1 can hash it out tomorrow.

2 MR. HERBERT: Thank you, Your Honor.

3 THE COURT: All right, let's get the jury out

4 then.

5 We are ready.

6 COURT OFFICER: All rise. Jury entering.

7 (At this time, the jury entered the courtroom)

8 THE COURT: Thank you, jurors. Thank you for

9 your patience. To accommodate the schedule of the

10 physician witness, we are going to interrupt the

11 plaintiff's testimony at this time. It is with the consent

12 of the parties and the Court, so it is okay, perfectly

13 fine. We will pick up on the plaintiff's examination when

14 we are done with this witness.

15 You may call that witness at this time.

16 MR. HERBERT: Thank you, Your Honor. At this

17 time I call Dr. Dov Berkowitz.

18 COURT OFFICER: Step up. Remain standing. Face

19 the clerk.

20 THE CLERK: Raise your right hand, please.

21 Do you solemnly swear or affirm that the

22 testimony you are about to give the Court and jury will be

23 the truth, the whole truth and nothing but the truth?

24 THE WITNESS: I so affirm.

25 D R. D O V B E R K O W I T Z, having been called as a

1 witness by and on behalf of the Plaintiff, having first been
2 duly affirmed, was examined and testified as follows:
3 THE CLERK: Thank you. Please be seated.
4 THE WITNESS: Thank you.
5 THE CLERK: May we have your name and business
6 address, please?
7 THE WITNESS: First name is D-O-V, Dov. Last
8 name is Berkowitz, B-E-R-K-O-W-I-T-Z. 80-02 Kew Gardens
9 Road, Kew Gardens 11415.
10 THE CLERK: Thank you.
11 THE COURT: Good afternoon, sir. These lawyers
12 are going to ask you some questions. What I want you to do
13 is to let them finish the question before you answer, so
14 you are not speaking at the same time. Please speak loud
15 enough so everyone can hear you. The lawyer who is not
16 asking questions is seated. When you see that lawyer stand
17 up, it is because he is going to say "objection". So when
18 you see him stand up, just stop and look to me. I will let
19 you know whether you should answer that pending question.
20 THE WITNESS: Yes, sir.
21 THE COURT: Is there a cup of water up there?
22 THE WITNESS: Yes, sir.
23 THE COURT: We are actually going to refill it
24 from time to time.
25 THE WITNESS: Okay.

1 THE COURT: You may inquire.
2 MR. HERBERT: Thank you, Your Honor.
3 DIRECT EXAMINATION
4 BY MR. HERBERT:
5 Q. Good afternoon, doctor.
6 A. Good afternoon.
7 Q. I am going to ask you to please keep your voice up so
8 everyone in the courtroom can hear you, okay?
9 A. No problem.
10 Q. Thank you, doctor. Doctor, are you a physician
11 licensed to practice medicine in the State of New York?
12 A. Yes.
13 Q. When did you become so licensed?
14 A. In, let's see, 19 -- let me just think for a second.
15 So many years ago. Thirty years ago already. So I think in
16 1979, 1980 would be about the time that I was licensed.
17 Q. And, doctor, where did you go to college?
18 A. City University of New York.
19 Q. And you graduated with a degree in what?
20 A. In BS, Bachelor of Science.
21 Q. When did you graduate?
22 A. In 1975.
23 Q. After graduation where did you go next?
24 A. To the Mount Sinai School of Medicine here in
25 New York.

1 Q. Did you complete that medical school?

2 A. Yes.

3 Q. After completion of medical school, what did you do

4 next professionally?

5 A. Well, I stayed at the Mount Sinai institution. It had

6 a very well known hospital, Mount Sinai Hospital in New York.

7 I enjoyed that hospital very much. So I stayed on there for

8 internship and residency in the field of orthopedic surgery.

9 Q. Doctor, does every doctor have to do residency, or

10 internship, or stay on?

11 A. No. I mean, it depends what you want to do in life,

12 so to speak. You may just want to have a medical degree and go

13 on to other things for whatever reason and not want to complete

14 your training. But completion of medical school does not in

15 any way complete your training. It gives you a degree. But

16 you need to go through an internship and a residency to gain

17 the experience level necessary to actually treat patients.

18 Q. What was your internship and your residency? What did

19 you specialize in, doctor?

20 A. I specialized in the field of orthopedic surgery which

21 is the field and study and treatment of problems related to

22 muscles, bones and joints. And when I finished the residency,

23 I took an additional year of fellowship training in at that

24 time what was a new field, today it is the most commonly done

25 procedure in the states today. But at that time it was a new

1 field called arthroscopic surgery which back in those days was
2 the beginning of the field where you would put little cameras
3 inside joints as opposed to making large incisions. It was a
4 tremendous advance in those days. Today it's, of course, very
5 common and most people are familiar already with it.
6 So I did an extra year of that. But the idea was the
7 field of orthopedic surgery is treating all problems related to
8 muscle, bones and joints and the field of arthroscopic surgery
9 and my particular specialty of shoulder and knee problems I
10 started to do more effort in that direction as the years went
11 by.
12 Q. Doctor, are you a board certified physician?
13 A. Yes.
14 Q. And what specialty or specialties of medicine are you
15 board certified?
16 A. In the field of orthopedic surgery.
17 Q. Doctor, what does it mean to be a board certified
18 physician?
19 A. The American Board of Orthopedic Surgeons are the only
20 empowered division in this country licensed to create a test to
21 test candidates who have finished an accredited residency in
22 this country in the field of orthopedics. You take that test
23 which is not a picnic. And if you pass that test, you get
24 their diploma or you become a diplomate of the American Board
25 of Orthopedic Surgeons.

1 In order to obtain that diploma, you have a two-day
2 test that involves an eight-hour written examination and the
3 day before you have an examination by five different
4 specialists in any specialty within orthopedics. Could be
5 trauma, could be total joint displacement, could be sports
6 medicine, could be pediatric medicine. It could be any type of
7 area within orthopedics. You are really not sure what's going
8 to happen. Like in the Supreme Court, everybody fires
9 questions at you from different directions at the same time.
10 And so if you can survive that first day, then you go onto the
11 second day of the eight-hour test. And between those two days
12 the American Boards come up with a minimum score, so to speak.
13 If you reach that score, you get their diplomate status.
14 So in order to become a board certified surgeon, you
15 need to complete the residency. After medical school I did an
16 extra year of fellowship which is not required. And then in
17 those days you had to wait two years in order to first sit for
18 the boards. I did that in 1986, I took them for the first time
19 and I was lucky I passed it on the first shot. So it was quite
20 an effort. It's a big thing to get that diploma.
21 MR. HERBERT: Your Honor, I would like to move
22 Dr. Berkowitz in as a qualified expert in orthopedic
23 surgery.
24 THE COURT: He is.
25 MR. HERBERT: Thank you, Your Honor.

1 Q. Doctor, are you a member of any medical societies?

2 A. State of New York Medical Society.

3 Q. Doctor, can you approximate for me how many shoulders

4 you have examined in your lifetime?

5 A. Well, now I am approaching 30 years in practice. Of

6 course, when you start out in your first year, you are not as

7 busy as you might be 30 years later. It takes time to build-up

8 a practice like any other thing. So today, 19 -- or let's say

9 in the year 2013, I am seeing thousands and thousands of

10 patients, maybe 2,000 to 3,000 patients a year, of which it is

11 equally divided between shoulders and knees. So that I will be

12 seeing over a thousand patients a year of shoulder problems and

13 over a thousand patients a year of knee problems, well over a

14 thousand. It's in the thousands per year. Of course, 30 years

15 ago it might have been 150 for the whole year, but it grows.

16 So I think I can legitimately say in the last ten years I have

17 been seeing thousands of patients a year for shoulders and

18 thousands of patients for knees.

19 Q. Now, doctor, have you had occasion before to testify

20 in court?

21 A. Yes.

22 Q. Would you approximate for the ladies and gentlemen of

23 the jury how many times you have testified in court before?

24 A. I think it's -- I am testifying only for patients that

25 I am actually treating with one exception. I testify probably

1 somewhere around seven, eight times a year, if that's how many
2 patients I need to come in to testify for, but only on my own
3 patients that I have treated and operated on. So those are the
4 patients that I testified.
5 Q. You mentioned something that I want to clarify. You
6 mentioned only for your patients.
7 A. Yes.
8 Q. Can you explain what that means?
9 A. Well, there are many people that spend their time and
10 their careers in being professional witnesses. So they reach a
11 point in their career maybe they can't practice anymore for
12 whatever reason and they get hired by law firms to review other
13 people's cases and testify on behalf of either the insurance
14 company or on behalf of the patient.
15 MR. NEWMAN: Objection. Move to strike.
16 THE COURT: That's okay. Continue.
17 THE WITNESS: That tends to happen to people
18 later in their careers. Maybe they can't operate any more
19 or --
20 THE COURT: Tell us about you.
21 THE WITNESS: I am not interested in being a
22 professional witness. I am actually a treating doctor. I
23 treat patients and I operate on patients and I don't have
24 the time. Even coming here today is an extremely difficult
25 thing for me.

1 MR. NEWMAN: Objection.

2 THE COURT: Sustained.

3 Q. Doctor, can you describe your current practice today?

4 A. My current practice is the following. I see patients.

5 I have a number of different offices. I see patients. I

6 examine them. I take their history first. I examine them and

7 then I prescribe treatment. The majority of that treatment is

8 non-operative. The majority of that treatment is conservative.

9 There is a certain percentage of patients that will naturally

10 need surgery and then I do the surgery myself.

11 Q. Doctor, what would you be doing if you were not here

12 today testifying in court this afternoon?

13 A. I would be in my Queens office right now seeing quite

14 a few patients.

15 Q. Did you have to cancel those patients because you are

16 here with us today?

17 A. Absolutely.

18 Q. Doctor, are you being compensated for your time here

19 today away from your practice?

20 A. Yes, sir.

21 Q. Doctor, how much are you being compensated to be with

22 us this afternoon and to cancel your patients?

23 A. $8,500.

24 Q. Doctor, did there come a time that you had seen a

25 patient by the name of Jessica Iovino?

1 A. Yes.

2 Q. Doctor, when was that?

3 A. November 14, 2011.

4 Q. Now, doctor, I see you are looking down. Are those

5 your records you are looking at?

6 A. Yes.

7 Q. Were those records kept in the ordinary course of your

8 business?

9 A. Yes.

10 Q. Were those records documented at the time you saw the

11 patient?

12 A. Of course.

13 Q. And are those records kept and maintained in your

14 office?

15 A. Yes.

16 MR. HERBERT: Your Honor, I would like to move

17 his file into evidence. I had an opportunity to show

18 counsel his file before Dr. Berkowitz took the stand.

19 MR. NEWMAN: Judge, I need to see the file again

20 because I don't recall every piece of paper.

21 THE COURT: So is it admissible subject to

22 redactions?

