THE COURT OFFICER: All rise, jury entering.

(Jurors entered the courtroom.)

THE COURT: Be seated. Good afternoon. I hope everybody had a good weekend. We will now proceed.

You may call your next witness.

MS. BORDEN: Thank you, your Honor. At this time, Plaintiff calls Dr. Gabriel Dassa.

THE COURT CLERK: Please raise your right hand, Doctor.

DR. GABRIEL DASSA, a witness called on behalf of the Plaintiff, having been first duly sworn, took the witness stand and testified as follows:

THE WITNESS: I do.

THE COURT CLERK: Please have a seat.

In a nice loud, clear voice, state your name and business address record for the record.

THE WITNESS: It's Gabriel Dassa, D-A-S-S-A. The address is 625 East Fordham Road, that's Bronx, New York, 10458.

THE COURT: Good afternoon, Doctor.

THE WITNESS: Good afternoon.

THE COURT: You may inquire.

MS. BORDEN: Thank you, your Honor.

DIRECT EXAMINATION

BY MS. BORDEN:

Q. Dr. Dassa, are you licensed to practice medicine in the State of New York?

A. Yes, I am.

Q. And when did you become so licensed in?

A. In 1992.

Q. All right. And can you please tell the ladies and gentlemen of the jury about your medical educational background?

MR. LAQUERCIA: Excuse me, your Honor. On behalf of the defendant, we concede that Dr. Dassa is a board certified orthopedic surgeon and his competent to testify in this case.

MS. BORDEN: I would still like the witness to answer.

THE COURT: Okay. You may answer.

A. I completed the premedical training at Fordham University in the Bronx, New York. Upon completing that, I was accepted to medical school at New York College of Osteopathic Medicine. Upon completing that medical school training, I was accepted into an orthopedic surgery residency program at the Albert Einstein College of Medicine at Bronx Lebanon Hospital.

Prior to commencing that, I did a year of internal medicine training as an internship in Coney Island Hospital in Brooklyn, New York, and then a year of general surgery training

at St. Barnabas Hospital in the Bronx. And then four years of orthopedic training at Albert Einstein College of Medicine and Bronx Lebanon Hospital.

Upon completing that, I applied for a fellowship in hand surgery which I was accepted to and completed at New York University Medical Center.

Q. All right. And are you board certified?

A. Yes, I am.

Q. And what are you board certified in?

A. I'm board certified in orthopedic surgery.

Q. And what is orthopedic surgery?

A. Well, as you look at medicine, there are several specialties or fields of focus. You know, there's focus on the heart, it's called cardiology, there's focus on the lung, it's called pulmonology. Orthopedic is a specialty of medicine that deals with injuries and conditions of the musculoskeletal system, the joint, the tendons, muscles, bones, things of that nature.

Q. All right. And can you tell us a little bit about your current practice?

A. Yes. Well, basically I have a practice that is a general orthopedic practice dealing with general orthopedic conditions, including trauma, fractures, and that nature. But I'm also a hand specialist, so I spend a portion of my practice caring for hand problems that most of the other orthopedic

surgeons in the community do not have comfort with.

Q. All right. And what offices are you affiliated with right now?

A. Well, I have an affiliation with Medalliance, which is on 625 East Fordham Road. I just opened up a private office on Third Avenue in the Bronx, New York. And I'm also affiliated with an office on the Grand Concourse, 2676 Grand Concourse.

Q. All right. In addition to those private practices you just told us about, do you sometimes examine plaintiffs who are involved in litigation?

A. Yes, I do.

Q. All right. Do you examine those patients for the defendants and the plaintiffs?

A. I examine patients for both plaintiff and defense.

Q. All right. Which percentage of those exams are for plaintiffs versus defendants?

A. Again, I don't have a specific quantification. The large part of my practice is spent caring for patients. In the course of doing that work, I do get intermittent requests to examine patients as a plaintiff expert.

I also have time that I set aside to do defense work just for those examinations. So by far, my practice is really geared towards caring for patients. I do enter medical exams and I probably do slightly more independent medical exams for defense purposes than plaintiff purposes, just because most of

the time I'm the treating doctor, so I'm not an expert, I'm actually the treating doctor.

