2002 WL 33968985 (N.Y.Sup.) (Expert Trial Transcript)
Supreme Court of New York.

KIRBY,
v.
COLUMBUS CENTRE.

No. 10757002.
2002.

(Transcript of Dr. Steven Touliopoulos)

Name of Expert: Steven J. **Touliopoulos**, M.D.
Area of Expertise: Medical & Surgical >> Surgery -- General
Area of Expertise: Medical & Surgical >> Orthopedics
Representing: Unknown
Jurisdiction: N.Y.Sup.

MR. BOROWICK: Thank you, Judge. I will call Dr. Touliopoulos.

STEVEN TOULIOPOULOS, called as a witness by the Plaintiff, having been first duly sworn, testified as follows:

THE COURT OFFICER: For the record, please state your name and county of residence.

THE WITNESS: Steven Touliopoulos. I practice in --

THE COURT: Spell it.

THE WITNESS: T-O-U-L-I-O-P-O-U-L-O-S. And my practice is in New York City.

MR. BOROWICK: May I proceed?

THE COURT: Please.

DIRECT EXAMINATION

BY MR. BOROWICK:

Q. Doctor, good morning -- I'm sorry, good afternoon.

I am going ask you to keep your voice up so everybody can hear what you have to say.

Doctor, what is your occupation?

A. I am an orthopedic surgeon.

Q. What does that mean?

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A. It's a physician that specializes in disorders of muscles and bones.

Q. And what background, education and training do you have that allows yourself to call yourself -- allows you to call yourself a physician and orthopedic surgeon?

A. I went to medical school at State University of the New York Health Science Center of Brooklyn. I did my orthopedic residency there, and then I did a sports fellowship at Lenox Hill Hospital in Manhattan.

Q. And what is -- are you registered -- licensed to practice medicine?

A. Yes, I am.

Q. By what state?

A. New York State.

Q. And can you tell the jury what did your fellowship involve?

A. My fellowship involved traumatic injuries of joints, specifically of the shoulder and the knee.

Q. And what experience have you had since taking that fellowship in connection with treating joints as an orthopedic surgeon?

A. The vast majority of my surgeries are surgery involving traumatic injuries of joints.

Q. And are they sports injuries or traumatic injuries or what?

A. They are usually traumatic injuries, usually sports related or from falls or various mechanisms.

Q. And would you tell the jury, are you a member of any professional associations?

A. I am part of the American Medical Association, American Academy of Orthopedic Surgeons, New York Society, the Queens and Brooklyn Orthopedic Society.

Q. With regard to the Academy of Orthopedic Surgeons, what kind of group is that?

A. It's a group that is limited to physicians that are Board certified.

Q. What does Board certification mean and are you Board certified?

A. Yes, I am Board certified. And to become Board certified, you have to pass a two-part examination. That is taken after you finish your training. First part is a written part and the second part is an oral examination.

Q. And after your fellowship, did you have any further training in orthopedic surgery?

A. After my fellowship I went into private practice.

Q. Are you still in private practice?

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A. Yes, I am.

Q. How long have you been in private practice?

A. Perhaps seven years now.

Q. And are you -- do you have a partner?

A. I have several partners, yes.

Q. Do you know who Andrew Merola is?

A. Yes, I do.

Q. Who is that?

A. He is a physician in my group. He's one of my partners who specializes in spine.

Q. And what is your specialty?

A. Again, sports injuries, or traumatic injuries of the joints.

Q. And do you have a specialty or subspecialty within that of any particular joints?

A. Again, the majority of my surgeries involve surgery on the shoulder and the knee.

Q. And would you tell the jury, are you familiar with a man named Blake Kirby?

A. Yes.

Q. And are you his treating physician or one of his treating physicians related to his shoulder?

A. Yes, I am.

Q. And when did you first meet Blake Kirby?

A. Can he I just see my chart?

MR. BOROWICK: I'm sorry.

Q. Did you bring -- do you maintain in the ordinary course of your business as a physician, are you required to maintain a chart on every patient?

A. Yes.

Q. And do you have a chart relating to Mr. Kirby?

A. Yes, I do.

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Q. And did you bring it with you?

A. Yes.

Q. Let me just ask you this, I'm going to ask you to do this. If you are going to refer to your chart for anything in particular or read from your chart, please, you can refer to it for anything, to refresh your recollection, just let us know that you are doing that.

A. Okay.

Q. When did you see him for the first time?

A. My initial evaluation was on May 7th, 2002.

Q. So approximately three-and-a-half weeks after an accident, he came to your office at whose referral?

A. He was referred to me by Dr. Merola.

Q. And for what condition was Dr. Merola treating him?

A. Dr. Merola was treating him for his neck injury, and he referred the patient to myself for his shoulder injury.

Q. When you first saw Mr. Blake Kirby, what were his initial presenting complaints with regard to his shoulder?

A. He complained of significant pain in the shoulder, with associated weakness and inability to move his shoulder because of the pain.

Q. And were you able to examine him at the time?

A. Yes, I was.

Q. And did you get a history prior to his examination, did you get a history of what happened to him, generally?

A. Yes. My history was that he was 36 years old at that time, he was right-hand dominant, and that he had no prior history of shoulder symptoms or trauma; and that while at work at a construction site, a steel rod fell approximately 90 feet, striking him in the neck and left shoulder region.

Q. And, sir, can you tell us with that type -- I want you to assume for a moment that the testimony by an eyewitness, the rod was approximately 15 feet long, made of steel, about a half-inch in diameter, and it fell approximately a hundred feet, without anybody having a tape measure.

Would the forces created by such a fall of a piece of steel be significant to you upon receiving a history like that?

A. Yes, it would be. And the force is a product of the mass times acceleration. So both the mass and acceleration are large numbers because it is a steel rod and it's falling from 90 feet, so there's a significant accelerating. So there's a tremendous force that's imparted to the body by the steel rod.

Q. I want you to assume that there's been testimony in this case that the length of the rod when it struck Mr. Kirby, there was some flex in it and it actually bent as it went around or made contact with his shoulder.

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With that kind of description, did you observe when you examined Mr. Kirby, any injury to his shoulder that would be consistent with that kind of impact?

A. Yes, on examination I elicited palpation along -- basically when I touched the shoulder, he had a lot of pain. There was a lot of muscle spasm. Muscles in the shoulder area were very tight. Other significant findings included positive apprehension and relocation tests.

That's the test that I perform to determine whether or not the shoulder is loose. And they were both positive.

In addition, when I tried to move the bones, they shifted to a significant degree, also confirming that his shoulder was loose.

He had very significant limitation in motion in strength, and, again, he had, when I moved the shoulder, it elicited a lot of pain.

Q. Now, you mentioned pain a couple of times.

Is pain objective or subjective?

A. Pain is a subjective complaint. But the way that it's elicited is an objective, is also an objective finding.

Q. And muscle spasm, the tightness in the shoulder or apprehension tests, you said that they were -- the tests were positive. Is that positive for abnormal or positive for normalcy?

A. That's positive for abnormality.

Q. And are those tests considered objective or subjective?

A. Those tests are objective.

Q. So that even though a report of pain is subjective, for example, if I have nothing wrong with my shoulder, if you put me through the motion and I said ouch, ouch, ouch, you know, but you didn't find any objective findings, whether it be spasm in my muscle joint or the positive apprehension or limitation of motion, you might not necessarily believe the subjective complaints, right?