23 MR. NEWMAN: Yes.

24 THE COURT: All right, it is admitted subject to

25 redactions. It is Exhibit 4.

1 (Received and marked Plaintiff's Exhibit 4 in
2 evidence)
3 Q. If you need to look at the documents, you can,
4 Dr. Berkowitz.
5 A. Thank you.
6 Q. Doctor, did there come a time that you saw the patient
7 by the name of Jessica Iovino?
8 A. Yes.
9 Q. And, doctor, when was that?
10 A. November 14, 2011.
11 Q. Now, doctor --
12 A. A little bit more than two years ago.
13 Q. Doctor, I would like to go through this visit, doctor.
14 Did you take a history?
15 A. Of course.
16 Q. Can you walk the ladies and gentlemen of the jury
17 through the history?
18 A. Yes. Ms. Iovino informed me that she was at the time
19 35 years of age. She was involved in a motor vehicle accident,
20 she was a pedestrian, on October 3, 2011. She stated that she
21 sustained blunt direct trauma to the region of her left
22 shoulder at the time of the accident. She was seen at Coney
23 Island Hospital. She was there specifically for persistent
24 pain in her left shoulder. She also had some neck pain
25 radiating down her left arm with numbness.

1 The pain in the left shoulder gave her difficulty
2 doing normal activities of daily living such as lifting,
3 reaching behind you to get dressed, carrying things, normal
4 activities, going to a kitchen cabinet. She couldn't do that
5 without pain. She also had pain at night, meaning it was hard
6 to sleep on that side. Critically, she had no prior history of
7 any difficulty with that left shoulder before. That's a very
8 important point.
9 MR. NEWMAN: Objection. May the doctor answer
10 the question and not editorialize and make speeches?
11 THE COURT: That's fair. Sure.
12 Just answer the question, doctor.
13 THE WITNESS: Okay. So as I mentioned she had no
14 prior history of difficulty with her shoulder before and
15 she was getting physical therapy at that time to her left
16 shoulder.
17 Q. Doctor, you mentioned that there is no prior history
18 or problems with the left shoulder. What does that tell you,
19 doctor?
20 A. That she doesn't have a prior reason to be having
21 ongoing pain in the shoulder from some other problem, whether
22 it was a disease problem like arthritis or from some other
23 injury that could have affected her left shoulder. There was
24 no history of any difficulty with that left shoulder before, no
25 matter what else she had gone through.

1 Q. At this point, doctor, did you have an MRI report?
2 A. Yes, I did.
3 Q. What was your understanding of the MRI?
4 A. The MRI report that was available showed that the
5 patient had what's called subacromial or subdeltoid bursitis
6 which in English basically means that she had an inflamed
7 shoulder, and that it was irritated, and it can cause pain.
8 Q. Doctor, just talking real quick subjective versus
9 objective. What is subjective and what is objective?
10 A. Subjective would be that I feel like it's raining
11 outside. Objective would believe I am outside and it's raining
12 on me. That's objective. So the difference is one thing is
13 evident and one thing is thought.
14 Q. And an MRI, is that subjective or objective?
15 A. It tends to be objective. The only subjective part is
16 the radiologist reading it. But the machine that produces the
17 films, that's totally objective.
18 Q. Continue reading, doctor, past medical history. Did
19 you take a past medical history?
20 A. Yes. She had no history of any major medical issue
21 such as diabetes, hypertension, heart, lung, kidney disease.
22 No problems.
23 Q. Did you take a past surgical history?
24 A. Yes.
25 Q. What was your finding for a past surgical history,

1 doctor?

2 A. Three years before the date of her coming to see me or

3 some time in 2008, she had undergone a surgery for the right

4 shoulder. She had an arthroscopic procedure to her opposite

5 right shoulder.

6 Q. Does that affect in any way your findings, doctor?

7 MR. NEWMAN: Objection.

8 THE COURT: We don't have findings here.

9 MR. HERBERT: Okay, we will get to it.

10 Q. Were there any medications at this point, doctor?

11 A. She was taking anti-inflammatory medications like

12 Ibuprofen better known as Motrin, things like that.

13 Q. Continue reading. Anything significant for the family

14 and social history?

15 A. No, I think the point is to get to the physical exam

16 which is what you really want to know.

17 Q. Doctor, can you explain to the ladies and gentlemen of

18 the jury what is range of motion?

19 A. Range of motion is the following. Every joint in our

20 body has a certain ability to move. It's a joint. It can

21 move. Some joints move less, some joints move more. The

22 shoulder is considered a universal joint because it can move in

23 many different directions. It can move up. It can move to the

24 side. For instance, you can't move your knee to the side. You

25 can only bend it and straighten it out, bend it and straighten

1 it out. A shoulder you can bring up, you can bring to the
2 side, you can rotate, you can cross your body, you can reach
3 behind you, universal. It has amazing ability to move.
4 Q. On this visit in November of 2011 with Jessica Iovino,
5 did you take range of motion tests, doctor?
6 A. Yes, I did.
7 Q. What were your findings?
8 A. The findings were very notable. The normal forward
9 flexion, meaning bringing your arm in front of you and going
10 straight up in the air, is 180 degrees. This would be 90,
11 straight out in front of us. 180 would be pointing straight up
12 to the ceiling. That would be a normal range of motion in this
13 direction (indicating). Her range of motion on that date was
14 90 degrees which is 50 percent of the motion.
15 The next motion is abduction which is lifting your arm
16 to the side. She had a similar loss of motion. Meaning the
17 normal range is 180 degrees, all the way up (indicating). Her
18 range was only 90. She could internally rotate 40 degrees.
19 The normal internal rotation is 80. Ladies, in particular, if
20 you reach behind you in the back, normally you can bring your
21 arm across. That's 80, 90 degrees. When a person can rotate
22 only a certain amount that's less, and less, and less, it's
23 very, very difficult to function your activities when you can't
24 rotate. She had a loss of 50 percent of her internal range of
25 motion as well.

1 External rotation, 30 degrees. Normal is,
2 approximately, 50 degrees. So she had a little bit less loss
3 but still significant because 20 degree loss out of 50 is
4 similar to a 90 degree loss out of 180. So she had similar
5 losses. She had severe pain with attempted rotational
6 movements at 90 degrees of abduction. Abduction is movement to
7 the side (indicating). Pain with rotation means that she has
8 difficulty doing her activities. If she had to rotate her arms
9 for anything, she had pain.
10 Two important orthopedic testing signs were positive.
11 She had a positive Neer's test and a positive O'Brien's test.
12 A Neer's test is a test for impingement and O'Brien's test is a
13 test that gives us an idea whether or not the patient has
14 what's called a labral tear in the shoulder. These are all
15 very -- of course, they are not 100 percent accurate, but they
16 give a high degree of expectancy to be true. So impingement
17 was positive and labral tearing was positive.
18 Q. Did you have an assessment or plan at this point,
19 doctor?
20 A. Yes.
21 Q. What was your assessment or plan at this point,
22 doctor?
23 A. At that point she was five weeks into her injury with
24 a very irritated shoulder. At the very least she had a lot of
25 irritation in that shoulder. What impingement actually means

1 is that there is pressure on the rotator cuff muscle. The
2 rotator cuff muscle normally elevates your arm, rotates.
3 Whether you are an athlete or just reaching into the kitchen
4 cabinet, you have to rotate your arm. So impingement is when
5 the muscle that does that which is the rotator cuff, it lives
6 within a certain space within the shoulder. When that space
7 becomes compromised for whatever reason, that rotator cuff is
8 not going to be a happy person, a happy muscle. And,
9 therefore, a person can have difficulty functioning when the
10 rotator cuff comes under pressure. And that pressure is known
11 as impingement.
12 This patient clearly had an impingement and I was
13 already concerned about a labral tearing because of the
14 positive O'Brien's test. At that point I recommended a
15 cortisone injection into the patient's shoulder in order to
16 calm down that irritation, calm down the inflammation and maybe
17 get her to function a little bit better. The patient did not
18 want the injection. She had a cortisone injection a number of
19 years ago for her right shoulder and she had such severe pain
20 from that injection. She remembered it. She doesn't want to
21 ever consider that injection again. I couldn't talk her out of
22 it, but that was it. So I told her to "continue your therapy
23 and let's hope you get better with conservative treatment."
24 Q. Thank you. Anything else with that visit, doctor?
25 A. No.

1 Q. When was the next time you saw Ms. Jessica Iovino?
2 A. I saw her November 28th. So the first visit was
3 November 14. She came back two weeks later. She was
4 continuing to work with conservative treatment with physical
5 therapy and she continued to have significant pain in that same
6 left shoulder. Her examination did not significantly change.
7 She still had limited flexion forward, limited abduction,
8 limited rotation and painful rotation. She still had the
9 positive orthopedic testing Neer's sign.
10 At that point she was approaching two months into her
11 injury. Once again, I tried to offer her cortisone injection,
12 but she was fairly steadfast in her feeling that she does not
13 want to go through that again and so she continued to stay on
14 conservative treatment. And I said to her, "Look, if this pain
15 keeps up and you have lost this much motion, you have lost this
16 much function, you may need what's called an arthroscopic
17 procedure." Remember the procedure I told you 30 years ago was
18 a brand new field and today is very can common? She may need
19 that procedure done on her shoulder to relieve the pressure
20 within her shoulder for the impingement and I had in my mind
21 additionally that she may have had a labral tear as well based
22 on my earlier exam. I said, "but for the meantime just
23 continue your therapy."
24 Q. So, doctor, this November 28, 2011 exam, you took
25 range of motion tests, correct?

1 A. Yes.

2 Q. And your findings were decreased range of motion; is

3 that correct?

4 A. Markedly. Fifty percent loss.

5 Q. When was the next time you saw Ms. Iovino, doctor?

6 A. About a month later.

7 Q. And when was that?

8 A. December 22, 2011. She continued to complain of

9 persistent pain despite continued efforts of conservative

10 treatment. Her examination again showed similar loss of motion

11 with forward flexion and abduction to 90 degrees. There were

12 some changes with rotational movements but very modest and very

13 minor. She continued to have marked pain with attempt at

14 rotation which was a very important finding and she continued

15 to have a positive Neer's sign. At that point, approaching

16 three months into her injury with persistent and significant

17 pain in the shoulder, left shoulder, despite efforts of

18 continued conservative treatment with positive findings on

19 examination and on the MRI report, I recommended at this point

20 an arthroscopic approach. When a patient is suffering already

21 for three months, that's enough. Loss of motion can get more

22 and more difficult to overturn and overcome the longer you wait

23 to try to intervene with a problem of this magnitude.

