SUPREME COURT OF THE STATE OF NEW YORK

COUNTY OF KINGS : CIVIL TERM : PART 33

- -X

JUAN CARLOS RIVERO VIVANCO : INDEX NO.: 517138/2017

PLAINTIFF :

- against - :

ZNKO CONSTRUCTION, INC., G & C CRANE SERVICE, LLC., and SULLIVAN HEIGHTS, LLC :

DEFENDANTS : TRIAL

- -X

360 ADAMS STREET
BROOKLYN, NEW YORK 11201
MAY 5, 2025

BEFORE: HONORABLE DESMOND GREEN,
JUSTICE, AND A JURY

APPEARANCES:

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JEANMARIE EPISCOPIA
SENIOR COURT REPORTER

THE COURT: Case on trial. Same appearances as noted.

Okay, counsels, let's go through all of them now.

17 is stipulated into evidence. 18 was stipulated into evidence. 19 ID only. 20?

MR. FARRELL: ID only.

MR. ROSE: Those are the two that are not agreed to.

THE COURT: 20 ID only. 21 stipulated into evidence.

MR. FARRELL: Yes.

THE COURT: We have one more, 22.

MR. FARRELL: Stipulated. And there is a 23, stipulated.

THE COURT: And 23 stipulated into evidence.

Let's deal with my Sunday afternoon motion.

MR. MORGENSTERN: Good morning, your Honor. Your Honor we bring a motion for a curative instruction to the jury and to strike any and all testimony regarding any mention of health insurance regarding the plaintiff, his wife. Anything that was on the record. It primarily starts on page 197 of the testimony and kind of goes all the way through to 201.

As you know, there was testimony about what

kind of insurance the plaintiff may or may not have. What he may or may not have been offered to him. And whether he could have opted into those plans. We cite to cases in our brief, your Honor, which show this is just legal issues, which shows that health insurance should never been presented to the jury.

As you see in Re V. New York, this First Department case they stated, we now find that the trial Court properly exercised its discretion in precluding inquiry into plaintiff's medical insurance coverage. As its admission in this negligence action would have clearly been improper.

Now, on the other issue where we cite as to Peters, which is a Second Department case, they mention the repeated references by the plaintiff and their turn to the nature of plaintiff's injuries and her lack of medical insurance at that time could have influenced the jury to be more sympathetic. In the exact opposite is true as well, it is extremely prejudicial for this testimony to be before the jury.

So much so, your Honor, that PJI 2:301 there is entire PJI section on collateral source hearings. This is strictly a collateral source issue and should not be before the jury. We put our request to a curative instruction in the brief, your Honor.

Now, lastly, I expect that counsel is going to say he hasn't had time to oppose the brief. However, this is just strictly a collateral source issue and the worry is all there is going to be testimony today from Dr. Katzman and we believe there is extreme prejudice to have him testify without that curative instruction being given before the jury. Thank you, your Honor.

THE COURT: Okay here's the issue that I have with your argument. It is a sound one legally, it really is. I am just surprised that it is coming now and it didn't come when it was coming out. I was surprised.

I, for the most part, consider myself to be a non-interventionist Judge. I let lawyers try their case. So I was sitting here and it is like when you hear insurance the antennas go up, but I just sat here. But I don't believe, if I am mistaken, please let me know, I don't believe there was an objection.

MR. ROSE: Your Honor, if we look at --

THE COURT: No, I am asking you was there an objection? If there was then it went right by me.

MR. MORGENSTERN: Yes, I have on page 198 Mr. Rose said, "may we approach? Objection. your Honor".

The question before that was, "if you can explain to me how it is that you have health insurance

benefits?" That started the whole discussion outside of the presence of the jury, your Honor. Bottom of the page 198 to line 21, Mr. Rose, "My only concern is that there is something here that can be said that could prejudice the jury that wouldn't be admissible. I would suggest an offer of proof outside the presence of the jury, your Honor".

We believe this is very properly objected to and was mentioned when the testimony went forward and it went deeper and deeper into the health insurance.

THE COURT: Mr. Farrell?

MR. FARRELL: A few things. One, I would like to address for the record the motion on papers and just receiving it yesterday on Sunday, I haven't had the chance to, but I do think there is two issues. One that it was -- although there was an objection stated, we then discussed at length the general line of questions wasn't stopped. Line of questioning, I should say.

In fact, I think plaintiff's counsel was so happy with the answer at the end when he got to the, I forget the name it, of the health insurance facility or whatever that he is testifying to. But although it was an objection so that we could go up and discuss it, I don't believe this was objected to to the point where anyone mentioned that this whole line of questioning

should be completely taken out of play.

Also, I think to some degree or large degree the plaintiff himself opened the door to it because right before that whole line of questioning during his direct examination he was being questioned and testifying all about his anxiety, about being able to pay his bill, et cetera et cetera, which is exactly what that whole issue goes to.

THE COURT: Well, being able to pay the bills is different because I took that that was because he was unable to work.

My question is now with regards to the issue involving insurance, because I think we all know that is a no no.

MR. FARRELL: Right, but --

THE COURT: The insurance thing though.

MR. FARRELL: I don't believe it was sufficiently objected to contemporaneously. The desire to have discussion was raised, but I don't think there was ever anything on the record stating specifically none of this can be even questioned about.

If I remember correctly, I don't have the transcript in front of me from when we were talking at sidebar, but it was basically I was directed to clarify it, which has to mean additional questioning.

MR. MORGENSTERN: If I may, your Honor. This is -- I have the transcript right in front of me, your Honor. This again is page 198 where counsel says, "if you can explain to me how it is that you have health insurance benefits"? That is the question immediately that ends at line 2. Line 3 is Mr. Rose, "May we approach? Objection, your Honor". That was contemporaneously the next line. Mr. Rose objects to this and then what I read later on Page 21, Mr. Rose goes into exactly my objection.

THE COURT: Line 21.

MR. MORGENSTERN: Line 21 of 198 where it says, "my only concern is that there is something here that could be said that could prejudice the jury that wouldn't be admissible". That is exactly the issue here because the worry is something wouldn't be admissible because the question was, "If you can explain to me how it is that you have health insurance benefits"?

MR. FARRELL: I understand that, but then I believe after that we had a discussion and basically the direction that I was given was to clarify, ask further questions to clarify. I wasn't told, no questions whatsoever on this topic. I was told to clarify it through additional questions, which is what happened.

THE COURT: Okay, all right, I am going to

give the curative instruction.

MR. FARRELL: Okay, your Honor.

MR. MORGENSTERN: Thank you, Judge.

MR. ROSE: If I can do one other thing real quick if we are waiting?

THE COURT: Yes, sir.

MR. ROSE: Thank you. We marked as a Court exhibit today, I believe it is Court Exhibit Roman numeral I, a letter form the lawfirm Hurwitz and Fine dated April 28, 2025. I am not going to read the entire letter into the record, however, in sum and substance this letter comes on behalf of the primary insurance carrier and what they are doing in this letter is unconditionally tendering their insurance limits, which are the remainder of a $1 million dollar policy. So they unconditionally tender $632,500 and they also state that they calculate pre-judgement -- they calculate interest in the amount of $120,556.23, which is based on the granting of the summary judgment liability finding.

The total amount of the tender at that point in time, which again they say is unconditional, is $753,056.23. The reason, your Honor, that we are making this a part of the Court record is because we are once again reiterating our position that the excess insurance carrier who has had insurance adjustors in this

courtroom. Has had lawyers, a lawyer in this courtroom since day one of the trial and to this date there has never been a good faith effort to protect their insured. Thank you.

THE COURT: When you say "good faith", what does that mean? I hear that often times from lawyers who don't get what they want and then they say the other side is not acting in good faith.

MR. ROSE: Well, your Honor, I do think that this is something that will play out later on in the event that there is a jury verdict where there could be additional litigation and discovery as far as whether or not the disclaimer in this circumstance is appropriate.

THE COURT: Well, that is for a different day.

MR. ROSE: Exactly my point.

THE COURT: We are waiting for one juror, then we will proceed.

Counsels, I have been going over the transcript and I see where Mr. Morgenstern was talking about. However, at no point, Mr. Rose, was there a mention of insurance. I am looking at the transcript. Mr. Morgenstern, where is it mentioned that we talked about insurance out of the presence of the jury.

MR. MORGENSTERN: Well, it says on line 21, "my only concern is that there is something here that

could be said that could prejudice the jury that wouldn't be admissible. Objection". Offer of proof outside the presence the jury, your Honor.

THE COURT: But that is so vague. Why didn't you just came out and say "insurance"? That was never said.

MR. MORGENSTERN: Your Honor, the initial objection is at line three right after the exact -- 198, one line after. "If you can explain to me how it is that you have health insurance benefits"? That was right after the question of, "how it is that you have health insurance benefits?", which was directly going to that issue.

