of medical probability?

A Yes.

Q All right. And by that, basically, will your

answers be more likely right than wrong?
A Oh, yes.
Q Okay. Thank you. Why don't you continue on and tell us the course of treatment for Washington Munoz.
A Sure. I've taken care of Mr. Munoz for several years now, so it may be a little long. I apologize. When I first saw him that first date, July 11, 2013, he was 5'6" tall and 145 pounds. I examined his neck, which showed tenderness, meaning when I press on the muscles, it hurt. He had good motion, but it was painful.

I examined his lumbar spine, which is the medical word for the lower back. He had severe tenderness and what I termed a moderate restriction of motion, difficulty bending and straightening out because it was painful. His left shoulder was normal. His right shoulder showed several abnormalities at that time. Number one, there was a tear that was very obvious of something called the biceps tendon. The biceps is the big muscle in the front of the arm. We're all familiar with that.

There's two large tendons that go into the shoulder joint. The tendons basically attach the muscle to the bone and allow the muscle to do its work.

Q I'm sorry to interrupt you, doctor, just because I have an exhibit that I want to ask you about. I'm going to show you what we marked as plaintiff's Exhibit 9.

A Yes.

Q Are you familiar with this exhibit?

A Yes.

Q Does this fairly and accurately depict the condition of Washington Munoz' shoulder before you did surgery?

A Yes.

MR. GULINO: Objection. Foundation.

THE COURT: Overruled. Go ahead.

BY MR. CLARK:

Q Will this assist your testimony to the jury to explain the nature and extent of the injuries that you treated him for related to the incident of June 25, 2013?

A Yes.

MR. CLARK: Your Honor, at this time, I would like to use plaintiff's Exhibit 9 as a demonstrative evidence or a demonstrative exhibit to assist the testimony.

MR. GULINO: Voir dire on the exhibits.

THE COURT: On the exhibits?

MR. GULINO: Uh-huh.
THE COURT: You're objecting to the use of the exhibits based on the foundation?
MR. GULINO: Yes. I am. I'm objecting to the use of the exhibits.
THE COURT: You can voir dire on cross.
MR. GULINO: Okay. I'll withdraw the objection, Your Honor.
THE COURT: You're allowed.
BY MR. CLARK:
Q Doctor, I'll -- I'll just put it up here and there's a laser pointer you have. You can use this to --
A Sure.
Q Is that angle okay?
A This is perfect. The biceps is the medical term for the muscle in the arm. The tendon goes up into the shoulder joint and it attaches into the shoulder. This shows where the tendon is still attached to the shoulder. This shows where it goes into the muscle in the upper arm. This is the shoulder joint. This is the humerus, which is the large bone in the arm, and this is the shoulder blade. This is the collar bone. This shows the tear where the tendon is ruptured. It is very clear.

Q And what caused the rupture that is shown in there based on your treatment and review of the materials?
A The injury from June 25th, 2013, clearly.
Q All right. Then if you could just continue on. First of all, just briefly, you said, you saw him in July?
A Yes.
Q Okay. But you weren't the first medical provider that gave him attention for this incident, correct?
A I don't believe so. No.
Q And I just have a medical note here. Will this assist you to say when he first received medical treatment for the injury?
A Right. This is the initial injury, June 26th, 2013, the day after the accident.
Q Okay. All right. Thank you. All right. If you would just continue on with your course of treatment of Washington, you know, as per the injuries related to the incident we're here for today.
A Sure. When I examined him that day, just to finish the July 11, he had limited motion of his right arm. He had signs that made me worried about a tear of what's called the rotator cuff. The rotator cuff or

tendons is in the shoulder that help a person to elevate or lift the arm.

Because of that, I sent him for an MRI. An MRI is a test you may or may not be familiar with, but it's a sophisticated radiographic test that shows things x-rays don't show, things doctors can't see just by looking at a patient. Basically, it shows the anatomy, the inside of the body.

He had the MRI done on July 19th, 2019, at Advanced Imaging Center. At that time, I reviewed the scan and the report from the radiologist. It showed a possible tear of the rotator cuff but without what we call retraction, meaning the tendon wasn't pulled away and out of position. Those findings could also be tendonitis. It was hard to say just by looking at the scan.

Q Doctor, we have --

THE COURT: I'm sorry. Hold on.

MR. GULINO: Can we move that over there, so everybody can see it? I can't see the doctor with this in front of me. If we can move that demonstrative evidence over there.

THE COURT: Well, you're done with this for now? We can move that. Okay.

MR. CLARK: Judge, he still will be talking

about the injuries. Is it all right if I leave it up there?

THE COURT: Sure.

MR. CLARK: Okay.

BY MR. CLARK:

Q Doctor, we have the films, the MRI film you just referred to. You reviewed -- you said you reviewed the film, correct?

A Yes. I did.

MR. CLARK: All right. I would like to post it up. Now, Judge, is it okay if the doctor comes down and points it to you because I don't think the laser pointer will work?

THE COURT: Sure. Sure.

BY MR. CLARK:

Q Doctor, just watch the easel and the cord there.

A This is the initial MRI scan on Mr. Washington Munoz performed on July 19, 2013. We can see the humerus, which is the bone in the upper arm. We can see the shoulder blade, which is here. This is the shoulder joint. The rotator cuff are tendons that come across the shoulder. This is the muscle. The rotator cuff tendon comes in and it goes into the -- into the bone and that's what allows the rotator cuff to lift

the arm.

Normal rotator cuff on an MRI should be very --

MR. CLARK: Is that -- I'm sorry. Judge, I don't know if all the jurors can see.

BY MR. CLARK:

Q Doctor, let me --

A So this is the normal rotator cuff but, here, the nor-- like the rotator cuff should be dark and black. There shouldn't be any white signal into it, which is a sign of either inflammation or an injury and, in this case, this is a partial tear. As I said, there's no retraction being that the tendon is not attached all the way by the bone and that's clearly shown here.

Q Okay. And you can continue on what your course of treatment was to treat that condition.

A A month later, August 13th, I did a cortisone injection into his shoulder. Frequently, that can help relieve pain and inflammation to facilitate rehab. I sent him for physical therapy, hoping that this could heal and that he could rehab without having to have surgery.

When I saw him another month later, June -- September 10th, he had very poor motion, could only lift the arm about half way, 90 degrees. Normal motion

should be 180 degrees, elevating the arm all the way over the head and, at that time, I recommended surgery because he had been through a fair amount of physical therapy, non-operative treatment, which didn't work, unfortunately.

On October 31st of 2013, I did surgery. It was arthroscopic surgery.

Q All right. If I can, doctor, I have another exhibit, plaintiff's Exhibit 10. Does that fairly and accurately depict the surgery and will it assist you in explaining that procedure and your treatment of him to the jury?

A Yes.

MR. CLARK: At this time, I would like to utilize plaintiff's Exhibit 10 to the extent the doctor wants to.

THE COURT: Yes.

BY MR. CLARK:

Q All right?

A Excellent.

Q I'll put it here, if that's all right and, again, we'll use the laser pointer.

THE COURT: You can -- you can move so you can see or move that.

THE WITNESS: I'm okay.

THE COURT: Okay. Counsel?

THE WITNESS: I performed surgery to his right shoulder. This is good representation. There's usually two or three incisions. The cuts are about a quarter inch or a centimeter long, one in the front of the shoulder, one to the side, and usually one to the back. We put a took called an arthroscope, which a sophisticated surgical telescope, through a hole in the back, and that allows us to actually visualize the inside of the shoulder and the anatomy on the TV screen. It's not (indiscernible).

When I did the surgery, I saw that the tendon was torn. That was very visible. And I did several things. Number one, there's a lot of inflammation as a result of the trauma, as a result of the injury. So we use a shaver. This is about three-and-a-half millimeters in diameter that shaves out the inflamed tissue. That's what this shows. And this is a close up of the same thing, the shaver shaving things out.

We could see, we would call this frame, a small partial tear of the upper surface of the rotator cuff. That's visualized right here, again, the rotator cuff muscle and the tendon coming into the bone and, again, it was not retracted or totally pulled away at that time.