24 Q. What happened next?

25 A. She agreed to undergo the surgery. Right before the

1 new year on December 28, 2011, the patient underwent
2 arthroscopic surgery to her left shoulder.
3 Q. At this point should we walk through -- do you want to
4 use any blowups to show the shoulder to help you with the
5 procedure?
6 A. With your permission.
7 MR. HERBERT: Your Honor, is it okay to use the
8 demonstrative evidence?
9 THE COURT: Of course.
10 MR. HERBERT: Thank you, Your Honor. May I
11 approach?
12 THE COURT: Do you want to put it on the board or
13 do you want to put it on the easel?
14 Q. Do you feel comfortable using the board behind you?
15 A. Are you talking about the big pictures? It will be
16 better to put it on that thing right there so they can see
17 that.
18 THE COURT: We will set up the easel. We will
19 put it somewhere there so all the jury can see.
20 Mr. Newman, when we put it up, if you want to,
21 you can move so you can see what the doctor is talking
22 about.
23 MR. NEWMAN: Thank you, Judge.
24 THE COURT: Those two exhibits are actually
25 already admitted by stipulation of counsel. So let's

1 spread the tripod. And, counsel, you will offer the
2 officer the document you want to use and we will put it up.
3 MR. HERBERT: Okay. Can the doctor approach?
4 THE COURT: Put it up first and then the doctor
5 will approach.
6 MR. HERBERT: Can we do this one first?
7 THE COURT: Now you can step down. You can move
8 anywhere that helps you see, counsel.
9 THE WITNESS: Thank you.
10 (At this time, the witness stepped off the
11 witness stand and approached the exhibit)
12 MR. HERBERT: The witness is looking at what's
13 been marked as Plaintiff's Exhibit 5. Thank you.
14 Q. You can proceed.
15 A. This is actually a more advanced picture than the
16 other picture. The other picture simply shows bones. No
17 muscles, just bones. So it's very easy to see the anatomy of
18 the bones. However, this picture fills in. If you take
19 muscles and put it in, now you see what it really looks like.
20 This is a real shoulder. So in this view we are kind of
21 looking from a perch, looking down at the patient, way up high
22 looking down here at the patient's head. We are looking at his
23 shoulder. Further down comes the belly. Here's the shoulder
24 (indicating). We will come back to that.
25 This is a front view. You are looking at my right

1 shoulder. That's what this view is. You can see this is the
2 bone of the humerus going down to the elbow. This is the top
3 of the shoulder what you can't see because it's covered by a
4 muscle and tendon, okay. The joint is going to be right in
5 here. This is a very critical space, the space between the top
6 of this muscle -- you see this is a very big, large muscle
7 here, a big red muscle? The big red muscle turns into a white
8 tendon because muscles don't attach into bones. Tendons do.
9 So when a muscle turns into a tendon, a tendon then attaches
10 into the bone.
11 The rotator cuff is a massive muscle. It is composed
12 of three different muscles that all mell together. Here you
13 can see there is some separation between muscles, but they all
14 merge together. You can't see the separation here. They
15 become a cuff. It's called a rotator cuff. What the rotator
16 cuff does is it allows you if you want to throw a baseball or
17 if you want to go to the kitchen cabinet, you have to take your
18 arm, you have to lift it, sometimes you have to rotate it to
19 throw. All that comes from the power of the rotator cuff. You
20 see on TV all the time athletes being injured. You don't have
21 to be an athlete to have a problem with the rotator cuff.
22 That rotator cuff lives in a certain space. It lives
23 in a certain space. And as long as that space is not
24 compromised, whether it's by disease or by trauma, things
25 should work well. But once things start becoming compromised,

1 the function of that rotator cuff to lift and rotate becomes
2 affected. Take a look at how small the space is. This is
3 called the acromion bone. If you take your own, let's say,
4 left arm and you put it on top of your right shoulder like you
5 are saying hello to someone, "how are you doing, Bob", right,
6 you are not hitting the shoulder, you are hitting the acromion
7 bone protecting the shoulder underneath.
8 This is the acromion bone. Right underneath the
9 acromion bone is the rotator cuff muscle. And the rotator cuff
10 is the roof of the shoulder, meaning underneath the rotator
11 cuff is the shoulder itself. If we were inside the shoulder
12 with a microscope and we looked up, we would see the bottom of
13 this rotator cuff. It functions like the roof. It separates
14 the compartment of the shoulder from this subacromial space.
15 So when you saw in the MRI the patient had subacromial
16 bursitis, that's what this is, inflammation in this area right
17 here affecting this rotator cuff. Anything that compromises
18 that space, inflammation, anything there, will make it hard for
19 the patient to function. So this is a key point.
20 So if you are looking down from the top, here is
21 another view. Here is the acromion. Here is, by the way, the
22 clavicle. That comes from the chest. The clavicle meets with
23 the acromion underneath it, just this much. This is the
24 rotator cuff. And just imagine, if we are lifting our arm,
25 this rotator cuff lifts and bangs into the undersurface of this

1 acromion bone. It's that rubbing and that banging when there
2 is inflammation in there that leads to problems.
3 There is only one other thing on the other photo.
4 MR. HERBERT: Your Honor, may I switch the
5 exhibits, Your Honor?
6 THE COURT: Yes.
7 Q. Putting up what's been marked now as Plaintiff's
8 Exhibit Number 6.
9 A. This is, by the way, a view if you take away all the
10 muscles, okay, this is the shoulder joint. Here is the bone
11 going down to the elbow. Now, you see the humeral head which
12 was covered by the rotator cuff. Now, you see there is nothing
13 in this space between the undersurface of this acromion bone
14 and the top of the shoulder. It was filled with the rotator
15 cuff before and a little bit of space. Much bigger space when
16 there is no rotator cuff in there. So this is the space that
17 we all are living in in terms of our function of the rotator
18 cuff. When it's compromised, we have problems.
19 There is one other thing I want to show you --
20 MR. HERBERT: Your Honor, there was one more
21 exhibit that wasn't marked. I showed it to counsel this
22 morning. I believe there was no objection to this. I
23 would also like to get this one marked for the doctor.
24 THE COURT: I will mark it. Show it to your
25 adversary and we will see what we are doing next. So let's

1 mark it for identification.

2 MR. NEWMAN: Well, subject to redaction I have no

3 objection, Judge.

4 THE COURT: May I have both counsel up here and

5 please bring the exhibit.

6 (Off-the-record discussion held at the bench)

7 THE COURT: The item is admitted for

8 demonstrative evidence with no objection.

9 Q. Now you can talk about it, doctor. Can you take a

10 look at this?

11 A. I just wanted to show you one thing on this picture.

12 Joints are not just muscles and bones. There's all types of

13 soft tissues inside like ligaments and other structures which

14 we did not get into. But the shoulder is supposed to be a ball

15 and socket joint just like the hip. Except in the hip it's

16 like a true socket. The hip is sitting inside a socket. If

17 you looked at the hip, you can't see it. It's surrounded by a

18 socket. To dislocate a hip is very hard. The shoulder ball

19 and socket looks like this, not quite a socket.

20 So the shoulder can commonly dislocate. What prevents

21 it from dislocating is not so much the bony restriction but

22 there is soft tissue that rims 360 degrees around the socket

23 called the labrum. I mentioned the O'Brien's test before. It

24 was positive on her which was for a labral tear. When that

25 labrum tears, it's the structure that helps prevent the

1 shoulder from dislocating. It can cause pain. It can
2 potentially cause instability. I just wanted to show all of
3 you that here is the shoulder joint. Here is the ball. The
4 socket is over here. This grayish, blackish area is called the
5 labrum. This white line in the middle of this structure is
6 representing a tear. The point I am just trying to make is
7 that there is a structure called the labrum. It has a specific
8 purpose. Like any other soft tissue, it can tear in certain
9 circumstances and it can cause pain. It's not only impingement
10 with muscles and bones, it's also soft tissue like the labrum
11 that can cause pain.
12 Q. Can you walk it to the side to show the jury.
13 A. The labrum is this structure here, this grayish black
14 structure. Just imagine it going 360 degrees around the
15 socket. It helps prevent the shoulder from dislocating. When
16 it tears, it can cause pain. This is the shoulder joint. The
17 socket is on this side and this blackish gray structure is 360
18 degrees around the socket trying to prevent the shoulder.
19 Because of lack of bony restriction, it tries to make it harder
20 for the shoulder to come out. That's all.
21 (At this time, the witness resumed the witness
22 stand)
23 Q. Thank you, doctor. I believe we were at the
24 operation, doctor.
25 A. Yes.

1 Q. When did the operation take place?
2 A. Just before New Year's, December 28, 2011.
3 Q. Where did the operation take place, doctor?
4 A. At Franklin Hospital in Valley Stream.
5 Q. And you were the doctor that performed surgery?
6 A. Yes.
7 Q. Can you walk the ladies and gentlemen of the jury
8 through the surgery?
9 A. Yes. Basically, the patient went to what's called a
10 same day procedure, an ambulatory procedure. You don't stay
11 overnight. You come in. You have the procedure done. You go
12 home. Generally speaking, you have to do some blood work ahead
13 of time just to make sure everything is okay, pretesting. And
14 then comes the date of surgery itself. She undergoes a
15 particular type of anesthesia. There are many different
16 anesthesias. This is called the interscalene block where a
17 needle is placed in the region of the neck to block the pain
18 fibers coming from the spinal cord going into the shoulder. So
19 that when you do that the patient can still breathe on their
20 own without a machine breathing for them because you are not
21 blocking under a general anesthesia the respiration. You are
22 blocking the shoulder. So a person can come through it a
23 little bit easier.
24 A person, in this case Ms. Iovino, she underwent the
25 interscalene block for the shoulder. And then I put a camera

1 inside her shoulder in the shape of a pen. In order to do
2 that, I have to make an incision in the skin. I then place a
3 camera that looks like a pen. The camera goes directly inside
4 the shoulder. I have pictures of that I take on every
5 procedure. And the image, I don't have to put my eye on the
6 back of the camera. We beam the image to a high definition
7 television screen. So even though the surgery is going on this
8 way, I am looking that way. That's why it's hard to transfer.
9 It's a little bit out of kilter.
10 So when I put the camera inside, I found that, in
11 deed, she did have a labral tear. I have pictures of it. She
12 had a labral tear and she had the impingement on the rotator
13 cuff filled with red angry tissue, inflammatory tissue, which
14 is like a layer of acid sitting on top of the rotator cuff and
15 also the tendon unit. The purpose of the procedure was, one,
16 to find out what's going on in the shoulder. I confirmed that
17 she had a labral tear and that she had the impingement. And
18 not only do I confirm that point, but I also fix the problem at
19 the same time. So I went in. I used special shaving devices.
20 I removed and excised all that inflammatory and angry tissue
21 within her shoulder and I also removed the labral tearing from
22 her shoulder. Once that was done I sew up the different holes
23 in the shoulder. There were three different portals I call
24 them to get into the shoulder. Then the patient goes to
25 recovery room, recovers in recovery room and eventually goes

1 home.

2 Q. Doctor, when you are doing the procedure, are you

3 actually literally able to see into the shoulder of Ms. Iovino?