THE COURT: There is also a lot of discussion with regards to Workers' Compensation.

MR. MORGENSTERN: Workers' Comp is admissible your Honor. That is not a collateral source. Where here the health insurance, with which Mr. Rose objected right away, is a collateral source and is absolutely inadmissible.

MR. FARRELL: Your Honor, there were a number of questions about health insurance at his new company before the objection to that at Page 197. There is number of questions about it before that.

THE COURT: My concern is, by Mr. Rose, "My

only concern is that there is something here that could be said that could prejudice the jury that wouldn't be admissible. I would suggest an offer of proof". To be quite frank, Mr. Rose, that wasn't clear to me. All right.

(Whereupon, a recess was taken.)

THE COURT: We are back on the record. It is now 10:45 a.m. the jurors were all scheduled to be here at 9:30. We have been waiting for one juror now, for, it has to be at least a half hour. I know Mr. Rose your position is that we should get going because you have an expert that you need to finish today.

MR. ROSE: Yes, your Honor.

THE COURT: Mr.Farrell, your position?

MR. FARRELL: I am in agreement. If we are going to let the alternate go we have four alternates. I think we need to get moving.

THE COURT: Okay, tell Mary to line them up.

COURT OFFICER: All rise. jury entering.

(Whereupon, the jury enters the courtroom and is seated in the jury box.)

THE COURT: Good morning. Welcome back. Do Both sides stipulate that all jurors with the exception of our second alternate are present and properly seated?

MR. ROSE: Yes, your Honor.

MR. FARRELL: Yes, your Honor.

THE COURT: Do both sides stipulate to going forward as the jury is now constituted?

MR. ROSE: Yes, your Honor.

MR. FARRELL: Yes.

THE COURT: Please be seated.

Okay, Mr. Rose?

One thing before we go there, we are going to have to unring the bell. You may have heard some testimony regarding health insurance, you are to disregard that testimony entirely and it is stricken from the record. At the conclusion of the evidence in this case you will be asked to decide the amount of medical costs that the plaintiff will incur as a result of the accident. You are not to consider health insurance, okay?

We are now ready to proceed.

MR. ROSE: Thank you, your Honor. Plaintiff calls Dr. Barry Michael Katzaman.

D R. B A R R Y K A T Z M A N, having been called as a witness by and on behalf of the Plaintiff, having first been duly sworn, was examined and testified as follows:

COURT CLERK: In a loud, clear voice, state your name and give your business address, spelling your name.

THE WITNESS: Barry Katzman, 261 Jericho Turnpike, Floral Park, New York 10001.

COURT CLERK: Spell your name for the record.

THE WITNESS: B-A-R-R-Y K-A-T-Z-M-A-N.

COURT CLERK: Thank you.

THE COURT: You my proceed.

MR. ROSE: Thank you, your Honor.

DIRECT EXAMINATION

BY MR. ROSE:

Q. Good morning, Dr. Katzman.

A. Good morning.

Q. Let's start with your education and training, if you could, please?

Where did you go to high school?

A. I went to Bronx High School of Science from there I went to New York University on a scholarship.

Q. That was undergrad?

A. Undergrad. I was accepting early decision to NYU Medical School and did residency in orthopedic surgery in Brooklyn Downstate Medical Center and then I did fellowship in Hand and Upper Extremity Surgery at the University of Pennsylvania.

Q. What is a fellowship?

A. I did specialty training. So if you do four years of medical school you learn all about medicine. Then we do

five years of residency where we learn about orthopedics and then I sub-specialized in hand and upper extremity surgery.

Q. Thank you. Have you been a affiliated with any hospitals?

A. Yes, I am on staff currently now at North Shore, Long Island Jewish Hospital, Mount Sinai Hospital and Trinity Hospital in South Nassau.

Q. Have you received any honors?

A. A myriad. I don't remember all the ones in college, but.

Q. If you could just be brief. Thank you.

A. Honors chemistry. I was Phi Beta Kappa as a junior. I don't remember all college honors.

In terms of my professional career, I have been an educator, so was the head of Franklin Hospital teaching residents about hands surgery. And emergency room residents from Long Island Jewish come to my office and I still have students come through my office to learn.

Q. Great, okay. Do you hold professional licenses?

A. I am a doctor.

Q. Okay. Board Certified?

A. Yes, Board Certified.

Q. Publications, I know there is has been quiet a few. If you could just give the jury an idea of some of your publications?

A. Sure. So I was the Guest Editor for The Atlas of Hand Clinics on Carpal Tunnel Surgery. So I had to do Carpal tunnel surgery. I was guest editor for The Atlas of Hand Clinics for rheumatoid wrist. Relative to knees, I fixed I longest quadriceps tendon at that time and wrote a new way to do it.

I published a lot of articles, some articles on trauma. A lot of articles on hands surgery. I've written chapters in books like Masses of the Hand and Upper Extremity. Fingertip and nail bed injuries.

I wrote a paper on Mallet Finger that was published by the Yearbook of Hand Surgery.

I can keep going.

Q. Have you made presentations as well, Doctor?

A. Yes, also a lot.

Q. Okay.

A. I have done Poster Presentations at Long Island Jewish. I have done Poster Presentations at the orthopedic Academy. I have presented to residents.

Q. Okay, you also lecture; is that correct?

A. Not as much anymore, but in the past.

Q. Okay.

MR. ROSE: Your Honor, I would ask this Court to recognize Dr. Katzman as an expert in the field of orthopedics.

MR. FARRELL: No objection.

THE COURT: Okay, so recognized.

MR. ROSE: Thank you.

Q. Now, do you maintain a private practice, Doctor?

A. Yes.

Q. Do you treat patients at your private practice?

A. Yes.

Q. Okay. Are you being compensated for your time away from your practice today?

A. Yes.

Q. Okay, great. How long have you maintained the private practice?

A. So I finished my fellowship in 1998. So I have been in practice for about 26 years. Almost 27 years now.

Q. Great. Thank you. I would like to speak about the anatomy of the knee just to start. Would a model of the anatomy of the knee be helpful to you in explaining this to the jury?

A. Yes.

MR. ROSE: Okay, your Honor, with the Court's permission I would ask that Dr. Katzman be permitted to come down off the stand in order to speak with the jury?

THE COURT: Yes, sir.

MR. ROSE: Okay. Thank you.

THE COURT: What I can say to our jurors there

is currently a state wide court modernization project. As you can tell they haven't reached us yet. At least in this courtroom.

MR. ROSE: All I am saying if the doctor is comfortable, we can improvise, your Honor. This is in evidence.

THE WITNESS: While we are waiting for that, I will talk to you a little about the anatomy of the knee and then I will get into the specifics.

MR. ROSE: Your Honor, may I hand Plaintiff's Exhibit 21 to the doctor, please.

THE COURT: Yes.

Q. Please explain the anatomy of the knee, Doctor?

A. So when you think about any joint and anatomy, think about a few things. The muscles that power the joint, the bones of the joint, the ligaments that keep it stable and then the other stuff on the inside. And also the cartilage.

So when you think about the knee, the knee is a hinged joint, meaning it can just go in one plane. Like our shoulders, will we talk about, go in a circle. Your knee can't go in a circle.

So we have essentially three bones, really four, but three main bones for the knee that we like to think about. One is the femur or the thigh bone. The other is

the tibia or the shin bones. So that would be here. The femur would be here. Can everyone see? And then the third is the patella or knee cap. So that is the front of the knee (indicating).

So getting back to the picture, you can see there is a thigh bone, a shin bone and a knee cap bone. If we take away the thigh bone and look down at the shin bone we can see the meniscus. Most people have heard of the meniscus. It is a shock absorber on the knee.

This is the ACL, the anterior cruciate ligament. You hear a lot of sports and athletes tear that. The posterior cruciate ligament. That is not as commonly injured.

So we have shock absorbers, we have bone, we have ligaments on the side as well. On the inside that we are talking about. We also have the cartilage and that is like a white glistening part. So if you had chicken and saw the white glistening part when you break up the bone, that is the cartilage.

Q. Please continue.

A. When we think about anatomy, like I said, there is the meniscus. So this will be medial meniscus, this would be the lateral meniscus. And the posterior ligament -- posterior cruciate ligament. This would be the knee cap and the patella.

Do you want me to go into the surgery at all?

Q. Not yet. Okay, we will be done with that right now. If you can take the stand, doctor, for a moment?

A. Okay.

Q. Okay, so we will keep going.

So Doctor, could you tell the jury what subjective findings are and what objective findings are?

A. Sure. Subjective means it is what you tell me. Like if I ask you, "does it hurt?" And you say, "it hurts". That is subjective. Objective would be something that you can see. Whether it be on an MRI or nerve study test or you had a black and blue mark, you were swollen. Those things would be objective because they are verifiable. They are not subject to what the patient says.