In order to prevent the problem -- in hopes of preventing the problem again, we performed something called acromioplasty. That's a fancy medical word for basically taking a powered burr. This is about a quarter inch in diameter and it basically shaves off some of the undersurface of the bone and it allows this space, we call it subacromial decompression, it's the space underneath this bone called the acromion. It opens it up and that allows the rotator cuff to have more room so that, during the healing phase of the post-op rehab, which is real important, mobility can come without impinging and this is called an impingement syndrome.

Basically, what happens is -- basically, what happens is because the bone rubs on the rotator cuff with motion, after an injury, this small tear can get worse and that's why we do this subacromial decompression of the impingement syndrome to free this up, and that's what we did.

BY MR. CLARK:

Q Okay. And then if you can just continue on with your going through the course of treatment that you did and this surgery was to treat injuries from the incident we're here for today, correct?

A Yes.

Q Thank you.
A As I said, part of the -- important part of the treatment of surgery is the post-operative rehabilitation, physical therapy, and Mr. Munoz went through a significant amount, pretty extensive physical therapy. He made some improvement, but he continued to have trouble and by June, 2015, he continued to have limitation of motion of the shoulder. We had had an updated MRI that showed a new problem and a worsening of the problem he had had when I did his surgery and we had to do a second surgical procedure in July, 2015.

That surgery is called an arthrotomy, which is a major incision, about two inches long, in the front of the shoulder. I did what's called a resection of the distal clavicle. That's a fancy medical word meaning I removed some of the bone at the end of the collar bone.

Q Doctor, before you go into that, can we show the -- you said there was an additional MRI. Can we pop that up?
A Oh, yes.
Q And then, if I can, we also have plaintiff's Exhibit 11. Is there any objection to -- Mr. Gulino?

THE COURT: Mr. Gulino?

MR. CLARK: Is there any objection to us

using this?

MR. GULINO: No. I have no objection to that, Your Honor.

MR. CLARK: All right. Also, if I can, Your Honor, I would like to put up plaintiff's Exhibit 11, which --

THE COURT: Okay.

MR. CLARK: So we have here as well the second surgery, Exhibit -- Exhibit 8.

THE WITNESS: This is an updated MRI that was done after the first surgery. Once again, we're showing the humerus. Again, (indiscernible) Mr. Washington Munoz. The date of this scan is January 12th, 2015. This is the humerus. This is the shoulder blade. This is that structure I told you before the acromion, and you can see there's some inflammation from where I had to remove some of the bone. That's not that important.

Here's the new problem. The tear that we saw before, this white structure that's not supposed to be there is still present and it's extended. It's gotten larger to the point that there's a lot of white signal in here. Now, this may not look so big, if you're looking at it from in the distance, but this is pretty significant.

Now, the good news is there's no -- again, that word retraction where the tendons pulled away. So when I saw this MRI and when we got the report from the radiologist, this is a high grade partial tear with inflammation and it could also -- just by looking at the MRI scan, this could even be a partial tear or this could be a complete tear without the retraction. It's impossible to say that from looking at the MRI just by and of itself.

BY MR. CLARK:

Q And then if you can -- now, you said it was a -- it was a new injury. We're here today to talk about the injuries related to the incident. So what you call a new injury, in your opinion, did you conclude that that was related to the incident of June 25, 2013?

A What I should say this is a new finding. I think this is an extension -- in fact, I know this is an extension of the tear that was there previously. It has gotten worse despite the arthroscopic surgery that I did.

Q And in terms of finding out what made it worse, did you read -- you're aware of the physical therapy treatment he had?

A Right. He had been going through very extensive physical therapy, initially starting to regain motion.

But after motion is regained, strength is important to try to get back to normal activities. After going through the strengthening exercises, after going through a program called work hardening, which is simulating work and actually, he did return to work briefly, he came back much worse. I think that contributed -- that extensive exercise program, that extensive rehab program contributed to the worsening of the problem.

Q Okay. Yes.

A So on -- in July, 2015, I had to perform a second surgery. As I said, this -- there was an open incision. This is about two inches long, and I completed -- I did an even more extensive decompression. This shows a tool called an osteotome. That's a nice kind of a word for a chisel, removing some more of the bone and doing the same thing to the edge of the collarbone.

The reason that's done is that the collarbone can contribute to crushing on the ner-- on the rotator cuff and can be painful, so we removed that, the same type of instrument, a chisel.

This depicts the tear. Now, the tear was not retracted. It was not pulled away, thank goodness, so it made it possible to repair it what we call

anatomically, actually put it back where it's supposed to be and we used something called suture anchors. They're 2.5 or 3.5 metal screws that are impacted into the bone. They're attached to stitches, which basically allow us to sew the tendon back to the spot where it's supposed to be. And these pictures really accurately describe what it looks like. This is the humerus again, the bone in the arm. This is the suture anchor, the big screw with the sutures, and this is the tendon back in place.

Q And just taking a look at plaintiff's Exhibit 31, is this consistent with the scar that you would expect from that surgery?

A Yes. That's it.

MR. CLARK: Okay. I would like to now move --

MR. GULINO: No objection. No. I told you that.

MR. CLARK: So P-31 in evidence. I would like to move P-31 into evidence.

THE COURT: There's no objection?

MR. GULINO: Yes. Yes.

THE COURT: P-31 in evidence without objection.

BY MR. CLARK:

Q Doctor, I note in your note of April 12th, 2014, you say that he still has a Popeye sign. What is that and how is that significant to you?
A If you're my age, you know who Popeye was. He was a cartoon character who had huge muscles and when he ate spinach, the muscles ballooned up. When the biceps tendon is ruptured, that -- you know, that tendon that attaches the biceps muscle to the bone, it allows the muscle to fall down into the arm and it looks like a big lump and we call that Popeye sign. That's a diagnostic test for a tear of the biceps tendon. It's very -- it's very obvious.
Q The rotator cuff tear to the shoulder that you talked about, it's your opinion or you concluded that that was also related to the incident?
A Yes.
Q Can you explain the discrepancy how in either the first MRI report it indicated not a full thickness tear but then later there was a tear? Can you explain the significance of that?
A Sure. Again, I apologize if I have to get a little long winded.
Q Because the -- because the -- the idea or the defense idea is that, well, it wasn't there on the first MRI or it wasn't visible when you did the first

surgery but then it showed up later, so it must not be related to the incident. So if you can just explain that.

A The first MRI that we looked at showed something termed an interstitial tear and that's confirmed on the radiologist's report also. Interstitial means it's inside the -- it's inside the tendon. So it's not something that would be visible from the outside even at surgery. There was some surface fraying and tearing of the rotator cuff tendon at that time, but I would not see the initial interstitial tear because it's inside, even though we're looking at the rotator cuff from the bottom and from the top.

The reason for attempting to do this arthroscopic surgery as the first surgical treatment and not repairing the interstitial tear is that if the arthroscopic surgery works, the rehab is much easier. The long-term sequelae, the long-term follow ups and problems in the shoulder from the injury and the surgery would be a lot less.

Unfortunately, as Mr. Munoz continued to rehab and to do what I asked him to, I mean, this was appropriate, that put extra stress on the already injured rotator cuff and it allowed this partial tear that was inside to extend to both surfaces, top and

bottom, and that became apparent when I did the second surgery. That's why I could see at the second time why I had to do the more extensive surgery as the second operation and that's why it's directly related to the injury. If he hadn't had the injury and had to have the first surgery, he wouldn't have had to have the second surgery.

Q And with regard to the shoulder injury and how he is in the present time and into the future, is the injury permanent? Is the injury permanent?

A Yes.

Q All right. And if you can just explain the conclusions that you have with regard to the permanency, the nature and extent of the injury that you treated for with regard to permanency and the permanent limitations that he has and will have as a result of the injuries from the incident?

MR. GULINO: Objection to form.

THE COURT: Objection to the form?

MR. GULINO: Does he have an opinion within a reasonable degree of medical certainty and then the basis of it? I'm --

THE COURT: I seem to recall there being a question that the doctor --

MR. CLARK: Yes.

THE COURT: -- would render whatever opinions he rendered within a reasonable degree of medical probability, and that was addressed at the outset. The objection is overruled.

MR. GULINO: Okay.

BY MR. CLARK:

Q If you can go ahead and explain that, the nature and extent that the injury was brought to permanency and the permanent limitations that you concluded with regard to the shoulder.

