In The Matter Of:

In the Matter of Carlos Melendez

Dr. Steven Toulipoulos & Dr. Aric Hausknecht
March 24, 2025

NYS Supreme Court-Civil Division

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SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK - CIVIL TERM - PART 11
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CARLOS MELENDEZ,

Plaintiff,

-against- Index No.: 114296/2005

PRO SPORTS & ENTERTAINMENT, INC., THE ROUSE COMPANY OF NEW YORK, LLC, SOUTH STREET SEAPORT LIMITED PARTNERSHIP, APPLE INDUSTRIAL DEVELOPMENT CORP., AND NEW YORK CITY ECONOMIC DEVELOPMENT CORPORATION, AND THE CITY OF NEW YORK,

Defendant.
----------X

Jury Trial

60 Centre Street
New York, New York
March 24, 2025

B E F O R E:

HONORABLE LYLE E. FRANK,
Justice of the Supreme Court

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(Whereupon, an item is received and pre-marked Plaintiff's Exhibit 8 in evidence.)

THE COURT OFFICER: All rise. Jury entering.

(Whereupon, the jurors entered the courtroom.)

THE COURT: Everyone could be seated, please. Good morning, members of the jury. I hope you had a nice weekend.

So we will get right to it. Without further adieu, I will call on Mr. Roth to call the plaintiff's next witness.

MR. ROTH: Thank you, your Honor. The plaintiff calls Dr. Steven Touliopoulos.

THE CLERK: Please raise your right hand. Do you swear or affirm that the testimony you are about to give is truth, the whole truth, and nothing but the truth?

THE WITNESS: I do.

(S-T-E-V-E-N T-O-U-L-I-O-P-O-U-L-O-S, called by and on behalf of the Plaintiff, having been first duly sworn, was examined and testified as follows:)

THE CLERK: I need you to state your name and then spell your name.

THE WITNESS: First name is Steven with a V, middle name is John, last name is Touliopoulos, spelled, T-O-U-L-I-O-P-O-U-L-O-S.

THE CLERK: You can have a seat.

The witness is sworn.

THE COURT: Okay. Thank you.

Mr. Roth, whenever you are ready.

MR. ROTH: Thank you, your Honor.

DIRECT-EXAMINATION

BY MR. ROTH:

Q. Good morning, Doctor.

A. Good morning.

Q. What kind of physician are you?

A. I'm an orthopedic surgeon.

Q. What does it mean to be an orthopedic surgeon?

A. An orthopedic surgeon practices a branch of medicine that deals with disorders of the muscular skeletal systems. That includes bones, joints, ligaments, tendons, cartilage.

Q. Can you tell the members of the jury, briefly, about your educational history and training?

A. Yes. I attended college at Columbia University. I majored in chemical engineering. After graduating, I stayed on at Columbia University and I obtained a masters degree in bioengineering before entering medical school at Downstate in Brooklyn. After graduating medical school, I stayed on at Downstate as a resident. After completing my residency in orthopedic surgery, I did an extra year of training called the fellowship in sports medicine at Lennox Hill Hospital.

Q. Can I stop you right there? What is a fellowship in

sports medicine?

A. So within the branch of orthopedics there are other areas of specialty that include pediatrics, tumor, and hand. I was interested in sports medicine. So after I completed my fellowship, I became board certified not only in orthopedic surgery, but orthopedic sports medicine.

Q. And what is orthopedic sports medicine?

A. It's kind of like what it sounds. It's a division of orthopedics that treat injuries of the extremities, namely, shoulders knees, elbows, wrists. They frequently occur in sports accidents, but they can occur in a fall or any other kind of accident.

Q. All right. And with regards to post-educational activities, did you teach residents?

A. Yes.

Q. And where did you teach residents?

A. Throughout the years, I taught residents at Saint Vincent's Hospital, Brookdale Hospital, Lennox Hill Hospital, New York-Presbyterian of Lower Manhattan Hospital.

Q. Did you ever teach a doctor named Sean Lager?

A. Yes.

Q. And how did you know Dr. Lager?

A. Well, he was my resident probably 20 years ago while, I would say, Vincent's was still open.

Q. Can you tell the members of the jury about your

practice currently?

A. Yes. I'm in private practice so I have an office both in in Manhattan as well as Queens. I have a general practice meaning that I don't just do sports medicine. I also do joint replacements and fractures, but the majority of my practice is related to joint injuries and I do perform a lot of arthroscopic surgeries.

Q. And what is arthroscopic surgery?

A. Arthroscopic surgery is surgery performed with a use of a camera basically. When it's done in the stomach, it is called laparoscopic. When it is done in a joint, it's called arthroscopic.

Q. And for what part or parts of the body do you perform arthroscopic surgery?

A. Shoulder, elbow, wrist, hip, knee, and ankle.

Q. And I want to talk to you a little bit about the anatomy of the shoulder. Just from 30,000 feet, what is the shoulder?

A. The shoulder is a -- it's a ball and socket joint. And the thing about the shoulder is that it has a very big ball and has a very small socket. So the ball kind of needs help to stay in the socket and it relies on the soft tissues around the ball and that's, namely, the labrum which is cartilage as well as the ligaments and the muscles.

Unlike the hip, the hip has a big socket and a small

ball. And the hip can stay in the socket just with its bony architecture. Whereas a shoulder tends to need help and, you know, you may have heard of people dislocating their shoulders. That's when the ball pops out of the socket.

Q. And if you weren't here testifying today, what would you be doing?

A. Surgery.

Q. Okay. And are you being compensated away from your time from your patients today?

A. Yes.

Q. At what rate?

A. It's determined by my office manager depending how long I'm away from the office. It's a number value usually around $10,000.

Q. All right. And did you and I prepare prior to you coming in today?

A. Yes.

Q. Did we review films?

A. Yes.

Q. Did we review medical records?

A. Yes.

Q. All right. And how much time, in total, would you say we spent preparing between phone calls, emails, and actual in-person practice?

A. Probably, two to three hours.

Q. And did you review records in preparation for your testimony today?

A. Yes.

Q. All right. And what records, if any, did you review in preparation for your testimony?

A. The records of previous treating orthopedic surgeons. I can't remember the names. I think Dr. Pearl and Dr. Kramer as well as records of Dr. Hausknecht and Dr. Merola.

Q. And did you review any films or MRIs in preparation for today's testimony?

A. Yes, I have.

Q. I know there's a lot of records, but can you estimate how many MRIs we went through in preparation for today's testimony?

A. I think at least four of the shoulder.

Q. Okay. I want to talk a little bit more about the anatomy of the shoulder. You mentioned the labrum. But what is the labrum in the shoulder. I know we have hip labrums too. Just the shoulder.

A. It's -- so around the cup of the shoulder. So the cup is called the glenoid. To make the cup deeper, there's a labrum and it's a disc of cartilage that wraps around the bone to make the cup deeper to help the stability of the shoulder.

Q. And then what is the rotator cuff?

A. The rotator cuff -- to get back to the labrum.

Q. I'm sorry. Please, continue.

A. My fault. So attaching to the labrum is the ligaments of the shoulder. And the ligaments -- it was -- a ligament holds bones together. A tendon holds a muscle to a bone. So the ligaments and the labrum act together for the stability of the shoulder joint.

The rotator cuff is a layer that is superficial of both that layer. And there's four muscles in the rotator cuff to help people move their shoulder. And then above that is your deltoid muscle which is another muscle that you can actually feel. The other muscles you really can't feel. The deltoid is the muscle that you can feel that helps you move forward, sideways, and backwards.

Q. So when I'm at the gym, that's the deltoids?

(Counsel indicating, raises arms above head.)

A. Primarily, but you're also using other rotator cuff muscles too.

Q. And how many muscles are there in the rotator cuff?

A. There are four.

Q. And what are the four muscles in the rotator cuff?

A. Subscapularis --

Q. Slow down. You know this; you went to med school; you got a fellowship, but no one else in the room is going to know it this quick and Denee needs to get it all.

So, nice and slow and clear, can you please tell us

the four muscles of the rotator cuff?

A. The subscapularis, the supraspinatus, the infraspinatus, and the teres minor.

Q. Okay. What is the subscapularis and where is it located?

A. Well, they all kind of wrap under the shoulder. The subscapularis is more in the front; the supraspinatus and the infraspinatus is more on the side; and the teres minor is more in the back. But, basically, the subscapularis helps you kind of move your arm inward, where the other two muscles help you raise your arm sideways.

Q. Okay. And how do they -- I mean, it's called the rotator cuff, but it's four separate muscles. How do they interact with each other?

A. So as the muscles come into the shoulder, there is a confluence. They kind of merge together to make a tendon. And sometimes you can't see where -- they say the supraspinatus tendon ends and the infraspinatus begins because they kind of merge together.

Q. What are the signs and symptoms for an individual presenting with a torn labrum?

A. Well, depending on the labrum -- within the labrum itself, I mean, there's usually three divisions or three areas that we speak of. The superior labrum, the labrum on the top; the anterior labrum; and the posterior labrum is the labrum in

the back of the shoulder. And the symptoms, it's variable: You can have pain, popping, clicking, and stability, where your shoulder kind of feels like it is going to come out, weakness and so forth.

Q. Okay. And what about -- what are the signs and symptoms for an individual presenting with rotator cuff tears or tear?

A. Again, if you have a torn rotator cuff tendon, it can affect your strength. So usually the main finding is weakness as well associated pain when the arm is moved.

Q. What are the treatment options for an individual presenting with a torn labrum and a torn rotator cuff?

A. It depends on what variables. Obviously, you treat someone that is 18 differently than you treat someone that's 60.

You treat a partial tear differently than you treat a full tear, but usually if you do have a partial tear or labral tear, there are some circumstances where you would want to do surgery sooner, but usually it's treated initially with physical therapy.

Q. And what are the signs and symptoms -- withdrawn.

As part of your practice, do you treat individuals who have post-traumatic arthritis of the shoulder?