A. If there were no physical findings that were confirmed to support the pain, then there may be other explanations for the pain, that's right.

Q. One of them might be that I'm a malingerer?

A. That's correct.

Q. Did you ever, in the two years that you have been treating Mr. Kirby, did you ever come to a conclusion or have a suspicion that he was a malinger?

MR. ROSS: Objection.

THE COURT: Sustained.

BY MR. BOROWICK:

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Q. Did -- based on your exams -- by the way, how many times have you seen Mr. Kirby other than for the surgery?

A. Eleven times.

Q. And in the -- when was the most recent?

A. March 9, 2004.

Q. So over the last two years, in those 11 visits, did he ever give you any complaints or report any symptoms subjectively that weren't objectively reconciled?

A. No, he has not.

Q. As part of your practice, do you on occasion get patients where when you listen to their symptoms and then evaluate them, you don't accept the validity of their symptoms or complaint; you feel they are lying or trumping it up?

A. I do. It's unusual. And there are patients may present with shoulder pain and it may be coming from the neck; so it's possible that you can have a normal shoulder exam and the patient has a bad neck problems. So there may be other reasons for the pain or the patient may be malingering, as you refer to.

Q. Ever have the opinion in the eleven visits plus surgery that my client, Mr. Kirby, was a malingerer or exaggerator?

A. Not at all. No at all.

Q. I want you to assume --

MR. BOROWICK: Subject to us getting a clean copy, Judge, and putting it in evidence, counsel has agreed that this will go into evidence, the Lenox Hill record and ambulance call report -- I.

Q. Want you to assume --

MR. BOROWICK: Correct?

MR. ROSS: Yes.

BY MR. BOROWICK:

Q. I want you to assume that the chief complaint to the ambulance was about the shoulder, and that he -- that according to the ambulance report, 36-year-old white male found standing, walking to ambulance with complaint of being hit by a rebar after it fell ten stories. Patient denies head trauma or loss of consciousness. Shoulder appears to be anteriorly dislocated.

And there's also a complaint in the triage notes of rebar fell from height, left shoulder, and complaint of pain shoulder and neck.

Sir, I want to ask you, based on the history and ambulance report, the history and the emergency -- by the way, have you reviewed those records?

A. Yes, I have.

Q. Have you also reviewed your own chart, including the operative report?

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A. Yes, I have.

Q. And in addition to those records, have I provided you with a copy of prior medical records, prior to the date of this accident, treating to an accident back in '91, which involved Mr. Kirby's low back?

A. Yes, you have.

Q. And did you review those records from Kateri?

A. Yes, I have.

Q. And I asked you, well, to review records from The Spine Institute, both of which records are in evidence.

Did you review those?

A. Yes, I have.

Q. Based upon your review of Exhibit 6, which is the Kateri Memorial Hospital Center, and Exhibit 7, which is The Spine Institute, did you consider whether or not Mr. Kirby had preexisting medical history that was relevant to his shoulder?

A. There's nothing in the records that I reviewed that refer to injury of the shoulder joint.

Q. Okay. Now, do either of those --

MR. ROSS: Excuse me, I didn't hear the very last word.

MR. BOROWICK: Shoulder joint.

BY MR. BOROWICK:

Q. Were there mention in these records from '91 and '92, are there mention in the records of anything related to the shoulder?

A. They allude to shoulder motion, and they allude to scapula pain, but nothing that states that there was injury or deficit or dysfunction of the shoulder.

Q. Now, I'm going to ask you to give the injury -- I am sorry, I didn't bring a model with me. But I'm going to ask you to give the jury a little bit of a lesson of the anatomy of the bones, muscles. Are there joints, are there -- what are there.

A. Sure.

Would you like me to demonstrate on a diagram?

Q. Well, the diagram --

THE COURT: Do you want the doctor to draw a picture, is that what you are asking him to do that?

MR. BOROWICK: I wasn't.

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Q. But you could -- let's use this. I am going to show you Exhibit 5 which is marked in evidence, and I am going to ask you, if you would, to come down, with the Court's permission, Exhibit 5 -- Exhibit 5 for the Court's reference is a depiction of the shoulder surgery that he did.

But in that context, would you use this document, this diagram, to explain to the jury the anatomy of the shoulder -- you can put it up there -- anatomy of the shoulder and the parts of the shoulder, either the scapula that was referenced in the old records or the joint which is referenced by you.

MR. BOROWICK: Try to stand to the side.

A. The shoulder is made up of ball and socket. The ball is called the humerus. The socket is called the glenoid. And here you see the ball socket is just on the inside of this. And this is a close-up of the shoulder joint.

The shoulder joint is surrounded by soft tissues. Soft tissues include muscles, tendons and ligaments, and they kind of hold the shoulder in place; otherwise, the shoulder just slides out of the socket. It's very unstable, joints. Unlike the hip joint, the ball doesn't want to leave the big socket. The shoulder has a shallow socket and big ball. Without the capsule and ligament, it tends to be extremely unstable.

Now, the rotator cuff is one of the muscles that helps move the shoulder. And this is -- there are four rotator cuff muscles. The most important one is the supraspinatus muscles, one of the rotator cuff muscles. The muscle becomes a tendon, attaches to the bone and that's what allows to you move your shoulder.

This is the ball, this is the bone, and this is the socket. This is the glenoid and this structure here is the ligament. And that is the structure that has a little bit of play in it which allows you to move the shoulder but does not have that much play in it; otherwise, the shoulder could become loose and some people can dislocate it, when that's the situation like that.

Q. Before you go any further.

You mentioned that the old records of the old injury, there was reference to the scapula and, in fact, the lowest end of the scapula -- on my back, would you first point to the level of the shoulder joint?

A. The joint is here.

Q. And where is the lower end of the scapula?

A. It's down here.

Q. And I want you to assume for a moment that in a prior injury, my client suffered an impact from a beam to his low back, which generated some pain and discomfort to the lower end of the scapula.

Does that have anything to do with the injury that he sustained in this accident to his joint?

A. No, it does not.

Q. Would you continue with the anatomy description.

A. This structure, that's actually what the pathology is, what was wrong with the shoulder, is that this ligament was loose. And the other structures, of course, this is the deltoid muscle which you can feel here. The rotator muscle is deep, not something that we can fully feel from the outside. And this area here we call this area of subacromial space. It's between the bullet and

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top bone here at the cromium. This area, usually a socket of fluid that we call the bursa. This joint here is called the acromia, collar joint. The shoulder has two joints, the main joint, which is the glenoid humerus, and small joint here called the acromial collar, collar joints.

Q. What's the definition of a joint generally?

A. The joint is structural, allows motion.

Q. Is it usually between two bones?

A. It's between two bones and it includes cartilage that covers the bones, as well as ligaments. Holds the bone together.

Q. During the course of your testimony, already you have given us some of the tests that you did and some of the results. You said positive apprehension and something else.

Would you tell the jury, showing them on the anotomical drawings, what you did, what it showed, as best you can on this drawing.

A. The -- well, the test translation which where I just test to see if the shoulder is loose -- maybe I can show on your shoulder. That would be easier.