Q. Now, did Mr. Vivanco come under your care at some point in time?

A. Yes.

Q. When was that?

A. August of 2020.

Q. Okay and at that point in time did you take a history?

A. I did.

Q. What was that history?

A. He was essentially hit -- he worked as a construction worker -- by a beam and fell down 15 feet. He

went to Kings County Hospital. He was severe enough that he was admitted for six days and then came under the care of orthopedic surgeon Dr. Seidenstein.

Dr. Seidenstein performed left knee surgery for him to 2017 in November, so three months after the accident. And then right shoulder surgery in 2018. He had had MRIs in September of 2017, shortly after the accident for both the shoulder and the knee.

Q. Did you review certain records in this matter?

A. I did.

Q. What did you review?

A. So at that time I probably reviewed his op reports and MRIs.

Q. Okay and it is you custom and practice to do this when a patient comes under your care?

A. It depends on the patient, but in this instance yes.

Q. And for the record, this was on August 10th, 2020 when he came to you for the first time; is that correct?

A. That is correct.

Q. Great. Okay. Now, did he speak to you about his issues? Meaning were there complaints that were discussed?

A. Yes.

Q. What were those?

A. So I would say he has, throughout the time and

course of me treating him, three major issues. The first issue is his shoulder. The second issue is his knee. The third issue is his thigh where he has essentially a rupture of the muscle of the quadriceps. I think that is the easiest way to think about Mr. Rivera in terms of me.

Q. Okay, great. Now, let's talk about the quadriceps muscle, if you could. Could you tell the jury what that is and explain the basic anatomy of the quadriceps muscle?

A. Sure so I didn't go into much on the pictures because it wasn't there, but you saw the patella -- can we have the picture again, please. It would be helpful.

Q. Absolutely.

A. If you think how you straighten your leg. You need really three things to straighten your leg. You need a muscle here, a connector and then a muscle here.

So this is the quadriceps tendon that comes in here. In the quad there are four parts, the patella, the knee cap and then the patella tendon. So if any of those parts in the link are broken, then it is like pulling a rope that is broken. And if it is broken, it is not going to close the door. So If I want to pull a rope from here and I pulled on it and it was torn, I couldn't pull it.

So these muscles start off in the hip and then they come into the top of the knee cap. As was just mentioned fortuitously, I had written a paper at that time where

someone had ruptured their quadriceps, did not be treated for like, I forget, like a year or two. I wrote it so long ago. Came to see us at the clinic, we treated him, we did a modification of a different treatment and described a new way to treat a quadriceps tear out that long.

So when you see a tendon, you can fix a tendon. It is thick, it has substance to it. But a muscle, it is kind of like when you look at the steak or chicken, that part doesn't sew together. Like when you cook it looks like it is hard, but beforehand, it is kind of just mushy.

And so you can't sew those parts together. So when you cut the muscle it is done. Is it is what it is.

So he had like a hole kind of by his thigh which corresponds with his muscle tear.

Q. Okay, now, is that something that we can visualize in diagnostic testing?

A. Yes. I think it is said it on his MRI.

Q. Great. Okay. Thank you.

A. Just to be specific, I am pretty sure it said it. He had an MRI early on and it showed that. Go ahead.

Q. Now, is there any significant prior medical history?

A. In terms of for his accident, he never had any problems with his shoulder or his knee before. He was 35, so as I am getting older, that is relatively young, and had

no issues with those problems before this accident.

He did have some depression, anxiety, insomnia. I am sure some of this was from this accident or most of it from the accident.

Q. I represent to you that it was, Doctor. You are not here for that, are you, today?

A. No.

Q. So, did you perform a physical examination?

A. I did.

Q. Could you explain your physical examination and your findings, please?

A. Sure, so when we examine someone we test range of motion to see, you know, you are moving your arm well. Your knee well. Does it hurt in certain parts and certain provocative maneuvers. Certain things that we think may help us clue in on the diagnosis of what is wrong.

When I looked at his shoulder he can lift it to 90 degrees, which is here. And he had some pain over the rotator cuff, which is here. And he had a positive impingement sign which means when we rotate the arm like this or lift it up it causes pain by the rotator cuff impingement.

He had some clicking in the shoulder, like some overall grinding in his shoulder.

Q. What do these things tell you?

A. So the clicking can be from a labral tear and tenderness of the rotator cuff and impingement sign, so the limited motion signifies a rotator cuff problem.

Q. Which is the rotator cuff?

A. So the rotator cuff is the muscles that help move the shoulder. There are four of them. But for most purposes we can simplify the two, supraspinatus and infraspinatus. They kind of come together over here, but they call that -- it is actually one is above the scapular spine and one is below the scapular spine.

Q. Did you formulate a plan at that visit?

A. Right, so I had seen him --

Q. I don't think you finished with your findings. I am sorry. Yes, I am sorry. Please do.

A. It's okay. I also examined his left knee. And he can bend his knee also to 90 degrees, so that is a right angle. And he had pain over the knee cap.

So at that point he was status-post right shoulder surgery. He already had right shoulder surgery and knee surgery, both of which had not helped him.

So at that point I recommended -- he was already being scheduled for MRIs, but I also recommended an MRI to just start essentially from scratch with him so we can treat him.

Q. Okay so this gentleman at this point in time had

had -- and again, we are not here to talk about Mr. Vivanco's back; is that correct?

A. I am here for the shoulder, the knee and the thigh.

Q. Okay. So at this point in time this gentleman had had his shoulder and his knee operated on and then he had come to you; is that correct?

A. Correct.

Q. Okay, now we didn't speak about the anatomy of the shoulder. We did a little bit just now, but I think --

A. Not really.

Q. So why don't we do that. I would like to show you, Doctor, plaintiff's Exhibit 22 and if you could come off the stand and explain the anatomy of the shoulder to the jury please.

A. Okay, so I started to allude to some of these things before, but I am going to go into more detail now. So the shoulder is a ball and socket joint. That is why we can move our arm like this. That is great and that gives us a lot of mobility, but we don't want the shoulder to pop off. So like most people probably have never heard someone have a knee dislocation, it certainly happens, but it is not as common because it is a hinge joint. And there is so many movements that help stabilize you.

In the shoulder, you can pop out your shoulder. And a lot of people have what is called shoulder

dislocations. So we need stabilization to rotate and to keep it from popping out, but not so tight that we can't move.

You also need -- we talked about the bones of the shoulder and then we have the muscles that move the shoulder. So a lot of people heard of rotator cuff and like I said, there are four rotator cuff muscles, the subscapularis, that is in the front. You have the super and infraspinatus on the top and they kind of come together as I said already and then back here, which you can't see in the picture, Teres minor.

So those muscles help us externally rotate our shoulder, internally rotate our shoulder and they help lift up your shoulder. We also have inside of the shoulder, you might not think about this, but the biceps.

So the word biceps, bi means two. There is two there. There is a long head that goes in the shoulder and there is a short head that goes to here, which is the Coracoid.

The biceps come into the labrum. The labrum is like a stabilizer for the shoulder. So people who tear their labrum badly down here can often dislocate their shoulder. But people that tear it up here can have clicking and catching in their shoulder. It is common with baseball players as well. So that is a labral tear.

So when you think about the labrum, just like everything, we like to give it like a name so it can sound nice and fancy. In the front we call it the anterior part, in the back we call the posterior part. Then there is the inferior bottom and then superior here.

So you may have had heard the term "SLAP tear" that stands for superior labrum anterior and posterior tear and that is where the labrum goes from the front to the back and it could be torn there.

The last thing we didn't talk about is that there is a ball and socket. And so -- there is one other part we have to talk about.

So you can sort of see the ball here and then this is a socket. So when I think about the shoulder, which I do a lot of shoulder surgery, we look inside the shoulder and at the structures here and then I come on top and we look above. So we are looking at the rotator cuff from blow inside and then above on the top.

On the top we also see this bone called an Acromion and that bone is thought to sometimes pinch on the rotator cuff and cause pain.

Q. Did we cover it?

A. I think I did a good job.

Q. Before you step down, why don't we do this. We are

going to look at the MRI films.

Let's start with the MRI of the right shoulder dated September 12 of 2017 which Plaintiff's Exhibit 17 in evidence.

DOctor, what we are going to do now, just so you know, we are going to look at the film before the surgeries were performed. We will do it for the shoulder and then the knee.

A. Okay. No problem.

This is going to be a little more complicated because it is not easy to visualize everything on the MRI. It is not intuitive.

Q. So Doctor, just for the record, what are you looking at here?

A. I am looking at an MRI of the shoulder dated September 12, 2017. So less than two months after the accident.

Q. Okay, please explain to the jury what is significant on this MRI film?

A. Okay, so let me start going through the MRI and let me just explain a little bit what an MRI is.

Q. They have heard it, just so you know, but in your own terms, of course.

A. So you guys looked at the spine, I would assume and so it is a similar concept, right? You can take it and

manipulate it in three difficult planes, and so you can look at it looking at the front, looking at it from the side and looking at it coming down sort of like you saw on the herniated discs.