A. Yes.

Q. And what is post-traumatic arthritis of the shoulder?

A. Arthritis is when the cartilage -- so there's two types of cartilage in the shoulder, to make it more confusing: It's the labrum cartilage which is that disc. And then there is articular cartilage, which is the cartilage on the end of the bone.

So when you eat a chicken leg and you notice the shiny white thing on the end of the bone, that is actually the cartilage that covers the bone and that's what is the cushion on the bone and that's what rubs together with the other side. When that articulate cartilage starts to wear out, we call that degenerative joint disease, chondromalacia -- osteoarthritis.

Basically, osteoarthritis is when you start to lose your cartilage and then over time -- initially, it is something that can be hard to diagnosis, but over time it becomes more evident the space between the bones gets more narrow and there can be other findings too.

Q. And what are the treatment options for an individual who presents with post-traumatic arthritis?

A. Well, initially, you want to treat it conservatively with activity modification, rest, antiinflammatory medications, perhaps, cortisone injections. Eventually, arthritis is progressive and eventually many of those patients would require surgery in the form of a shoulder replacement.

Q. Okay. And did there come a time where you treated Mr. Carlos Melendez?

A. Yes.

Q. And for, approximately, how long have you been treating Mr. Carlos Melendez?

A. I believe, over 10 years.

Q. Did you bring your records to court today?

A. Yes.

MR. ROTH: And I would like to admit these as Plaintiff's Exhibit 8.

MR. ROSS: No objection, your Honor, subject to redaction.

(Whereupon, the item referred to is received and marked Plaintiff's Exhibit 8 in evidence.)

THE COURT: Okay. It's in evidence.

MR. ROTH: Can you please give it to the witness, officer? Thank you.

BY MR. ROTH:

Q. Okay. So let me know when you're ready.

A. Okay. So you asked the first time I treated this patient. It was December 17 of 2014.

Q. All right. And when you first saw him, did you take a history?

A. Yes, I did.

Q. And what was the history?

A. When he presented, he was 50 years of age. He reported being involved in an accident at work while working as

a construction worker. On July 16th of 2004, this is about 10 years previous, he was struck in the head, neck, and left shoulder and presented for evaluation of his left shoulder injury. He did report seeing Dr. Hausknecht for his head and neck injuries.

With respect to his left shoulder, he had difficulty raising his arm above his head, difficulty performing repetitive activity using his left arm, as well as overhead activities. He also reported a lack of strength and difficulty grasping, pushing, and pulling, as well as carrying out activities using fine dexterity with his hands.

He reported the pain as being dull and achy in nature. And the symptoms persisted despite having received two prior injections, physical therapy, and medications in the form of Naprosyn which is an anti-inflammatory medication.

Q. Did you perform a physical examination?

A. Yes, I did.

Q. And what did the physical examination consist of?

A. It consisted of a range of motion, meaning, how much motion did the patient have or lack. His flexion, which is your ability to raise your arm in front of your body, was about 110-degrees which is around here. Normal is 180. You should be able to raise your arm right over your head. His extension was 30. I would say that was slightly lacking. His abduction was 95-degrees which is about here. Again, normal is 180. You

should be able to raise your arm over your shoulder.

The impingement signs were positive. These are tests performed by the examiner where the arm is rotated and elevated to see if that reproduces his pain and it did. And the apprehension test and the relocation test were positive. These are tests performed by the examiner to assess the stability of the shoulder.

The apprehension test is performed by bringing the arm at a abducted and externally rotated position. And if it recreates the pain, it signifies the ball is wanting to slip out of the socket and the relocation test is performed when the examiner pushes back in -- the ball back in with his fingers and if that helps relieve his pain, that is also considered a positive, meaning, that the shoulder was trying to slip out, but now it feels better because you are pushing it back in.

Q. And what was the significance of your findings on the physical exam, if any?

A. Well, the patient had weakness, limited strength, he had limited motion, and he had findings of shoulder looseness or instability.

Q. Okay. And at that point in 2014, did you reach a plan of treatment after that first examination in getting the history?

A. Yes.

Q. And what was your initial plan of treatment when you

first saw Mr. Melendez?

A. Because -- that, you know,symptoms were going on for 10 years and he had all of these treatments before that didn't really help him, I did recommend or arthroscopic surgery of the shoulder.

Q. All right. And then in addition to the recommendation of arthroscopic surgery, did you also order new imaging?

A. Yes.

Q. And what was the reason why you ordered new imaging?

A. Well, you know, the imaging was several years old and the quality of the imaging wasn't really good and I did want to carry out a new MRI or a 3 Tesla MRI.

Q. All right. Let me slow you down. No one needs three Teslas, but what is a 3T MRI?

A. So a Tesla is basically the strength of a magnet. An MRI uses magnets to look inside your body. So the more powerful the magnet, the more powerful the magnetic field and the better and the more detailed the image you get.

His previous MRIs were, I believe, 1.5 or less. And I wanted a 3 Tesla to get better quality images of the shoulder.

Q. And the Tesla refers to the power of the magnet; is that correct?

A. Yes.

Q. And how does that gradation work? Do you know?

A. How does what work?

Q. The gradation of the Tesla rating work.

A. Well, again, it's the magnetic field and prior to the 3 Tesla MRI, the average MRI that you would get would be a 1.5. And then there are extremity MRIs that only do the extremities that's even less than 1.5. So I wasn't happy with the quality of the previous MRIs and I wanted a better imaging.

Q. And now when did Carlos obtain that 3T MRI?

A. I believe in 2016.

Q. Okay. In between the first time you saw him in 2014 and the time he gets the MRI of the left shoulder with the 3T Tesla MRI in 2016, did he continue to treat with you and your partners?

A. Yes.

Q. Approximately, how many times?

A. With me, I think it was twice. With my colleague, I believe three times -- three or four time.

Q. So he presented -- and you said your colleague. Is that Dr. Demarco?

A. Yes.

Q. And is Dr. Demarco your partner?

A. Yes.

Q. So you two were partners and interchangeably see patients?

A. Yes. We are in the same practice and we usually treat the same patient.

Q. So did, both, you and Dr. Demarco treat Mr. Melendez?
A. Yes.
Q. Did you discuss this case with Dr. Demarco?
A. Yes.
Q. And did you agree on the assessment?
A. Yes.
Q. And what was the assessment prior to reviewing the MRI?
A. We suspected rotator cuff injuries because of the weakness; possible labral injuries because of the instability; and possibly also chondral damage because it is now an injury that's 10 years old.
Q. And what is chondral damage?
A. It's the wearing out of the cartilage that I mentioned earlier.
Q. Now, did Mr. Melendez eventually obtain this 3T MRI?
A. Yes,he did.
Q. And when he obtained the 3T MRI, were the discs or the images provided to you?
A. Yes, either by CD or by online access.
Q. And did you review the MRIs?
A. Yes.
Q. And in reviewing the MRIs, did you form an opinion to a reasonable degree of medical certainty what they showed?
A. Yes.

Q. And would you like -- well, would it be easier to explain your findings if you review them with the jury?

A. Yes, it would be.

MR. ROTH: So, with your permission, judge, can he step down?

THE COURT: Of course.

MR. ROTH: We are going to play some musical chairs.

THE WITNESS: So this is an MRI of the left shoulder --

MR. ROSS: I object. There is no question, yet.

THE COURT: There is no question.

BY MR. ROTH:

Q. Make sure you talk this way because Denee, the most important person in the room, next most important people in the room, so keep it this way.

What is it that we're looking at, Doctor?

A. This is an MRI scan of the left shoulder of patient, Carlos Melendez.

MR. ROSS: I'm sorry. Can I have the date of the image, please?

THE WITNESS: This is dated September 19, 2016. And you see, here, it is a 3 Tesla MRI. From Lennox Hill Radiology Tesla.

Q. Again, from 30,000 feet, because we all don't have

your training, what are we looking at here, generally? And then we will get into what you're seeing on the film.

A. So this is a cross-section of the shoulder. And it's a cross-section in this way. So kind of taking the slice of the shoulder this way. So the MRI slices this way and slices this way and we call them sagittal axial and coronal imaging.

On this image you can see the ball which is the humeral head and the cup which is called the glenoid. And now, this white signal is some fluid inside the -- and then you can see the white signal entering this black area. So this area should be just black, right? So when there is a white line there, that signifies a tear. This is a tear of the superior labrum. That's the labrum that's on top of the glenoid.

And, also, you see this white signal, here, in the rotator cuff. The rotator cuff tendon should be also dark and black. There should be no white signal in the rotator cuff. And you can see all this white signal that goes through the tendon signifying a significant tear, almost, perhaps, a full thickness tear of the -- this tendon will be the supraspinatus tendon.

Q. What is a full thickness tear as opposed to a regular tear?

A. The tears of the rotator cuff are divided into different categories: A full tear is a tear that goes all the way through the tendon. The partial tears, I also divided into

undersurface, they are torn partly from the underside or -- which will be this side or partial bursal side of the tear. Tears on the other side. And they are also subdivided into how much they penetrate into the tendon.

You can -- 10, 20, 30%. And the deeper the tear, the more likely it's something that needs to be fixed surgically. A more superficial tear, say, a tear that is smaller, like, 30%, usually is treated with a cleaning, a debridement, and may not need to be repaired. Where as a deeper tear, tears that are usually over 50%, you usually need to be repaired.

Q. And just based on the MRI, coupled with your clinical exam pre-surgery, did you form an opinion to a reasonable degree of medical certainty what the pathology seen in this was?

A. Yes. So he had, based on my review of all the images, a significant partial thickness rotator cuff tendon tear. He had a superior labral tear. We call that the SLAP lesion, meaning, superior labrum, anterior, posterior. It is a SLAP lesion. He also had a tear of the inferior labrum. It was more posterior in the MRI, but, surgically, I wanted to give the surgery both in the front and the back and that which goes along with shoulder instability.