I actually pulled the -- I hold the ball with one hand and I stabilize the shoulder with the other and I move the ball forward and backward to see if it moves. And that's objective findings. Patient has no control over that. And I go to the other side to see if there's a difference.

In this patient there's a big difference between the two shoulders as far as the amount of distance the shoulder moved.

Q. What is the apprehension test?

A. The apprehension test, another test that also helps us to figure out if the shoulder is loose. What we do is we raise the arm in this direction, adduction, an external rotation, and we push forward in this direction on the ball and to see if that causes the ball to shift. And that actually did, the ball wanted to slide out of socket, and the relocation is when we push it back in. And we were able to actually put the ball back into the socket, which reduced the patient's level of pain.

Q. And based on those tests, when compared to the other shoulder, did you find pathology?

A. Yes, I did.

Q. And, Doctor, in addition to your examination and your solicitation of symptoms and complaints, and your review of the medical records, did you have any tests or review any tests, scientific technological tests relating to his shoulder?

A. Yes. I reviewed the MRI scan, left shoulder.

Q. And was that MRI scan, if you could look at the record for the moment and turn to the surgery, would you tell us, what was the date of that MRI scan?

A. Dated May 1, 2002.

Q. Okay. So that would be a month after the accident, the MRI scan was done, and what did it show?

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A. It showed findings consistent with a partial tear of the mid-portion of the such spinatus tendon, as well as mild osteoarthritic changes of the AC joint.

Q. Mild arthritic change, is that a significant finding for you?

A. No, it's not. It's found in most MRI scan patients his age with no significance.

Q. What about the tear on the supraspinatus, is that a normal finding for a 36-year-old man?

A. That is not a normal finding.

Q. And would you show us what -- when you did the surgery, were you able to confirm what the MRI had shown?

A. Yes.

Q. Were there additional injuries that he suffered as a result of this impact that were not shown and demonstrated on MRI?

A. Yes, there other findings that I have -- that I have in my operative report.

Q. Would you please --

MR. BOROWICK: I am going, subject to counsel and I'm sure will stipulate the operative report, subject to putting them in clean copies, I will refer to them, Judge.

BY MR. BOROWICK:

Q. And reading from your operative report, the St. Vincent's Hospital, May 16, 2002. Surgeon, Steven Touliopoulos, procedure performed, left shoulder open anterior-inferior capsulorrhaphy --

A. Capsulorrhaphy.

Q. Left shoulder arthroscopic debridement of partial rotator cuff tear and arthroscopic subacromial bursectomy.

And your post-operative diagnosis was left shoulder under surface rotator cuff tear, left shoulder anterior-inferior instability, and left shoulder secondary subacromial bursitis.

With that description, Doctor, would you tell us what that means? First of all, before, you tell us what you did.

A. The patient, again, primary pathology doesn't show up in the MRI. He has a loose shoulder. MRI is very good at showing things that are ripped, but it hardly ever shows you something that's been stretched out. So the shoulder was loose, something that we know, it's obvious in the examination. We confirmed it at the time of surgery but not something that shows up on the MRI. And the MRI does not diagnose instability. What the MRI does show are the other findings, the other things that go along with the loose shoulder.

When a shoulder is loose, it wants to kind of come out. Every time it does that, this ball slides down, this muscle gets pulled up, and that causes pulling on the tendon and these patients almost always develop a partial injury on the under surface of the tendon. So --

Q. Did he?

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A. And he had -- we saw it when we opened the shoulder. Under the tendon here, it was partly torn, and the trigger for that is actually to just shave it and trim it down. You don't have to sew up, most partial tears don't need to be sewn up, also, because the shoulder kept sliding out, because the inflammation of the certain areas, and he had that, he had a bursitis in this area here, which is also found with loose shoulders. And we also actually shaved that down and cleaned that up.

The primary procedure, however, was the capsulorrhaphy, meaning tightening the ligaments.

Q. And that's shown on right side of the diagram?

A. Yes.

Q. And would you describe what you did in that procedure?

A. The first part of the operation actually is not even an operation. Once the patient is asleep, I re-examine the shoulder when there's no pain, so nothing that could possibly limit me from getting a good exam, and I was able to notice that the shoulder was loose again.

Then we position the patient so that we are able to pull the cameras in. We made three little holes in the shoulder where we introduced the camera and the shaver to do our work, the work I just mentioned, the cleaning of the partial tear and bursectomy, removing the inflamed bursitis.

We were also able to confirm at that time that the ligaments were stretched out, that the shoulder was loose.

And we looked at this, the joint here where the MRI said there was some arthritis, and I looked inside it and there was really no significant arthritis in that joint. There was nothing that needed to be done for that. The joint was not causing any of the patient's symptoms.

We then finished with the camera portion of the surgery and then went to the open procedure. The procedure is done through a two, three-inch incision in front of the shoulder, which is approximately here. And we have to split the muscles, so we go between the deltoid muscle here and pectoralis muscles which is on the inside, which brings us to the deeper level.

We also have to reflect the rotator cuff muscles before we can get to the capsulorrhaphy.

What we do is something called a T-shaped capsulorrhaphy. So this whole structure is loose. It's like inflated like a balloon and we have to tighten it up.

So, we make this incision in the capsule. We bring the bottom portion up and we bring the up portion down. And that reduces the overall volume of the shoulder capsule.

So, we do it so that we don't want the shoulder too loose, too tight, but there's a fine balance. And quite frequently, the surgery is very successful at alleviating instability, but can result in some loss of motion because there is a tradeoff; you have to tighten the ligaments.

So we sewed up the ligament, closed the muscle layers and closed the skin and that was the end of the surgery.

Q. And was this surgery, you mentioned scope procedure, was that done under general anesthetic or lower?

A. He had regional block, where they anesthetize the arm. And he also had general anesthesia in addition to that.

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Q. So he was out cold for it?

A. For the whole operation he was out.

Q. So, would it be fair to say that being totally anesthetized, he would not have felt pain during the

Q. Okay. Now after you did the surgery -- are you done with that diagram? Have you described the entire procedure?

A. Yes, I have.

Q. Do you teach orthopedic surgery?

A. Yes.

Q. Who did you teach it to?

A. I have privileges at three teaching hospitals: I teach in Lenox Hill, residents at St. Vincent's and residents at Downstate Hospital.

Q. You can resume your seat now, if you would.

Before you do, actually, I'm sorry, I am making you go back and forth.

Have you looked at this diagram, Exhibit 4?

A. Yes.

Q. And is it a fair and accurate depiction of the mechanics of the accident insofar as it relates to the shoulder injury?

A. Yes, it is.

Q. And I have covered the portion relating to in connection with the -- at the Court's direction. I am going to ask you to describe how the accident itself is described by Mr. Emerson, how it caused the injuries that you have identified.

A. The metal pole, pipe, landed on the patient's shoulder. The force was transmitted through the bones to the joint causing the joint to move, and could have actually come out all the way, half way, all of the way and popped back in. The EMS notes stated that there was an obvious disformality consistent with the dislocation. It probably was. And the patient may have somehow got it back in on his own.

Regardless of how far it came out, it did cause the shoulder to move. And when that happened, it pulled on the ligaments and that causes the ligaments to stretch out.