4 A. Correct. You can see directly -- well, your eyes

5 don't go through the skin, but the camera does. So that you

6 are looking at the patient. The skin is still overlying. It's

7 not like the old days where you make a large incision and

8 separate and retract muscle to look inside. Now we do it with

9 a camera through a smaller incision, but we actually see

10 better. The camera can see all around the shoulder. And then

11 while we are seeing the problem, we also find ways to get into

12 the shoulder with various instruments and then we fix the

13 problem. I have those pictures too.

14 Q. We will get to that. When you stated you removed

15 pieces of Ms. Iovino, are you literally taking pieces of her

16 shoulder out of her body?

17 A. Of course. I removed the tear and I removed all that

18 inflammatory red hemorrhagic tissue from within her shoulder

19 joint which is only serving to give her pain.

20 Q. Do you have pictures or photographs of this procedure,

21 doctor?

22 A. Yes. And, by the way, not only do you remove all that

23 tissue, but I also had to remove bone tissue because bone was

24 also putting pressure on the rotator cuff as a result of this

25 injury.

1 Q. Can we take a look at the photographs?

2 A. Of course.

3 MR. HERBERT: Your Honor, are these to be marked

4 individually or --

5 THE COURT: How many photos do you have there or

6 how many sheets?

7 COURT OFFICER: Five.

8 THE COURT: Show them to Mr. Newman.

9 MR. NEWMAN: It's okay, Judge. I know what they

10 are.

11 THE COURT: Do you want them marked collectively?

12 MR. HERBERT: Whatever is good with the Court.

13 THE COURT: What are we up to now? We will make

14 it 8-A through E.

15 MR. NEWMAN: May we approach?

16 THE COURT: Yes.

17 (Off-the-record discussion held at the bench)

18 THE COURT: Make it 4-A through E. Since those

19 photographs are already part of the file that is admitted

20 as Exhibit 4, I will make it 4-A through E and that's your

21 signal that it's taken out of 4. By knowing that it's 4,

22 it's just part of it. 4-A through E.

23 MR. HERBERT: Thank you, Your Honor.

24 (Received and marked Plaintiff's Exhibits 4-A

25 through 4-E in evidence)

1 COURT OFFICER: Do you want them published
2 individually to the jury?
3 THE COURT: What do you want to do?
4 MR. HERBERT: Can he explain what the pictures
5 represent?
6 THE COURT: Of course.
7 MR. HERBERT: Thank you, Your Honor.
8 THE COURT: Do you want to approach to do that?
9 THE WITNESS: Yes. It's too small.
10 THE COURT: You can stand before the jury. Hold
11 it up.
12 Mr. Newman, you can change where you are to see
13 what he is doing.
14 (At this time, the witness stepped off the
15 witness stand and approached with the exhibit)
16 A. I will try to walk it this way but these are the
17 actual intraoperative photos of the patient's shoulder. This
18 is where there is only truth. It is not just MRI readings.
19 MR. NEWMAN: Objection.
20 THE COURT: Sustained.
21 A. This is where I can see exactly what's going on. No
22 one can interfere with my interpretation of what's the truth.
23 MR. NEWMAN: Objection.
24 THE COURT: Can you just give us facts and keep
25 out the editorials, doctor?

1 THE WITNESS: Yes.
2 THE COURT: Thank you.
3 THE WITNESS: This is a ball and socket joint,
4 ball and socket joint, ball and socket of the patient's
5 left shoulder. The camera is coming in from the back. So
6 you are seeing the ball to the left, the socket to the
7 right, okay. This is a picture of the rotator cuff muscle,
8 white, attaching directly into the bone. Remember I said
9 it's the roof? Looking inside the shoulder looking up you
10 see the rotator cuff muscle. Here she had a tear.
11 I will show you a picture now of the socket.
12 This is the socket right here, part of the socket, okay.
13 And here is the labral tissue. That is supposed to be
14 attached firmly to the socket. You see it's sticking up in
15 the air from here to here? You see this piece from here to
16 here? Do you see this? That's not supposed to be sticking
17 out. That's supposed to be flat right on the socket. This
18 is the labrum sticking straight up in the air. It's
19 supposed to be firmly adherent to the socket.
20 Here is a picture where the labrum is adherent to
21 the socket. Here is the socket. Here is the labrum. It
22 is not up in the air. Do you see that? Here is the
23 labrum. Here is the socket. You see it is not sticking up
24 into the air? It is right there. As opposed to this.
25 This patient had a labral tear which is painful.

1 In addition, I am going to show you impingement,
2 pictures of impingement. This is a picture of the rotator
3 cuff. Do you see it's covered with this red tissue, okay?
4 There is not supposed to be any red in the shoulder. It's
5 all supposed to look like this. Do you see this red from
6 here to here? It fills the space. This red is a
7 hemorrhagic bursitis. It is sitting right on the rotator
8 cuff. It's very irritating. It causes a lot of pain.
9 This is a picture of the bone. First off, here
10 is more inflammatory tissue. All this tissue here, it's
11 supposed to be clear color. All of it, thick and
12 inflammatory angry tissue. I was in there with a special
13 shaving device just cleaning everything out so that in the
14 end it's a wide open space. I am here removing some bone.
15 See the red, yellow bone area up here. That bone is
16 putting pressure on that rotator cuff when the person lifts
17 their arm and the purpose of this was to show that she had
18 red hot inflammatory tissue inside the shoulder. She
19 needed to have that all cleaned out and she had the labral
20 tearing which needed to be cleaned out as well.
21 (At this time, the witness resumed the witness
22 stand)
23 Q. Thank you, doctor. Anything else, doctor, with the
24 surgery?
25 A. No.

1 Q. When did you next come to see Ms. Jessica Iovino,
2 doctor?
3 A. She returned on January 9, 2012. She came for her
4 first postoperative visit. At that time I removed the
5 stitches. There was no sign of infection and I told her she
6 needed to begin postoperative physical therapy. The patient
7 came back again on March 19, 2012. Again, there was no sign of
8 infection. She was working with therapy. She still complained
9 of pain on a daily basis, but she said the pain was improved
10 from where it was before the surgery. Her range of motion was
11 already beginning to improve. Remember she was only able to do
12 90 degrees in both directions. Now she was up to in the
13 neighborhood of 150 degrees in this direction and 130 degrees
14 to the side or abduction.
15 I knew that that could fluctuate, but she was on the
16 road to a better shoulder than she had before the surgery. I
17 told her to continue her therapy. She returned again on
18 September 24, 2012. Her range of motion was similar. Flexion
19 to 150. Abduction to 140. And, again, she remained with some
20 pain, but she was improved. June 24th, she came back again
21 just for a routine follow-up. She said that she did have
22 persistent pain that was intermittent. She had some difficulty
23 with stressful activities such as when lifting or carrying
24 things were involved. But her motion had stayed fairly steady
25 at about 140 degrees of motion between forward flexion and

1 abduction. She returned again for follow-up --
2 Q. Doctor, just a real quick comment. So on these visits
3 you are talking about range of motion. These are decreased
4 range of motions?
5 A. Yes, normal is 180 degrees in each direction. She was
6 now up to about 140ish. August 26th she came back. Similar
7 situation, persistent pain but still better than it was before.
8 Range of motion again in that 140 degree range. She came back
9 November 4, 2013. At that time she saw my associate. She was
10 complaining that she had some increasing pain which she felt
11 was related more to the recent cold weather that started and
12 her motion had significantly decreased back down to 90 degrees
13 but that was temporary. When I saw her again, I believe it was
14 December 9th. I don't know where that one is. Her motion had
15 come back to that 140 degree range. I can't find that note
16 now. I saw her again and she was improving from that time that
17 she was starting to decline a little bit.
18 Q. In your notes looking at, for instance, November 4th
19 or the December visit, can you talk about home physical
20 therapy, doctor?
21 A. Yes. Basically, she was no longer getting formal
22 physical therapy at a rehabilitation facility. So I had
23 demonstrated to her exercises that she could do on her own
24 which was basically stretching exercises to try to improve her
25 motion. 140 degrees is better than 90 what she had before, but

1 it's still not 180 degrees. So I was demonstrating some
2 exercises for her to do at home which she could creep up a wall
3 with her fingers and slowly stretch her arm out. I
4 demonstrated to her what position she should be in when she
5 does that. Also, some strengthening exercises to lift various
6 things with forward flexion and abduction to not only help with
7 her motion but to try to help her with her strength.
8 Q. These dates that we just talked about, December and
9 November, so it's clear for the ladies and gentlemen of the
10 jury, these are December of 2013 visit and November of 2013
11 visit?
12 A. Yes, just about a month ago.
13 Q. How would you rate Ms. Iovino as a treater, seeing her
14 in the last two, two and a half years?
15 MR. NEWMAN: Objection.
16 THE COURT: Let me hear the question again
17 please?
18 (The requested portion was read by the court
19 reporter)
20 THE COURT: Sustained as to form.
21 Q. Doctor, going back to your first visit in November of
22 2011, you talked about a right shoulder prior scope; is that
23 correct?
24 A. Yes.
25 Q. Would this right shoulder prior, approximately, 2008

1 scope affect any of your diagnosis for the left shoulder?
2 MR. NEWMAN: Objection.
3 THE COURT: No. You may answer that.
4 A. No, it would not.
5 Q. Why is that, doctor?
6 A. Very clear why. The patient never complained about
7 her left shoulder at the time of her problems in 2008 or after
8 her problems in 2008.
9 MR. NEWMAN: Objection. Move to strike. There
10 is no foundation.
11 THE COURT: Sustained.
12 Q. What was your understanding at the time when you
13 started treating her, doctor?
14 MR. NEWMAN: Objection.
15 THE COURT: Sustained as to form.
16 Q. What was your diagnosis in November of 2011, when you
17 saw her, doctor?
18 A. My diagnosis was that she had a new problem with her
19 left shoulder. The problem was an impingement problem and my
20 belief was on exam she might also had a labral tear as well
21 which turned out to be true. That was the diagnosis for her
22 left shoulder. No prior difficulties with the left shoulder.
23 Q. Doctor, I want you to assume -- strike that.
24 Part of your file, did you have the hospital records
25 with you, doctor?

1 A. Yes.

2 Q. Were those hospital records consistent with your

3 treatment?

4 A. Absolutely.

5 Q. Doctor, do you have an opinion within a reasonable

6 degree of medical certainty as to the cause of Ms. Jessica

7 Iovino's impingement syndrome in the left shoulder, her

8 intra-articular labral tearing and the labrum tear, doctor?

9 MR. NEWMAN: Objection.

10 THE COURT: Overruled. You may answer.

11 A. I do have an opinion on that.

12 Q. What is your opinion, doctor?

13 A. My opinion is that the injuries that I had diagnosed

14 and found at surgery and confirmed were directly related to the

15 motor vehicle accident of October 3, 2011.