He also had thinning of the cartilage on the -- of the humeral head. So he had the findings of some early arthritis in the shoulder. So he had those findings.

Q. And based on your clinical exam and your review of the MRI, did you form an opinion to a reasonable degree of medical certainty as an approximate cause of Mr. Melendez's SLAP tear and associative rotator cuff injury?

A. Yes, I did.

Q. And what was your opinion?

A. That it was related to his work accident.

Q. Okay. And then did Mr. Melendez undergo the surgery that you had recommended for the five times?

A. Yes.

Q. And do you recall the date of the surgery that you performed?

A. I believe it was July of 10th of 2017.

Q. Okay. One second. I'm going to pull this up. Okay. All right.

Now what are we looking at, Doctor?

A. This is a depiction of the surgery that we performed on patient Carlos Melendez.

MR. ROSS: Excuse me. I'm sorry. Just a clarification. These are not actual pictures of Mr. Melendez.

Q. No. Those are going to come next. This is an artist's -- for the record -- this is an artist's illustration of the surgery. The actual pictures from the surgery will be covered next.

MR. ROSS: Thank you.

Q. And just, Doctor, you mentioned that an arthroscopy is a surgery performed with a camera?

A. Correct.

Q. And do you actually take pictures when you're inside of the joint?

A. Yes.

Q. And do you keep the pictures in your file?

A. Yes.

Q. And those pictures actually physically depict what you saw when you were in there?

A. Yes.

Q. And the surgery that you performed when you were inside of Carlos' shoulder?

A. That's correct.

Q. Okay. So --

A. Just to add to that, you can do 10 MRIs, but the MRI -- the issue with an MRI is it has false positives and false negatives. So it may something is torn and it may not be torn and vice versa. The gold standard is to look at things with the camera. So and that's basically the first thing we do is when the patient is asleep, we examine the shoulder. When the patient is asleep, which gives us a better exam, because he doesn't have pain to limit us. And then we perform a diagnostic arthroscopy. We go into the shoulder with a camera

and we just look around and we pull on things and we see what is injured and not injured.

This is performed on this patient with four holes: One in the back, one on the side, and two in the front. And through those holes, we insert the camera and the instruments that we use to perform the surgery. So on this top left of the picture, there is -- you can see the subscapularis muscle which becomes a tendon. And the tendon attaches to the humeral head.

This is the biceps tendon that becomes the biceps muscle. And this is the supraspinatus of the muscle is here as it comes more to the shoulder it becomes a tendon and attaches to the humeral head. The subscapularis had a partial tear. I have to look at my note. It was under 30%. And that just needed a cleaning. So we used a shaver to clean the undersurface of that tear.

The supraspinatus tear was more significant, over 70%. And that needed to be repaired.

Q. Okay. And how did you go about repairing the supraspinatus tendon during the arthroscopic surgery of 2017?

A. We used -- with the arthroscopy, we placed stitches in the tendon. We attached the stitches to an anchor. The anchor is plastic with a metal tip and then we inserted that into the bone. And it has a dial you turn that actually pulls the sutures down to pull the tendon back to the bone.

And then, inside of the shoulder, we saw an area where

there was significant cartilage damage and the grading system is zero to four. So zero would be normal cartilage; four would be, like, cartilage lost all the way down to the bone, to the bone level. So on the cup, on the low end of the cup, there was a moderate sized area of grade three to grade four cartilage damage.

Q. You said grade four?

A. Yes.

Q. Is that the highest or lowest grade?

A. That's the highest.

Q. Do you have an opinion to a reasonable degree of medical certainty as to the cause of the grade four chondromalacia that was seen on the arthroscopy during the 2017 surgery of Mr. Melendez?

A. Yes.

Q. And what is your opinion?

A. It's also caused by the accident.

Q. Okay. I'm sorry to interrupt, Doctor, please continue with the surgical procedure you performed on Mr. Melendez.

A. In the same area as the cartilage damage, there was tearing of the labrum. So this is actually a good illustration. This disc that goes around the bone, this is the bone. This shiny part is normal cartilage; this red area is damaged cartilage. This disc that goes around the bone is the labrum that makes the cup deeper to keep the bone in the

socket. When you tear the labrum, there is a higher chance the bone wants to come out of the socket. And the tear was really really next -- right next to the cartilage damage, all incurred by the same mechanism. And there was a tear in the posterior labrum. And that was superficial. So that was something that didn't go through and through and something I was able to debride and smooth out.

Q. When you say "debride," can you describe what that means arthroscopically speaking?

A. We use a arthroscopic shaver to go in. And it looks like that actually. It spins and actually just removes tissues that you want to debride.

Q. Is that like when you go to the dentist and they run that thing along your teeth?

A. That's more of a bur. It's similar in they both spin.

Q. Okay. Same mechanism?

A. Yes. So this was a full tear and this is something that needed to be repaired as well as the tear and the SLAP, S-L-A-P lesion that I noted on the MRI scan. So these two tears, we actually tore all three areas of his labrum. The back was something that just needed to be debrided, but the top and the front both needed to be repaired.

And we use a suture anchor to do the repair. So we drill a hole in the bone. We have three anchors in the front and two in the top. And we insert this anchor into the hole.

This anchor has stitches or sutures on it. We pass those sutures around the labrum with a suture passer and then we just tie knots to sew the labrum back to the bone.

We did it in the front and we also did it at the top. We did a total of five anchors in the shoulder. And this actually shows it after the repair. And then --

Q. Did you continue -- after performing the suture anchor repair of the labrum, did you continue with the arthroscopic procedure?

A. Yes. So we then our attention then turned to repairing the rotator cuff tear. We went into -- this -- so this is the glenoid humeral joint space in the shoulder. And above it is the subacromial joint space. And to make that space bigger to help with the repair and the healing, we removed a little bit of bone prominence here in the acromion.

And in a similar fashion, we put sutures in the tendon, attached them to a metal plastic anchor, and put that anchor into the bone to repair the tendon back to the bone. And this is kind of the after-result here that you see.

(Continued on the next page.)

Q So just to be clear, you had to put two anchors in Mr. Melendez's shoulder as well as remove bone during the arthroscopic surgery of 2017?

A Yes, we had five anchors for the labrum. And I have to check my notes if he has one or two for the rotator cuff. I just don't recall. I'll be able to check.

Q All right. Is that a fair and accurate depiction of the surgeries you performed of the arthroscopic --

A Yes.

Q And do you have an opinion for the proximate cause of the rotator cuff repair?

A Yes, I do.

Q And what is your opinion, Doctor?

A That it's also related to his work accident.

Q You may return to the stand.

(Whereupon, the witness retakes the stand at this time.)

Q Okay. Now, all right -- now, Dr. Touliopoulos, you mentioned that you had a camera attached to one of the four holes that was put into Mr. Melendez's shoulder.

Did you take pictures during the surgery?

A Yes, I did.

Q And are those pictures part of your file?

A Yes, they are.

Q And do they depict what you saw therein with I guess

three of the -- through the arthroscope while you're performing the surgery?

A Yes.

Q And do they further depict the various anchoring and repairs that you performed during the surgery?

A Yes, they would.

MR. ROTH: At this point, your Honor, I would like to publish the pictures to the jury, your Honor.

THE COURT: Any objection?

MR. ROSS: I just -- can I see them?

MR. ROTH: Go. Sure.

MR. ROSS: I will not have an objection, your Honor. I just want to see.

(Brief pause.)

MR. ROSS: No objection, your Honor.

Q If you could pull the pictures out, you could show them to the jury. Well, why don't we do this.

Take a look at the pictures and tell us step by step what each one depicts and then we'll publish them to the jury.

A So you want to pass these around?

Q So what I would ask, explain -- so we have how many different sheets of pictures?

A There's like seven, and then images.

Q All right.

THE COURT: Let's just wait for the siren.

(Brief pause.)

THE COURT: I think we're good.

MR. ROTH: Thank you, your Honor.

Q Can you please describe what is depicted on the first sheet of the images?

A So the first sheet depicts primarily that the tear of the superior labrum, and the repair of the superior labrum.

MR. ROTH: Judge, with your permission, could we --

THE COURT: Sure. So you want to do a page at a time?

MR. ROTH: I think that is the most efficient way. I think everyone will want to see them so they know what they're looking at.

THE COURT: All right.

THE WITNESS: You want me to step down and show them?

MR. ROTH: That might be better. Is that all right, Judge?

THE COURT: Yes.

(Whereupon, the witness steps off the stand at this time.)

A The pictures are kind of small. Maybe I will stand in the middle here. Again, these are images -- so on the camera there is a button where we could push it and take pictures during the surgery.

So this top left image one shows the tear of the superior labrum. And that is the -- this is the bone, this is the glenoid here. And this is the labrum there. And you could see this hole here is the SLAP lesion. All right. And basically we pass -- we drill a hole -- this is a guide here. Image 2. That is a guide we use to put a drill over and we make a hole in the bone. And then we push in the anchor into the bone and make sure it locks into the bone.

Then we take the ends of the sutures from the anchor, pass it around the labrum and then we tie a knot. And basically this shows the 2 image, number 6, image number 6 is down here. It shows the two anchors tying the labrum down -- and you could see there is a very secure seal on that.

Now, page 2, image 7, shows the cartilage damage here. So this is the area of the grade 3 to grade 4 cartilage damage and we use a shaver to kind of smooth out that area. You could see I am -- on image 8, on the top right here there's a shiny white thing that is more normal cartilage whereas down here you could see yellow. You are looking at a bone. You are not supposed to see bone.

The cartilage is gone, so you could see the bone of the cup. And then we debride that with a shaver. And then again on the bottom right of image 9 is an anterior that you see here. And we -- there is subsequent images, 11 and 12 show a passing of the sutures around the labrum.