A Sure. I would characterize Mr. Munoz' surgical result -- those are words that surgeons use to evaluate our work. I would call it fair. It's not good. It's not great. He worked very hard before and after the second surgery. He's worked very hard with physical therapy up until now. I've seen him a -- last week, and he still has a lot of pain in the shoulder. His mobility is fair. I apologize. I can tell you what it was. He has pretty good mobility raising the arm forward, almost full normal. He has moderately -- actually, moderately severe restriction of what's called an abduction, lifting the arm to the side. Those are all quite painful when he does them. Unfortunately, his arm is weak, so trying to do any heavy work, any repetitive lifting, really, any

overhead activity, which is something that really can bother a person with a shoulder problem is something he's never going to be able to do.

I don't see that this shoulder issue, even though I've done the surgeries, is going to resolve to the point where he's going to get to the point of being able to do any even medium heavy labor, any heavy work.

Q And so what is your conclusion with regard to whether or not he can probably return to his prior employment as a Union plasterer mason?

MR. GULINO: Objection to form. No foundation.

THE COURT: Do you want to respond?

MR. CLARK: I think the expert did lay a foundation.

THE COURT: Overruled.

BY MR. CLARK:

Q You can go ahead.

A A person who has a serious problem with the shoulder will have a lot of difficulty and probably find it impossible to perform repetitive overhead activities. I say "overhead," I don't mean reaching up to the light bulb, but anything above what we call 90 degrees approximately here. So anything that he's going to have to do, -- you know, maybe once he can go

into his kitchen and unscrew and put the light bulb in, although it will probably hurt him. To go back and try to do any heavy work, repetitive up and down on walls, up and down on ceilings, it's not going to happen. It's impossible.

Q Okay. And just briefly, did you also conclude that he sustained a back injury as a result of the incident of July 25, 2013?

A Yes.

Q Okay. Can you just please briefly describe the nature and extent of that without going into all the appointments and treatments, the nature and extent of the treatment?

A Sure. Well, as I said, the first day I saw Mr. Munoz, he was complaining of pains in his lower back. He had positive physical findings throughout with tenderness with limitation of mobility. He did go through physical therapy for his back, which sometimes helped and sometimes didn't. When I last saw him, actually, he was still having a lot of pain in his back.

He had limitation of motion, difficulty bending. He had had an MRI done of the lumbar spine. It was done at St. Barnabas in Livingston in 2016, and there was two findings.

Q Doctor, if I can just put this up. This is plaintiff's Exhibit 12.

MR. GULINO: No objection.

BY MR. CLARK:

Q So if you want to use that as well, you can as well just to --

A Sure. By way of anatomy, this is an MRI of the lumbar spine, the lower back. Again, we're looking at the inside of the body. This is an artist's rendition. It's accurate. This is a copy of what the MRI looked -- this is a copy of the MRI. This is the front of the body. This is the back of the body. Each of the vertebrae has a number. The vertebrae are the bones in the spine, so the lumbar vertebrae are L1, 2, 3, 4, 5, and this is called the scrum. It's where the spine blends into the pelvis.

There's a small disk protrusion at what's called L5/S1, the very bottom part of the disk. Disk protrusion means that a portion of the disk material is pushing out of place and it's irritating some of the small nerves in the back, and that can cause pain.

Q Okay. And the injury -- and you're still treating him for that injury?

A Yes.

Q All right. And, now, we're not going to go

through all the medical records and all that, but just in sum, with regard to the things you reviewed, is it -- is it a fair estimate that he's had about 39 or 40 doctor visits with you over the last three years or so?
A Yes.
Q Okay. And we have all the -- we have all the physical therapy records here as well. Is a fair estimate about 110 physical therapy visits, without going through each one and counting them up?
A Yes.
Q Now, I have here plaintiff's Exhibit 33. You've had a chance to go through these?
A Yes.
Q Okay. And what are those?
A These are the medical bills for Mr. Munoz' treatment related to the injury of June, 2013.
Q All right. And are those medical bill amounts that you've gone through, do they appear to be reasonable?
A Yes.
Q And do they reflect for treatment that was necessary to treat the injury from the incident?
A Yes.
Q Okay. And what is the total amount of the medical bills demonstrated there?

MR. GULINO: I renew my objection, Your Honor.

THE COURT: Overruled.

THE WITNESS: The total is $104,671.14.

MR. CLARK: And I would like just formally to move them into evidence, but we can deal with it later.

THE COURT: Deal with it later.

MR. CLARK: Okay.

BY MR. CLARK:

Q And just -- is the back injury that you talked about a permanent injury?

A Yes.

Q And you also -- you gave in your report -- just let me briefly have your report. There was an estimated cost of future treatment. Do you recall that in your report?

A Yes. I did.

Q And what was that estimate and please give us the basis for it.

A I estimated -- and this is a rough estimate -- approximately $25,000 future treatment. As far as the shoulder is concerned, at this point, further physical therapy is not probably necessary right now, but it's certainly, as he goes forward, it may be necessary in the future. As far as the -- and I would say there is

some chance of -- the problem with a rotator cuff tear that's repaired surgically is that there's a higher incidence of a reoccurring tear. He's more vulnerable to any further trauma that might tear it again. I hope this doesn't happen, but further surgery is a possibility. I think it's a small possibility but not zero.

As far as the lower back is concerned, I've -- he hasn't had these done, but we have talked about pain management for the lumbar spine, what we call epidural injections. That's spinal injections of cortisone into the spinal column. I don't do them personally, but a good pain management doctor could put a cortisone injection into this area and try -- the cortisone relieves the inflammation and can help control pain. Those would probably be pretty expensive with the anesthesia fees, with the pain management doctor's fees, and the surgical fees.

Q And then just, finally, working off the brief report of December 27 of 2016, you had the opportunity to look at the defense medical expert report?

A Yes. I did.

Q All right. And as far as you understand it, did that doctor treat Washington Munoz or just see him one time?

A I'm sure he did not treat Mr. Munoz, and I believe he only saw him one time.

Q Okay.

A To the best of my knowledge.

Q And after you reviewed that report, did that change your opinions?

A No. Not in any way.

Q And why not? If you can just briefly explain.

MR. GULINO: Objection. Out of the scope of the report. May we approach?

(Discussion at side bar)

MR. GULINO: My objection, Your Honor, is based upon the fact that the report doesn't explain why he didn't change his opinion. All he did (indiscernible) conclusion.

THE COURT: Mr. Clark, your response?

MR. CLARK: The response is that the four corners rule does not require the testimony to be choreographed in the report. It just requires to put fair notice on the defense of the issues to be discussed and under the MC CALLA (phonetic) case, the parties can give the logical predicates for it. I forget the other phrase, but the logical predicates for and conclusions leading from what is in the report. So

I think it fairly meets the four corners rule.

THE COURT: It does. The objection is overruled.

(End of discussion at side bar)

BY MR. CLARK:

Q If you can just please explain why it did not change your opinion.

A Dr. Decter, basically, gave the opinion that the second surgery was not -- and let me rephrase that -- but Dr. Decter stated that the first surgery was related and necessitated by the accident of 2013, but he said that the second surgery wasn't and I just -- I explained before why it was, the fact that there was a non-visualized tear weakening the tendon and that with the post-operative treatment after the first surgery, the tear extended and became a full thickness tear necessitating the surgery that I had to do.

MR. CLARK: That's all I have. Thank you, Your Honor. Thank you, doctor.

THE COURT: Cross-examine?

MR. GULINO: Yes, Your Honor.

CROSS-EXAMINATION BY MR. GULINO:

Q Doctor, did you bring any notes with you today or a file?

A Yes.

Q Do you have it with you in front of you?
A Yes.
Q May I have a moment to look at it? May I approach?
THE COURT: Yes. Thank you.
MR. GULINO: Thank you. All right.
BY MR. GULINO:
Q Good afternoon, doctor. You've testified before, right, in a courtroom?
A Yes. I have.
Q Have you ever testified before on behalf of nay of Mr. Clark's clients?
A I do not believe so. No.
Q When you first saw Mr. Munoz, would it be fair to say that he was sent to you by Mr. Clark's firm?
A I don't think so. In fact, I'm sure he wasn't.
Q How did he come to see you then?
A My -- he was hurt at work, and he was referred through that.
Q Okay. Now, when -- did you ever learn the specifics of his accident?
A I learned the specifics of the injury from what he told me.
Q And when a patient comes to you for the first

time for a consultation, would it be fair to say that you depend upon that patient to tell you the full, complete, and truthful version of either their pain or how an accident occurred?