16 Q. How do you know that, doctor?

17 A. Very simple. The patient did not have any complaints

18 of her left shoulder prior to her coming to see me or prior to

19 her accident on October 3, 2011. Only after that particular

20 trauma to her shoulder did she first begin to complain of

21 problems with her left shoulder, only after that. And after

22 that accident she had problems. She was treated for that. She

23 had MRI testing. I followed her along for months and clearly

24 there is a cause and effect between a trauma she sustained --

25 MR. NEWMAN: Objection.

1 THE COURT: Overruled.

2 A. There is a cause and effect between the trauma she
3 sustained at the time of the accident and the problems that I
4 found in her left shoulder. There was nothing before, only at
5 the time of the accident. And they are clearly related.

6 Q. Doctor, do you have an opinion within a reasonable
7 degree of medical certainty as to whether Ms. Jessica Iovino
8 had suffered a disability as a result of this accident, more
9 specifically, her left shoulder?

10 MR. NEWMAN: Objection.

11 THE COURT: Overruled. You may answer.

12 A. Yes, I do have an opinion on that.

13 Q. What is your opinion, doctor?

14 A. She clearly has sustained an injury, a permanent
15 injury, to her left shoulder. She has persistent loss of
16 motion. She has persistent pain, although improved from where
17 it was. But she still has it.

18 Q. Doctor, do you have an opinion within a reasonable
19 degree of medical certainty as to whether Ms. Jessica Iovino
20 has suffered a permanent consequential use of limitation of her
21 left shoulder?

22 MR. NEWMAN: Objection.

23 THE COURT: Overruled. You may answer.

24 A. Yes, I do have an opinion.

25 Q. What is your opinion, doctor?

1 A. I believe she has sustained a permanent injury and a
2 consequential loss of use.
3 Q. Doctor, do you have an opinion within a reasonable
4 degree of medical certainty as to whether Ms. Jessica Iovino
5 has suffered a significant limitation of the use of her left
6 shoulder?
7 MR. NEWMAN: Objection.
8 THE COURT: You may answer.
9 A. I do have an opinion.
10 Q. What is your opinion, doctor?
11 A. She clearly has suffered such a loss.
12 Q. What is your opinion based on, doctor?
13 A. I have been following her for quite some time, over a
14 lengthy period of time in her shoulder. She did make progress
15 and she knows it. She made progress and she is happy with that
16 progress, but it's nowhere near a normal --
17 MR. NEWMAN: Objection.
18 THE COURT: Overruled. You may answer.
19 A. It nowhere near a normal shoulder.
20 Q. Doctor, do you have an opinion within a reasonable
21 degree of medical certainty as to whether Ms. Jessica Iovino
22 will need future treatment with regard to her left shoulder?
23 A. Yes.
24 Q. What is your opinion, doctor?
25 A. I do believe that she needs to have more continued

1 rehabilitation, physical therapy to try to gain range of motion
2 and try to help her with her remaining pain and function.
3 MR. HERBERT: No further questions, Your Honor.
4 THE COURT: All right. You may cross-examine.
5 MR. NEWMAN: Thank you, Judge.
6 CROSS EXAMINATION
7 BY MR. NEWMAN:
8 Q. Good afternoon, doctor.
9 A. Good afternoon, sir.
10 Q. We have never met before, correct?
11 A. No, sir.
12 Q. But you have testified many times in this courthouse
13 and courthouses in other counties in New York, correct?
14 A. What is "many times"?
15 Q. You said you testified last year about eight times.
16 A. Yes, sir.
17 Q. In 2011, how many times did you testify?
18 A. I would say about the same number.
19 Q. In 2010?
20 A. I mentioned it's about the same number the last number
21 of years.
22 Q. So in the last three years you have testified at least
23 30 times?
24 A. No. I said seven or eight times per year.
25 Q. Twenty-five times?

1 THE COURT: He hadn't finished his answer.

2 MR. NEWMAN: I'm sorry, Judge.

3 THE COURT: Please complete your answer, doctor.

4 THE WITNESS: I don't have a formal record, but I

5 would suggest it's probably in the low 20's over three

6 years.

7 Q. So can we say that's many times?

8 MR. HERBERT: Objection. I'm sorry.

9 THE COURT: You may answer.

10 A. I don't think that's many times if I am called to

11 testify by people for their own problem.

12 Q. But you understand the rules. If I ask you a question

13 that calls for a yes or no answer --

14 A. I am give you one.

15 Q. -- you will answer it yes or no.

16 A. Yes, sir.

17 Q. If I ask you a question and ask you if something is

18 correct or incorrect, you will do that too, correct?

19 A. Correct.

20 THE COURT: I beg your pardon. There is no such

21 rule that you have to do that, although counsel can ask you

22 to do that. Would you be willing to do that?

23 THE WITNESS: If it could be answered with yes or

24 no, I will do my best. If I feel that --

25 THE COURT: And if you can't, you will say you

1 can't do it yes or no?

2 THE WITNESS: Yes.

3 THE COURT: Fair enough. Proceed.

4 THE WITNESS: Thank you, sir.

5 Q. Thank you. Now, you said you treat about a thousand

6 patients or more a year?

7 A. No, a thousand shoulders.

8 Q. And a thousand knees?

9 A. Approximately.

10 Q. So about 2,000 patients a year?

11 A. Yes.

12 Q. How much did you make in your practice in 2012?

13 MR. HERBERT: Objection.

14 A. I don't see any relevance to that question. Do I have

15 to answer that?

16 Q. You don't want to answer that?

17 MR. HERBERT: Objection.

18 THE COURT: Yes, there is no relevance.

19 Sustained.

20 Q. How much money did you make testifying in court in

21 2012?

22 A. When I testify, I ask for $8,500. So you do the math

23 better than me.

24 Q. So it's about $60,000 a year just for testifying in

25 2012?

1 A. Is this about money? I don't understand.

2 Q. Could you please answer my question? You said you

3 would answer my question if I asked yes or no.

4 A. You are right. I didn't know where you were going.

5 The answer is yes.

6 Q. Right about $60,000 just for testifying in 2012,

7 correct?

8 A. Yes, sir.

9 Q. And of the 1,000 or 2,000 patients that you saw in

10 2012, how many of those were related to people who sustained

11 injuries in accidents?

12 A. Oh, I have no idea about that.

13 Q. Well, was it half?

14 A. I doubt it.

15 Q. Less than half?

16 A. Yes.

17 Q. Any number that comes to mind that you could give us

18 an estimate?

19 A. No. I see too many patients to keep that statistic in

20 my head.

21 Q. You keep no records about that?

22 A. I keep records on every patient, but I don't keep a

23 statistic. I see ten patients on --

24 Q. Where do you get most of your referrals from?

25 A. Physicians, chiropractors, friends.

1 Q. Lawyers?

2 A. Lawyers, not most. They are a very small part.

3 Q. Do you know the law firm of Krents & Guzman?

4 A. Krents & Guzman, no. I know Krentsel & Guzman.

5 Q. Krentsel & Guzman?

6 A. Yes.

7 Q. Have they referred clients to you?

8 A. Yes.

9 Q. And, approximately, how many have they referred to you

10 over the years?

11 A. A few a year. I wouldn't say they are any major

12 significance.

13 Q. For over how many years?

14 A. I have no idea.

15 Q. You have no idea about how many years Krentsel &

16 Guzman have been referring clients to you?

17 A. I have so many hundreds of referral sources. I have

18 no idea that I am dealing with their law firm for two years, or

19 nine years, or 15 years. But I do know their name.

20 Q. Do you have other law firms that regularly refer

21 clients to you?

22 A. There are some firms that send patients to me, yes.

23 Q. How many other law firms regularly send you patients?

24 A. Regularly?

25 Q. Yes.

1 A. Not many.

2 Q. How many?

3 MR. HERBERT: Objection.

4 Q. How many in 2012?

5 MR. HERBERT: Objection.

6 THE COURT: He can answer.

7 A. I can't give you a number yes or no or something of

8 that nature.

9 Q. More than a hundred less than a hundred?

10 A. Less than a hundred. Oh my God.

11 Q. Can you give me any estimate?

12 A. Ten, 15.

13 Q. How about in 2011, how many law firms have referred

14 clients to you?

15 A. I can't give you that kind of information because I

16 don't keep that in my head. I am a treating physician, not a

17 statistics physician.

18 Q. Do you know how Ms. Iovino came to you?

19 A. I don't have that in my record that I brought with me.

20 Q. Is there some other record that's back at your office

21 or someplace else that you didn't bring with you?

22 A. Just background information meaning insurance

23 information that's not relevant. I brought the clinical

24 relevant information.

25 Q. So you don't think who brought or recommended

1 Ms. Iovino to you is relevant?

2 A. For the jury, no.

3 Q. If Krentsel & Guzman recommended her to you, wouldn't

4 that be relevant in your opinion?

5 A. To what? Relevant to what?

6 THE COURT: See, the agreement was yes, no or I

7 can't answer yes or no.

8 THE WITNESS: I can't answer yes or no. Thank

9 you, sir.

10 Q. So what kind of other records are there that you

11 didn't bring today to the courthouse?

12 A. Billing records on the patient.

13 Q. You knew you were testifying today and you have done

14 this at least 20 times before, correct?

15 A. Yes, sir.

16 Q. And you purposely chose to bring certain records and

17 not other records, correct?

18 A. Absolutely.

19 Q. Now, when Ms. Iovino first came to you, that was at

20 the beginning of 2011? I'm sorry, at the beginning of November

21 of 2011?

22 A. Yes, sir.

23 Q. And she gave you a history at the time, correct?

24 A. Yes.

25 Q. And she told you she was involved in some kind of an

1 accident on October 3, 2011?

2 A. Yes, sir.

3 Q. And she told you she went to Coney Island Hospital the

4 next day?

5 A. Yes.

6 Q. And what else did she tell you on the first visit?

7 A. The history about the problems that she is feeling in

8 her left shoulder.

9 Q. And you asked her if she had problems or complaints to

10 her left shoulder before?

11 A. Yes, sir.

12 Q. And she told you no?

13 A. Yes, sir.

14 Q. And you didn't investigate that any further, correct?

15 A. Correct.

16 Q. You didn't look at any of her prior doctors' records

17 to see if there were any complaints about shoulder problems or

18 anything like that, correct?

19 A. That's correct.

20 Q. And she told you she had right shoulder surgery,

21 correct?

22 A. Yes.

23 Q. Did she tell you she was in a prior accident in 2008?

24 A. Yes.

25 Q. And as a result of that prior accident in 2008, she

1 had to have shoulder surgery to her right shoulder?

2 A. Yes, sir.

3 Q. Did she tell you who performed the surgery?

4 A. I didn't ask.

5 Q. Did she also tell you in that prior accident in 2008,

6 she also injured her neck and her back?

7 A. I didn't ask.

8 Q. So you didn't take a complete history from her about

9 her medical picture completely, you just asked her certain

10 questions about her left shoulder and what she claims happened

11 to her, correct?

12 A. Yes, sir.

13 Q. Now, were you aware that Ms. Iovino had been seeing

14 another orthopedic surgeon after this October 3, 2011 accident

15 up until the time she first saw you?