So this is the part of the -- this is one anchor. This end of the suture is in the bone, this end was passed around the labrum, around the labral tear, and now that is tied down to perform the repair. And, again, that was a -- the first one there, with the knot. And image 13, you pass the second one. You pass the suture, tie knots, and then you could see in image 15 they all -- all three knots were tied. And now the labrum is reattached to the bone with a suture anchor.

Images 16 through 18, kind of blurry, but these show the partial tear of the subscapularis tendon. That was I believe less than thirty percent. We just debrided that. And then image 19 shows a significant tear of the supraspinatus tendon.

So two of the four tendons in the shoulder were torn. One was more superficial and needed to be cleaned and the other needed repair. And, again, so this -- this shiny white thing on the top of image 19 is the actual end of the torn tendon. That should be down on the bone. And you could see, it's almost -- it's not quite going through the tendon. So this was not a complete tear. But I would say it's a near complete tear of the rotator cuff tendon. And then -- let me see.

Image 20 shows the posterior labral tear. Now, this was not through and through. And it just needed to be debrided and you could see how we were able to seal it up using the shaver and the electrocautery.

Now, we are done with inside the shoulder and now we'll go above the shoulder where the rotator cuff is. And this shows images, images 22, it shows the image of the inflammation in this area. The redness is bursitis. We all have bursae in our shoulder. It acts as a cushion. We call that bursitis. We do a bursectomy; we use a shaver to the remove the bursae. There was also a bony prominence here that we burred down with a burr. And to make the space bigger. Again, this whole page 5 shows us kind of removing the bony prominence, and now you could see, it's nice and smooth here (indicating).

Now, images 32, 33 show the tear. This is the rotator cuff tendon. And then you pass sutures around the tendon. And this is the anchor. So you could see this is the anchor. It has around the anchor is plastic, which you don't see on X ray. But the core of the anchor, you could see this on image 36, is metal. And it has a metal tip so it could help penetrate into the bone. We hit that into the bone with a mallet and tension the repair using a dial. And then this image 37, which is the following image, it shows the rotator cuff tendon, which was this structure here. And you could see the suture to the anchor, kind of pulling down the tendon.

Q Okay. You could go back up to the witness stand. Thank you, Doctor.

(Witness complies.)

Q Now, did Mr. -- post-surgery did Mr. Melendez perform

rehabilitation?

A Yes, he did.

Q What is the rehabilitation from arthroscopic surgery with multiple anchors and suture repairs?

A The post-op, it's important that the patient do exercises. Some patients are able to do this on their own. The majority do get at least some physical therapy which he did, to help regain your motion and regain your strength.

Now, obviously in the first couple months you are very limited as far as what you could do because things are not healed yet. So you have to go slow in the beginning because you don't want to -- like, you know, maybe move the arm a certain way and maybe pop a stitch in the shoulder. So it's a recovery that could take six months to a year, sometimes longer. But in the first few weeks there really isn't much you could do while it heals.

Q Did Mr. Melendez -- I will try to speed this up a little bit.

Did Mr. Melendez treat with you say 2017 through 2025?

A Yes.

Q During that time did you see him on a regular basis?

A Um, I saw him -- let me see.

(Brief pause.)

A Initially after surgery I saw him regularly and then after a certain point we saw him once a year.

Q Did you see him at some point in late 2024, early 2025?

A Yes. I saw -- I don't know, but my -- I saw him in April 2024 and also January 2025.

Q Did you order -- well, what were the results -- was the last visit the 2025 visit?

A Sorry?

Q What was -- when was the last visit, the 2025 visit?

A January 7th, 2025.

Q And in January 7th, 2025, did you perform an examination?

A Yes.

Q And what were the results of the examination you performed on Mr. Melendez in January of 2025, just two and a half months ago?

A Yes. So examination of the shoulder revealed that he had active flexion, his ability to move on his own was about ninety-five degrees. When I moved his arm it went to like one hundred ten degrees. His abduction, his sideways motion was about eighty degrees. He did it on his own, to about ninety when I moved the shoulder. His external rotation, which is usually around ninety degrees, this patient was forty-five degrees. And his internal rotation, which is your ability to kind of reach up your back was -- reach up your back, which is the middle to the upper back, he was only able to do his lower back.

So his ranges of motion were limited. Even though his strength was better than before the surgery it was less than the other shoulder. There was some crepitus with motion; meaning that the shoulder was making cracking and popping noises when it was moved. The impingement signs were diminished but did give some discomfort. And there was also moderate atrophy of the left arm compared to the right arm. Atrophy is basically when the muscles get smaller, waste away. And that is usually from the --

Q Did you -- did you order an MRI or review an MRI that was taken in 2025?

A Yes. An MRI was performed in 2025.

Q Did you review the MRI?

A Yes.

Q And in reviewing the MRI did it help you form your ultimate prognosis and your opinion on if Mr. Melendez's injuries?

A It did, together with X-rays and operative findings and so forth.

Q We ask that you step down and take a look at the 2025 MRI please.

(Witness complies.)

A So this is an MRI image on patient Carlos Melendez performed January 22, 2025, at Lennox Hill Radiology. Again, this is a 3 Tesla MRI.

Q Is this again a coronal cut of the MRI?

A Yes, this is more of a sagittal.

Q Again, what is the difference between the sagittal and the coronal?

A Sagittal is this way (indicating) and coronal is this way (coronal) and axial is this way (indicating.)

Q Okay.

A And so because of the metal in the shoulder, the anchor, and because the MRI uses magnets, there is -- it effects the quality of the MRI. So you have this whole area here (indicating). We call this artifact. Because the MRI, the signals are effected by the metal. So it's safe to do the MRI despite the metal but it does effect the picture quality.

And then the rotator cuff is here (indicating). There is something presignal -- there is no obvious re-tears of -- perhaps a little bit here, a partial. But it's hard to say because of the artifact in the shoulder. And then here you could see this white line here that enters where the superior labrum is.

MR. ROTH: If you finished your answer, I think it might be time for the morning break, just indicating from the jury.

THE COURT: Sorry?

MR. ROSS: One of the jurors is requesting a break.

THE COURT: Okay. So we'll take our morning break.

So we'll see you back here in fifteen minutes.

COURT OFFICER: All rise. Jury exiting.

(Whereupon, the jury exits the courtroom at this time.)

THE COURT: All right. You ready to go?

MR. ROTH: Yes, Judge.

MR. ROSS: Yes.

COURT OFFICER: I will get them.

(Brief pause.)

COURT OFFICER: All rise. Jury entering.

(Whereupon, the jury enters the courtroom at this time.)

THE COURT: Everyone could be seated please. All right.

So why don't we continue. I don't know where we were.

Q Doctor, as you were, please.

THE COURT: Right. You were talking about the 2025 MRI.

Q All right. Now, Dr. Touliopoulos, you were saying that the signal is difficult to tell with the hardware.

As you were, Doctor.

A So, again, it's hard to say if there is a recurrent problem with the rotator tendon because of the artifact. And here in the labrum, you see this -- the white signal that goes

into the labrum and cuts off that area from that area.

Now, the problem is after surgery sometimes you don't know what is new and what is old, and what is leftover. So even though that is somewhat suspicious for a recurrent tear, you can't be sure but it is a possibility.

Q Do you see any evidence of post-traumatic arthritis?

A Yes. You see -- you see irregularity of the head here. So as you follow this black line around, as it comes down here it becomes irregular and little squiggly. That is the wearing out of the cartilage actually on both sides of the shoulder.

Q Do you have an opinion to a reasonable degree of medical certainty whether that film of 2025 shows evidence of post-traumatic arthritis in Mr. Melendez's left shoulder?

A Yes.

Q What is your opinion?

A That it does.

Q Do you have an opinion to a reasonable degree of medical certainty as to the proximate cause of the post-traumatic arthritis demonstrated in Mr. Melendez's left shoulder?

A Yes.

Q And what is your opinion?

A That it's from his work accident.

Q You could return to the stand. Thank you.

(Witness complies.)

Q Okay. Doctor, now, based on your most recent examination, coupled with the history and treatment you rendered to Mr. Melendez as well as the findings on MRI, and that you saw with your naked eye or through I guess the camera in arthroscopy, do you have an opinion to a reasonable degree of medical certainty whether Mr. Melendez's injuries to the shoulder are permanent?

A Yes, I do.

Q What is your opinion?

A That the -- that they are.

Q And do you have an opinion to a reasonable degree of medical certainty based upon the cumulative total of your experience; be it the MRIs, the surgery, the treatment, the physical examination as well as Mr. Melendez's complaints, whether he is a candidate for future left shoulder surgery?

A Yes.

Q And what is your opinion?

A My opinion is that he would be a candidate for a left shoulder replacement surgery to address progressive arthritis in the future.

Q Do you have an opinion to a reasonable degree of medical certainty as to the proximate cause for the need for the total shoulder replacement?

A Yes, that would be his work accident.

Q Now, in your practice you -- is it arthroplasty, is

that the right term?
A Yes.
Q Do you perform arthroplasty?
A Yes.
Q And can you, to a reasonable degree of medical certainty, tell the members of the jury of the total cost for shoulder arthroplasty currently?
A Yes, the -- the cost for the hospital and anesthesia is around I believe 46,000, and for the surgical fee would be around 22,000.
Q And in addition to the $68,000 in expenses, does -- would Mr. Melendez also require rehabilitation from the total shoulder?
A Yes, he would.
Q And what would that rehabilitation typically consist of?
A It would be physical therapy few times a week for approximately three months, at which point he could be reduced to one or twice a week for a couple months.
Q And, now, I guess the last time you saw Mr. Melendez was in January of this year?
A Yes.
Q So it's fair to say you have been treating Mr. Melendez for eleven years at this point?
A Yes.

Q Okay.

MR. ROTH: All right. Nothing further at this time.

Thank you very much.

THE COURT: Thank you. Mr. Ross?

MR. ROSS: All right.

CROSS-EXAMINATION

BY MR. ROSS:

Q Good morning, Doctor.