Q. And I want you to assume that as a result of the accident, when he was taken, as you said, by ambulance to the emergency room, and in the emergency room did you review the hospital record with a view toward assessing what treatment, if any, they gave?

A. I did review the hospital record, radiographs of the shoulder, and which are x-rays. And they gave him a sling to go home with.

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Q. What about medication for the pain?

A. I have to review the records.

Q. Would you step back and would you resume your seat.

Sir, would you tell the jury, was he given any medication at the hospital?

A. Yes. They have notations here that Vicodin, which was a narcotic medication, was prescribed.

Q. What does it mean, a narcotic medication?

A. It's a -- Vicodin has codeine, which is a narcotic.

Q. How does it act on pain?

A. It's an opiate that acts on the central nervous system to suppress pain.

Q. Would you tell the jury after you did the analysis of his injury and you operated on him, how did his post-operative course go. Tell us what happened as his treating physician, tell us what happened.

A. Early on, he saw me -- I am referring to my chart -- for the first post-operative visit on 5/28/2002. He had complaints of surgical pain, expected complaints. Shoulder was examined. There were no signs of infection. We removed the staples and we instructed him to continue with the shoulder sling and to begin physical therapy in two or three weeks and continue with his medication.

Q. And according to the chart -- by the way, do you know or do you recognize Mr. Kirby?

A. Yes, I do.

Q. And having seen him eleven times over the two years and operated on him, did you follow his progression? Did he make any progression after of the surgery?

A. Yes, he has made some progress.

Q. Was the surgery successful?

A. It's successful with respect to he is better than he was before the surgery.

Q. Did the surgery cure his shoulder problems?

A. It cured his instability, yet, he does have residual limitation in shoulder function.

Q. And does that limitation continue through 2004?

A. Yes, it does.

Q. And do you have an opinion with a reasonable degree of medical certainty in your field, having operated on him, having seen him all those times, as to whether or not that those sequelae, those residual problems are permanent?

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A. At this point, more than two years post-operative, they were permanent, yes.

Q. And let's talk about those residuals for a moment.

What exactly are his permanent residuals from the shoulder injury?

A. You can refer to my most recent examination.

Q. Please do.

A. And the patient states that his pain and function had improved with the surgery, that he does have -- but he does have some residual stiffness, discomfort in the shoulder, stiffness. He complained of difficulty performing repetitive overhead activity because of these symptoms, and had difficulty lifting objects of moderate to heavy weight.

He denied numbness of his hand.

On examination, motion, range of motion reveal flexion, which is in this direction, of approximately 150 degrees. Abduction, which is in this direction, of 130 degrees. And ex-rotation, which is this direction, 40 to 45 degrees. His internal rotation which is measured in this direction was T9, which is the level of his vertebral bar that he could reach.

When we tested his strength, he still had residual difference in strength. Left was weaker than the right. There were no longer signs of looseness. The shoulder was tested and it was no longer loose.

Q. Now, Doctor, as his treating physician, did you have occasion after his surgery to prescribe any prescription medication?

A. Yes. I -- following his surgery, I also prescribed to the patient Vicodin, the same medication that was prescribed to the patient in the emergency room.

Q. Other than pain medication, have you prescribed any anti-inflammatories?

A. I recommended anti-inflammatories and the patient has been taking Aleve as an anti-inflammatory.

Q. What does an anti-inflammatory do?

A. It works on different principles. It helps reduce inflammation which also helps with pain.

Q. And the pain and the limitations that you have described as being permanent residuals, how do they react at the present time to exertion?

For example, the more he exercises, the more he uses, the more he lifts, if he was to try to go back to work, what would do that to his shoulder?

A. The more he lifts, heavier, the more symptoms he would have.

Q. And as a matter of opinion, with your experience and expertise in shoulder injuries and shoulder conditions, when you first saw him, did you have an opinion as to whether or not he could be an ironworker?

A. When I first saw him, initial evaluation was that, my opinion, was that he was totally disable.

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Q. Do you have an opinion at the present time in March of 2004, having treated him for two years, do you have an opinion as to whether or not he is currently able or disabled from his career in iron work?

A. My opinion he's currently disabled from a career in ironworker.

Q. Do you have an opinion as to whether or not he is able to or disabled in doing any physical manual labor?

MR. ROSS: Objection.

THE COURT: Did you say something?

MR. ROSS: Objection.

THE COURT: Really.

MR. ROSS: Any physical manual labor, yes.

THE COURT: You are objecting to this?

MR. ROSS: Yes.

THE COURT: On what grounds? Just state the grounds.

MR. ROSS: Well, I have to state it to you.

THE COURT: Just state the legal grounds.

MR. ROSS: It's objected to because there's no testimony.

THE COURT: That's not stating the legal grounds.

MR. ROSS: There's been no evidence offered in that area, your Honor, at this stage, nothing.

THE COURT: Well, he's asking for the evidence. That's -- if that's the objection, I don't really understand the objection. Overruled.

THE WITNESS: Can you repeat the question?

BY MR. BOROWICK:

Q. Can he do, in your opinion, can he do any physical manual labor in a vocation -- in a vocational sense as a job?

MR. ROSS: Objection.

THE COURT: Do you understand the question, Doctor?

THE WITNESS: Yes, I do.

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MR. ROSS: Objection. I would like to approach.

THE COURT: State the objection. I'm giving you another chance.

MR. ROSS: He is not qualified as an expert in vocational rehabilitation.

THE COURT: All right. Is the question whether --

MR. BOROWICK: I will ask this --

THE COURT: -- whether Mr. Kirby can do work that involves lifting? Why don't you to put it in that context?

BY MR. BOROWICK:

Q. Sir, do you have an experience assessing the vocational ability of a patient post-operative with regard to reentering a work force and doing lifting, heavy lifting?

A. Yes, I have experience.

MR. ROSS: I note my objection again.

THE COURT: For the same reason?

MR. ROSS: Yes, because the questions are very general and broad. If counsel wants to ask him specifics about how much he thinks this individual can or cannot lift in pounds, that's fine.

THE COURT: No, no. The objection to whether -- the present question is whether the doctor has any experience in that area. And the answer is yes.

THE WITNESS: Yes.

THE COURT: What's the next question?

BY MR. BOROWICK:

Q. In your opinion, Doctor, having that experience in assessing ability or disability with regard to working in heavy lifting situations, do you have experience assessing whether or not somebody could do exertional manual labor?

MR. ROSS: Objection, your Honor.

Q. Do you have that experience?

THE COURT: Do you want to put it in that question, involving, instead of weight lifting.

Q. I want you to assume that an ironworker foreman has testified that iron work requires a person to lift heavy materials over his head, lift and carry, climbing up columns, holding heavy tools overhead for a period of time and use pneumatic tools.

Is there any question in your mind, based on your experience, as to whether or not this man could ever be an ironworker again?

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A. My opinion is that he can never been an ironworker again.

Q. I want you to assume that there are other manual labor jobs, whether it means sweeping, being a custodian, I'm talking about 40 hours a week on a regular basis, two, three weeks off in a year, but on that regular full-time basis, could this man do any exertional physical manual labor pain free with his shoulder the way it is?

MR. ROSS: Objection.

THE COURT: Wait. Wait. Are you referring to labor that would involve the shoulder?