Q. And so you've given testimony in court like this before?

A. Yes.

Q. All right. About how many times a year do you do that?

A. Again, I don't quantify it, but I can tell you I've been told by other attorneys it's averaged out over the last ten years about five times a year. So, you know, but I couldn't tell you exactly how many times per year.

Q. Okay. And are you being compensated for your time here today?

A. I am.

Q. And how much are you being compensated?

A. $6,000.

Q. If you weren't here today giving testimony, what would you be doing?

A. I would be caring for patients at the office and I also had half day surgical schedule I would have been participating in.

Q. So you currently perform surgeries in your practice, right?

A. Yes, I do.

Q. All right. Did you examine the plaintiff Luis Molina

prior to giving testimony here today?

A. Yes, I did.

Q. And at whose request did you examine him?

A. At the request of a firm called Burns & Harris.

Q. And when did you perform that examination?

A. September 22nd, 2011.

Q. What -- did you review any records prior to your examination of Mr. Molina?

A. Yes, I did.

Q. What records did you review?

THE WITNESS: May I refer to my report?

THE COURT: Yes, you may.

A. I reviewed the medical records contained in Medalliance. There was several office notes of Dr. Randall Ehrlich. I did review MRI films and reports of Mr. Luis Molina's left shoulder and right shoulder. Also, the surgical reports from Dr. Ehrlich pertinent to surgery performed to his left and right shoulder.

Q. Who is Dr. Ehrlich?

A. Dr. Ehrlich is another orthopedic surgeon.

Q. And you work with him at Medalliance?

A. Again, we're colleagues, we don't share the same practice, but we do have the same employer.

Q. All right. I want to -- before we get into the treatment and the injuries sustained by Mr. Molina, I would like

you to first explain the anatomy of the shoulder to the ladies and gentlemen of the jury and if you would like to --

MS. BORDEN: Your Honor, may the witness step down and may we use the diagram?

THE COURT: Yes.

MS. BORDEN: Thank you.

MR. LAQUERCIA: May I?

THE COURT: Go ahead.

THE WITNESS: Well, essentially what you're looking at here is a graphic representation or a drawing of what is considered to be the anatomy of the shoulder. In looking at this, this is an anatomically correct representation of what the shoulder is made up of as far as the tissues, the bones, and we'll go over that.

So, in essence, you know, there are connections of joints, and essentially we're dealing with the shoulder joints, so we have a long bone here called the humerus and you have your shoulder blade. And, again, you can see this is a larger representation, the shoulder blade and your humerus bone.

That joint, which is the joint between the humerus and the glenoid, which is the ball and socket, so on the humerus bone, you have the ball, you can see it shaped like half a ball, and then the socket, it's almost like the bottom of a saucer. It's not a very deep cuff

like the hip joint, but it's nonetheless a shallow cup. And the reason that the shoulder has a propensity to gain injury is because that cup is very shallow. And it relies on the soft tissues to maintain the stability of that joint.

So hence, what you're looking at here is a shoulder without any of the attachments. And if I just took the two bones and put the shoulder there, it would just fall off on the floor. So, in essence, the shoulder is really maintained by the attachments of the muscles, ligaments and tendons, and that's how your shoulder is attached to your body.

So what are those ligaments and tendons? If you look here, this is internal to the big fat muscles that are on the outside of your shoulder. This is your rotator cuff. And they are a series of tendons that attach the humerus bone to the shoulder blade. And essentially they function like cables on a suspension bridge.

If you see when you're driving over say the George Washington Bridge, you see all the suspension cables that hold the bridge up, that's how these muscles function to hold your shoulder onto your body at the same time they function to give you balance when you move it. So when you're dealing with the rotator cuff, you have four muscles, and this view here is if I took and pulled the

humerus bone out of the cup, so you see the base of the tea cup, now you see there are the cut ends of tendons, so this would be the supraspinatus here, so this is the cut end of the supraspinatus here, this is the subscapularis and that would be in the front part of the shoulder. And then you have the infraspinatus and Teres Minor. So there's four muscles or musculature tendon units that make up the rotator cuff, and they function again to suspend the shoulder from the body.