A Good morning.

Q I am going to be asking you a series of questions this morning. I would ask that if you don't understand one of my questions, please let me know so I could rephrase or clarify the question for you.

Okay?

A Yes.

Q The jury is fully familiar with that because they heard me say that every time I am up here. I will ask also that if I ask a question and you respond to it, then we will assume that you understood my question.

Is that fair?

A Yes.

Q Doctor, this is not the first time you testified at a trial like this; is that correct?

A That is correct.

Q You have done this quite often, is that fair?
A I have been in practice for over twenty years. On average I would say about three or four times a week year. It's a small part of what I do.
Q And the three or four times a year that you testify, that is on behalf of plaintiffs who are suing for money damages and claiming injuries as a result of an accident, correct?
A Primarily, although there is an instance where I did testify for the defense.
Q Okay. It was that one time?
A Yes.
Q Okay.
(Brief pause.)
Q And a significant part of your practice involved individuals who have on-the-job injuries, construction accidents, et cetera; isn't that correct?
A Well, it's part of my practice.
(Brief pause.)
Q Okay.
A It's part of my practice. I wouldn't call it a significant part.
Q Over fifty percent, correct?
A I don't know the percentages.
Q Now, Doctor, we will go backwards a little bit because you right at the end of the Direct Exam counsel for the

plaintiff indicated that you have been treating the plaintiff for almost ten years now, eleven years?

A Yes.

Q Okay. But we could agree, Doctor, that you really haven't been treating this individual since after the surgery was done; isn't that correct?

A Well, I have seen him after the surgery. And he was also seen by my colleague after the surgery.

Q But we could agree that all you did was have him come in so you could examine him, prepare reports, which you obviously know is going to be shown to a jury at some point if we're going to a trial, and outline what your findings are, correct?

A Are you asking me the purpose of the post-op visits?

Q Yes. The purpose of the post-op visits for almost eight years after the surgery, the arthroscopic surgery that was done, yes.

A So the purpose of the post-op visits initially, they are more frequent. You want to make sure the incisions are healing, no signs of infection, that he's receiving therapy, but eventually the visits could be spread out. They could be spread out to once a year, twice a year.

Q But, Doctor, you are not telling this jury that every patient that you perform an arthroscopic surgery on is going to keep seeing you once a year forever, is that what you are

saying?

A No, I am not saying that.

Q Or is it only individuals that are suing for money damages that continue to see you once a year or whatever the time frame may be, which is it?

A I would say I was not aware that the patient was involved in a lawsuit until recently. But I treat patients -- obviously if a patient has surgery and have a really good result, I tell them come back as necessary. And if there is a patient that gets surgery, that we find arthritis, ongoing symptoms, that is a patient I do want to see. It may not have to be every month, but I want to see them periodically.

Q Doctor, well, you saw this plaintiff in January of this year; is that correct?

A That is correct.

Q Okay. And, Doctor, you knew there was going to be a trial coming up because it was scheduled; isn't that correct? You would have been contacted to make sure you could come in and testify; is that right?

A I don't -- my office handles a -- the scheduling for my testimony. So I am not certain when they were contacted. I don't recall being aware of that when I saw this patient in January.

Q So you saw him on January 7th, 2025, and the last time you saw him before that was about nine months earlier, April

24th, 2024; is that right?

A Yes, that's correct.

Q And when you saw him you examined him; is that correct?

A Yes.

Q And examining him includes doing the range of motion testing, is that fair?

A That is correct.

Q And range of motion testing is subjective, correct?

A Well, there are subjective and objective factors to range of motion measurements. If you don't mind, if I could elaborate a little further?

The active motion, when you ask the patient to move, yes, that is obviously one hundred percent subjective because the patient is doing it on his own. The passive motion, when they -- when the examiner moves the extremity, there could be both subjective and objective factors and limitations of that measurement.

Q Right, because when you are doing it you are going to stop when the individual says something, it hurts, I am in pain, or, I can't move it, fair?

A Yes. So passive motion measurements could be limited by pain, reported by the patient, but it also could be limited by a mechanical block to the shoulder.

Q Now, before you saw him on April 24th, 2024, you saw him on February 21st, 2023; is that right? So about fourteen

months before; isn't that correct?

A Yes.

Q We could agree, Doctor, in that fourteen month period of time the plaintiff was never treating with you or anyone in your office; is that correct?

A I just want to double-check my colleague's notes. The answer is yes.

Q And, Doctor, isn't it also a fact that after you did the arthroscopic procedure to Mr. Melendez back in 2017, he never underwent any actual physical therapy treatments from a physical therapist after that surgery, correct?

A I don't have the physical therapy notes to be able to answer that.

Q Well, in your records, doesn't it say there is no physical therapy, he only did home exercise program?

A Well, home exercises were recommended.

Q Isn't it a fact that in your notes it says "no physical therapy was done, only home exercise?" Yes or no.

A I don't recall. If you could refer me to that visit date.

Q Okay. I will get to that in a second and I will show you.

Now, Doctor, go to your 4/24/24 visit which was the last one before just a couple months ago before this trial started.

MR. ROSS: May I approach, your Honor?

THE COURT: Sure.

Q So you're looking at your April 24th, 2024, visit; is that correct?

A Yes.

Q And in these visits, essentially when you do your reports and you do your records, you are essentially doing the same format, is that correct, you take the history from prior reports, you put them into your record, then you do a physical exam on that particular day; is that correct?

A Well, I look at the previous notes and then I ask the patient to do questions and also whether or not the previous complaints were still valid.

Q Okay. And then you do your physical exam, is that fair?

A Yes.

Q And obviously if there was radiographs, meaning MRI or X-rays or something, you will comment on that; is that right?

A That's correct.

Q All right. Now, in this particular note, all right, from April 24th, 2024, this was the last time that you saw him up until January of 2025; is that correct?

A That's correct.

Q And when I say "you", I mean your entire office.

In other words, he wasn't seen by Dr. DeMarco, wasn't

seen by anybody else in your office; is that correct?

A That's correct.

Q Okay.

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CROSS-EXAMINATION

BY MR. ROSS:

Q. Now, Doctor, I want to point you to your following visit and please read to the jury what is indicated in the April 24th, 2024, record right here.

A. "Yes. I have -- he has never received physical therapy, but is compliant with home exercises for his left shoulder."

Q. Okay. So you have confirmed that after you did an arthroscopic procedure in 2017, Mr. Melendez never had to undergo any actual physical therapy from a physical therapist as a result of your surgery, correct, or any other -- the claimed shoulder condition or injury that he is asserting, correct; yes or no?

A. Well, I would say that I can't say yes or no because I do have notations earlier that he had received therapy at least before the surgery. So I'm not quite sure what this note -- this sentence is referring to. But that, he had been compliant with his home exercises.

Q. Okay. That is your record; is that correct?

A. That is correct.

Q. And you try to be as accurate as you can; is that fair?

A. That is correct, yes.

Q. And what you read was as clear as day. He was not

undergoing any physical therapy; isn't that correct?

A. That he is not undergoing any therapy, that is correct.

Q. Now, Doctor, so prior to the April 2024 visit that we just talked about, you saw him in February of 2023; is that right?

A. That is correct.

Q. And no one in your office treated him, saw him, examined him, or did anything during that essential 14-month period of time, fair?

A. That is correct, yes.

Q. And the last time you saw -- the next time, I should say, the time before that -- excuse me -- was on May 2nd, 2022; is that correct?

A. That is correct.

Q. And again, Doctor, between May 2nd, 2022, and February 21st, 2023, he never treated at your facility; is that right?

A. That is correct.

Q. And to your knowledge, he wasn't undergoing any physical therapy that you are aware of; is that correct?

A. That is correct.

Q. And he didn't have any diagnostics ordered during that timeframe, certainly, by your office; is that correct?

A. That is correct.

Q. The last time -- so the last time you saw Mr. Melendez before May 2nd, 2022, when was that, Doctor? Please tell the jury.

A. That was April 17th of 2019.

Q. Almost three years before; is that right?

A. That is correct.

Q. So for almost three years he never treated with you for any alleged continued shoulder problems whatsoever; is that right?

A. That is correct.

Q. And to your knowledge, he didn't go and see some other orthopedic because he was having problems with his shoulder because he couldn't lift it, or he couldn't use it, or he couldn't use his left arm; isn't that correct, to your knowledge?

A. To my knowledge, I don't have any records of any other visits with an orthopedic surgeon since the surgery.

Q. So for almost three years, he was not required to go and see you, he wasn't examined by you, and he wasn't treated by you or anyone in your office; is that correct?

A. That is correct.

Q. Prior to April 17th, 2019, when was the last time he was seen in your office?

A. That was February 13th of 2019 by Dr. Demarco.

Q. Now, Doctor, we could agree, can we not, that --

withdrawn. Let me back up and start over again. I apologize.

When you look at an MRI, as you showed this jury, okay, and I think -- when did you order him to have the shoulder MRI done?

A. The MRI was done in 2016.

Q. 2016. And, Doctor, we could agree that the MRI of the plaintiff's left shoulder that was done in 2016, that MRI is not going to tell you that those findings were related to an accident at any given date, fair?

A. So if you're asking me could I date the time of the injuries based on the MRI?

Q. Correct.

A. If the injuries were 10 years earlier, I would say it would be hard to date. So I would not know if it was 10 years or 8 years or 12 years based on the MRIs done.

Q. Correct. We can agree. And you would also agree with me that you also wouldn't know if it was older or more recent, meaning -- more recent, meaning, within a few years, for example, when the MRI was done; is that fair?

A. Well, I only have the patient history that he denied any problems or injuries of the shoulder prior to this accident. I have, I believe, two MRIs that I reviewed that were done after the injury, but before I saw the patient. But based on the history and my findings, I do believe that the injuries are related to his accident.