MR. BOROWICK: Sure.

THE COURT: That's part of the question. Anything involved, lifting, reaching, carrying on a regular basis during a full-time job.

MR. ROSS: Objection. I would like to have a voir dire. We can do it outside the presence of the jury, considering this vocational assessment that he's trying to get from the witness.

THE COURT: I don't know why we have to do it in terms of vocational assessment. Withdraw that question and ask the doctor whether that he could do anything that involves the shoulder.

MR. BOROWICK: Withdrawn.

BY MR. BOROWICK:

Q. Doctor, could this patient, given just his shoulder injury and the permanent residuals that he has, could he on a regular basis consistently during a week lift significant weight?

MR. ROSS: Objection, your Honor.

THE COURT: Overruled.

A. No, he cannot.

Q. Could he on a consistent, and I'm -- all of these questions are going to relate to consistent regular basis over the course of a week, could he perform activities over his head?

MR. ROSS: Objection.

THE COURT: By that you mean lifting over his head?

MR. BOROWICK: Either lifting or manipulating any tools or devices over his head.

THE COURT: Okay.

MR. ROSS: Objection.

THE COURT: Overruled.

A. He would not be able to do repetitive overhead activity.

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BY MR. BOROWICK:

Q. Would he be able to drive a vehicle on a consistent 40-hour a week basis where his right arm would be required either to operate a stick shift or to man a steering wheel?

MR. ROSS: Objection. function of the shoulder?

A. Yes. I mean, we were all born with certain ligament, and it's a certain length. And the ligaments were stretched and we tighten them up. But it's never -- we never put -- can't put exactly the way it was born with, as a result in shortening and results in limitation of motion which I spoke with earlier.

Also, it's ligament that's been injured, so it's a shoulder that is prone for reinjury, with degree of force that may not be as severe as it would have been prior to his work injury.

Q. And you mentioned before that exertion would cause him pain and discomfort. Is he more prone, if not to reinjury mostly which you have just describe, but is he more prone to fatigue and pain than he would normally be but for this accident, just in the ordinary use of his shoulder?

A. Yes, he would be.

Q. Would you tell the jury the scarring that occurs either from the incisions or from the holes for the portals for the scope, or even in his tissue when you sewed it up, is that scarring inside and outside of his body, is that permanent?

A. Yes, it is.

Q. And is scar tissue, is it as good as normal tissue, meaning, as -- is it possessed of the same qualities of the elasticity and function that regular tissue is?

A. No, it's not.

Q. Do you have an opinion with a reasonable degree of medical certainty in your field as to what his prognosis is with regard to his ability to ever do exertional manual labor?

MR. ROSS: Objection.

THE COURT: Overruled.

A. Prognosis is poor.

Q. And do you have an opinion with a reasonable degree of medical certainty as to what his functional or pain level would be in the future, if he does moderate?

MR. ROSS: Objection.

Q. Is his pain going to get worse, stay the same or get better?

MR. ROSS: Objection.

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THE COURT: To the form?

MR. ROSS: Yes.

THE COURT: Clarify the question, please.

MR. BOROWICK: Sure.

BY MR. BOROWICK:

Q. As he ages, now 36 years old, or 37 years old, do you have an opinion as to whether his joint, which has now been altered permanently, according to you, will it cause him more pain, less pain, or will it stay the same?

A. I think in the next several years his shoulder symptoms and function will not significantly change. There's always a chance of developing post-traumatic arthritis after any significant joint injury later in life.

Q. Assuming that he -- assume for a moment he was an active outdoorsman, enjoyed fishing, canoeing, Lacrosse, baseball.

Do you have any opinion with a reasonable degree of medical certainty as to whether or not those things that gave him joy are something that he will be able do in the future?

A. He will not be able to participate in the same level as he had before.

Q. What would canoeing do to his shoulder?

A. Canoeing.

MR. ROSS: Objection.

THE COURT: You mean the act of rowing?

MR. BOROWICK: Yes.

Q. He couldn't do that?

A. No.

Q. What about throwing a ball or Lacrosse basket, that motion?

A. He's allowed to throw, but it's not something that he could do repetitively.

Q. What about fishing. If he had to cast a rod or pull in the big one that didn't get away?

A. I wouldn't pull in a big one. But he can fish. He can't use his arm to throw with any significant force and he shouldn't be throwing things with any significant force.

Q. Now, I want to ask you a few more questions.

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Doctor is there -- do you have an opinion with a reasonable degree of medical certainty as to whether or not the things that you diagnosed, upon your examination and surgery, whether or not they were caused solely by the accident of April 1st, 2002?

A. Yes. My opinion is that they are caused solely by his accident of April 1, 2002.

Q. And in reviewing the Kateri record and The Spinal Institute record which are in evidence, I'm going to read portions of the Kateri record first and that is page -- November, Exhibit 6. It is dated June of 1992, which would be ten years before the accident that we are here for, and the summary is that over the last four months, progress has been made and there was a return of the full pain-free range of motion of neck, back and shoulder.

Is there this notation in the local hospital, where there's full pain-free range of motion, and it references the shoulder, I'm not going to ask you about his neck and back, based on that, the hospital -- the hospital and physical therapy that he was doing, does that confirm or belie or reconcile or not reconcile with your opinion that the '91 event where he injured his low back and the bottom part of his scapula had anything to do with his present condition in his shoulder?

A. It confirms my opinion.

Q. Now, again, there's another document, The Spinal Center, Exhibit 7, and I'm going to read from the discharge summary. And, by the way, you have reviewed those records?

A. Yes.

Q. And with regard to the discharge also in June of 1992, ten years before the accident, the recovery summary. “Blake plans to look for work as a steel worker when it becomes available. He has demonstrated physical capacity during the rehabilitation program appropriate for this type of work.”

Now other reasons, aside for not coming back to New York and resuming his career in inro work, the fact that he was cleared by this Spine Center for -- from his injuries to his low back to resume that type of work, does that confirm or belie or reconcile in any way with your opinion that the prior accident and injury had nothing do with this, the present condition in the shoulder?

A. It helps confirm that.

MR. ROSS: I need ten minutes or so. If I can look at the file.

THE COURT: Okay. Members of the jury, I have to ask you to step out while counsel reviews the records. Please do not discuss the case.

(Jury exits the courtroom.)

THE COURT: We have a forthcoming problem, the juror is writing a note.

(Pause in proceedings.)

THE COURT: Okay. This witness has to be in Brooklyn by 5:30 tomorrow, so that's not terrible. The other one, I have a 9:30 appointment with my neurologist, March 24, so we probably don't have to deal with that.

MR. BOROWICK: That's the next witness, they will be either deliberating or done.

THE COURT: Mark these 2 and 3, court exhibits.

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Jury centering the courtroom.

(The jury entered the courtroom and the following occurred:)

THE COURT: Okay, before we begin the cross-examination, the jurors who wrote me note, no problem, in each case.

CROSS EXAMINATION

BY MR. ROSS:

Q. Good afternoon, Doctor.

A. Good afternoon.

Q. Is it Touliopoulos?

A. Correct.

Q. I am just going to say “doctor” and stay away. I figure I would give it a shot.

Now, with respect to Mr. Kirby, you only treated him for his shoulder, is that right?