16 A. I don't have that written down but somehow I do recall

17 that she mentioned something to me, but I didn't get into it.

18 I didn't write it down, so it didn't bother me.

19 Q. Who is the orthopedist who she had been seeing?

20 A. I don't remember that.

21 Q. Did you ever contact that orthopedist?

22 A. No.

23 Q. Did you ever get his office records?

24 A. No.

25 Q. The first visit that you had with her, did you take

1 X rays?

2 A. No.

3 Q. Where was that office visit, by the way?

4 A. I believe it was in my Brooklyn office.

5 Q. That's not listed on your letterhead, correct, only

6 the Kew Gardens office is listed?

7 A. Maybe in 2011 it wasn't listed, but they are all

8 listed now.

9 Q. But in 2011, you had a Brooklyn office but only your

10 Kew Gardens office was on your letterhead, correct?

11 A. Yes.

12 Q. Okay. When she came to you, she had certain

13 complaints, correct?

14 A. Yes.

15 Q. And they were about her left shoulder, correct?

16 A. Yes.

17 Q. Was she also complaining about her neck?

18 A. Yes.

19 Q. And you did some testing on her?

20 A. Yes.

21 Q. And you described the testing that you did on your

22 direct examination, correct?

23 A. Yes.

24 Q. And there is a difference between subjective

25 complaints and objective complaints, correct?

1 A. Yes.

2 Q. So if a patient that you are examining is complaining

3 about pain, that's a subjective complaint, correct?

4 A. Yes.

5 Q. And the way you do range of motion testing is you ask

6 a patient to lift their arm over their head, correct?

7 A. How I do the test personally?

8 Q. Yes.

9 A. Part of the test is asking the patient to see what

10 they can do.

11 Q. And if the patient says, "I can only raise my arm to

12 here and then it starts to hurt", you don't force the arm up

13 higher, correct? You rely upon what the patient is telling

14 you.

15 A. No, I don't do that. Don't forget, I am in the

16 practice for 30 years. I am very aware of that.

17 Q. Can you answer the question?

18 A. I am trying to.

19 Q. Can you answer it yes or no? Do you force the arm up

20 higher if the patient says at some point "my arm hurts"?

21 A. I don't force, but I move the arm beyond where the

22 patient says.

23 Q. So you move it beyond where the patient says it hurts

24 to make it hurt more?

25 A. Yes.

1 Q. And that's how you do the testing of the arm, over a
2 head and out to the side and to the back?
3 A. No. What I do is this, I give the patient an
4 opportunity to move the shoulder, in this case, on her own.
5 Then I take over the examination and I see differences between
6 what she does and what I do. If there is no significant
7 differences, I don't have to record it.
8 Q. So if I say, "my arm hurts here", and you start to
9 move it up and I say, "Oh, my God. It hurts more. Don't do
10 that", you stop, correct?
11 A. No.
12 Q. So you keep pushing it up higher even though the
13 patient is complaining it hurts like heck?
14 A. Everybody has a different physical examination. As an
15 orthopedic surgeon with 30 years of experience I think I know
16 the difference when a patient is telling me it really hurts and
17 it doesn't.
18 Q. So you filter out whether you think the patient is
19 being truthful or not truthful during your examination, is
20 that --
21 A. That's a good truth.
22 Q. So if a patient is complaining --
23 MR. HERBERT: Objection. Could you ask him not
24 to yell at the doctor?
25 MR. NEWMAN: I am not yelling.

1 THE COURT: I don't find you to be yelling. Go
2 ahead.
3 Q. Again, if the patient says, "Please stop. Don't do
4 that. My arm hurts when you are making me move it higher", you
5 disregard that if you think the patient is not telling the
6 truth?
7 A. Correct.
8 Q. And you keep moving it higher?
9 A. I try.
10 Q. And you are not listening to the patient's complaints
11 because that's not your concern.
12 A. I always listen to the patient. It's not so rigid the
13 way you are trying to make it look.
14 Q. Okay. Thank you, doctor.
15 A. My pleasure.
16 Q. Now, you are aware that Ms. Iovino had an MRI done on
17 her left shoulder, correct?
18 A. Yes.
19 Q. You didn't send her for that MRI, correct?
20 A. No, sir.
21 Q. Do you know who sent her for that MRI?
22 A. No.
23 Q. Do you know where it was conducted?
24 A. Yes.
25 Q. Where was that?

1 A. It's written on the sheet. Actually, I do know who
2 sent her because it says that on the sheet. It was done by a
3 place called Park Avenue Radiology.
4 Q. Are you referring to that -- is that the report of the
5 MRI that was done?
6 A. Yes, sir.
7 Q. And that's part of your file, correct?
8 A. Yes, sir.
9 Q. According to that report who sent her to Park Avenue
10 Radiology to have that MRI conducted?
11 A. It's a little hard to read the last name, but it's
12 David E. Carola, C-A-R-O-L-A. There is some other letter there
13 that I can't quite read.
14 Q. How about Capiola?
15 A. You got it. That must be it.
16 Q. When was that done?
17 A. The date is 10/20/2011.
18 Q. Okay. And, doctor, an MRI is a radiographic study,
19 correct?
20 A. Yes.
21 Q. An X ray is used principally to see or look at bones?
22 A. Yes, sir.
23 Q. And an MRI is principally to look at soft tissue,
24 correct, because an X ray can't detect --
25 A. It's much better. It is definitely true what you ae

1 saying.

2 Q. So Dr. Capiola on October 20, 2011, sent her for an

3 MRI at Park Avenue Radiologists, correct?

4 A. I think that was the date of the MRI. Probably sent

5 her a little bit before.

6 Q. Fair enough. She had the MRI done on October 20, 2011

7 at Park Avenue Radiologists?

8 A. Yes.

9 Q. Are you familiar with their practice?

10 A. No. You mean Capiola or Park Avenue?

11 Q. No, Park Avenue.

12 A. I am familiar with neither.

13 Q. Fair enough. But this typically would be something

14 that you would do in your practice. You would send a patient

15 of yours to a radiology group to have an MRI done on a shoulder

16 or a knee --

17 A. Yes sir.

18 Q. -- or a hip or something of that nature if you were

19 investigating a source of pain and you thought it was because

20 of soft tissue, correct?

21 A. Yes.

22 Q. And radiologists are a medical specialty group,

23 correct?

24 A. Yes.

25 Q. They are licensed medical doctors?

1 A. Yes.

2 Q. And their specialty is reading radiographic films,

3 X rays, MRI's, CAT scans, things of that nature, correct?

4 A. Yes.

5 Q. And they have more familiarity with reading those

6 films of CAT scans, MRI's, X rays than you would as an

7 orthopedic surgeon, correct?

8 A. Not necessarily. I would not necessarily say they

9 have more experience than I do. I have seen thousands of

10 patients per year. I have seen thousands of MRI's. And at

11 this point I am pretty experienced.

12 Q. So a board certified radiologist in your mind would

13 have the same experience in reading MRI films as you would?

14 A. If not better but yes.

15 Q. So you believe you are in a better position to read

16 MRI films than a board certified radiologist?

17 A. No, I said if not better for them.

18 Q. Oh, the board certified radiologist is in a better

19 position?

20 A. Yes. I am similar but I think they would be a lot

21 better at it.

22 Q. Because that's all they do for a living?

23 A. Yes.

24 Q. You got this report from Park Avenue Radiologists?

25 A. Yes.

1 Q. Where did you get it from?

2 A. It was faxed to my office.

3 Q. By who?

4 A. When the patient comes in, they ask the patient if

5 there are any relevant MRI's for the reason that you are coming

6 here to see me.

7 Q. So Ms. Iovino faxed it to you?

8 A. No, no. I said when the patient comes in, we ask the

9 patient were there any relevant MRI's done. She would answer

10 yes.

11 Q. I'm sorry. I misunderstood. So you called Park

12 Avenue Radiologists to fax over the report?

13 A. That's the most likely scenario of what happened.

14 Q. But do you know in this case?

15 A. No.

16 Q. Is there any faxed banner on it to indicate it was

17 faxed to you?

18 A. I am not involved in that procurement process. I just

19 want to know if there is an MRI, let me see it. How the girls

20 in the office get it, I leave up to their ingenuity.

21 Q. When you got the MRI report, did you read it?

22 A. Yes, sir.

23 Q. And did you also get the MRI films that accompanied --

24 A. No.

25 Q. -- that this report related to?

1 A. No.

2 Q. Wouldn't it be important for you to see the films?

3 A. Depends. It depends on what the MRI said and it

4 depends on what my examination is looking for. In this case, I

5 did not need them.

6 Q. Well, was the MRI report consistent with your

7 examination of Ms. Iovino and the opinions that you started to

8 formulate about the labrum tear?

9 A. That was the only exception. The only exception was

10 that she had a positive O'Brien's test on examination and it

11 made me wonder about a labral tear. But my treatment for that

12 versus the impingement would not have differed. She would have

13 needed physical therapy. Injection would still be helpful for

14 pain, not for a labral tear. It would still help with pain for

15 the impingement. So it wouldn't have altered anything. If she

16 would have gotten better conservatively, we wouldn't be here

17 having this discussion.

18 Q. Thank you for that speech, doctor.

19 A. My pleasure.

20 Q. Can we go through the MRI report?

21 A. Anything you would like.

22 Q. So starting with the findings --

23 MR. HERBERT: May we approach, Your Honor?

24 THE COURT: Yes.

25 (Off-the-record discussion held at the bench)

1 THE COURT: Please continue. I am asking counsel
2 to continue.
3 Q. Dr. Berkowitz, when you got this MRI report from Park
4 Avenue Radiologists, did you read it?
5 A. Yes.
6 Q. Isn't it a fact that you relied upon it in part in
7 your examination and diagnosis and treatment plan for
8 Ms. Iovino?
9 A. In part.
10 Q. Okay, so let's go through the report.
11 A. My pleasure. Can I ask you one favor, sir? My copy
12 is a little bit hard to read.
13 Q. I think we have a subpoenaed copy.
14 A. If you have one, it would be very helpful to me.
15 MR. NEWMAN: Judge, may I?
16 THE COURT: You can approach the subpoenaed
17 records.
18 MR. NEWMAN: Thank you.
19 COURT OFFICER: Excuse me, Your Honor. The
20 jurors are asking for a break.
21 THE COURT: Let's take a five-minute recess. Do
22 not discuss the case. Keep an open mind. Do not form any
23 judgment about the case.
24 COURT OFFICER: Jury exiting.
25 (At this time, the jury left the courtroom)

1 THE COURT: There will be a five-minute recess
2 for everyone. A break was requested by the jury. They
3 need to use the facilities. If you want, you can take five
4 minutes yourself. I will stand by since I have nowhere to
5 go.
6 We will be breaking at 4:30 and coming back
7 Monday at 10:00.
8 MR. HERBERT: Can Your Honor ask counsel how much
9 time he anticipates?
10 THE COURT: You are free to confer with him now,
11 if you would like.
12 (RECESS TAKEN)
13 THE COURT: Everybody ready?
14 MR. HERBERT: Yes, sir.
15 THE COURT: Everybody stay seated except for
16 Mr. Newman.
17 COURT OFFICER: Jury entering.
18 (At this time, the jury entered the courtroom)
19 THE COURT: Jury panel is present. You may
20 continue.
21 MR. NEWMAN: Judge, may I show the witness a
22 better copy of the Park Avenue radiology report?
23 THE COURT: Have you had a chance to look at it,
24 counsel?
25 MR. HERBERT: Yes, Your Honor.