Q. Again, my question -- I'm not asking you about the history and what Mr. Melendez was telling you after he followed his lawsuit and sued my clients. I'm not talking about that. I'm talking about you looking at diagnostic films. The MRI that you looked at is not going to tell you what the cause of those findings are in the MRI; yes or no? I think you answered it, but let's make it clear.

A. No. I think you asked me about the timing and I said I could not exactly date the injuries on the MRI, but I think you are asking me about the mechanism. Is that what you are asking me now?

Q. Sure.

A. You know, you can't tell based on an MRI how the accident happened. You can only tell what's been injured.

Q. Okay. And now, I'm going to back up a little bit. Doctor, as an orthopedic surgeon, you told the jury in responding to questions on direct exam that you were specializing in sports medicine, correct?

A. Well, I have a general practice, but the majority of what I do is arthroscopic or sports related.

Q. Right. And we could agree that a number of patients who are not plaintiffs in lawsuits, all right, you treat because of everyday degenerative wear and tear, fair?

A. I do treat some patients that have wear and tear or degeneration of their joints, that is correct.

Q. So in responses to some questions from counsel, you told him -- you mentioned and said, degenerative joint disease; is that right?

A. Yes.

Q. Which can be seen and developed in one or both shoulders; is that correct?

A. Degenerative joint disease as a general question can develop in any joint over time depending upon the age and the lifestyle of the patient.

Q. And, Doctor, we also can agree that in this case you have no idea about the actual mechanism of the injury that plaintiff is claiming in this case regarding his left shoulder in terms of how he was injured, fair?

A. Well, I only have what came from the patient.

Q. Well, are you aware of the fact that the patient did not see, you know, what had happened to him when some piping fell onto him and hit him on the left side of his head?

A. He reported to me that that is what happened. I'm not certain if that was something he witnessed or something that was reported to him.

Q. And you have no idea whether the pipe that fell and struck the plaintiff on the head impacted his left shoulder or not; is that correct?

A. Well, the patient said it did and there is no reason to believe it's not true.

Q. Okay. Well, by the way, in addition to reviewing -- well -- withdrawn. Let me back up.

You're not telling the jury that every time somebody has some kind of an impact to their left shoulder that they are going to sustain an injury that's going to require a arthroscopic repair 13 years after that incident, are you?

A. Every time? I would say not every time, no.

MR. ROTH: Judge, can we approach?

THE COURT: Sure.

(Whereupon, there was a bench conference held off the record in the presence of the jury.)

(Whereupon, the following takes place at sidebar outside the presence of the jury:)

THE COURT: Outside the presence of the jury.

MR. ROTH: This is now the fourth time that Mr. Ross made a deal about 13 years. It is incredibly misleading. He is taking advantage of your honor precluding the workers' comp. He is deliberating misleading the jury. And not only that, on cross of my client, he accused me and the client of colluding to make up a falsehood in court.

This behavior by my adversary is completely unacceptable. And is flouting your ruling about the workers' comp. I'm, again, renewing my request for a curative instruction --

(Crosstalk.)

MR. ROSS: Again --

MR. ROTH: Look, Judge. I want a curative instruction and I want you to admonish Mr. Ross --

THE COURT: Mr. Roth, please keep your voice down so the jury doesn't hear --

MR. ROTH: Mr. Ross is flouting your ruling. He is taking advantage. He is deliberately creating a misrepresentation to the jury about the 13-year time period. This surgery was not approved by nine years by workers' comp. And the fact that he is doing it on something he knows this was requested nine years before is deliberately creating a misrepresentation to the jury. He's doing it on purpose. I want a curative instruction. I want him to be admonished not to do it again.

MR. ROSS: With all due respect, okay, I'm not taking advantage of anything. The plaintiff, as we pointed out -- we can't address and deal with the issues on the workers' comp side in terms of length of side, but the plain fact of the matter is, your Honor, is that Mr. Melendez went to work as a traffic enforcement agent for the NYPD with full health coverage. If he needed to get a surgery that was actually related to this accident or just the fact that he needed it, he could have had it done. He had health insurance and everything else. What is

happening here is -- let's not talk about --

MR. ROTH: Can you keep your voice down?

MR. ROSS: I am. Look who's talking. Let's not talk about, you know, who's doing what to who. They send them to these doctors right before -- I will try to --

(Crosstalk.)

THE COURT: Counsel.

(Crosstalk.)

THE COURT: Counsel.

(Crosstalk.)

THE COURT: Counsel.

(Crosstalk.)

THE COURT: Counsel.

(Crosstalk.)

THE COURT: Counsel.

(Crosstalk.)

MR. ROSS: Yes.

THE COURT: I think you're going beyond.

MR. ROSS: Okay. My point is, your Honor, the ruling which -- obviously, we agree was correct -- I'm not flouting it. I have the absolute right to cross. This individual could have done those things, okay; however, Dr. Touliopoulos is getting up here, sees the person 10 years after his accident, and he is causally relating it. I have the right to challenge that. I'm doing it based on the

issue of degenerative wear and tear.

THE COURT: I think the issue with this one is you're saying that they requested surgery nine years later. That's not.

MR. ROSS: I didn't say that.

THE COURT: No. I'm saying Mr. Roth said that. You're saying that, Mr. Roth. The problem, here, is there was nothing on direct that indicates this is a doctor that saw him 10 years later. So, I mean, look -- I think, you know -- so that's the issue here. So the very best for you is 10 years later and apparently no surgery was done. He asked for it. I don't have testimony that says nine years -- and four years in, there's a doctor who says they want to do it. That's sort of my issue.

MR. ROTH: Richard Parker in 'O5 per my client's testimony and per the evidence in the record recommended surgery; and again, Dr. Kleinman in '09, per the client's testimony -- '08, I'm sorry -- recommended shoulder surgery. And we were blocked from eliciting any questions about comp authorization and comp denial --

THE COURT: I hear what you're saying. Your exception is noted. The issue, to me, that was regardless of the reason -- regardless of the reason, yes, you are having doctors on surgeries that were years later, causally relate them. And it would be prejudicial not to let them.

And then, again, the issue of comp, it's probative versus prejudice. It's a big issue here in terms of, you know -- it really comes down to this wasn't right after it was something years later. I mean, again, to me, I see the comp issue at this time is sort of collateral in the sense that you have something 13 years later you are causally relating, great, if they believe that it is causally related.

He has something that does not causally related it based on his cross. I think it's fair game for cross. Again, as I said, if -- I mean, I would suggest, if you want, and I made the ruling about workers' comp. I don't see myself changing that. If you -- my suggestion is maybe talk amongst yourselves on the plaintiff's side to see if there is some sort of instruction or something I should give that any delay from when it is ordered to when it -- shouldn't be used against him or something. I don't know. I mean, I would just think that's something you might want to do and you can certainly object to that, Counsel.

MR. ROSS: Yes.

THE COURT: I just think the workers' comp is absolutely prejudicial and, to me, the issue here is, I don't know what happened. We don't know if the surgery was done three years later. We have the facts as we have them,

which is that it is years later and well after and he's entitled to ask 13 years later. And he is not harping on the fact that, why did it take three years? It must be not that serious because it took three years for the surgery to happen after he ordered it. If he did that, that would absolutely be objectionable --

MR. ROSS: I didn't do that.

THE COURT: And you haven't done that. Your exception is noted, absolutely.

MR. ROTH: I'm just stating for the record: He is using the ruling as a shield and then using the timeline as a sword. It's exactly the thing you are not supposed to be allowed to do. It's underhanded and it's sharp. And I'm taking my exception again. If you call me a liar again on the record --

MR. ROSS: I'm not calling you a liar. Please, stop it. This is completely -- I never said you are lying.

MR. ROTH: You just accused me of --

(Crosstalk.)

THE COURT: Okay. okay.

I made a ruling. We are going to go back.

(Whereupon, the following took place in the presence of the jury in open court:)

THE COURT: I don't believe there is an open question. We can go on to the next question.

MR. ROSS: Thank you, your Honor.

BY MR. ROSS:

Q. Doctor, before we just had a discussion outside the presence of the jury, we were talking about the issue of degenerative joint disease, degenerative wear and tear. Do you recall that?

A. Yes.

Q. Now, Doctor, we were also talking about the mechanism of injury in terms of the issue of whether or not the pipe that struck the plaintiff in the head actually impacted or came into contact with his left shoulder. Do you recall that?

A. I don't recall your statement or your question. If you can repeat it.

Q. So I will ask that: Doctor, other than the plaintiff contending that he was hit, first, in the head and then somehow in the left shoulder, have you seen any other objective evidence in any of the medical records to indicate that the plaintiff sustained an impact to his left shoulder; yes or no?

A. Yes. In the form of the records of Dr. Hausknecht and the other two orthopedic surgeons that saw him before me.

Q. There was nothing in those records, Doctor, isn't it a fact, that there is nothing in those records to indicate that there was objective evidence of this pole or pipe striking the plaintiff's left shoulder; isn't that correct?

A. Can you define objective evidence? Do you mean such

as a video of the incident? Is that what you're asking? Or...

Q. Doctor, it's pretty simple. Other than Mr. Melendez telling every doctor he's treated with that he sustained an injury, that this thing hit his left shoulder, okay, you've not seen anything in any medical record to say that he had some kind of an objective injury to his left shoulder; isn't that correct? Yes or no?

A. Again, objective is saying that it was witnessed by someone else? Or...

Q. Well, let me ask you this, Doctor: Did you look at the actual ambulance call report or the hospital records for Mr. Melendez on the day that his injury occurred? Is it anywhere in your file?

A. No, it's not.

Q. Well, don't you think that that would have been helpful to know that those records say on the day that this accident occurred as to whether or not he might have an actual objective injury to his left shoulder?

A. Again, I'm relying on the patient's history that the pain started after the accident.

Q. Are you aware of the fact that other than the plaintiff complaining about pain in his left shoulder, there was nothing else found in the hospital records, objectively, to indicate a left-shoulder injury from the July 16th, 2004, accident? Are you aware of that; yes or no?