A. That's correct.

Q. And I think you testified that Dr. Merola is a colleague of yours in terms of being in the same medical group?

A. That's correct.

Q. At the time that you first saw Mr. Kirby, that was at that point in time in May of 2002, in the beginning, about four weeks or so after the accident, correct?

A. Correct.

Q. And at that time, you obtained a history from Mr. Kirby, is that right?

A. That's correct.

Q. And you looked through your notes here and at that time you obtained a history, you asked him about the accident in terms of how it occurred?

A. That's correct.

Q. And did you ask him about any prior medical conditions? Would it be helpful?

A. Yes. I asked him if he had injured his shoulder previously, and he denied that. And I asked for prior surgical history, history of allergies, any significant medical problems.

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Q. So when you asked about prior injuries, prior conditions, then you were very specific; you said only with respect to the shoulder?

A. That's -- when I -- when I was eliciting prior history of injury, that's correct. It was only for the shoulder.

Q. When you saw him for the first time, did he tell you at that time that he had been struck in the back just under the left shoulder blade by a steel beam back in 1992, did he tell you that?

A. I don't recall. It's not in my notations.

Q. It's not in your notations?

A. That's correct.

Q. Would you agree with me that had he mentioned that to you, that is the kind of information that you would have placed into your notations, would that be fair to say?

A. I usually, if patients have a history of back strain, as this probably was that he recovered from, it would probably be of the degree that I would not mention in my report.

Q. If the person told you that he was struck with a steel beam just under the left shoulder blade, you are saying that that's not something that you would have placed in there?

A. I asked him if he had any shoulder injury and he denied it.

Q. And when he denied that, and, in fact, at that time, Doctor, he also did not tell you that he was receiving treatment for his shoulder or had received treatment for his shoulder, correct?

MR. BOROWICK: Objection. Two questions.

THE COURT: Sustained.

BY MR. ROSS:

Q. Doctor, when you saw Mr. Kirby for the first time, he never indicated to you that he was treated for his left shoulder, is that correct?

A. That's correct.

Q. And you would agree with me, Doctor, that given that you were treating him for the shoulder injury in April of -- May of 2002, that you would want to have that history, would you not?

A. If the patient was aware that he was actually being treated for a shoulder injury, that would be information that I would like to have known.

Q. In fact, you would agree that as a doctor, as the treating physician, you would want to get a complete history of this individual and this patient before you treat the individual, is that fair?

A. With respect to the shoulder and injuries and the injury of the shoulder.

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Q. Yes. And Mr. Kirby never told you that he treated for his shoulder at Kateri Hospital back in 1991 and 1992, is that right?

A. That is correct.

Q. Now, the scapula area, where is that? Could you tell the jury?

A. Scapula is, I pointed out earlier, actually, it's on the mid back area.

Q. And is that below the shoulder blade or above? Does it go -- is the scapula only in that area? Where does it go?

A. The scapula is between the second and seventh ribs.

Q. And if we refer to the upper scapula, where would that be?

A. It would be in the upper back area.

Q. In the upper back.

So approximately where would that be, if you can show the jury?

A. Upper scapula would be back here. Actually, my finger is on the upper scapula right there.

Q. And -- okay. And you would agree, Doctor, that pain in the upper scapula area and pain in that area is pain that one would feel in the left shoulder, correct?

A. You are pointing toward this area?

Q. What's that?

A. You are saying feeling pain in the left shoulder.

Q. Well, in the shoulder area.

MR. BOROWICK: I think we are being vague here about scapula or shoulder.

THE COURT: Fine, just clarify the question.

BY MR. ROSS:

Q. My question to you, Doctor, with respect to the assuming that an individual had the injury as we described prior injury where he was struck with a beam in the left shoulder blade.

MR. BOROWICK: Objection, Judge.

MR. ROSS: That's not --

MR. BOROWICK: The lowest portion, just under the scapula. That's not the left shoulder blade.

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THE COURT: Try not to characterize it

BY MR. ROSS:

Q. Assuming that this, the gentleman was struck in the left shoulder blade. Okay. All right. Below the left holder blade, okay? And I want you to further assume, Doctor, that he was also complaining of upper scapula, upper scapula pain, would that not also affect his shoulder, the left shoulder?

MR. BOROWICK: I am sorry, the shoulder joint or shoulder blade?

MR. ROSS: I am asking him the shoulder. The whole point is it is the shoulder.

THE COURT: Is that a question that is capable of being answered, Doctor, or do you need more information?

THE WITNESS: If you could rephrase it.

THE COURT: All right. Please do that.

MR. ROSS: Yes.

BY MR. ROSS:

Q. Complaints of pain to the upper scapula, and what I will do is, if I may, I am showing you what's been marked as Plaintiff's Exhibit No. 6, which is the hospital records from Kateri Memorial Hospital.

And I would like to show you this reference here, right here, Doctor. And just for the jury's benefit, when we see a C/O, that means “complain of.”

A. Yes.

Q. Complains of upper scapula pain.

Do you see that?

A. That's correct.

Q. What I'm asking you, complains of upper scapula pain. In your experience as an orthopedic surgeon who treats shoulder injuries, someone who has complaints of upper scapula pain, that type of pain would affect -- and this is on left side, would affect someone's left shoulder, correct?

A. It's too vague a question.

Q. You tell me, then, Doctor, it would affect the left shoulder blade?

A. The scapula pain would affect the shoulder blade. Whether or not it affects shoulder motion or the glenoid humeral joint, which is the area of injury, a different anatomical area.

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Q. And you had mentioned about whether or not it would affect the motion. So, in other words, injury might be struck in the lower shoulder blade and then complaining of upper scapula pain, that sort of injury, okay, in your expertise could affect one's range of motion, correct?

MR. BOROWICK: Objection as to what it could affect.

MR. ROSS: Well, your Honor, I'm asking him as an expert. He's an orthopedic surgeon who specializes in treating shoulder injuries.

MR. BOROWICK: But he's asking from records and he's going general, specific, general. I am objecting to the format of the question.

THE COURT: Are you asking as to this patient or general manner?

MR. ROSS: General proposition.

MR. BOROWICK: Objection to that comment. Objection to the form of the question.

THE COURT: All the lawyer's comments are to be disregarded about injury.

As a general matter, do you remember the question?

THE WITNESS: I believe the question was can shoulder pain limit shoulder motion.

BY MR. ROSS:

Q. Yes. Can that type of injury affect one's range of motion in the shoulder?

MR. BOROWICK: In a scapula injury, is that what you are asking?

BY MR. ROSS:

Q. In the scapula injury with complaints of upper scapula pain, can that affect the range of motion with one's shoulder?

A. For the scapula injury has associated muscle injuries above the shoulder, the patient may not want to move the shoulder because it may hurt the scapula, but it won't result in any mechanical limitation of shoulder motion.

Q. Now, the medical records from Kateri Hospital and Spine Institute records, those records you looked at those, was that today for the first time or did you look at them at some point while you have been treating Mr. Kirby prior to today?

A. The records from his injury ten years ago I reviewed the first time today.

Q. Now, you talked about the shoulder being loose, all right, with respect to now, after you saw Mr. Kirby, is that right?