A I would be hopeful the patient would be truthful to me. Yes.

Q Because in order for you to properly treat them, you need to know or diagnose them -- you need to know what caused it, what are the effects, and how you're going to, hopefully, take care of them, right?

A To do effective diagnosis and treatment, I would need to know the condition of the patient when I see them. Knowing what caused it may or may not be important. Knowing what the effects of the treatment, of course, would be important.

Q Now, the shoulder itself, would you agree with me that the shoulder is probably the most flexible joint in the human body?

A Yes. It is.

Q Because we can raise it over our heads, right?

A Yes.

Q We can push things using our shoulder, correct?

A Yes.

Q It helps us to pull things. Does it not?
A Yes.
Q It helps us to lift things off the floor, correct?
A Yes.
Q We can twirl it around, right?
A Right.
Q It has a lot of stress on it. Doesn't it?
A Yes. It does.
Q And you gave an opinion before about Mr. Munoz' ability to return to work. What did he do for a living?
A I believe he was a construction and plasterer.
Q What particular part of construction did he do?
A I'm not sure.
Q If I were to tell you that he was a stucco painter in which regularly he would carry 60 pounds of liquid in a bucket and that for hours a day, he would overhead activities, would that be something that you would want to know when the patient comes in and you're trying to ascertain what is the cause of their complaints?
A That wouldn't really be germane to the treatment at that point.

Q I'm not talking about treatment. I'm talking about the cause.
A It might be germane.
Q Okay. And do you know the term, repetitive stress activity?
A Yes.
Q And can you tell the jury what that is?
A Repetitive stress activity is a term that can be used to describe an injury that's caused by repetitive use or a problem that's caused by repetitive use. I don't know if it would be called an injury or not.
Q Swimmers get repetitive stress on their shoulders, correct?
A Yes.
Q Painters, right?
A Probably.
Q Baseball pitchers?
A Yes.
Q Okay. And when he came into you and he gave you his complaints, the left shoulder was fine, right?
A Yes.
Q And when you look at the right shoulder, you found a rupture of the proximal biceps tendon, correct? We talked about -- you talked about that before, right?
A Yes.

Q Okay. And what is that used for, the biceps tendon?
A What is the biceps tendon used for?
Q What is it used for? What is its use?
A The biceps is used for two -- the biceps in the shoulder is used for two functions. It helps to elevate the arm. The biceps muscle also has a large tendon that's attached into the elbow that's vital for a function called supination, which is turning the arm outward, turning -- you basically turn the forearm, so that the palm is facing up.
Q So, technically, it wouldn't affect too much, if you were taking something or rubbing something along the wall? It would affect it if you were using a screwdriver, right?
A It would affect it if it -- it would affect both. As I said, it adds to the strengthening of lifting the arm, although it's not the primary muscle that does that work. It would have more of an effect on the lower arm, the forearm.
Q Now, when he came to you and you took his history, you performed an examination, correct?
A Yes.
Q And would it be fair to say that there were three types of ways we can diagnose somebody? One is a

clinical examination, two is a film study, and three is an arthroscopic procedure? If you wanted to look at someone's joint, for example, shoulder?

A Yes. That's true.

Q And so your clinical examination of Mr. Munoz is geared towards finding his limitations, correct?

A Yes.

Q And you're trying to figure out what's wrong with him, right?

A Yes.

Q And would it be fair to say that, sometimes, when you try to figure out what's wrong with a patient after a clinical examination, you're still not sure. So what you do then is you order a film study, such as an MRI, correct?

A That's correct.

Q All right. And that was done in this particular instance. Wasn't it?

A Yes.

Q Right? Okay. Now, when you saw him the first day, which was in July 11th, about three weeks after the accident, two weeks after the accident, you also reviewed medical records from the Center for Occupational Medicine at Hackensack University. Did you not?

A Yes.

Q And as a matter of fact, you made reference to that in your report. Did you not?

A Yes. I did.

Q And would it be fair to say that when you referenced that in your report, the only two complaints that he made, according to your interpretation of that record on the two dates that he went there, 6/26 and 6/28/2013, was upper back strain and right biceps strain. Is that correct?

A That's correct. That's what their records said.

Q Now, --

MR. CLARK: I'm just -- I object to that. And (indiscernible) of the record. It's a little different. I object to that question.

THE COURT: Okay. You can go back on redirect to the extent it says something different according to you.

BY MR. GULINO:

Q Rotator cuff is a very (indiscernible) --

A Yes. Usually.

Q And you did a fellowship in 1986/1987 or 1987/1988, did you not, in spine surgery?

A '86/'87 spinal surgery. Yes.

Q Would it be fair to say, you still perform

spine surgery?
A No.
Q Not anymore?
A No.
Q Have you performed examinations of litigants on behalf of defendants?
A Yes.
Q And have you also testified on behalf of plaintiffs?
A Yes.
Q Have you ever worked for a company called Exam Works?
A Yes.
Q Have you done examinations for them on behalf of defendants?
A Yes.
Q Now, -- so you can go back to your -- the first report, if you don't mind. You can use it, if you would like. So we'll look at your July 11th, 2013, report and you indicated that the plaintiff had good rotation. Do you want to show the jury what good rotation means? It's on the second page, I believe, of your report, doctor, on the top.
A Yes. Rotation is reaching behind the head and reaching behind the back. This is rotation. Yes. It

does say good.

Q And you note his rotation is good, correct?

A Yes.

Q So if he had made any complaints to you, you would have made a notation to that effect, right, concerning rotation?

A Yes.

Q Now, an equivocal impingement sign, why don't you tell the jury what that means.

A We were talking about impingement before, where the rotator cuff, when elevated, gets caught between the bones -- the humerus and the bone of the shoulder. An impingement sign is the doctor elevating the arm and rotating the arm forward. It can be done with the arm to the side or the arm in front. When that happens, that brings the rotator cuff under pressure and if a patient complains of pain, that's what's termed a positive impingement sign. That's a sign for a rotator cuff problem.

Q What if it's equivocal? What does that mean?

A That means he was having so much pain at the time I did the first exam, I couldn't tell whether it was -- he was having pain from what I did or whether it was just from the injury itself.

Q Now, there was one test that you performed on

him in your clinical examination. That's called a drop test, correct?

A Yes.

Q And do you want to tell -- tell the jury what a drop test is.

A If the examiner, the doctor holds the -- whips the arm passively and carefully lets go, the arm might fall to the side and that would be a sign of a ruptured rotator cuff.

Q And you performed that test on him. Did you not?

A Yes.

Q And when you performed that test on him, the test was negative, meaning he was normal on the drop sign, right?

A Yes. Of course.

Q Which at that time indicates there's no rotator cuff problem.

A That's -- that's a possible indication that there's not a complete rupture of the rotator cuff. No test is 100 percent accurate, and it would not be a sign that would say, there's no partial tear or rotator cuff tendonitis or impingement.

Q Well, let's put it this way. If the drop sign was positive, would it be fair to say you would

opine and say, you know what, he's got a rotator cuff tear?

A I would be much more suspicious of a rotator cuff tear, if that were true. Of course.

Q So, now, after that, -- and you wanted to have an MRI done, correct, because you still try to figure exactly what's going on, right?

A Yes.

Q And he was sent for an MRI at some point, correct?

A Yes.

Q And it was an MRI of the right shoulder, right?

A Yes.

Q Now, you wanted to at the end of your first report, you wanted to rule out a rotator cuff tear. Didn't you?

A Yes.

Q Because that's some serious stuff, right? You wanted to make sure -- when you say, rule out, I want to make sure that he does not have a rotator cuff, so you ordered an MRI, correct?

A Yes.

Q And you had the MRI done. You not only looked at the radiologist report -- and this is

referring to your August 9th, 2013, report. You also looked at the MRI yourself. Did you not?

A Yes.

Q And, now, we put them on a CD just as you have them here and you can look at them on a screen, correct?