Let's take a look, okay? So actually, this picture shows you a lot of what I need to show and talk about and some other stuff. So this is looking at the shoulder from the front. So it is called a coronal view. And so it is sort of like you would be looking at my right shoulder, which is his right shoulder.

We said that the shoulder is a ball and socket joint. And low and behold there is a ball and there is it a socket. We also said that there is a rotator cuff. We showed you how it went into the side of the shoulder. I am going to try to show you both simultaneously. I think sometimes it is hard for you. You are looking at one slice, sometimes it is hard to get a visualization of everything.

So this is the rotator cuff coming in that we are looking at right there, okay. So this is the muscle. In this picture it kind of looks like a muscle. And you can see it coming into the tendon. And you can see here the white. That white is a little bit of the tearing that you see on the rotator cuff.

The other structure we talked about was the labrum. And so there is a top and bottom to the labrum. And you can

see here -- the labrum is not projected well in general on MRIs, but you can see this is the socket and off the socket is another part and that is at labrum.

I know it is going to be hard to see. I will do my best. This is inferior labrum and this is the superior labrum.

Q. What does that mean?

A. The bottom and the top. If you look at the bottom, you don't really see much white between the gray and the socket. If you look up here you can see the white between there, that is the fluid and that is significant for a tear.

So when we look at the shoulder, again, that is the best way to see -- I am going to show you more pictures. Again, these are the different parts of the rotator moving on the back of the shoulder. Again, you seek like the little tear. You can see the tearing in here. You can see the fluid in there for the labrum. The socket, the ball, the rotator cuff.

The other thing we need to see that is relevant to this is -- it is not a great picture of it, but this is the Acromion. That is bone and shaving down that bone can sometimes be helpful.

So again, looking at this from the side, this is not in two, so like looking at it like that, so looking at it like where your arm is. And you can see how it is nice

and gray. There is some white and this sequence happens to pick up fluid, well, the white, so you can see it is torn there.

If we are going look at the labral tear, you can see some small tear here, how this gray structure is lifted up a little bit. So that is the labral tear.

For most people looking at the rotator cuff, labrum, some people the biceps, are probably the most important structure.

Q. Now, Doctor, while we are on the shoulder, do you think it would be a good idea to explain the surgery performed to the jury now?

A. Yes.

Q. Okay. If you are comfortable holding this so we don't have to keep switching things.

Plaintiff's Exhibit 22, so would an illustration of the surgery be helpful in explaining the operation performed on Mr. Vivanco to the jury?

A. Sure.

MR. ROSE: May I please have Plaintiff's Exhibit 20.

Your Honor, this has been marked for identification.

May I hand this to the witness?

THE COURT: Yes.

COURT CLERK: 20 marked of ID. Do know show to the jury.

Q. Doctor, you said that would be helpful?

A. Yes.

Q. And is that medical illustration that is Plaintiff's Exhibit 20 a fair and accurate representation of the surgery that was performed on Mr. Vivanco?

A. Yes.

Q. Okay.

MR. ROSE: Your Honor, plaintiff moves this exhibit into evidence.

MR. FARRELL: Your Honor, I object to that being in evidence.

THE COURT: Okay.

MR. FARRELL: Do you want us to approach or no?

THE COURT: Yes.

(Whereupon an off-the-record discussion was held.)

Q. Doctor, now we can show this exhibit to the jury.

THE COURT: Jurors, it is not in evidence, which means and I know all of you can't see it. You will not be able to get it when you are deliberating. However, the Doctor can use it to illustrate exactly what happened.

MR. ROSE: Your Honor, could you just explain to the jury what demonstrative purposes means? Admitted?

THE COURT: Well, he can use it to show you visually, rather than simply words, that might be in a report and describe by using that exactly what occurred.

MR. ROSE: Thank you, your Honor.

Q. Okay, Doctor, if you could explain the surgery that was performed on Mr. Vivanco?

A. Yes. So he had a shoulder arthroscopy. And a shoulder arthroscopy, arthroscope its like laparoscoope, it means inside a joint. So we take a camera and we put it inside the shoulder so we can visualize the structure and then we clean up what we need to clean up. And shave down what we need to shave down.

So in his procedure he had done a debridement and a acromioplasty. He took down the ligament. He took down part of the clavicle and removed the bursa. So I am going to go over all that with you because there is a lot to digest of that.

So we look inside the shoulder, we are seeing inside here kind of like you saw in the first picture with the labrum. And so our camera is in the back and we are looking here. So we take our camera and bring it to here, to here and even to here(indicating.) There is not that

much that goes on down there, but we can do all that with an arthroscope.

That let's you look at the labrum, the under surface of the rotator cuff, right. So this is the rotator cuff, the bottom part of it. The labrum and the bones and that is the major other stuff.

So he found the tear of the labrum, which they saw on the MRI, which I showed you. And he cleaned that up. So that was the part that he did inside the shoulder.

Then he went on top of the shoulder, so you remember I talked about you can look at the rotator cuff from above. I am only showing you that, it doesn't show you the rotator, it shows you the bone.

There is a space between the rotator cuff and the Acromion. And that is in here. We start here and we take out the camera and we go essentially like here (indicating). And that let's us look at the rotator cuff from above and also look at the bone.

And he shaved down the bone and took down part of ligament. So the theory is that bone presses down on the tendon and also the ligament can press down on the tendon. He took out inflammation there.

If we look at these pictures, one is just showing you the instruments going in and then two is showing cleaning up the labrum. So looking from the front, putting

in the camera and looking from the back putting the instrument in the front to clean that up.

Then three, four and five deals with the second part of the procedure which is cleaning up the rotator cuff, shaving down the bone. So in this case he also shaved down part of the clavicle to make this flat together. It is coplaning. He took out inflammation between the tendon and the Acromion.

Q. Does that cover it?

A. I think that was good.

Q. Great. So now, why don't we discuss the knee, okay, while you are up?

MR. ROSE: Your Honor for the record, we will be showing the Doctor Plaintiff's Exhibit 18, which is the MRI of the left knee dated September 8th of 2020.

Your Honor, we are going to offer without objection the MRI of the left knee dated September 5th 2017 in evidence by stipulation between the parties.

THE COURT: So that would be 24.

MR. ROSE: Thank you.

THE COURT: It is in evidence.

A. Okay, we are going to look at the knee, go over the anatomy again and I will try to show you some representative pictures of the anatomy.

Q. Incidentally, Doctor, you read films on behalf of

your patients, correct?

A. I do. So if we look at this picture we see there is like smooth cartilage here, it is not 4K, but if you look here, you can see this black line and you can see like almost like a little indentation there. So that is the trochlear. That is this part of the knee cap.

So the knee cap goes there when it moves. So it slides in a groove. That is the groove it slides in. And this is the top. Also there is some damage to the cartilage there on the patella. I will show you some other things that I think are interesting even if they are not exactly for us here.

So this is looking at the knee from the side. So like when you are looking at the shoulder, you are looking at the knee this way. That allows us to see the ligament swell that we talked about. So this is the PCL ligament. It likes it is almost not perfect. If you look at it it looks like nice in the middle and maybe not as great at the edge.

You say, oh, that is abnormal. No, that is normal. PCL doesn't go in a straight line. So they kind of twist. So if you are cutting it, a slice, in one space it may look like it is not perfect on the top or the bottom, but good in the middle, but it is not torn.

Then this is the PCL. You see it goes from the

back toward the front. Then here's the ACL and again, that goes from the front to the back.

We then have -- we talked a little bit about the menisci. So you see there are triangles here. I am not going to go through every picture, but there are triangles here. There is white there. Well, if that white goes to the top or bottom it is considered like a meniscus tear, but otherwise it is not.

In this case they didn't read meniscus on the MRI, they didn't see meniscal tear at surgery. I wanted to cover that. It is like anatomy 101.

There are a couple of other things I want to show you. You can see the ACL going in and up and there is your PCL.

Okay. Again with the knee cap, you sort of see like it is coming down. This is the bone. This is the cartilage and then you can see there that white space and that's the defect that they see in arthroscopy.

Q. Okay great. Would this be a good time now to explain the surgery that was done?

A. Yes.

Q. Great. So and again same question. Would an illustration of the surgery be helpful in explaining the surgery performed on Mr. Rivera to the jury?

A. Yes.

Q. Okay.

MR. ROSE: Your Honor, Plaintiff's Exhibit 20 for demonstrative purposes. Okay for me to show it to the witness?

MR. FARRELL: Yes.

A. This is the shoulder.

Q. Thank you for checking me. Exhibit 19, Doctor.

A. Yes.

MR. ROSE: I apologize. Exhibit 19.