And also when you're moving it, gives balance, it gives you nice circular movement to the shoulder. And in addition to those muscles which are not adequate, there is tissue called the labrum, which is an extension of that cup.

So if you just image this center part is the cup, this tissue folds up almost like a flower and it attaches to the humerus bone, as well, and it's those structures that give you the stability and maintains the balance function of the shoulder.

And in addition to the other bony parts, you have your collarbone, which is called your clavicle, and this smaller piece is called acromion and that is your coracoid.

So it's a series of bones and muscular tendon units that basically form the joint of your shoulder blade.

Q. All right. Thank you, very much, Doctor.

Right now, what I'd like for you to do and I can provide you --

MR. LAQUERCIA: May I interrupt? Was that exhibit identified for the record?

MS. BORDEN: Yes. It's Plaintiff's 11.

MR. LAQUERCIA: Thank you.

MS. BORDEN: If I may hand the Doctor what has been marked into evidence or court officer would.

Q. Doctor, if you could just explain Mr. Molina's course of treatment at Medalliance in regards to his right shoulder from the time he started treating at Medalliance up until the time of his right shoulder surgery in May of 2009?

A. Yes. Well, I had reviewed the record, the treatment records from Dr. Ehrlich, and also the medical records at Medalliance. Those records reflected that he did have what's considered to be conservative treatment, which includes physical therapy. There was also interventional pain management to the shoulder, he had some injection to the shoulder. And Dr. Ehrlich's notes reflected those nonsurgical treatments were not effective in alleviating his pain in the right shoulder. So as a result, he did have an MRI. The MRI did show some damage to the tissues internal to the shoulders, specifically some of the tissues that I discussed on the board a few moments ago.

Q. Doctor, I would ask that you explain or show, demonstrate to the ladies and gentlemen of the jury what that

shoulder, right shoulder MRI showed?

MS. BORDEN: If I may, your Honor.

MR. LAQUERCIA: Can we have the exhibit number, please, for that film?

THE WITNESS: That is 9A.

Q. And, Doctor, if you could just tell us the date of that study and what it is?

A. From what I can make out here, it says 1/23/2009.

Q. Okay. Thank you.

A. Okay. So now just we understand, you know, because conceptually it's difficult for lay people to understand the anatomy on an MRI. Just so you understand that we're talking about apples and apples. This is the same diagram we spoke about.

Here's the shoulder, this is the humerus bone, that's the ball, so on all these views, you see the ball of the joint and then on these views you see the socket. So it's the ball and it's sort of the tea cup saucer. Okay. So this is the humerus, and that's the glenoid.

Now, what are all these dark structures that you are seeing? They basically are the soft tissues that I discussed on this diagram. So I can show, everybody can see, basically an MRI is a photograph taken with magnetic, and what it does, it starts from the front and it slices going through to the back. So as you come across, you can see you're seeing the front

muscles in front of the shoulder, and that would be this area here, which is the subscapularis. Okay?

And as it's slicing through, you start to get deeper into the shoulder and you start to see the ball of the ball and socket, and as you get further into the shoulder, you start to see the ball is getting bigger, so you're getting to the larger part of the joint.

Now, the first thing you look at when you're looking at MRI's, you look for signals that are not normal, so when you look at bones in this particular image, bone has bone marrow which has fat, and fat will show up as a bright signal. If there's any abnormality in that signal, it will show up as dark areas in that particular bone. So as you can see, just by comparison, the bone is uniformly bright, it's all white, there's no breaks in the whiteness.

So you can see that the signal is uniformly the same throughout the tissue. And as you go through the muscles, as you go from superficial to internal, the muscles are all uniformly dark.

Now, as you come into the area of the rotator cuff, specifically the supraspinatus tendon, which is this structure here, you can see here's the cup, here's the saucer, and here's the supraspinatus tendon. Now, you can see that it's uniformly dark until you get into this area, which is right under this zone. And the lack of uniformity in color represents a process

of abnormality.

And in this particular case, my interpretation of this is that there's a tear of the rotator cuff. Normally you would see the rotator cuff coming across and attaching uniformly to the bone with a uniform thickness and color. And as you get in its attachment to the bone, it goes from dark to light. Dark to light. So that represents a tear of the rotator cuff, or the supraspinatus tendon.