A Yes.

Q Now, the MRI thought that there was tendonitis and a partial tear without retraction, correct?

A Yes.

Q And tendonitis is something that occurs in over use. Does it now?

A It can. Yes. That's one of --

Q Like tennis elbow, right? It's like a tendonitis. Tendonitis is in the shoulder. Is it not on the MRI?

MR. CLARK: Judge, I just object to that. It's like a triple compound question.

THE COURT: Yes. Re--

MR. GULINO: I'll withdraw the question. Thank you.

THE COURT: Thank you.

BY MR. GULINO:

Q The tendonitis that was found on the MRI had

to do with his right shoulder, correct?
A Yes.
Q Okay. And does the tendonitis also indicate inflammation or can inflammation be a product of the tendonitis?
A Tendonitis is inflammation.
Q It is inflammation? Okay. Now, you talked before during direct examination. We used a film, but we don't have to look at the film study. I want you to look at the CAT -- the MRI report of 7/19/13, which you both looked at the report and you looked at the film.
MR. CLARK: Judge, just briefly.
THE COURT: Side bar?
MR. CLARK: Yes. Just briefly.
(Discussion at side bar)
MR. CLARK: I spoke to the (indiscernible) the single abnormality with the radiation from stomach cancer has nothing to do with the finding of the back and I have made that in limine motion that stomach cancer shouldn't come in and radiation. We talked about it. It would just be the single abnormality. He can talk about that. But linking into radiation and stomach cancer, we had made that motion and I just want to -- I just want to ask that we stay away from that. I don't have any problem with the single abnormality,

but saying radiation and cancer. Thank you.

THE COURT: Well, the cancer part it, you know that you're limited.

MR. GULINO: I was wondering why he didn't bring it out on direct then and say that it has nothing to do with it.

MR. CLARK: Judge, how about radiation, that he had radiation therapy because that's the equivalent of saying cancer because I think most people would equate that with cancer.

MR. GULINO: I'm not going to use it, Judge. I won't go into it.

(End of discussion at side bar)

BY MR. GULINO:

Q Okay. So do you have the report in front of you?

A Yes.

Q All right. And an MRI was taken of the right shoulder and that was taken on July 19th, 2013, which is less than -- less than a month after the accident, right?

A Yes.

Q All right. And the MRI says, the (indiscernible) humeral joint and the AC -- and did I pronounce that correctly -- glenohumeral?

A That's fine.
Q And AC joint are intact. The AC is the acromioclavicular, correct?
A Right. That's the joint between the collarbone and the shoulder.
Q And they're intact, right? No problems in there?
A Yes.
Q And there was impingement noted. Now, you talked before about impingement. That's when the tendons get sort of caught up in the bone, right?
A Yes.
Q And the person has a tough time moving the arm. Do they not? When they have impingement or at least it's restricted, correct?
A Sometimes, they do. Sometimes, they don't.
Q Sometimes, you hear a click or something or do you hear anything or feel something?
A Sometimes, you do. Sometimes, you don't.
Q Does it -- does it sometimes result in weakness, impingement?
A It can. Yes.
Q And is it -- is it the tendon that goes through the outside of the shoulder? Is that the one where you worry about when we talk about impingement?

A We worry about the biceps tendon and several of the rotator cuff tendons. Yes.

Q Okay. And with the impingement syndrome that they noted was -- withdrawn. The MRI showed a rotator cuff, didn't it, tear, the first one.

A The MRI report is partial rotator cuff tear. Yes.

Q Tendons and rotator cuff reveal a partial rotator cuff tear of the supraspinatus and infraspinatus portion, correct?

A Yes.

Q And so the supraspinatus is up here, right?

A Yes.

Q And the infraspinatus, is that the one back here?

A It's behind it. Yes.

Q Yes. Okay. Lower, right?

A Yes.

Q And there was no subacromial or subdeltoid bursa, glenohumeral you would see, right?

A Right.

Q And when you get fluid, would it be fair to say that that, a lot of times, is a sign of trauma in somebody, that something happened and the body creates this fluid?

A It could be a sign of trauma. Yes.

Q And -- and so the absence of fluid in that area would lead you to believe that there was no trauma to that part of the shoulder?
A No.
Q At least no impact?
A No.
Q Is it one of the things that would have led you to believe that if it was a trauma, it would be a slight trauma, if he didn't have any (indiscernible) --
A No.
Q Fluid is created by what, irritation?
A Yes.
Q And is the fluid also created by an impact?
A It can be.
Q Is it also created by a twisting, somebody's arm gets wrenched behind them, correct?
A It could be.
Q All right. And we didn't have any fluid in this instance in this MRI. Did we?
A No.
Q Now, you thought, still, that there might have been a rotator cuff tear because the MRI is telling you that it looks like there's some kind of rotator cuff problem, right?
A Yes.

Q And so the third part of our diagnosis is when we go in and we do a full operation, correct?
A Yes.
Q And you do an arthroscopic surgery, correct?
A Yes.
Q And an arthroscopic surgery is when you go in and you have a camera, right? Correct?
A Yes.
Q How many holes do you make, three?
A Two or three, depending on the separation.
Q Two or three and you go right into somebody's shoulder. Don't you?
A Right.
Q And what you're looking in, it's you and the camera in that shoulder, correct?
A Right.
Q And so you're the one -- I know you were assisted during the operation, I think, by Crystal Jackson. I'm not too sure.
A That's correct.
Q Okay. But you're the one who performed the surgery, correct?
A Yes.
Q And you were the one who used the camera to look into Mr. Munoz' shoulder. Is that correct?

A Yes.

Q Now, when you do an operation, would it be fair to say that there are requirements that you prepare an operative report, right?

A Yes.

Q And I don't know if it's a state law or a federal law, but there's some kind of a requirement that when you prepare that operative report, it has to be pretty accurate, correct?

A We would hope it would be accurate. Yes.

Q Just as professional pride would have you do it anyway, right?

A Right.

Q Okay. And you do these operative reports within a few minutes or maybe a few days of the surgery. Do you not?

A Well, usually the same -- usually, right afterwards.

Q Okay. Which would mean it would be more accurate than one you did a week later, correct?

A I don't think so. It would be accurate either way.

Q Now, you had a preoperative diagnosis. Did you not?

A Yes.

Q And can you tell the jury what preoperative diagnosis is? What is it?
A It's the diagnosis made before the operation.
Q I know it's not a guess, but is it your estimate as to what you think is wrong with the person?
A Yes.
Q And then you have a post-diagnosis -- post-operative diagnosis, which is your findings after you perform the surgery, correct?
A Yes.
Q All right. So what was your preoperative diagnosis before the surgery?
A Impingement syndrome of the right shoulder with chronic biceps rupture.
Q And do you want to tell the jury what the post-operative was after you performed the surgery?
A The same.
Q No mention of rotator cuff, is there?
A Well, in the findings, there is.
Q Findings have -- and you're going to go down and you did the surgery, correct?
A Yes.
Q And we'll go back to the findings in a minute. When you went into -- you went to one, two, three, four, five, six paragraphs in on the second

page, procedure and detail -- procedure and detail, -- do you see it? Okay. So the arthroscope was sent in and you looked at the glenohumeral joint. It was identified and -- correct?

A Yes.

Q And then you found mild to moderate degenerative change with softening and irregularity of the articular surface of the glenoid and humerus were noted, correct?

A Yes.

Q Degenerative. This acci-- your surgery was in October, about four months after the accident?

A Right.

Q And degenerative by medical definition means having to take place over a long period of time. Doesn't it?

A Usually. Yes.

Q And you found degenerative changes four months post-accident, correct?

A Yes.

Q Now, all things being equal then, what you found that was degenerative existed before June 25th, 2013?

A He had a little arthritis in his shoulder that preexisted the accident. Yes.

Q So you found that it preexisted?
A Yes. Yes. Obviously.
Q Okay. Now, the glenoid labrum was intact?
A Yes.
Q The biceps tendon, you said, is absent, correct?
A Yes.
Q Now, you chose not to do anything with the biceps tendon. Is that correct?
A Yes.
Q I'm not going to ask you could have something been done, but you just chose not to do it, right?
A That's correct.
Q All right.
A I felt that that was best for him.
Q And you had looked at the rotator cuff. Didn't you?
A Yes.
Q And I'm going to quote from your report. The rotator cuff was visualized and the articular was intact with no tears noted. Is that accurate?
A Yes. Absolutely.
Q And so when you looked in that time, there were no tears. Were there?
A On that side, on the bottom side of the rotator

cuff, there were no tears.