A. I'm not aware of that, no.

Q. Okay. Are you aware of the fact that there was no evidence that he had any swelling or bruising of the left shoulder? Did you know that?

A. I'm not aware of what the records said.

Q. And, Doctor, are you also aware that he did have x-rays of the left shoulder that were done later on, like, months later; is that right? Or are you not aware of that?

A. I believe when he first came under the care of another orthopedic surgeon, yes.

Q. Was that Dr. Richard Parker?

A. I believe so.

Q. And you're aware of the fact that Dr. Parker indicated from the x-rays of the left shoulder that there was no evidence of any fracture. Were you aware of that?

A. Yes.

Q. No evidence of a dislocation?

A. Yes.

Q. That there were no gross bony abnormalities. Were you aware of that?

A. Yes.

Q. What does that mean, Doctor? Tell the jury, please.

A. That the bony structure of the shoulder looked normal; that there was no abnormal spurs or findings on the x-ray.

Q. Are you aware of the fact that, you know, in Dr.

Parker's August 2nd, 2005, record he indicated that the plaintiff had no significant shoulder injury? Were you aware of that?

A. I don't remember his exact terminology. I do believe he believed a lot of the pain was from the neck.

Q. And, Doctor, you talked about chondromalacia. Do you remember that on direct exam?

A. Yes.

Q. Or chondral. You used different terms: Chondral injury, chondromalacia; is that right?

A. Yes.

Q. And you talked about the different grades. You said grade four, [SCOPE]chondromalacia; is that correct?

A. Or grade four chondral injury.

Q. Grade for chondromalacia, that can be wear and tear that takes place over time. Doesn't have to be the result of any impact or injury, fair?

A. That is correct. You can get chondromalacia; you can get arthritis in our joints without a history of trauma, that is correct.

Q. What about tendinosis?

A. You can also get tendinosus without a history of trauma. There are other mechanisms of getting tendinosus.

Q. And you would agree, Doctor, that somebody could have a partial tear and go on for -- for years and not do anything

about it. They might have pain, they may not. They go about their lives and they don't necessarily get any type of surgical procedure, fair?

A. I would say that overall it's fair. It depends on the location of the tear, the size of the tear, the activity level of the patient. Some tears can be more symptomatic than other tears.

Q. Doctor, did you look at the MRI of the left shoulder that was done in June of 2008?

A. Yes.

Q. Did that indicate fibers of some sort, tendinosus?

A. As I said earlier, it was a very poor quality MRI of the very few images and that's one of the reasons why I wanted to get a 3 Tesla MRI scan.

Q. But the fibers that show up, that certainly can evidence, like, fraying and tearing which would be degenerative wear and tear; is that fair?

A. Well, there is evidence of tendinosus that can have various causes. One, of which, can be trauma.

Q. And, one of which can be wear and tear over time?

A. It can be overuse or of wear and tear, yes.

Q. Doctor, there also are different types of surgical procedures and surgeries that are done with respect to the shoulder, correct?

A. You mean the procedure that I performed?

Q. Well, in other words, you did what's commonly referred to as an arthroscopic procedure; is that correct?

A. That is correct.

Q. Sometimes you will hear the term or phrase "scope;" is that right?

A. Yes.

Q. As you indicated, you go in with a camera and is it, like, through a little hole like a needle or something like that? And you go in and then you do the repairs that you described to the jury on direct exam; is that fair?

A. Well, it's not the size of a needle. It's the size -- the scope is -- the holes are usually, like, five to six millimeters. So I would say it would be like, you know, double the size of a pencil and it would be four of them.

Q. And, Doctor, when you were describing to the jury the different -- the different procedures that you did on Mr. Melendez when you went in, you talked about, for example, where you just did a debridement or a cleaning out. Do you recall that?

A. Yes.

Q. And the area that you debrided or cleaned out, we could agree that that could have been from wear and tear and have absolutely nothing to do with some sort of an acute trauma or injury that occurred in July of 2004; is that fair?

A. Well, again, I'm relying on the history of the absence

of any prior trauma or symptoms and that I believe that the findings during the surgery were related to this accident.

Q. The operative photos that you showed to the jury, Doctor, those are the photos that are taken while you are doing the procedure, correct?

A. That's correct.

Q. So when you are looking at those photos, they are not going to tell you whether what is seen in the photo is from an accident that occurred, you know, a number of years earlier, fair?

A. Yeah. You also -- like the MRI scan, you can't date the findings on the pictures to any particular date in the past.

Q. A grade four chondromalacia takes place over a longer period of time; is that fair -- for it to develop to grade four?

A. Well, you can get grade four immediately from trauma and it's also something that can develop over time.

Q. When -- Doctor, do you speak Spanish either fluently or a bit or partially?

A. Very little.

Q. When Mr. Melendez would come to see you, did you have your conferences or discussions with him in Spanish or in English or something else?

A. I don't see in my notes that a translator was

required. Sometimes I do use my office staff to help with the translation.

Q. Well, when you saw Mr. Melendez just a couple of months ago in January, did you talk to him in English and have him describe his complaints to you and everything else?

A. The note doesn't go into the language that was spoken and I don't recall what language was used.

Q. Doctor, you talked about arthritis and, obviously, arthritis can develop over time for wear and tear. It doesn't have to be related to a specific incident or accident, fair?

A. As a general question, that is fair. You can get arthritis for various reasons other than trauma.

(Continued on the next page.)

Q The doctor, other than Dr. DeMarco, who is in your practice, you didn't speak to Dr. Hausknecht or any of the treating physicians; is that correct?

A That is correct. Not to my knowledge, no.

Q When Mr. Melendez came and you saw him for the first time in December of 2014, okay -- and please, if you need to refresh your recollection, by all means, please do so.

A Yes.

Q Okay. You have an individual -- you have it in your notes here where it states he -- he states a "bay", B-A-Y, "fell striking the patient in his head, his cervical neck and left shoulder."

Is that correct?

A Yes.

Q In other words, again, that is what Mr. Melendez told you; is that right?

A Well, that is apparently a typographical mistake. Bay, I am not sure what bay is. More like a bar.

Q That is fine. But what I am getting at, sir, this is again what Mr. Melendez told you?

A Yes, that is correct.

(Brief pause.)

Q Doctor, what is glenohumeral osteoarthritis?

A It's -- osteoarthritis is the shoulder joint.

Q And osteoarthritis of the shoulder joint, again, could

be developed as a result of every day wear and tear, fair?

A That is a possibility. I don't believe that is what happened here, but -- in general, that is a possibility, yes.

Q Okay. So just so we're clear, Doctor, the basis for your opinion that the plaintiff's left shoulder condition was an injury that was the result of this accident is because the plaintiff told you that he was hit in the left shoulder, correct?

A Yes, the basis for the mechanism of injury that I have recorded is based on what was reported to me by the patient.

Q And that would be because unlike, for example, if somebody got smashed in the shoulder and the impact was enough that it caused swelling, then you would see that on an X ray when they would take it and it would show up, fair?

A No. Usually -- X-rays are good for bone. But also good for soft tissues. Swelling may or may not be present or visible on an X ray.

Q Okay, but if there was swelling in the shoulder, you could certainly see that when you observed them, when the doctors are examining the individual, the patient, whether it's in the emergency room or in a follow-up visit a week later or couple weeks later? If there was swelling, you would observe it, or if there was bruising, black and blue, something like that would be observed, fair?

A Yes. So swelling, external swelling that you could see

is -- would be visible, so it would be bruising -- bruising is something you could see. But internal swelling, internal injury would not be visible by -- with your eyes.

Q Or obviously if somebody broke a bone, the X ray would pick up on that, if there was a fracture or dislocation then an X ray would pick up on that?

A So X-rays pick up on most fractures. You could have a microfracture where the X ray could miss it and the MRI would pick up on it.

Q Obviously there was no evidence of a microfracture to any part of the shoulder in this case, correct?

A That is correct.

(Brief pause.)

Q Doctor, each time the plaintiff would come to your office and you do range of motion, was it basically the same every time he came on a number of visits or did it vary or change?

A I think the last few visits it was about the same, there was a period after the surgery where he was actually -- he actually had better motion. But over time, as his arthritis progressed, his motion has become more limited.

Q Okay. Doctor, in your later records you indicated other things that the plaintiff was complaining about; is that correct?

A Yes.

Q So even if it was an area that you were not treating, fair?

A Yes, on certain visits I would. If he made complaints of them I would, yes.

Q And, Doctor, we could agree that on any of the occasions where you saw Mr. Melendez there was never any indication where he was unable to communicate with you, or was having other issues that would not allow him to communicate with you, fair?

A I believe that is a fair statement, yes.

Q Are okay. And, Doctor, according to a couple of your records you actually wrote down that Mr. Melendez was claiming that he was having a seizure disorder as a result of this accident, did you write that down?

A Yes. I have it in my January report, yes.

Q Are you aware of the fact that there's absolutely no claim whatsoever, or evidence to indicate that Mr. Melendez sustained any kind of a seizure disorder as a result of this accident or has any seizure disorder at all, did you know that?

A I did not know that. I don't have all his neurological records.

(Brief pause.)

Q Doctor, you mentioned earlier when I asked about the physical therapy that he may have gone for some physical therapy before the surgery, you recall that?

A Yes.

Q Do you know if that was -- sorry. Excuse me.

Do you know if that was for his shoulder or his neck or both or something else?

A I only have that he received therapy.

Q Okay.

MR. ROSS: I am just about done. Let me round third base again.

(Brief pause.)

Q Doctor, when you hear where they say, you know, there was no deformity in the shoulder, what is your understanding of that, Doctor?

A That's on a diagnostic study, it on a visual inspection of the shoulder.

Q Visual inspection of the shoulder?