A. Okay, so when we perform an arthroscopy you typically use two incisions now. One we start at laterally, it means the outside and then one would be medially. So the outside of the knee and the inside of knee. It is a lot to go through in a short time.

So if we look at this picture here, for example, we will have one here and one here. That allows us to look all inside the knee. So we can look here in the knee, here in the knee. We can see the ACL. We can see the PCL and then if we look at this picture here picture we can see the trochlear and the patella.

So that is where the parts go into. And so on Mr. Rivera he had a defect in the patella and he cleaned that up. He also had a defect in the trochlea, which I was showing you and he cleaned that up as well. And then he felt that the knee cap was tilted, so he released the

structures that were pulling it laterally or this way, so it sit more normally.

The other stuff that I looked inside was all pretty good, but this can cause a lot of pain because every time you bend your knee, your knee cap would tear apart and that can cause pain. People also say their knees click. That is pretty much what they say is going on.

Q. I will quickly show the jury the illustration so they can understand that.

A. Yes. This is the camera, this is the shaver. And he is cleaning the underside of the patella and then the trochlea. So he is cleaning off the part that is not good and trying to make it smooth.

Q. Okay, did that cover it?

A. I think so.

MR. ROSE: Your Honor, by stipulation, the parties offer the MRI of the left femur dated September 11th of 2020.

THE COURT: That is 25?

MR. ROSE: Yes.

A. So, we are now looking, to orient you, this is the hip. Down below is the leg. Muscles should look almost like -- we use that to make it look like that. It is an MRI, we can make it any color they want. They chose this.

And so where its gray it is pretty normal. This is

the bone right here. But if you look here you can see how it is all white in there.

Q. This is the femur, the upper bone in the leg?

A. This is the femur part. This is the a quadriceps muscle and you can see like where it is kind of white. That is the fatty part where they had the muscle tear. You can see a little better over here where you can see it looks like it is pretty gray and all of a sudden it is white.

And so at that level it is not at the tendon part. So you can't -- you just can't sew muscle to muscle. And so if you cut your muscle, you cut your muscle.

Q. And can you explain to the jury where, so we can understand from a common sense perspective, where in the person's leg would that be and how does that impact them?

A. In the front it gives you some weakness because your muscle is not going to be as strong.

Q. Indicating --

A. Yes, you can see he has a defect in his leg. If you saw him in shorts you can see he has like an indentation in his leg. He has a defect in his leg.

Q. Okay and, Doctor, I am going to represent to you that at the time of this accident Mr. Vivanco was struck by whom a beam that was approximately 4,000 pounds and I am going to show you Plaintiff's Exhibit 6, which is in evidence.

Do you see that there?

A. Yes.

Q. Plaintiff's Exhibit 7, which is an in evidence which shows the back of his leg.

What do those photographs tell the jury and why are they instructive to us?

A. I mean, so we mentioned a little bit about subjective and objective at the beginning. So this would be objective, meaning you can see the scar and you can see the bruising. I didn't know he was going to show these pictures when I said it, but it would be objective because it is clear, you see the other side, it is not bruised. You don't have to be an orthopedic surgeon fellowship trained written books on hand surgery to know that. And you can see the bruising on the back as well.

Q. And would a blow to this area be considered a competent producing cause of the muscle tear that he described?

A. Yes. I mean, again, it is just logical. He had a huge thing fall, 4,000 pounds, hit him in the leg. Whatever is underneath that leg will be damaged. I think he, actually he was lucky and he didn't break his femur, but he did tear his muscle.

Q. Thank you. You can take the stand now.

Did Mr. Rivera return to you on November 9th of

2020?

A. Yes.

Q. Okay and what were his current complaints at this point in time?

A. He always essentially had the same issues in the right shoulder pain, in the left knee pain and the problem with his quad muscle.

On the previous visit back in September I had given him an injection in his shoulder to try and help him. So you would also always try to treat patients conservatively just like we all would like to be treated. He already had therapy, a surgery and he was still having issues.

I did give him an injection. It helped him for a few days. Unfortunately it didn't last longer.

Q. Did you perform an examination on his right shoulder?

A. I did.

Q. What were your findings?

A. They remained pretty much the same the whole time. He had forward flexion to 90 degrees. The tenderness over the rotator cuff. The Neir Hawkins impingement sign and the clicking.

Q. You say he had a Nier Hawkins impingement sign is positive, what does that mean?

A. So I think we touched on this earlier. Two ways,

Neir is one of the Godfather's of shoulder surgery. He described lifting up your shoulder and if that caused pain of the rotator cuff that that was a positive impingement sign. That is a Neir impingement sign. It is actually N-E-I-R not N-E-A-R. So it is named after Charles Neir.

And then Hawkins said, oh, I need something because I am a famous guy too. So he said, well, if I rotate the shoulder and it causes pain you can name this one after me.

Q. Okay and did you come up with a medical plan at that point in time?

A. So I think at that point he had a few issues. So he did have some new MRIs and so one issue is just to get a nerve study test and the other and probably most important thing was we talked about surgery on his right shoulder.

Q. Were the knew MRIs instructive to you in any way?

A. Uh --

Q. I am not going to make you read the films again.

A. I know. Essentially, it is always more complicated to read MRIs after you have surgery because the normal anatomy gets distorted. So when I think about Mr. Rivera, I say to myself, here's a young gentleman who's had an injury, who I am seeing three years after an accident. He already had one surgery and didn't get better. I gave him an injection. It helped temporarily.

From my perspective that is a good sign that I can

make it better with surgery. That is not a guarantee, but the MRI didn't show anything that I said, oh my God, something terrible is going, but it just confirmed that he was a candidate for surgery.

Q. Okay and fair to say he still to this date has not had that surgery; is that correct?

A. Fair and accurate.

Q. If he did choose to have the surgery, what would it consist of?

A. Similar to what he did before, but it might change based on what I saw inside the shoulder. So based on his MRI we might do clean up, but when we got in there we might see something. That happens all the time that the labrum looks worse than I thought. Maybe we would fix the labrum. Maybe we would have to cut the biceps and reattached it as he is getting older.

There is whole bunch of different permutations that can happen based on the findings.

Q. And incidentally, Doctor, did I ask you to review a life care plan in this case?

A. You did.

Q. Okay and did you agree with those findings?

A. I did.

Q. And as it pertains to his shoulder and his knee, correct?

A. Yes.

Q. Okay. Great.

Now, just moving along. He came back to you on December 21 of 2020?

A. Correct.

Q. Again, same complaints?

A. You would think, and he has proven it out, you get to a certain point and you kind of plateau out. So it is treatment in general for let's say you had whatever injury was to your body, you are going to get better most of it at the beginning and then you kind of -- your slope of getting better slows down and eventually it is flat, where you would expect that you essentially can be, what I say, you are who you are. And you are you will the same. He has been the same since 2020.

Q. Okay, now he came back to you on January 11th of 2021, correct?

A. Correct.

Q. He came back to you again on February 10th of 2021?

A. Correct.

Q. He came back to you on February 20th of 2022; is that correct?

A. I think it is 2023.

Q. I didn't say it right?

A. I was trying to be nice.

Q. That's okay, don't be.

A. I saw him November 15, 2022 and then I saw him February 2023.

Q. Exactly. So let's talk about what his current complaints were on that 2023 visit?

A. So he still had right shoulder and the left knee problems. He had a lot of other issues, some of which weren't particularly my area of expertise. They were more GI issues. And then he had issues where he wasn't able to exercise, couldn't carry on his normal activities. He couldn't jump, couldn't walk long distances, couldn't lift weights. And those are for a combination of reasons.

Q. Did you perform a physical examination at that point in time?

A. I did.

Q. Okay, could you discuss the examination and your findings?

A. Sure, so right shoulder had forward flexion to 90 degrees. He had --

Q. When we are talking about the range of motion findings now, if you could, could you explain normal and what you found with Mr. Rivera?

A. So you had forward flexion to 90. Obviously he should have been able to flex his shoulder to normal and that is 180. I did measure the other side for comparison

and he had full motion in his other shoulder and his other shoulder had no pain to palpation.

Q. Did you measure both sides?

A. The truth is, for the gentleman on the other side of you, but there is a reality that they are not really sure that measuring the contralateral side is indicative of what people are. Having said that, I have heard sometimes, oh, how do you know the other side was normal? So I measured the other side just for the sake of completion. I don't know if it is scientifically borne out that that is really an accurate way to say what is normal.

And so in this case he had the clicking in the shoulder, the pain over the front and back of his shoulder.

Q. What did that tell you?

A. That is more indicative of a labral tear.

THE COURT: Doctor, one quick question, you use the term normal, what is normal?

THE WITNESS: Normal would be what we expect a young person who has no problems to have.

THE COURT: How did you get to normal, because each person is unique, we are all different. So how do you get to normal? Is it normal based on symmetry? The thing you do the is same with the left and the right?