Q There were no tears in the rotator cuff when you looked that day, right?

A On the articular side. Yes.

Q Okay. And is that the side he complained of?

A What?

Q Was that the side that he complained of? Where is the articular side?

A I have to go into anatomy again. I apologize. The rotator cuff runs from the scapula, which is the shoulder blade, underneath the acromion, which is the point of the shoulder, into the humerus. It sits between two bones, the acromion, which is the bone at the point of the shoulder, and the humerus, which is the bone. We were looking at that before.

There's two -- orthopedists use two medical terminology to describe two sides of the rotator cuff, the articular side, which is the bottom of the rotator cuff, and the bursal side, which is the -- or the subacromial side, the side under the -- under the bone of the acromion, so that's the top side.

Q You then went down to the subacromial joint? Is that true? Right?

A Yes.

Q And marked, m-a-r-k-e-d, hypertrophy,

h-y-p-e-r-t-r-o-p-h-y, was noted of the bursa, correct?
A Yes.
Q Hypertrophy means too much of something?
A Right. Enlarged.
Q Too much of --
A It's enlarged.
Q It's enlarged. The bursa is enlarged. Is it not? Now, the bursa, is that near the outside or the top of the shoulder?
A That's the top of -- that's the upper -- it's on the upper side of the rotator cuff.
Q Is it between bones, the bursa?
A Yes.
Q And does it get a lot of stress during construction activity or painting activity or anything like that?
A It could. Yeah.
Q Sure. And when it gets a lot of stress on it, it starts to expand, swell, right?
A It can. Yes.
Q And is that what you found here?
A Yes.
Q Okay. And in order to take care of that, would it be fair to say that what you needed to do is you get a subacromial decompression?

A Yes.

Q And subacromial decompression is that you go in and you basically shave the bone that's near or around the bursa. Did you not?

A Yes.

Q The rotator cuff was clearly identified. There was fraying on the bursal surface, right?

A Yes.

Q And the fraying, rubbing, right? It wasn't a tear, correct?

A One could call it a tear. I think fraying is a more accurate word.

Q I understand that, but you didn't -- you didn't call it a tear in your operative report?

A That's true.

Q So there's no tear because if there was a tear, would it be fair to say that you would have put it in your operative report, the man has a rotator cuff tear?

A If there were a full thickness tear at that time and I specify that there's not, I would have put that in.

Q There is also a term, partial thickness tear, correct?

A Right.

Q And you didn't use that term?
A No.
Q Okay. So we don't even have a partial thickness tear there. Do we?
A Like I said way at the beginning, I didn't visualize a partial tear when I did the scope because it was interstitial.
Q You also did an acromioplasty?
A Yes.
Q And tell the jury what that is.
A Like we talked about before, we use 5.5 millimeter burr that shaves some of the bone down to allow better motion.
Q If I may. The acromioplasty, right here, referring to the demonstrative exhibit of your 10/21/13 surgery, this is the burr that you used, right?
A Yes.
Q And you're basically shaving away too much bone. Aren't you? You want to give this tendon and/or bursa, whatever is down there, some room to breathe, correct?
A Well, I'm not shaving away too much bone. I'm shaving away the right amount of bone.
Q Well, I'm not saying you -- I know you did the right thing, doctor. I'm just saying that you--

whatever was there was too much.
A Right.
Q How about that?
A That's right.
Q Okay. So you're trying to bring it back to where it's supposed to be, right?
A Right.
Q Okay. That's not indicative of trauma. Is it?
A No. That was probably there before the accident.
Q Okay. So that part of the surgery was there before the accident, right? Now, we also did a subacromial decompression. Did we not?
A Yes.
Q Okay. And that is where you take care of the bursa, right?
A Yes.
Q Okay. Now, how did -- what did he tell you how the accident happened? What did he say?
A He was -- he told me he was working on a roof. He stepped through a hole in the roof and landed on his right arm while carrying a heavy bucket.
Q So that would be the trauma that you would think would cause injury to the shoulder, to the need of anterior or the bursal excision or the subacromial

decompression?
A Yes.
Q Okay. Now, what if I were to tell you that there's testimony, and there was this morning, by a witness who was five feet behind him who said he never fell down? Would that in any way affect your opinion?
A No.
Q If he had no trauma to the shoulder or to the arm because he fell, would that affect your opinion?
A Is the question, if he had no trauma, would that affect my opinion?
Q Uh-huh.
A Yes.
Q Okay. And if he had stumbled and stopped and put down what he was carrying, would you agree with me that he didn't have any trauma to his shoulder?
A If we were -- if he was stumbling, if a heavy load pulled onto the shoulder, then, no, I would not agree with you.
Q Okay. Do you know if he had a heavy load in his right arm?
A I don't know.
Q And if he didn't have a heavy load in his right arm, would that affect your opinion?
A If he had a load of even a few pounds, that would

be sufficient to damage the shoulder.

Q If he had no load in the right arm, he stumbled, would that affect your opinion?

A If his -- if his arm -- if his arm were empty and he were carrying nothing, yes, that might affect my opinion.

Q Okay. So if the jury will find that he had nothing in his right arm and he did not fall to the ground, would you agree with me that the surgery that you performed on October 21st, 2013, was not related to the accident?

MR. CLARK: Judge, I would just object to that as to what the jury would find.

THE COURT: Rephrase your question.

MR. GULINO: Sure.

BY MR. GULINO:

Q If the jury finds that Mr. Munoz did not fall, --

MR. CLARK: Judge, I'm just --

THE COURT: So the objection is with respect to the question as it relates to that part of your question.

MR. GULINO: The last part of the question?

THE COURT: The first part of the question.

MR. GULINO: The first part of the question?

THE COURT: Yes. Rephrase it.

MR. GULINO: Oh, I apologize. I apologize, Your Honor.

BY MR. GULINO:

Q If it is shown or if he did not have a weight in his right arm and he did not fall to the ground but, rather, stumbled, would you agree to me that the surgery that you performed on October 21st, 2013, was not because of this accident?

MR. CLARK: Judge, I just object. It's a hypothetical that doesn't really match anything. It's not a proper hypothetical because it's being -- it's being tied to this actual incident.

THE COURT: The objection is overruled.

THE WITNESS: If there was no trauma, then what he's trying to say is probably correct.

BY MR. GULINO:

Q Okay.

A If there was trauma, he's wrong.

Q Thank you. Now, he came back to see you on October 31st, 2013?

A Right.

MR. GULINO: Judge, may we approach?

THE COURT: Sure.

(Discussion at side bar)

MR. GULINO: I don't want to bring the doctor back. It costs them money, but I'm going to be another 20 minutes. I don't know what time you close.

THE COURT: Well, we close at 4:30.

MR. GULINO: Yeah. I'm not -- I haven't even gotten to the second surgery. That's a big part.

MR. CLARK: Is there any kind of exception we can make? I know the doctor really wanted --

MR. GULINO: I mean, I'm willing to -- whatever you can do.

THE COURT: All right. Let me check with the jurors because we did tell them that they would be out of here at 4:30, so let me --

MR. CLARK: Thank you.

(End of discussion at side bar)

THE COURT: So to the jury, members of the jury, I indicated to you that our court date typically ends at 4:30. I'm being told that at least another 20 minutes or so and I don't know whether or not there will be any redirect after that. So the question for you is whether or not this presents a problem for any of you staying beyond the 4:30 hour. Anyone? Okay. I don't see any affirmative responses, so you can continue.

MR. GULINO: Thank you.

BY MR. GULINO:

Q You had office notes here on Halloween, how about that, October 31st, 2013. And do you see the fourth line, I'm going to read it to you. Let me know if I'm accurate. The findings of surgery were impingement syndrome of the right shoulder, intact rotator cuff, and chronic biceps rupture. Okay?

A Yes.

Q And he told you that he was going to go down and travel to Ecuador, didn't he, right after that?

A Yes.

Q And he was going to be away for three weeks, correct?