A That would signify that there was no obvious deformity, that -- that the bones are not sticking out where they shouldn't be sticking out of. And that everything is -- on visual inspection, everything is lining up.

Q A SLAP tear could occur by wear and tear, fair?

A A SLAP tear can occur over time with degeneration, but I believe again the time of this injury, he was -- the patient was in his forties.

Q Understood. In general, what I am getting at is SLAP tears could occur as a result of some kind of a, you know,

external injury or trauma, or they could occur as a result of wear and tear over time, fair?

A Yes, it can occur as part of the degenerative process, yes.

Q Same with a rotator cuff tear?

A Yes.

Q Correct?

A Yes.

Q And, doctor, you were aware of the fact that after this accident within, you know -- well, you are aware of the fact that two months after this accident Mr. Melendez had gone back to work doing some temporary jobs, did you know that?

A Yes.

Q And you are aware that within eight months after this accident he became a traffic enforcement agent for the NYPD?

A Yes.

MR. ROSS: Thank you, Doctor. I have nothing further.

THE WITNESS: Thank you.

THE COURT: Redirect?

MR. ROTH: Thank you very much, Doctor.

REDIRECT EXAMINATION

BY MR. ROTH:

Q Dr. Touliopoulos, you mentioned on Direct that you reviewed Mr. Melendez's prior orthopedic reports?

A Yes.
Q What recommendations, if any, did Mr. Richard Parker make regarding Mr. Melendez's left shoulder?
A Arthroscopic surgery.
Q And what recommendations, if any, did Dr. Tal Kleinman make with regards to his left shoulder?
A Arthroscopic surgery.
Q And what recommendations, if any, did Dr. DeMarco make with regards to Mr. Melendez's surgery?
A Arthroscopic surgery.
Q And in reviewing those records, did each of those doctors form an opinion as the proximate cause of the --
MR. ROSS: Objection, your Honor.
THE COURT: Sustained. Sustained.
Q Okay. So the records are in evidence.
So my colleague touched on the difference between subjective and objective range of motion. And we talked before about passive versus active range of motion; correct?
A That's correct.
Q And now when you perform -- is the active where you move it yourself?
A No, active is when the patient moves it.
Q And passive is when you perform it?
A Yes.
Q And if a patient is resisting or guarding when you are

trying to move it, would you note that?

A If the passive motion is limited, it's usually limited by pain and/or some sort of mechanical restriction.

Q And as an orthopedist, can you feel a mechanical restriction?

A You -- usually you have a good idea.

Q Do you have an opinion to a reasonable degree of medical certainty whether Mr. Melendez was not putting forth a genuine effort?

MR. ROSS: Objection, your Honor. How -- objection.

THE COURT: I don't see how the reasonable effort is -- sustained.

Q Did you see any indication Mr. Melendez wasn't trying?

A No.

Q Okay. Now, are you going to be able to see a rotator cuff on X ray?

A No.

Q Are you going to see a rotator cuff tear -- withdrawn.

Are you going to see a labral tear on X ray?

A No.

Q What is the mechanism to make that diagnosis?

A Well, the gold standard to make that diagnosis would be an arthroscopy. We actually go in to look, but second best would be an MRI.

Q And do you have an opinion to a reasonable degree of medical certainty whether a forty pound beam -- forty pound, fifteen foot tall beam falling on someone, hitting their head and shoulder is a mechanism of injury consistent with a traumatic rotator cuff tear and labral tear?

A Yes.

Q What is your opinion?

A That it is.

MR. ROTH: Nothing further. Thank you.

THE COURT: Recross?

RECROSS-EXAMINATION

BY MR. ROSS:

Q Just real quick, other than counsel's question where he asked you to assume that the pipe or the tubing hit Mr. Melendez in the head and the left shoulder, you have no other evidence to indicate that his left shoulder was ever actually impacted as a result of this accident, yes or no?

A I -- again, I am relying primarily on the patient's -- and also my review of the records that I have in my possession.

Q And, again, the records do not have any objective evidence that he was struck actually in the left shoulder, it's only what the plaintiff told each of those doctors, correct?

A I believe so.

MR. ROSS: Thank you. I have no further questions.

THE COURT: Anything else?

MR. ROTH: No, your Honor. Thank you.

THE COURT: Thank you very much, Doctor. You may step down.

(Witness excused.)

THE COURT: Can the attorneys approach?

MR. ROTH: Sure.

(Whereupon, a side-bar conference was held at this time.)

THE COURT: All right. We will take our lunch break now. So get an extra lunch and see you at 2:15.

Have a good lunch.

COURT OFFICER: Jury exiting. Please rise.

(Whereupon, the jury exits the courtroom at this time.)

THE COURT: Anything else before we break?

MR. ROTH: No.

THE COURT: Hearing none, have a good lunch.

MR. ROSS: Thank you. You too.

(Whereupon a luncheon recess was taken at this time.)

THE COURT: All right. So on the record. So we're about to show for the jury -- we're outside the presence of the jury for now. But we are about to show a video of Dr. Hausknecht that was taken last Wednesday, correct?

MR. ROTH: Yes. Yes.

MR. ROSS: Yes.

MR. ROTH: That's correct.

THE COURT: Obviously that will be incorporated into the trial testimony and the trial transcript.

So I guess my question is, are you both stipulating whatever is the transcript that you both have will be incorporated into the official transcript of this trial?

MR. ROTH: Yes. Stipulated by plaintiff, Judge.

MR. ROSS: Stipulated by defendant.

THE COURT: So we won't have you take it down. Why don't we bring the jury in and give a short introduction and then we'll play the video.

Off the record.

(Discussion off the record.)

COURT OFFICER: All rise. Jury entering.

(Whereupon, the jury panel enters the courtroom at this time.)

THE COURT: Okay. Everyone could be seated please.

Good afternoon. Members of the jury, I hope you had a good lunch. So what we'll be doing at this point is showing a video of the trial testimony -- trial testimony of Dr. Hausknecht. So it was videotaped strictly for scheduling purposes.

So what I will do is, I will instruct you that you are to consider it as if the doctor was right here. There

was cross-examination. He will be -- so consider this as you would any testimony live in-person in court.

MR. ROSS: Thank you.

(Whereupon, the videotape is played in open court at this time.)

(Whereupon, the videotaped deposition of Dr. Aric Hausknecht was played in the presence of the jury in open court.)

MR. ROSS: Objection.

THE COURT: Can you rewind for about 30 seconds?

MR. ROTH: Should we approach?

MR. ROSS: Yes.

THE COURT: Okay.

(Whereupon, there was a bench conference held off the record in the presence of the jury.)

THE COURT: What is the page of the transcript?

MR. ROSS: It's page 36, your Honor.

THE COURT: On the record. For our record, on page 36 there was an objection raised. I'm overruling the objection. So I'm allowing the jury to certainly consider the answer. I overruled the objection. So we will continue on.

(Whereupon, the videotaped deposition of Dr. Aric Hausknecht was played in the presence of the jury in open court.)

MR. ROSS: Objection.

(Whereupon, there was a bench conference held off the record in the presence of the jury.)

(Continued on the next page.)

(Whereupon, the videotape was played in open court at this time.)

MR. ROSS: Objection.

THE COURT: So if this were in person, I would sustain the objection.

Jury, just disregard about his other treating physicians. The rest of the answer would be okay. That would be hearsay. I instruct you to disregard that last portion, sentence fragment, that he got out before the objection was made.

Okay. Continue.

(Videotape played.)

THE COURT: And can you just -- I am sorry, what page was that? It will be disjointed.

MR. ROSS: Page 50, your Honor.

THE COURT: That is page 50 for the record.

MR. ROTH: Thank you, your Honor.

(Tape played.)

THE COURT: Hang on. Hang on.

MR. ROSS: I was wondering if we could take our break --

THE COURT: Yes, let's take our afternoon break. Come back in fifteen minutes.

(Recess taken.)

COURT OFFICER: All rise. Jury entering.

(Whereupon, the jury panel enters the courtroom at this time.)

THE COURT: So everyone could be seated please. Let's continue on with this video.

All right. So what page is that?

MR. ROSS: 59, your Honor.

THE COURT: So I overruled the objection. I am allowing the jury to regard this testimony.

(Whereupon, the videotape was played in open court at this time.)

THE COURT: This whole line of questioning was overruled, the objection, so you could regard it.

MR. ROTH: Thank you, Judge.

(Whereupon, the videotape was played in open court at this time.)

THE COURT: Can you pause it? Just pause it. In terms of that last question, I will sustain that question. I will instruct the jury to disregard that question on relevance grounds.

What page is that? Sorry.

MR. ROSS: 62, your Honor.

THE COURT: Okay. Page 62.

(Video played in open court.)

THE COURT: I didn't hear. What was the question on that one?

MR. ROSS: You want me to read it to you?

THE COURT: Sure.

MR. ROTH: Whoa. Why don't we read it up front?

MR. ROSS: Sure.

(Whereupon, a side-bar conference was held at this time.)

THE COURT: I will sustain the objection to that last question. So there might be an answer.

Well, there was an answer, so I will instruct you to disregard about this Complete Care, and -- on-the-job as irrelevant.

MR. ROTH: Thank you.

(Whereupon, the videotape was played in open court at this time.)

THE COURT: Okay. So I just do want to say there was a motion to strike.

As with everything, disregard the nonresponsive portion and we'll strike that.

All right. So thank you for your patience. We are a little past 4:30, but I wanted to finish the tape. We will see you tomorrow morning. We have witnesses starting in the morning. See you in the morning at 10.

Have a good evening.

COURT OFFICER: All rise. Jury exiting.

(Whereupon, the jury exits the courtroom at this

time.)

THE COURT: Anything we need to cover before we finish for the evening?

MR. ROTH: Nothing from plaintiff.

MR. ROSS: Nothing from defendants.

THE COURT: All right. See you tomorrow.

(Whereupon, the case is adjourned to March 25, 2025, at 10:00 a.m.)

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