1 THE COURT: Show it to the witness.

2 Q. Doctor, is that a better copy for your review?

3 A. Much better.

4 Q. Good. So let's go through it. It's an MRI to the

5 left shoulder, correct?

6 A. Yes.

7 Q. Of Jessica Iovino that was done on October 20, 2011?

8 A. Yes.

9 Q. And then under the "Findings" section, it has "Normal

10 supraspinatus tendon", correct?

11 A. Yes.

12 Q. And "normal infraspinatus tendon", correct?

13 A. Yes.

14 Q. What's the difference between the supraspinatus and

15 the infraspinatus? In fact, if you can use the chart for us to

16 help us understand.

17 A. It's no problem. I could, if you want. It's very

18 simple. As I showed you before, there are a number of

19 different muscles that turn into a confluent white tendon.

20 Those are actually three different muscles that join together

21 to make the tendon of the rotator cuff.

22 Q. Those are reported as normal by the radiologist who

23 read these MRI films, correct?

24 A. Yes.

25 Q. And then the radiologist found "normal teres minor

1 tendon", correct?

2 A. Yes.

3 Q. And then normal deltoid muscle, correct?

4 A. Yes.

5 Q. And normal long bicipital tendon, correct?

6 A. Yes.

7 Q. And a normal intracapsular segment, correct?

8 A. Yes.

9 Q. And a normal reflective pulley, correct?

10 A. Yes.

11 Q. And then continuing on the next page, she found a

12 normal humeral head, correct?

13 A. Yes.

14 Q. And then it's also reported by the radiologist that

15 there is a normal glenohumeral articulation without a labral

16 tear, correct?

17 A. Yes.

18 Q. That's what the radiologist who read these films of

19 Ms. Iovino's left shoulder reported of her interpretation or

20 his interpretation of reading these films, correct?

21 A. That's correct, yes.

22 Q. And then there are other normal findings, correct?

23 A. Yes.

24 Q. And the impression that the radiologist had was mild

25 subacromial-subdeltoid bursitis, correct?

1 A. Yes, sir.

2 MR. HERBERT: Your Honor, may we approach?

3 THE COURT: Not at this time. Please continue.

4 Q. And then the radiologist reports "otherwise

5 unremarkable MRI of the shoulder"?

6 A. Yes.

7 Q. So the only thing that the radiologist was reporting

8 was bursitis?

9 A. That's correct.

10 Q. And the radiologist is not reporting that there is any

11 labral tear that's depicted in the MRI films of the left

12 shoulder, correct?

13 A. Yes.

14 Q. Now, bursitis is an inflammation of the bursa,

15 correct?

16 A. Yes.

17 Q. And explain for us what the bursa is.

18 A. The bursa is a soft tissue that ordinarily is not

19 visible in particular joints such as the elbow. We are all

20 familiar sometimes a person banks an elbow and it gets all

21 swollen. The body has a mechanism by which a bursal tissue

22 which is normally something that you can barely see even with a

23 microscope, that when something is irritated inside the

24 shoulder and the body would prefer that you don't move that

25 joint, let it the rest and recover, it causes the bursal tissue

1 to become inflamed and swollen. And when it does that, it's
2 like a layer of acid.
3 Q. Again, I just asked you what the bursa was. I didn't
4 ask you for a medical analysis, okay. Just tell us what the
5 bursa is.
6 A. Maybe I did already.
7 Q. What is the function of the bursa in the human anatomy
8 in the shoulder?
9 A. Can I now go back to where I was?
10 Q. No. Just explain for us what the bursa is, what it
11 does.
12 A. The bursa is a protective tissue that remains quiet
13 and almost not visible until there is an inflammatory problem
14 in that particular joint and then it becomes inflamed to try to
15 protect that joint from motion.
16 Q. And that's what's called bursitis, correct?
17 A. Yes.
18 Q. And the "itis" at the end of bursitis is Greek or
19 whatever the root is for inflammation, correct?
20 A. Yes, like laryngitis.
21 Q. So bursitis is an inflammation of the bursa?
22 A. Yes.
23 Q. And typically inflammation of the bursa comes from a
24 repetitive movement over time, correct?
25 A. It's one of the things that are typical.

1 Q. Well, that's one of the typical ways that a bursa
2 becomes inflamed and a patient develops bursitis, it's from
3 repetitive motion over time, correct?
4 A. Yes, it could be from repetitive motion.
5 Q. And it's less likely that it comes from one single
6 traumatic event, correct?
7 A. If a person has one single traumatic event, then it
8 could easily occur that the patient has a bursal inflammation.
9 Q. Well, doesn't there have to be a certain force or
10 mechanism involved to cause the bursa to become inflamed by one
11 single traumatic event?
12 A. There's never been a study -- that actually is a very
13 good question. There's never been a study that actually said
14 you need to have X amount of force applied across a joint to
15 get an episode of swelling. So it's a hard question to answer.
16 Q. So I can bump into a lectern here just like that and
17 develop bursitis in my shoulder?
18 A. In your elbow.
19 Q. In my elbow. So if I hit the lectern like that, I can
20 develop bursitis?
21 A. I don't know if that's all it takes but certainly --
22 Q. You don't know --
23 THE COURT: He is answering. Let him finish.
24 MR. NEWMAN: I'm sorry.
25 A. I am trying to say there is no study that says you

1 have to hit it with 30 pounds of force or 80 pounds of force,
2 but it's a great question.
3 Q. So you don't know what part of Ms. Iovino's arm was
4 struck by this accident, correct?
5 A. I don't personally know, but she said that she had
6 blunt trauma to her shoulder. She said that.
7 THE COURT: We are going to take a recess, so I
8 can get you out of here by 4:30. We need you back on
9 Monday. Tomorrow is Friday and I have a motion calendar.
10 So you have a break tomorrow while I do the calendar. We
11 see you on Monday at ten a.m. Between now ad then don't
12 discuss the case. Keep open mind. Form no judgments about
13 the case. Have a great and safe weekend. Follow the
14 officer. We will see you.
15 COURT OFFICER: Jury exiting.
16 (At this time, the jury left the courtroom)
17 THE COURT: All right, so you may step down at
18 this time. Do not discuss your testimony during the recess
19 period. We will see probably on Monday morning. Counsel
20 can speak to you about scheduling but cannot speak to you
21 about your testimony.
22 MR. NEWMAN: Can we talk about scheduling?
23 THE COURT: Monday morning we are meeting. We
24 are not meeting on Monday morning? That's what I told the
25 jury.

1 THE COURT: Okay. Are we ready to go?

2 MR. NEWMAN: Yes.

3 THE COURT: Let's get the jury out.

4 (D O V B E R K O W I T Z, having resumed the

5 witness stand, was examined and testified further as

6 follows:)

7 THE COURT: It's a little warm in here. I am

8 going to tell the jury since it's a little warm that I told

9 you to remove your jacket.

10 We are ready for the jury.

11 COURT OFFICER: Jury entering.

12 (At this time, the jury entered the courtroom)

13 THE COURT: Everyone be seated. Good morning,

14 everyone. Please do continue to make your efforts to get

15 here on time, okay.

16 Now, it's a little warm in here so I told all of

17 the parties here that if they wanted to, they could take

18 their jackets off. The doctor took advantage of it.

19 Counsels decided to keep their jackets on. We are still on

20 cross-examination.

21 Mr. Newman, you can pick up wherever you want.

22 Doctor, you are still under oath.

23 THE WITNESS: Yes.

24 MR. NEWMAN: Judge, may I move the lectern?

25 THE COURT: Yes, you can. Hold the bottom and

1 the top together. They are not connected.

2 CONTINUED CROSS EXAMINATION

3 BY MR. NEWMAN:

4 Q. Good morning, doctor.

5 A. Good morning, sir.

6 Q. We were talking on Thursday about Ms. Iovino's left

7 shoulder. Do you recall that?

8 A. Yes, sir.

9 Q. And she went to Coney Island Hospital the day after

10 the accident. You are familiar with that, correct?

11 A. Yes.

12 Q. She had some subjective complaints when she went to

13 Coney Island Hospital, correct, doctor?

14 A. She had complaints, yes.

15 Q. They examined her and found no abnormalities, correct,

16 doctor?

17 A. No abnormalities? I am not sure if that's the case.

18 I don't have that right in front of me now.

19 Q. Isn't the Coney Island record part of the your file

20 there?

21 A. Yes, and it was there when I left. Apparently, it may

22 have slipped. Oh, wait, wait. No slipping. Right here. I

23 got it.

24 Q. Let me refer you to Page 8 of 23.

25 A. Coming right up. Got it.

1 Q. The lower third of the page.

2 A. Yes.

3 Q. It says "pain pre-evaluation"?

4 A. "Unscheduled pain, pre-evaluation", that one?

5 Q. Yes. And then it is says, "left upper arm, no

6 observable abnormalities. It hurts a lot."

7 A. Yes.

8 Q. So at the emergency room they examined her left

9 shoulder and found no left upper arm observable abnormalities,

10 correct?

11 A. That's what it says.

12 Q. And if she had torn her labrum in this accident the

13 day before, wouldn't you expect there to be some evidence of

14 bruising on her left arm or shoulder?

15 A. Bruising, not necessarily, no. You don't have to have

16 visible signs. A labral tear is a soft tissue tear in the

17 depth of the shoulder. When you have bleeding or bruising from

18 that, it can take days and days for it to eventually surface to

19 the skin.

20 Q. If it came from an external event, wouldn't there be

21 some appearance of some kind of bruise on her shoulder that

22 would be observable, swelling, black and blue marks, some kind

23 of observable abnormality on her left shoulder?

24 A. With these type of soft tissues injuries, no fractures

25 and things of that nature, it's not --

1 Q. Thanks, doctor. Can you answer the question, doctor?

2 THE COURT: I am going to direct you to let the

3 doctor finish the question before your next question is

4 asked.

5 You were interrupted --

6 MR. NEWMAN: I apologize.

7 THE COURT: Don't interrupt me either. Take your

8 answer and you can give it again, if you would like.

9 THE WITNESS: Thank you, sir.

10 What I was trying to explain, I understand the

11 point you are trying to make and I am not trying to be

12 difficult. What I am trying to say is, soft tissue

13 injuries in the shoulder, not fractures, not dislocations,

14 you don't necessarily have to see a visible mark on the

15 shoulder or a visible swelling at the time of the injury.