A Yes.

Q Now, when he returned to you on January 28th, 2014, the physical exam showed he had no acute distress, correct?

A Correct.

Q All right. Why don't we jump to April 15th, 2014. Now, you did -- you asked him if he could return to work and he said, no, correct?

A Yes.

Q And we go down to May 13, 2014. You performed some testing on him. Did you not?

A Yes.

Q Flexion and abduction. So you did a forward flexion test. Can you -- can you show the jury what that is?
A It's raising the arm forward. He had full motion.
Q And what's the best you can do? We -- withdrawn. We use degrees to measure. Do we not?
A Yes.
Q And what's the best in degrees you can do?
A 180.
Q And what did he have?
A 180.
Q All right. So he was the best (indiscernible) right?
A Yes.
Q At least on forward flexion?
A Right.
Q And on abduction, what is that?
A-b-d-u-c-t-i-o-n.
A That's lifting the arm to the side.
Q And he was like 165 degrees?
A Correct.
Q And the best you could do was 180?
A Correct.
Q Okay. So he was, I don't know, four percent off, right, five percent off, if you do it by

percentages?
A That's a good estimate.
Q Okay. And he also did internal and external rotation. What is that? Show the jury.
A Like we did before, external is putting the hand behind the head. Internal is reaching behind your back.
Q So he did this and he did this and it was excellent. Wasn't it?
A Yes.
Q Okay. August 12, 2014. Your physical examination showed no tenderness in the rotator cuff, correct?
A Correct.
Q And would it be fair to say, this is right now 14 months after the accident, correct, about 13, 14 months?
A Yes.
Q All right. And there is 180 degrees of forward flexion and abduction. Now, the abduction, he can do 180 degree, right?
A Yes.
Q With mild pain, correct?
A Yes.
Q He comes back in in October 6, 2014. He said

that he -- he attempted to return to work. He was not -- only able to stay there for a few hours, right?
A Yes.
Q And the left shoulder, full range of motion, correct?
A Yes.
Q All right. Now, this was October of 2014. How was the physical therapy going along? I mean, this is 14, 15 months after the accident and you write another report in November of 2014. How is he doing on the physical therapy?
A I think at that point, he was doing the physical therapy the way it was supposed to be done.
Q Okay. And you're sure? Now, where was he going? There wasn't a gap for months and months where he didn't go to physical therapy?
A I don't think so.
Q Okay. Where was he going for physical therapy?
A Kessler down in Newark, Ferry Street.
Q So he comes back to you in or about November and you do forward flexion, again, and abduction with pain, but it's still 180 degrees and it's full rotation, correct?
A Yes.

Q And positive impingement sign, correct?
A Correct.
Q Meaning that he's got some kind of impingement?
A Yes.
Q And the drop sign is negative?
A Correct.
Q That means there really shouldn't be a rotator cuff tear, correct?
A It's a sign that there might not be. There still could be.
Q Right. So if I were to tell you that -- withdrawn. Withdrawn. So, now, we're going to get to about three months later, you're going to -- he comes in and he wants an MRI, right, because he's making complaints to you. You send him for another MRI. I misspoke. I know he doesn't want the MRI. You sent him for an MRI, right?
A Yes.
Q All right. Now, this is in January of 2015, which now is, I don't know, 6/13 of '15, 18 months after the accident give or take.
A It's a year-and-a-half after he got hurt, right.
Q Year-and-a-half, right? Okay. And there's an MRI done and the findings -- and you reviewed both

the report and the film. Did you not?
A Yes.
Q And film shows that there is severe acromioclavicular joint arthrosis with capsular hypertrophy, right? He's got too much of something?
A Right.
Q And the severe acromioclavicular arthrosis is what?
A Arthritis.
Q Huh?
A Arthritis.
Q All right. Now, edema of the distal clavicle, what is the distal clavicle?
A It's the end of the collarbone.
Q Is identified. Isn't it?
A Yes.
Q And what is edema?
A Swelling.
Q Swelling? Okay. Is it fluid helping the swelling?
A It could be. Yes.
Q All right. Well, doesn't that MRI also say right after that sentence, there was fluid noted in the subacromial subdeltoid bursa. Where is that?
A That's the bursa we looked at there.

Q Where you did your surgery on?
A Yes.
Q Okay. Which wasn't there back in October, 2013, correct? You didn't have fluid in that area when you did your surgery?
A Well, I pumped fluid in when I did the surgery. Yes.
Q Before your surgery, there was no fluid there? How is that?
A That's correct.
Q Okay. Okay. You go to the second paragraph, there's a high grade partial tear of the supraspinatus tendon affecting the undersurface, right? It's up here? You've got a tear?
A Right.
Q It wasn't there before. Was it?
A No.
Q You never saw it before in any film studies?
A No.
Q You never saw it in any of your surgeries, correct, the one surgery you performed?
A That's correct.
Q Okay. The subscapularis tendon is thickened, and where is the subscapularis tendon?
A That's the front of the shoulder.

Q And that's thickened and a thickening is indicative of a trauma?
A It could be from trauma. It could just be from just the physical therapy, from using it.
Q Trauma is a possibility?
A Yes.
Q The next paragraph, mild atrophy. What is atrophy?
A Shrinkage.
Q Of the superscapulus (sic) muscle. Where is the superscapulus muscle?
A It's the subscapularis. It's the same one as we just discussed. It's the front of the shoulder.
Q And there is small joint effusion. Is there not?
A Yes.
Q Now, possible small Hill-Sachs, H-i-l-l - S-a-c-h-s, deformity. Is that indicative of a separated shoulder?
A It could be indicative, if it were there, of a dislocated shoulder.
Q But on the MRI, when you see the term Hill-Sachs deformity, you're saying might be separated shoulder, correct?
A We would say dislocated, not separated.

Q So we go down to the impression and high grade partial tear, supraspinatus tendon, correct?
A Right.
Q Small joint diffusion, correct?
A Right.
Q Acromioclavicular joint arthrosis with bone marrow edema likely post-traumatic with narrowing of the subacromial space, correct?
A Right.
Q Which means, at least, the MRI or the radiologist says, it looks like trauma, recent trauma of this man's shoulder 18 months after his accident, right?
MR. CLARK: Judge, objection. That's complete hearsay that a radiologist --
THE COURT: With respect to the radiologist, the objection is sustained.
BY MR. GULINO:
Q Trauma means an accident, correct?
A That's one type of --
Q Of some sort, right?
A That's one type of trauma, right.
Q What else do we have? What other kind of trauma?
A As we discussed before, the repetitive trauma of

the physical therapy and the work --

Q Or -- or --

A And --

Q Going back to work?

A The work --

Q Or going back to work, repetitive stress, could that be trauma, too?

A It could be. Yes.

Q Okay. Now, likely post-traumatic with narrowing of the subacromial space. Now, you read the report, correct?

A Yes.

Q And did you call the radiologist to say, I don't agree with you, I've looked at these films?

A No.

Q Okay. I'm almost done. Okay? I'm going to get to your surgery, and then I'm going to get you out of here. So why don't we do this. You're now going to do surgery July 24th, 2015, right?

A Yes.

Q And that is 25 months after the accident, two years, correct?

A That's correct.

Q And you are -- your preoperative diagnosis is torn right rotator cuff.

A Yes.
Q And an AC arthritis. Is that the acromioclavicular arthritis?
A Yes.
Q And arthritis is a congenital type condition, correct?
A No.
Q What does it come from? How about degenerative condition?
A Arthritis is a degenerative condition.
Q All right.
A It can be age related or it can be due to trauma.
Q It takes a long time for somebody to get it. That's what it means, right? Degenerative? Having to take -- having to take place over a long period of time?
A Over a period of time. Yes.
Q Well, it's not two dates, correct?
A No.
Q All right. Degenerative is not two weeks, correct?
A No. But it could be two --
Q And it's not two months?
A It could be two years.
Q Okay. It could be two years, correct. Just

like in the first --

MR. CLARK: I'm sorry. I thought the witness was about to say something. I believe you said something and you got cut off.

THE WITNESS: I said, it could be two years. I was going to say, it could be a year.

BY MR. GULINO:

Q It could be two years, right?

A Yes.