THE WITNESS: So that is what I was alluding to when I look at the other side. We have what would be

considered to be a standard normal by looking at a group of individuals over the span have -- you know we have been doing this for hundreds of years.

If we looked at, you know, what I would say is a perfect person to normal would be like what you should be if there is no problems.

THE COURT: There is a perfect person?

THE WITNESS: There are perfect joints. There are no perfect people.

MR. ROSE: Sounds like a doctor joke.

A. For example, every kid should be able to lift their arm straight up. Most of problem here was he had a shoulder issue. He could probably lift his arm up to here.

We can disagree about how much we can bring our arms behind our back, but like they should be able to do this.

We should be able to straighten it all the way and bend it all the way. We can take different normals 135, 140, 150 but at the end of the day we've looked at enough of shoulders and knees that we have what we consider a normal value or ideal value, maybe better than normal. Because when sometimes we guess with normal you can think of like an average, this is what it should be.

THE COURT: Thank you.

Q. Back to your examination.

A. So that was the shoulder. I looked at the hip also. He lost a little bit of flexion in his hip, so he can bend it perpendicular, but not all the way. He should be able to bend to 120. Like I say if you brought it near to your chest it would go past the 90 degree mark.

His thigh has the atrophy and deformity from the quads muscles rupture. His knee again had flexion to 90 degrees and tenderness around the kneecap area which he had essentially the whole time. Which is why he had the surgery to begin with. The other sides were pristine.

Q. So did you discuss the left knee range of motion?

A. Yes.

Q. Okay.

A. I already said it, but I can say it again.

Q. Please.

A. So he bent his knee again to 90 degrees. To give you idea, this would be 90 degrees. And 140 is normal. You should be able to bend it back.

In other words, your heal should touch your buttocks, essentially.

Q. He couldn't do that?

A. Correct.

Q. Thank you. Okay, now, the last time you saw Mr. Rivera was on April 30 of 2025; is that correct?

A. Correct.

Q. Okay, so let's talk about that visit. What were his current complaints at that time as they relate to the incident and the injuries that you treated him for?

A. Essentially the same thing. There has been no change. He has been status quo for the last -- since I know him, essentially.

Q. Okay.

A. Which is what you would hopefully expect.

Q. Okay, was he taking any medications at that point in time?

A. He was taking some medications. The ones that are relevant to him and his injuries are the Cyclobenzaprine, that is a muscle relaxer. Gabapentin, that is a nerve pill. And Tylenol, a pain pill.

Q. Now, did you discuss his work status with him at that visit?

A. I did. One part I wrote, that was a mistake on my part, he was unable to work, but he was working, but not the heavy duty job he had. It changed from an iron worker to light duty doing inspecting goods and quality control.

Q. Great. Now at that point in time you had in your possession an MRI of the left femur dated July 3rd of 2024; is that correct?

A. That is correct.

Q. Okay and what were the findings and if you could

describe the significant findings to the jury, please?

A. He had the atrophy of his quad muscle.

Q. What is atrophy and why is that significant?

A. So we can have atrophy for, in general I would say, one of three reasons. One reason is we are taut, right? So like if you are taut, the muscle is not working, it atrophies.

So like let's say you tore your rotator cuff really badly and you never -- so it wasn't working, over time that muscle in not firing, it atrophies. Another reason could be you had a nerve injury, so people have back issues can have the nerve isn't functioning and that is not stimulating the muscle. So at the end of the day the muscle has to be stimulated or it atrophies. And the third reason would be it is so painful that you are not moving your joints and therefore, you get atrophy.

In his case he tore his muscle, so it is atrophy. It is not anymore complicated than that.

Q. Great, okay. Thank you.

You tested range of motion again?

A. Correct.

Q. Any changes there?

A. No.

Q. In regard to the left knee, positive Lachman and Drawer, what does that mean?

A. So that is a sign of an ACL injury. I think from him it is because his quads are so weak that where you should have stability, you are not having the stability. I don't think he tore his anterior cruciate ligament. I am not telling you that he tore his anterior curciate ligament. I think his quads are so weak he lost the ability in his knee.

Q. Doctor, for the next series of questions I would ask that you give your opinion to a reasonable degree of medical certainty?

A. Okay.

Q. I want you to assume that on October 9th of 2017 Mr. Rivera was standing on a ladder when he was struck in the left leg by a beam that weighed, approximately, 4,000 pounds. The force caused him to fall from the ladder to the ground below.

With a reasonable degree of medical certainty, would that event be the competent producing cause of the injuries that you described to the jury today?

A. Yes.

Q. Okay, why?

A. I mean, we have to take a look at him in totality. He is a young man with no preexisting problems who has a significant injury, both from direct impact and then from falling to the extent that he is admitted to the hospital

for six days. To put that in comparison, if you had a knee replacement tomorrow half of you would go home that day, half of you would go home the next morning.

So if you are in the hospital for six days, that is a long time, it is a significant injury.

Q. You are talking about the initial hospitalization at Kings County Hospital, correct?

A. Correct.

Q. Great. Now, are the injuries that you described permanent?

A. Yes.

Q. Why?

A. I have seen him now for the last five years and he has essentially, for the most part, remained relatively the same throughout that time.

Q. Are the injuries that you described a competent producing cause of pain?

A. Yes.

Q. Why?

A. He has problems with his labrum. He has problems with the cartilage in his knee. All of which can cause problems and correlate with what the symptoms are.

For example, let's say you have a meniscal tear, but you are not painful in that area, that doesn't always correlate. In his case everything kind of lines up.

Q. Doctor, have all of the opinions you have given today been to a reasonable degree of medical certainty?

A. Yes. That is why I was going to say you don't have so that because it has been that way the whole time.

Q. I have to say that.

MR. ROSE: Thank you for your time today. Thank you.

THE COURT: Okay, thank you.

Jurors our reporter has been since taking testimony since 10:51, but she was in courtroom with us before that. Just to give you an example, this is what she had produced for us over the weekend. So I think she is entitled to ten minutes now.

Okay, we will take a brief ten-minute recess. Please continue to keep an open mind. Do not talk about this case amongst yourselves or with anyone else. And we will begin again, promptly, at 12:21.

All right, thank you.

COURT OFFICER: ALL rise. Jury exiting.

(Whereupon, the jury exits the courtroom.)

Recess taken.

COURT OFFICER: All rise. Jury entering.

(Whereupon, the jury enters the courtroom and is seated in the jury box.)

THE COURT: Both sides stipulate all jurors

are present and properly seated?

MR. ROSE: Yes, your Honor.

MR. FARRELL: Yes, your Honor.

THE COURT: Okay. Cross Examination?

CROSS EXAMINATION

BY MR. FARRELL:

Q. Good afternoon, Dr. Katzman.

A. Good afternoon.

Q. When you first saw Mr. Vivanco you said that was in August of 2020, correct?

A. Correct.

Q. That is three years after the accident?

A. Yes.

Q. And you are not the surgeon who performed these two surgeries on Mr. Vivanco, correct?

A. That is correct.

Q. How did it first come about that you first saw Mr. Vivanco? Was he referred to you, something else?

A. I am not sure. He may have been referred from his attorney, but I am not sure.

Q. I believe a couple of times today you referred to the surgeries that were performed as a clean out; is that the terminology that you used?

A. I don't think so, but I don't think it is a terrible description of it.

Q. You don't think it is what?

A. A terrible description of it.

Q. Okay. What would you refer to a clean out as; what was does term mean?

A. So in the case of Mr. Rivera he didn't have anything to repair per se, but he had parts that were defective, clean up, essentially. And the technical term is debrided for the shoulder, a chondroplasty for the knee. Chondro meaning cartilage and plasty, essentially, cleaning.

Q. Starting with the shoulder, you say nothing repaired, there was nothing within the shoulder sewn back together, correct?

A. Correct.

Q. There were no plates, screws or anchors put into his shoulder, correct?

A. Right. I would say we never put plates and screws in a shoulder arthroscopy, but we sometimes put in anchors if needed. None were needed in his case.

Q. THe same with regard to the knee, there was no plates, screws, anchors or anything like that put into his knee, correct?

A. In the knee we were less likely to -- I guess you can call it a meniscal tear. None of these are, again, put in, in general, for this kind of repair. You never use plates, anchors or screws.

Q. For an ACL repair for instance, screws are used and usually put in, but nothing like that was needed in this case?

A. Correct. It is screws or buttons to be technical.

Q. Now the 2017 knee MRI and 2017 shoulder MRI that you were shown here today, those were both well before the time you were treating him, correct?

A. By definition, yes.

Q. Had you ever actually reviewed those films before today?

A. I think so.

Q. Okay, do you know for a fact that you reviewed those films before today?

A. I am pretty sure I did, but I am under oath, so I don't to want to say something that may not be true. But I am pretty sure.

Q. I want to go through the MRIs that we have discussed. So with regard to the left knee and you have your file with your here today?