A. That's correct.

Q. And what area of the shoulder was loose?

A. The medical term is the glenohumeral joint.

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Q. Did you examine Mr. Kirby, you had him move or attempt to move his shoulder in all of those different areas, is that correct?

A. Yes.

Q. Was there any clicking at all when he attempted to do that, do you recall?

A. Usually, there is a clicking, I would have a notation. And I don't have any note of that here in my chart.

Q. If there was clicking when someone moves their shoulder, when they try to do it -- I am going to move it around, trying to move my shoulder around, complete, shoulder arm rotation, what, if any, indication would that be? What significance, if any, is there to clicking?

A. Recalling the patient, let me add one thing. When I saw the patient initially he could barely move the shoulder. So clicking with motion would not be practical.

Q. Understood.

A. Clicking in the shoulder could be caused by many different things.

Q. Is there any significance to the fact that one has a shoulder that clicks, that's what I am asking you?

A. No. As a general rule of thumb in the orthopedic community, painless clicking of the joint is nothing to be concerned about.

Q. And when you say painless clicking of the joint, is that what would be effected If someone's shoulder is clicking, it's because it's in the joint?

A. Like I said, there are many different causes for clicking.

Q. Okay.

A. Your question was --

Q. In other words, when you responded, you said clicking in the joint. Is that the only area where clicking would take place? Does it have to do with something affecting the joint or can clicking result from some other portion of the shoulder?

A. It can also involve tendons that snap and click as they move. But it has to do with something moving basically for, something has to move for something to click.

Q. Now, you indicated that you reviewed the hospital record where Mr. Kirby was taken right after the accident, correct?

A. Correct.

Q. And there was an x-ray that was taken of the left shoulder and left clavicle, is that right?

A. That is correct.

Q. And there was no fracture or dislocation noted with the x-ray, is that correct?

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A. That's correct.

Q. Do you know how much this piece of rebar weighed?

A. No, I don't.

Q. Did Mr. Kirby ever tell you that?

A. No, I don't.

Q. Do you know the amount of force or impact that it came down on Mr. Kirby when it first hit his hard hat on his head and then his shoulder?

A. I anticipated earlier about the force that would be a factor of the mass accelerating and, actually, I didn't mention the angle of impact. So that coming straight on it, his body would absorb the full impact, but if it came down in an angle, it would absorb not the majority but a portion of the impact.

Q. He went to the hospital, gets examined, and there was no fracture of any part of the shoulder, correct?

A. That's correct.

Q. And shoulder was not dislocated as indicated by an x-ray of the left shoulder that they took on the day of the accident?

A. That's correct.

Q. Now, you also mentioned on direct examination that there were -- I think this was in response to the MRI of the left shoulder. Did you actually review the MRI film?

A. Yes, I have.

Q. You mentioned, you indicated that there were osteoporotic or mild osteoarthritic changes in the joint, is that correct?

A. That's correct.

Q. And osteoarthritic changes --

A. In which joint? It's in the acromial collar joint. It's not in the glenohumeral joint which is the joint that had the problem.

Q. Understand. But you did observe mild osteoarthritic changes in the acromial AC joint for short?

A. Okay.

Q. And would you agree, Doctor, that was a degenerative condition?

A. That's correct.

Q. In other words, it's clear that the MRI that was done sometime about a month after the accident which showed that, it's clear that that would have preexisted the accident that took place four weeks before, is that right?

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A. Yes, that's correct.

Q. And the x-ray that was done on the day of the accident also indicated some, I think it said mild spurring or bone spurring, something along those lines?

A. It records there's probably early bony spurring at the acromion.

Q. That's a degenerative condition, as well?

A. That's correct.

Q. And that's spurring is like bone growth, is that correct? They start little pieces, they start growing bones?

A. That's correct.

Q. And, again, that was done with the x-ray on the day of the accident, and, therefore, definitely preexisted the accident, correct?

A. That's correct.

Q. And a degenerative condition such as that that was noted in the AC joint, okay -- withdrawn. I will back up.

Have you treated construction workers prior to treating Mr. Kirby?

A. I have treated construction workers.

Q. People who do manual heavy lifting, bending?

A. Yes.

Q. Such that you were describing before?

A. Yes.

Q. And that degeneration condition identifying the MRI in the left shoulder and x-ray of the left shoulder is something that would be consistently found in construction workers that do that type of work, correct?

A. It can be found in construction workers. It can be found in non-construction workers.

Q. In other words, you, me, the Judge or anyone on jury could have that kind of condition, is that correct?

A. Yes. In fact, it's so common that I would say the majority of the patients at some points in their lives would have it.

Q. Now, Doctor, you are not a vocational rehabilitation specialist, is that fair?

A. That's correct.

Q. And you did not make any kind of determination as to what occupations Mr. Kirby is or is not capable of engaging in either in the United States or in Canada, is that right?

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A. I think so. Can you repeat that question?

Q. Sure.

I said that you have not done any type of research or review in terms of determining what occupations Mr. Kirby may be capable of engaging in either in the United States or Canada, is that right?

A. Have I done a review? No, I have not done a review.

Q. And you are not telling this jury that Mr. Kirby is incapable of any type of employment, is that correct?

A. That's correct.

Q. Based upon your examination of Mr. Kirby and the injuries that you described to the jury with respect to the shoulder, if I understood your testimony, your testimony is that do you not believe that he could lift heavy objects, for starters?

A. Moderate to heavy weight.

Q. And you are not telling the jury that Mr. Kirby is incapable of driving, are you?

A. He's allowed to drive. The question before was driving for prolonged periods.

Q. And you are telling this jury that based upon the shoulder injury, he would be incapable of driving for what, X numbers of hours a day, how many hours? Did you do a testing, do you know that, did you do any kind of functioning physical testing to determine how long he would be able to do that?

MR. BOROWICK: Is that all one question?

BY MR. ROSS:

Q. Did you do any type of functioning to determine how long he would be capable of driving a motor vehicle, a car, or anything of that sort?

A. My testing was the testing that I performed in the office.

Q. What was that last part?

A. The testing that I performed was the testing that I testified to previously.

Q. And what testing was that?

A. The testing of motion, strength.

Q. And would you say that motion, strength, you are talking about asking him to move and do certain things?

A. Not only that, but actually moving the shoulder on my own power.

Q. So, your testing consists of him, asking Mr. Kirby -- were you aware of the fact that Mr. Kirby had a lawsuit started already prior to him coming to see you for the first time?

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A. No, I did not.

Q. So your testing consisted of asking Mr. Kirby to move his shoulder in different ways, correct, and then you lifting it up?

A. Yes.

Q. And when you lift it up, you stop when he says it hurts?

A. No, I stopped because of a mechanical limitation.

Q. Doctor, based upon -- based upon your examination, and in reviewing your notes, you would agree that Mr. Kirby has made steady improvement from the first time you saw him through the surgery you performed up until the present time, is that right?

A. He made improvement following the surgery and has plateaued over the last two visits.

Q. Has what?

A. Plateaued.

Q. Okay. In terms of improvement, improvement to the present, there's no instability of the shoulder?

A. That's correct.

Q. And his strength has improved, as well, correct?

A. That's correct.

Q. And range of the motion of Mr. Kirby's shoulder has also improved?

A. That's correct.

Q. And I think, based upon your notes, essentially when Mr. Kirby comes to see you, the last time being a week before this trial, he would complain of some residual discomfort and/or weakness, is that right?