Q All right. So he has a recurrent -- withdraw that. You go back in. Why don't you go on the second page, doctor. Hypertrophy of the AC joint with degenerative changes of the AC joint were noted. Hypertrophy of the AC joint is too much bone?

A Yes.

Q Okay. He's got too much bone. Again, he has too much bone like he did the first time, right?

A Right.

Q First surgery?

A Right.

Q Okay. Because either he keeps swelling or he keeps using it, one or the other, correct?

A Or it has progressed because of his initial injury.

Q Now, but if he's not using the sur-- his

shoulder working like he was before all those years as a laborer, -- or maybe he was. Did he go back to work?
A I believe he went back to work very briefly.
Q So you performed another acromioplasty?
A Yes.
Q You went back in again to do the same thing you did the first time, right?
A Yes.
Q Because there's too much bone there, right?
A Right.
Q Okay. Now, I'm sure the first time you operated on him, you took the amount of bone out you were supposed to, correct?
A I hope so.
Q Something came back. Didn't it?
A Yes.
Q Okay. More bone, right, which is not caused by trauma, correct, not 18 months after your first surgery?
A Probably not.
Q Okay. And you went in and fixed his rotator cuff, correct?
A Correct.
Q Or repair?
A Correct.

Q Which was not there the first time in the first surgery?
A Correct.
Q I'm almost done. Oh, you gave an opinion before about whether or not he could go back to work. Do you recall that?
A Yes.
Q Did you know he's got a commercial driver's license?
A No.
Q Okay. He had a commercial driver's license. Would you agree with me that he could go back to work as a commercial driver?
MR. CLARK: Judge, objection. It's a hypothetical -- it's a hypothetical without sufficient facts. Having a license isn't the only requirement, so I would object. It's a hypothetical without facts.
THE COURT: So the objection is sustained.
MR. GULINO: Okay.
BY MR. GULINO:
Q Do you know what a commercial truck driver does? Drives a truck, right?
A Right.
Q Okay. And if you -- would you -- if I were to -- why don't we do this. If Mr. Munoz is driving a

truck in which he has to use the steering wheel and that's all he does or drives a van and that's all he has to do or drives a cab and that's all he has to do, would he be able to do that after your second surgery?
A Maybe yes, maybe no. That would have to be specifically tested.
Q Okay. Now, I want you to assume that Mr. Munoz goes back to driving a truck. I want you to assume that Mr. Munoz does not have to do loading or unloading. I want you to assume that he drives a truck that's an automatic, so he doesn't have to shift gears. Now, I'm going to ask you, do you have an opinion within a reasonable degree of medical certainty whether he can go back and do that job after your second surgery?
A No.
Q Now, is it because you didn't fix him?
A No. You asked me the question, do I have an opinion. I said, no. I don't have an opinion.
Q And I said, is it because you didn't fix the problem?
A Is it because -- is the reason that I don't have an opinion to answer your question because I didn't fix the problem? The answer to that question is, no. It's because, as I said before, I think that would have to

be tested.

Q You would what?

A It would have -- to get back to that specific job, operating a motor vehicle, I would think, would have to be tested specifically. I don't know the answer to that question.

Q Well, if I were to tell you he's got a commercial driver's license in his -- would you accept that?

A What?

Q He has a commercial driver's license. Who would he have to be tested by? If you can't answer the question, that's fine.

A If a patient came to me --

Q And --

A -- who had a shoulder injury and I was asked, can he operate a motor vehicle safely, I would say, no, I don't know the answer.

MR. GULINO: Thank you, Judge. Thank you. Thank you, doctor.

THE COURT: Redirect?

MR. CLARK: Yes, Judge. I'll be as brief as I can. All right? I want to get through this quickly.

REDIRECT EXAMINATION BY MR. CLARK:

Q Just real quick, doctor. Do you recall there

was cross-examination about reviewing the records from the Center for Occupational Medicine? Do you remember that?

A Yes.

Q And then there was a question as to whether or not he really sustained a trauma. Do you remember that?

A Yes.

Q Okay. And just briefly, Page 1 of the medical records, what does it indicate in the diagnosis with regard to the arm?

A Up here is Page 1?

Q Yeah.

A Upper back strain, right biceps tear.

Q And then what is noted in there? Now, you reviewed these records in connection with writing your report, correct?

A Yes.

Q All right. And what is noted there with regard to the mechanism of the injury?

A At the time of the injury, the patient also had his tools on his shoulder and in his hand. He states that his tools may weigh approximately 40 pounds.

Q And how about here in the same note from 6/26/13 from that provider in the blue with regard to

the mechanism of the injury?
A Patient verbalized that when he fell into the hole, his tool belt fell down his right upper arm. Noticed a bulge on his biceps area that was not there before.
Q And the bulge on the biceps area is what?
A It's the Popeye sign. It's the sign of the acute tear of the biceps.
Q All right. And is that from trauma or is that from being a laborer?
A That's traumatic.
Q And in all the materials you reviewed, was there any history of injury to the shoulder or any history of trauma injury to the shoulder before September 25 of '13?
A Not that I'm aware of. No.
Q Okay. And same with regard to the back?
A That's correct.
Q And just to sum it up, in your report, you -- just what did you note in the summary section there in the blue?
A Mr. Munoz sustained a partial rotator cuff tear of the right shoulder with impingement that necessitated two surgical procedures. He has a right biceps tendon rupture. He has chronic thoracic and lumbar sacral

sprains with an MRI showing L5/S1 disk herniation. He's had treatment for almost two years, continues to have significant symptomatology substantiated by objective findings. The prognosis for returning to unrestrictive duties in his previous job as a construction worker is guarded at best.

Q Okay. And what did you say there about that being caused by the incident?

A These are causally related to the work incident of June 25th, 2013.

Q All right. And is anything that was discussed on cross-examination, does anything change that opinion, your bottom line opinion?

A No.

Q Okay. And just real quick, the thing about whether or not there was a full thickness tear and you said, it was an interstitial tear. Can you just explain that briefly? That's my last question I have for you, what you had meant by the interstitial tear in terms of --

A The interstitial tear that was noted on the original MRI before any surgery is damage to the tendon, inside the tendon. It's in the middle, so it would not be visualized when I look with the arthroscope from the top to the bottom.

Q Okay. And the injuries and treatment for both surgeries you causally relate to the incident?
A Yes.
MR. CLARK: All right. No further. Thank you, Your Honor.
RECROSS-EXAMINATION BY MR. GULINO:
Q Doctor, tears are caused by wrenching. Aren't they?
A What?
Q Wrenching, movement, quick movement, rotator cuff tears or repetitive stress?
A Those are some of the causes.
Q They're not caused by trauma like that. Are they?
A A fall onto the shoulder could --
Q Rotator cuff tears are not caused normally by a trauma or direct hit on your shoulder?
A Yes. They could be.
Q They could be, right? But they're not ordinarily. Are they?
MR. CLARK: Judge, objection.
THE COURT: He's answered your question. Move on, please.
MR. GULINO: Thank you, doctor.
THE COURT: All right. Thank you, sir. You

may step down.

THE WITNESS: Thanks, Your Honor.

THE COURT: All right, members of the jury, that's all we have for you today. Thank you for your patience and having accommodated the end to this witness, and we'll see you tomorrow morning at 8:30. Please get home safely and, remember, don't talk about the case. All right? See you tomorrow morning.

(Jury excused for the day)

MR. CLARK: Judge, I just want to thank Your Honor and your staff and defense Counsel for accommodating that. That would have been a big problem.

THE COURT: Sure. All right. So tomorrow --

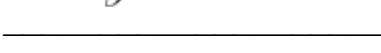
MR. GULINO: I forgot half of my cross. What are we doing tomorrow? Who are you going to call, guys?

THE COURT: Do you want to go off the record?

(Day's proceedings concluded)

CERTIFICATION

I, SHERRY M. BACHMANN, the assigned transcriber, do hereby certify the foregoing transcript of proceedings, time from 9:12 a.m. to 10:31 a.m., from 10:48 a.m. to 12:31 p.m., from 1:38 p.m. to 2:41 p.m., and from 3:07 p.m. to 4:54 p.m., is prepared in full compliance with the current Transcript Format for Judicial Proceedings and is a true and accurate non-compressed transcript of the proceedings as recorded.



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