A. Yes.

Q. So feel free to refer to any documents in your file of necessary.

With regard to his left knee MRI from September 5th 2017. Well, that was taken, approximately, or I should say less than a month after the accident, correct?

A. They are all jumbled up from jumping up and down. If you can repeat the date again?

Q. September 5th, 2017. Left knee.

A. Yes. Less than a month after. That is correct.

Q. Are you aware, just to clarify, because you reviewed all of his records, did he sustain a tib fib fracture in this case?

A. No.

Q. Were any of the bones in his leg broken in this case?

A. No. I mean, I would say not a classical broken bone. Did he have a defect? If you wanted to be super technical, because you can say maybe a defect is like a broken bone. But not a typical broken bone that you would think.

Q. Left knee MRI was done, was there a finding with regard to the osseous structures in the knee?

A. Osseous, yes.

Q. What was that finding?

A. If you have it I will take it instead of looking through all these papers.

Q. I am sorry?

A. If you have a copy instead of me looking through all these papers -- I think I have it.

Q. Well, let me just ask, there was no fracture seen

on the MRI?

A. No, this isn't a broken bone case.

Q. And is it correct that the time of that MRI the cruciate ligaments were all in tact?

A. Yes. I will make your life simple because you are a nice man. The cruciate ligaments were in tact. It is not an ACL case and he did not tear his meniscus. These were in tact on the MRI and intraoperatively. It is not a meniscus case as well.

Q. Thank you.

A. I think I showed you both of those on the MRI. I did not say they were torn.

Q. So all those things that we just discussed were found to be essentially normal at the time of September 5th, the left knee MRI?

A. Yes.

Q. Now let's talk about what he actually had. There was an issue with his left knee at that time. There was a chondral fissure over the central trochlea; is that correct?

A. He had issues with his trochlea, his patella. They were both cleaned up and then he had a lateral release done. That is essentially his surgery.

Q. So I am not talking about the surgery, I am talking about the MRI?

A. At that point --

MR. ROSE: I have it if you want to hand it up.

MR. FARRELL: Sure. That is fine.

Q. Doctor, chondral fissure is essentially --

A. It is the wrong one. We need the knee. You gave me the femur. I have it. I found it. I found it. Thank you.

Q. Chondral fissure is essentially is a crack in the cartilage, correct?

A. He had a full thickness fissure which could be considered a crack -- and I showed it to you on the MRI, you know what it looks like -- as his major finding.

Q. And that can be caused by trauma, correct?

A. Yes.

Q. Also can be caused by sports injury or gradual wear and tear?

A. Probably not gradual wear and tear. It could be caused by an injury such as a sports injury. In this case he has no preexisting history, but as a general principle, yes.

Q. When you say he has no preexisting history, that is based on a subjective history given to you by him?

A. I wouldn't say a subjective history, but that is a history given by him.

Q. And also another finding that this small joint

fusion, that is essentially liquid or fluid on the knee joint?

A. Yes.

Q. Would it be unusual to see findings like this on a man in his 30's who works in the construction field absent a traumatic event?

A. I would say it would be in the realm of possibility. I wouldn't expect everyone who worked in construction would have those MRI findings.

Is it possible that if you took an MRI of an asymptomatic 35-year old gentleman that would be working in construction would have it, yes. Would I expect the majority to have it, no.

Q. What kind of conservative treatment have you done for chondral fissure?

A. I can try therapy.

Q. Do you know whether at the time of this September 5th 2017 MRI and the November 2017 knee surgery if he had any physical therapy in that time?

A. That I am not sure of.

Q. Based on the findings that you have seen from that September 5th 2017 MRI, it was your recommendation at that time B, to perform a surgery or to do some more conservative treatment?

A. It is hard to say because I wasn't there to be

honest. So I think it is an excellent question, but it is one I really couldn't answer because I wasn't there to see the patient.

Q. Do you know whether he had any injections in his knee in that time period, between the September 5th 2017 MRI and the November 2017 knee surgery?

A. I don't think so, but I am not 100 percent sure. But I don't think so.

Q. To the left knee surgery that you had gone over in pretty well detail today, you weren't the surgeon who performed the surgery, correct?

A. Yes. You asked me that.

Q. Did you request the operative photos from that surgery?

A. No.

Q. You never actually seen what the inside of his knee looks like?

A. Outside of the MRIs. No.

Q. And I believe we covered there was nothing sewn or stitched up inside his knee, correct?

A. I said that. You asked me that already, yes.

Q. Now, I want to direct your attention to the September 8th 2020 MRI report of his left knee, do you have a copy of that in your file?

A. I do. I have to find it. I was more organized,

but I am discombobulated from going up and down.

I would ask that you just hand me the MRI so I don't have to waste my time looking through it.

MR. FARRELL: I can do that. I have a copy of it.

A. I am looking at it.

Q. Okay, with regard to the cartilage loss in the central trochlea, was there a finding with regard to what that was like compared to the prior MRI?

A. Yes, they said it was improved.

Q. So the cartilage loss in his knee when you looked at, when the September of '20 MRI was done, had improved over the prior MRI?

A. Based on the MRI it did improve.

Q. Is it your opinion that would have been based on or because of the surgery would cause that improvement?

A. That would be the most likely conclusion.

Q. Were there any other findings in that September 8th, 2020 left knee MRI that showed improvement over the prior MRIs?

A. Yes, the subchondral marrow edema and cystic changes had resolved.

Q. That is improvement from the prior MRI?

A. I don't think it is a big issue, but it is improvement.

MR. FARRELL: I will take that back from you.

Q. I want to draw your attention to the right shoulder MRI from September 12, 2017?

A. That one I have right in front of me.

Q. Good. Again, no fraction seen in the bones of the shoulder, correct?

A. No fraction. This is not a fraction case for the shoulder, the knee or the thigh.

Q. Did you request the intraoperative photos for the right shoulder surgery?

A. I did not.

Q. You made reference, I believe in your direct testimony, that he had a slight tear in his rotator cuff; is that correct? Is that the terminology?

A. On the MRI?

Q. On the MRI, correct. So it wasn't a full tear on the rotator cuff, correct?

A. Correct.

Q. Can a slight tear also be referred to as a fraying?

A. It can. I don't think that is what they were saying here. They didn't use the word fraying, but so they can be -- I wouldn't say they are interchangeable, but sometimes they could be interchangeable. Sometimes they could not be interchangeable. I wouldn't say a small tear is fraying, but sometimes a fray could be described as a

small tear.

Q. Can small tear or fraying be caused by a traumatic event?

A. Yes.

Q. Can it also be caused by repetitive overhead motions of a shoulder?

A. As a general principle, yes.

Q. Would it be uncommon for a 30-year-old iron worker lifting heavy beams all day to have fraying or a slight tear in their rotator cuff?

A. Plus minus. If we look statically at patients under 40-years-old, so it is not quite analogous and they have done the study. Essentially, they put a bunch of people that were dead, right, because we are not going do it on people that are alive and looked at their rotator cuffs for a full tear. Again, that wasn't a full tear. I am saying that with that caveat. If you looked at patients under 40 with a full tear it is essentially zero percent.

Q. Do those studies involve people that are in the industry working as iron workers?

A. They are dead.

Q. When they were alive, were they working as iron workers?

A. I don't think they categorized them by job. And so that is why I said it is with that caveat, but just to give

you an idea for most people under 40 the chance of having a full rotator cuff tear is essentially close to zero.

Q. Right, but the question was, would it be uncommon for a iron worker in his 30's who repetitively lifted steel beams over his shoulder to have fraying or slight tears in his rotator cuff?

A. So I said to that answer I said plus minus.

Q. Okay. The left knee surgery, I believe you had mentioned -- well, what types of incisions were done with the left knee surgery?

A. It is typically two arthroscopic portals.

Q. We you say portal, can you estimate, approximately, the size of those? Indicating like two inches, give or take? One inch?

A. Inch and a half. Every one is a little different.

Q. After the surgery the portals are stitched or how is that closed?

A. I close them with stitches.

Q. Okay, can you estimate how many stitches it would take to close the portal?

A. One to two. I put them on the inside so you don't see them and you don't have to take them out.

Q. As to the shoulder surgery, how many incisions, in this particular case, how many incisions are we talking?

A. I think I did three. I don't remember

specifically. I typically do three for this kind of surgery.

Q. Would those portals be similar in size to what we are looking at in a knee surgery?

A. Maybe a little bigger on the lateral portal of the shoulder because the instruments are bigger.

Q. Okay.

A. But it is not a large --

THE COURT REPORTER: I'm sorry, I didn't hear you.

A. He is trying to basically say that they didn't have any large incisions like what you see in a knee replacement. The answer is they did not.

Q. And I don't want to put words in your mouth. I believe you said talking about the right shoulder surgery now, the labral tear was debrided, correct?