A. That's correct.

MR. ROSS: I have nothing further. Thank you very much.

THE COURT: Is there any redirect?

MR. BOROWICK: Just a little bit.

REDIRECT EXAMINATION

BY MR. BOROWICK

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Q. Doctor, counsel has asked you a whole bunch of the questions from the Kateri record back in 1992. I'm going to ask you whether or not being treated for an injury below the scapula has anything to do with the joint injury that he sustained in this accident?

A. It has nothing to do with it.

Q. And if I read to you from the same Kateri record where I got some hot packs ten years before this accident associated with a low back injury, would hot packs indicate to you that he had mechanism, and I'm talking about to the low back, would it indicate to you anything in the joint?

A. No, it would not.

Q. In reviewing the hospital record from Kateri ten years before this accident, was there anything that related to the shoulder joint?

A. Nothing.

Q. And, again, if you would point to my back, where is the lower part of the scapula?

A. Over here.

Q. Is that the mid back?

A. That's in the area of the lower thoracic spine, which is the mid back.

Q. Where is the medial and upper part of the scapula?

A. Medial is here. And the upper part over here.

Q. And is any part of that, other than the glenhumeral joint, any part of that near -- any part of it near where the impact to his low back occurred?

A. I'm sorry, can you repeat the question?

Q. Is any part of the shoulder joint and the injury to his glenohumeral joint?

A. Injury that I said before was not anywhere where his trauma occurred.

Q. And this degenerative spurring that you referred to that you said any of us could have even if we are not construction workers have to be symptomatic?

A. It's rarely symptomatic.

Q. Let me ask you this. Assume for the moment that from '93, when he was cleared by The Spine Institute and he was clear by Kateri to go back to work as an ironworker, from that point on either worked in construction as a carpenter building houses, he worked as a truck driver or backhoe operator, bulldoze operator, and then ultimately back in ironwork, doing full-time ironwork at a clip of 2,100 hours a years, 40, 50 hours a week without pain, without symptoms, without treatment and without medication, surgery or otherwise, do you have any opinion as to anything associated with the '91 incident where he is hit in the low back has anything to with his present injuries?

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A. My opinion is that there's no relationship.

Q. Counsel asked you if the x-rays showed his injuries or any significant injury to the shoulder.

When he went to the hospital right after the accident, would an x-ray show laxity in the shoulder?

A. No, it would not.

Q. Would an x-ray slow rotator cuff tear?

A. No.

Q. Ligament damage?

A. No.

Q. Doesn't mean it's not there?

A. No, it doesn't.

Q. And let's talk about perspective.

Would an x-ray be the appropriate test to see if a ligament is torn or muscle is torn?

A. The --

Q. An x-ray?

A. -- x-ray would not be a test for that. That's only a test for bone injuries.

Q. Even an MRI, given a joint with this kind of complexity, three bones coming towards, humerus, clavicle and scapula acromion, would an MRI be conclusive of whether or not there's injury in the joint?

A. An MRI cannot diagnose an unstable joint.

Q. So that even though there was a negative x-ray or normal x-ray showing no fracture and even though of this an MRI that did show tears, et cetera, when you open his shoulder and eyeballed it for yourself, is there any doubt in your mind as to what injuries he had and what caused them?

A. There's no doubt. There was examined in the office, exam under anesthesia and also the arthroscopic exam; so there are three different points of evaluating that confirmed that this shoulder was loose.

Q. And given his complaints and what is the clinical correlation?

A. They -- if you are referring to a radiographic report.

Q. I am looking for anything that would clinically correlate his complaints.

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A. The clinical correlation means that the practitioner to assess the pathology according to history and examination.

Q. When he made complaints and you suspected pathology, were you able to clinically correlate them by an exam?

A. Yes, I was.

Q. Were you able to clinically correlate more definitively by MRI?

A. The MRI correlated with the time, on arthroscopy and with this type of injury.

Q. And even further than an x-ray or MRI, by eyeballing it yourself during an open procedure with the scope, were you able to see for yourself what his injuries were?

A. Yes, I was.

Q. And the degenerative condition that you saw that everybody has to some degree or another, did that rise to the level of anything that was producing any symptoms before this accident?

A. No, it does not.

Q. Was it producing any limitations before this accident?

A. Not before, not after.

Q. Not after either.

Was it anything that disabled him or limited him in any way at all?

A. No, it did not.

MR. BOROWICK: Nothing further.

RECROSS EXAMINATION

BY MR. ROSS:

Q. The tears, counsel referred to tears. When you actually went in there and took a look at him and did the arthroscopic procedure and looked through, you found a partial under surface tear, is that right?

A. Yes.

Q. Where was that?

A. On a tendon of the supraspinatus.

Q. It was not at full tear of the rotator cuff?

A. Correct.

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Q. Which was what was suspected at first, is that correct?

A. I believe the MRI also reported a partial tear.

Q. The under surface, and that's underneath, is that correct? You said under surface of the --

A. The partial tear of the mid portion, supraspinous tendon.

Q. And glenoid lateral, you inspected that when you went there?

A. Yes.

Q. When you say anterior and posterior, what does that mean?

A. Anterior is the front and posterior is the back of the shoulder.

Q. And the anterior and posterior glenoid cavity, you inspected them and they were intact.

A. Yes.

Q. No problem with that?

A. Yes.

Q. And when you referred to superior biceps anchor, what are you referring to, Doctor?

A. It's where the biceps tendon attaches to the glenoid.

Q. And where is that?

A. Well, it's deep within the shoulder.

Q. And there are things you want to look for to make sure there's no injuries to the area?

A. Yes.

Q. And there was no injury to that, that was intact?

A. Yes.

Q. There were no gross abnormalities of the tendon of the biceps?

MR. BOROWICK: Objection. This is improper recross.

MR. ROSS: He opened up.

THE COURT: Didn't mention the bicep or labrum. When you are all talking --

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MR. ROSS: He went into that whenever he started going through the shoulder. He didn't go through specifically each one. He went back and asked him.

MR. BOROWICK: That was three exams ago.

MR. ROSS: He was talking about the tears.

THE COURT: Counsel -- counsel, do you have any more questions, is that what you said.

MR. ROSS: That's it. I am done. That's fine.

FURTHER REDIRECT EXAMINATION

BY MR. BOROWICK:

Q. Just brought up the glenoid labrum, okay. Does the fact that it wasn't torn change your opinion about anything?

A. Not at all.

Q. Does the fact that the biceps tendon was not ripped off the bicep or ripped off the insertion point, does that change your opinion as to his injuries or disability or prognosis at all?

A. No, it does not.

Q. He didn't break his foot either. Does that change your opinion?

MR. ROSS: Objection, your Honor.

THE COURT: Sustained.

BY MR. BOROWICK:

Q. The fact that it wasn't a full thickness tear, it was only a partial tear, does that change your opinion as to whether -- can people with a partial tear be disabled from their occupation?

A. That's correct.

Q. Does it matter that it was a partial tear as opposed to full tear with regard to his functional limitations?

A. No, it does not.

MR. BOROWICK: Nothing further.

MR. ROSS: Nothing further.

THE COURT: Thank you.

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