And the other thing that we're also looking at is, as part of this tea cup, the labrum, which is this tissue, again, has its normal appearance on this film, and you can see on this particular image, and it would be the second row, the farthest film to my left, you can see that there's a change in the tissue quality of the labrum, so there's also a tear of the labrum, the superior labrum.

Q. Okay. Thank you, Doctor.

I want to ask you now about the surgery performed in May of 2009 on Mr. Molina's right shoulder.

What surgery was performed on his shoulder in May of 2009?

A. Well, I have an operative report that was prepared by Dr. Ehrlich from May 26 of 2009, and essentially he did what's called a diagnostic travel around the shoulder just to see what the findings internal to the shoulder, and essentially he found what he described in his postoperative diagnosis as

post-traumatic impingement syndrome. He did find a supraspinatus tear, which is a full thickness rotator cuff tear.

He did find some arthritis of the acromial clavicular joint, but also noted some tearing of the superior labrum as well as the biceps anchor.

Q. Okay.

A. So what basically his surgery to address those findings, I mean the major part of the surgery was to repair the rotator cuff. And what he did was he actually inserted a bony anchor with a suture into the humerus bone, and that anchor has the two stitches attached to it, and he basically harnassed the rotator cuff and brought it back down to the bone to facilitate a repair. And he also repaired SLAP lesion or the labral tear.

Q. So he repaired the rotator cuff and labral tears, correct?

A. Yes.

Q. Now, after a surgical intervention where you repair those structures, is it possible for a patient to ever get full range of motion after that type of surgical intervention?

A. I mean, generally if a labrum is torn off where it has to be reattached, a consequence of the surgery is loss of motion if the surgery is going to be successful. I mean, a successful labrum surgery, you know, rarely if ever achieves full range of motion when it has to be attached the way Dr. Ehrlich has done it.

If your labrum is debrided or if it was an end to end repair, which you can do without having to reattach it to the bone, then conceivably on a theoretical basis, you could get your motion back, but on a repair like this particular one, I don't think that would be possible.

Q. Okay. What was Mr. Molina's postoperative course following that right shoulder surgery?

A. Again, according to Dr. Ehrlich's notes, he was referred for formal physical therapy in the postoperative period. And essentially continued with his post surgical rehabilitation.

Q. And can you explain for the ladies and gentlemen of the jury what type of treatment Mr. Molina underwent at Medalliance for his left shoulder?

A. Yes. Well, again, Dr. Ehrlich's notes do make mention of an onset of increase in left shoulder symptoms. He did attribute those symptoms to overuse of his left shoulder to compensate for the lack of use of his right shoulder. Because with the treatment, the rehabilitation of a rotator cuff and labral repair, it's at minimum six months of rehab. The first three months you cannot actively move your arm at all. So he would be highly dependent upon the left arm completely for three months, and to a larger extent than normal for the following three months.

So in the time of his rehabilitation that he began

feeling pain in his left shoulder and he was sent out for another MRI of his left shoulder.

Q. All right. And I would like you again to just explain the finding on that left shoulder MRI to the ladies and gentlemen of the jury. And for reference, we're looking at Plaintiff's 9D.

A. Okay. Again, just for comparison purposes, and we're dealing with exhibit 9D and this is 9/24/2010, this is Mr. Luis Molina's left shoulder MRI.

So just to refresh your memory, again, the ball, the socket, you can see it on all views. On this particular image, the superficial slices are the lower ones. As you get deeper into the shoulder, you can see the ones that are deeper to the shoulder. And as I point out, this is the supraspinatus tendon. You can see again there's a change in the appearance of the tissue, not uniformly dark. And actually you can see that there's a detachment and retraction of the tendon from the humeral head.

So there is a rotator cuff tear of the supraspinatus tendon of the left shoulder as well as what also appears that the labrum, but I only see it on one image on this particular study, it appears that the -- this is a labral tear, as well, but to be definitive about it, it's suggestive of it, but it's not diagnostic of it, and I believe that Dr. Ehrlich did confirm in his operative report that there was a labral tear, as well.