A. Correct.

Q. And that is essentially like trimming away of pieces of the labrum so they don't get caught or cause pain?

A. Yes.

Q. There was also a bursectomy performed in this procedure, correct?

A. Correct.

Q. And can you explain that? I don't think it came out during the anatomy of the shoulder discussion what the

bursa are in the shoulder?

A. I thought I did, but.

Q. Maybe you did.

A. Basically the bursa is a potential space. If we think of what this means, it is very difficult. I remember when I was in medical school trying to understand what a bursa was. But essentially you have a tendon and then you have space and then you have your Acromion and between those is a bursa. And that could be inflamed and then we take that out during surgery.

Q. An inflammed bursa, is that what bursitis is?

A. Bursitis is the concept of the pain of that.

Q. And bursitis would be caused by trauma; I would assume?

A. Yes.

Q. Can it also be a symptom or can it be caused by overhead repetitive motions?

A. Yes. Again, in this case, by his history, so we knocked that out of the box, there was no history of that that he was working as a construction worker before this, but as a general principle, yes.

Q. I want to direct your attention to the right shoulder MRI from September 8th, 2020.

A. All right.

Q. And similar to the questions about the -- is it not

true that the right shoulder MRI from September of 2020 indicates that the appearance of your shoulder has improved since the prior examination?

A. Yes. So what happened was I received the MRI report from Lenox Hill Radiology that I ordered and I wanted to make sure in his case what they were seeing. And so I called the radiologist and I spoke to him about the report and we went over it together and he issued the addendum that you are speaking about now that shows that there could be a small recurrent tear in the labrum. Overall appearance has improved since the prior examination and that they could see the shaved down bone which is called acromioplasty.

Q. And is it correct that the frayed appearance in the labrum could be evidence of a surgery that they did as opposed to a new tear?

A. Right, so that is why I said it is difficult to read MRIs after surgery because, what I tell my patients is, -- and you are not going to be able to type this. If you have a tear here, I cleaned up the tear. When you take a new MRI it is still looks like it is torn. So he wrote that it could either be some new tears or it could be the result of his debridement.

Q. So if I understand that correctly, there is no definitive evidence of new tearing?

A. Correct.

Q. You issued a report in this case on November 15 of 2022, correct?

A. Yes.

Q. Okay and in that report there is a section called "comment" on the last page; do you see that?

A. No, because I have like five million pages here. I am trying to find it.

Q. Well, let's cut to the chase.

A. I have it.

Q. You see the section called "comment"?

A. Yes.

Q. And what was your comment as of the November 15, 2022 report that you issued?

A. That he is a candidate to do the right shoulder surgery again.

Q. He was a candidate at that point for revision of the right shoulder. And I know you were asked by plaintiff's counsel whether that would be the same surgery or not and I believe you answered and correct me if I am wrong, that it might be the same surgery; is that fair to say?

A. I said it would be similar. In other words it would be right shoulder arthroscopy. I am not saying I am giving him a new shoulder. I would do the right shoulder arthroscopy and then as I said before, depending on the

intraoperative findings I would do whatever I needed to do.

Q. Okay, so fair to say once you were in there if you had to veer off to do something different because of what you saw you would?

A. Yes.

Q. So, but --

A. I wouldn't say that because that makes it sound like I wouldn't be prepared and I was going on a different plan. I would have my plan in place and address it accordingly.

Q. Understood. As of the time of your November of '22 report, the revision surgery that you were saying he could be a candidate for would be another surgery where there is no screws or anchors implanted; is that fair to say?

A. No screws. I don't know about anchors. Depending on what I found.

Q. You have recently examined the plaintiff again, April 30th, actually, which was last week, I believe, correct?

A. Yes, correct.

Q. Now, you issued a report after that examination, correct?

A. I did.

Q. Of the same date?

A. Yes.

Q. All right, now, in this report from April of 2025, you put forth a plan on the last page, correct?

A. I have to find it now.

Q. Page 4 of the report.

A. Yes.

Q. What was your plan as of last week?

A. To get updated MRIs of his shoulder and knee.

Q. Okay, in your April of 2025 report, is there any indication that he is being recommended for any revision surgery?

A. It is not in the report, however, the purpose of getting the MRIs is to educate about potential surgery.

Q. Educate about potential surgeries, correct?

A. He is a candidate. So I just want to be clear so that is no misunderstanding. I have seen the patient for five years intermittently. I have tried to treat him conservatively and he hasn't gotten better. He has been a candidate for revision shoulder surgery for a long time, we have talked about it. We don't have the updated MRI so before I said I would do surgery again, I want to see an updated MRI. Just so we had a clear plan going forward.

Q. As we sit here today though, those MRIs have not been conducted as far as you know?

A. From last week? No, they have not been conducted.

Q. So you haven't had a chance yet to review any

revised MRIs from -- that were suggested last week, correct?

A. I wouldn't use the word revised MRIs. I would say I did not get a chance to view any updated MRIs. Revise sort of means like you revise a report. Updated means, look he hasn't had an MRI in a while. Just like all of us, we have new MRIs before we have surgery.

It doesn't negate the fact that he needs shoulder surgery, but it just part of the plan.

Q. Right. Is there any potential that findings would come out on that MRI that changes the plan?

A. Unless it showed horrendous arthritis. Meaning the arthritis was so bad that the shoulder scope wouldn't work, I would say no. In that case you need a shoulder replacement. I think the chances of that happening are close to zero.

Q. Is there any chance that a revised MRI would show improvement in his right shoulder?

A. So again, on the updated MRI, I would say it could be improved. The unfortunate problem is you still have a 36-year-old gentleman who used to be a construction worker who still has shoulder pain and can only lift his arm up half way and still has pain on his exam and that hasn't changed.

Q. Okay, the question though was --

A. Right, so I am saying even with the updated MRI and

I thought I answered, but I probably wasn't clear so I will say it again. If his MRI showed improvement you still need the surgery because it would still be the same person in the same pain. You said could it change your opinion and I said yes. If his MRI showed tremendous arthritis and you needed a shoulder replacement instead of a shoulder arthroscopy, that would change what I would do, but I think the chances of that are close to zero.

That is why I didn't put it in my reports that I think he is going to need a shoulder replacement because I don't really believe that and I am not going to put down something just to put down something.

Q. But you also didn't put in your April of 2025 report that he is a candidate for revision shoulder surgery, did you?

A. No. So I want to be clear, I didn't put that in because I would say if I am getting an updated MRI we should have that before I say he is going to need surgery, just as a matter of fact, but it didn't negate that I still -- if I thought he didn't need shoulder surgery I wouldn't bother to get the MRIs.

Q. But, we don't have --

A. We can do the --

THE COURT REPORTER: One at a time, please.

Q. But we don't have the results of the MRIs yet, do

we?

A. We can do the chicken and the egg all day but my opinion doesn't change.

MR. FARRELL: Thank you, sir. I have nothing else for this witness.

MR. ROSE: Yes, your Honor.

REDIRECT EXAMINATION

BY MR. ROSE:

Q. The term clinical correlation, what does that mean to the thigh?

A. That the thigh can indeed correlate with the patient's either history or physical examination.

Q. How does that term apply as it relates to the medical causation question regarding Mr. Vivanco's injuries from this accident?

A. I don't understand what you are saying.

Q. Okay, so counsel was asking you questions about work in the field of being an iron worker, for example?

A. So you have to --

Q. Do you understand what I am getting at now?

A. Yes. You are asking me essentially did I think his injuries are causally related from this accident or from potential repetitive use as a construction worker. I think that is what you are trying --

Q. Well, I was hoping that you would say that

yourself, but yes.

A. So you have to make decisions, right, in life and the patient is a 35-year old gentleman. And again, by his history, I said this three times already, he had no preexisting problems. He was working as a construction worker. It is not like they said he is taking time off every other week because he couldn't lift up his arm or he couldn't climb up a ladder.

He then has a huge traumatic injury to the point that he is in a hospital for six days. A 4,000 pound beam hits him in the leg. You saw the pictures of the leg. I don't think that his impetus or his issues, his surgery and those finding are related to repetitive use. I think they related to his accident.

MR. ROSE: Thank you.

MR. FARRELL: Nothing else, your Honor.

THE COURT: Okay, thank you very much.

Okay jurors, I am going to make our reporter very happy, that is it for today. Tomorrow we will have a full day. And when I say a full day, we are going to start at 9:30 and then I don't know when it will end. Today was a definite end at this time for us.

Okay, so please continue to keep an open mind. Please do not talk about this case amongst yourselves or with anyone else. Get home safe. I know it is rainy.

The Knicks play tonight at seven.

And so I will see you tomorrow morning. Please be in the jury deliberations room no latter than 9:30. 9:30. All right, thank you.

COURT OFFICER: All rise. Jury exiting.

(Whereupon, the jury exits the courtroom and the trial is adjourned for the day.)