16 It could take a long time for that to come out. So the

17 answer --

18 Q. I'm sorry, I didn't mean to interrupt.

19 A. So the answer to that is not necessarily.

20 Q. And this is 24 hours after the accident and you find

21 nothing unusual about that, that there is no evidence of any

22 kind of abnormality, no black and blue mark, no swelling?

23 A. No.

24 Q. Nothing on the left arm or shoulder to indicate that

25 she had subjected the left arm and shoulder to a traumatic

1 event the day before, correct?

2 A. Correct. That's exactly correct.

3 Q. So you told us on Thursday that she saw you several

4 times before you did the surgery at the end of December of

5 2011, correct?

6 A. Yes.

7 Q. And the surgery was done at Franklin Hospital?

8 A. Yes, sir.

9 Q. And where is that located?

10 A. Valley Stream.

11 Q. Is that where you had privileges?

12 A. Yes.

13 Q. Do you have privileges at other hospitals?

14 A. Yes.

15 Q. Where are they?

16 A. The New York Hospital of Queens in Queens and the Dan

17 Center in Mineola, Long Island.

18 Q. Any other hospitals in Manhattan or Brooklyn?

19 A. Can't go to too many. It's too much time.

20 Q. No hospitals in Brooklyn, correct?

21 A. No.

22 Q. Now, the procedure that you performed was a day

23 procedure, correct?

24 A. It was a day procedure. Day, yes.

25 Q. And the procedure itself from the time you did the

1 incision to the time that the incision was closed took about a
2 half hour, correct?
3 A. I don't have the exact -- if you have the time, you
4 can let me know but, usually speaking, from the time the
5 patient gets into the room until they get out of the room is,
6 approximately, one hour.
7 Q. But I am talking about the procedure itself.
8 A. Surgical time goes anywhere in there.
9 Q. Let me show you a copy of a portion of the Franklin
10 Hospital record that's in evidence.
11 A. Sure.
12 Q. It's the intraoperative record. Would you take a look
13 at that?
14 THE COURT: What exhibit is that in evidence?
15 Please give that item to the clerk.
16 MR. NEWMAN: I believe it's Plaintiff's 2.
17 THE COURT: What's Plaintiff's 2 in evidence?
18 THE CLERK: I have Franklin Hospital.
19 THE COURT: We will make that 2-A. The "A" means
20 it's part of Exhibit 2 that's already in evidence.
21 There is no objection to its admission?
22 MR. HERBERT: No, Your Honor.
23 THE COURT: Fine.
24 (Received and marked Plaintiff's Exhibit 2-A in
25 evidence)

1 THE WITNESS: Thank you. I have it.
2 Q. Dr. Berkowitz, at the top there are times that the
3 incision began and the closure ended.
4 A. Yes.
5 Q. The procedure, correct?
6 A. Yes.
7 Q. And the whole procedure took about 31 minutes,
8 correct?
9 A. Yes.
10 Q. So that was the entirety of the time that you took to
11 do the labrum debridement and the decompression on Ms. Iovino's
12 left shoulder was 31 minutes, correct?
13 A. Yes.
14 Q. Now, when you did the procedure, you put a camera in
15 to see what you were doing in there, correct?
16 A. Of course.
17 Q. Okay. And the biceps were intact, correct?
18 A. Yes.
19 Q. And you saw a SLAP tear in the labrum at the 3:00
20 position, correct, doctor?
21 A. Yes, I showed that.
22 Q. And that SLAP tear was indicative of a repetitive
23 motion that caused the labrum tear that you found in there,
24 correct?
25 A. Absolutely not.

1 Q. Now, you didn't do a repair of the labrum, correct?

2 A. That's correct.

3 Q. You just put the shaver in and you cleaned up the

4 frayed edges, correct?

5 A. Not the frayed. It's not just doing that.

6 Q. What did you do, doctor?

7 A. I removed the torn part of the tissue to create a

8 stable situation so that the tear does not propulgate and get

9 even larger than it was.

10 Q. Right. There were frayed edges that you had to clean

11 up, correct?

12 A. No, sir. There's no frayed edges. There is a SLAP

13 tear. A tear fraying suggests a different problem. There was

14 no fraying.

15 Q. You didn't do a repair, correct?

16 A. That's correct.

17 Q. And you also found a significant amount of fluid in

18 there, correct?

19 A. Where do you see that?

20 Q. In the radiology report it says, "there was marked

21 hypertrophic synovial and hyperemic bursal tissue response."

22 A. That's different than fluid, sir.

23 Q. It's not fluid. What we are talking about here again

24 is the inflammation of the bursa, correct?

25 A. That's the hyperemic bursitis. That means that there

1 is blood in the bursal tissue that's inflamed.

2 Q. What you saw there, again, was from repetitive motion,

3 not caused by an individual traumatic event, correct?

4 MR. HERBERT: Objection.

5 THE COURT: May I have that question read back?

6 (The requested portion was read by the court

7 reporter)

8 THE COURT: You may answer that.

9 A. Absolutely incorrect. There is no evidence to suggest

10 such a mechanism of injury of repetitive motion injury in this

11 patient, none.

12 Q. Thank you, doctor. Now, when she left the day op at

13 Franklin Hospital that day, she was in a sling?

14 A. Yes, sir.

15 Q. She wore that for about two weeks, correct?

16 A. Yes.

17 Q. And then at some point she returned to you and you

18 removed the stitches that closed the three portal incisions

19 that you made, correct?

20 A. Correct.

21 Q. And she started on a course of physical therapy,

22 correct, with a physical therapist?

23 A. Yes.

24 Q. And after you removed the sutures, the stitches, when

25 was the next time she returned to your office?

1 THE WITNESS: May I consult my records?
2 THE COURT: Yes.
3 A. Okay. So the surgery date was the 28th of December,
4 right, before the new year. The first post-op visit was
5 January 9th, January 9th. At that date the sutures were
6 removed and she was given a prescription to begin a program of
7 physical therapy. The first date after that you asked?
8 Q. Yes.
9 A. Was March 19th, 2012.
10 Q. And at that time you examined her, correct?
11 A. Yes, I did.
12 Q. Was she still going to the physical therapist at that
13 time?
14 A. Yes.
15 Q. Was her condition the same, improved --
16 A. She was improving.
17 Q. -- worse or anything else?
18 A. From before the surgery to that point she showed signs
19 of some improvement.
20 Q. When did she come back to you next after March 19,
21 2012?
22 A. September 24th.
23 Q. So you didn't see her for six months, correct?
24 A. Correct.
25 Q. And were you aware when she returned to you in

1 September of 2012, that she had ceased going to the physical
2 therapist?
3 A. Let me just see. I didn't mark down at that point if
4 she was still seeing the therapist, so I can't answer that
5 question.
6 Q. Well, I want you to assume hypothetically that she
7 testified that she stopped seeing the physical therapist about
8 two months after the surgery.
9 A. Okay.
10 Q. Would that be consistent with your treatment protocol
11 for her?
12 A. Generally speaking, therapy is from six weeks to 12
13 weeks after a procedure of this magnitude. So if she had
14 therapy for two months, that's an eight-week stint, so to
15 speak, so that's fine.
16 Q. When she came to you on September 24, 2012, she was
17 still complaining about pain in her left shoulder?
18 A. She still had pain in the shoulder.
19 Q. She was still complaining about loss of range of
20 motion in the left shoulder?
21 A. Well, she didn't complain about that. I basically
22 examined her and marked down what it was.
23 Q. Fair enough. You didn't send her back for more
24 physical therapy, correct?
25 A. No, no. Actually, I said the plan was for her to

1 continue rehabilitation. So I demonstrated some home exercises
2 for her because commonly the insurance company prevents the
3 patient from having more treatment. They stop paying for it.
4 So I demonstrate exercises for the patient and that's what I
5 mean by doing more therapy.
6 Q. But you weren't at home with her, so you don't know
7 whether she was doing it or not, correct?
8 A. No, I first demonstrated to her on September 24th. I
9 didn't demonstrate it to her before then.
10 Q. Okay, but she said she stopped going to physical
11 therapy two months after the surgery which would have been
12 February of 2012.
13 A. Yes.
14 Q. So from February of 2012 until September of 2012, she
15 wasn't doing any therapy, correct?
16 A. That's correct.
17 Q. And then you taught her or gave her instructions on
18 how to do home therapy in September of 2012?
19 A. Yes.
20 Q. When was the next time you saw her?
21 A. June 24th, 2013.
22 Q. So that was nine months later?
23 A. Yes.
24 Q. And during those nine months you don't know what she
25 was doing, correct?

1 A. Well, obviously, I don't know everything that she is
2 doing.
3 Q. Well, you don't know if she was doing home therapy,
4 correct?
5 A. Let's see. No, I don't know.
6 Q. Okay. And her condition was about the same in June of
7 2013?
8 A. Yes, it was very similar. Similar range of motion.
9 Q. Was there a reason or do you know why she waited nine
10 months to come back to you from September 24, 2012 to June of
11 2013?
12 A. I can't. I can only guess.
13 Q. We don't want you to guess.
14 A. Good. So then I won't.
15 Q. You know she wasn't going to any other doctor for her
16 left shoulder, correct?
17 A. Not that I was aware of.
18 Q. And after June of 2013 -- by the way, on September
19 24th, when you saw her, you just examined her, correct?
20 A. What do you mean by "just examined her"?
21 Q. Well, you examined her. You checked her range of
22 motion. You asked her some questions, correct?
23 A. Of course.
24 Q. You didn't do any overt treatment on her, correct?
25 A. No injections or anything like that, correct.

1 Q. And you didn't send her any place for any kind of
2 treatment, or injections, or testing, correct?
3 A. No, just told her to do the program at home.
4 Q. And the same thing in June of 2013, you examined her
5 the same way you did in March and in September of 2012,
6 correct?
7 A. Correct.
8 Q. When was the next time you saw her after June of 2013?
9 A. August 26th.
10 Q. Why did she come back to you the next month?
11 A. She said that she was still having difficulty with
12 doing stressful activities. So anything stressful to her,
13 lifting anything heavy, carrying, pushing, pulling, those types
14 of stressful activities were still giving her difficulty. That
15 was the main reason why she came in.
16 Q. How many more times did you see her in 2013?
17 A. I saw her August 26th. I saw her -- actually, my
18 associate saw her November 4th. And then I saw her again
19 December 9th.
20 Q. Doctor, in the medical field is there something called
21 symptom magnification or secondary gain?
22 A. Of course, there is.
23 Q. What is that?
24 A. Secondary gain is when a person has a reason for their
25 having a problem. There is some benefit to the patient by --

1 Q. Such as a lawsuit?

2 A. A lawsuit could be one.

3 THE COURT: I'm sorry, is this a medical term?

4 THE WITNESS: No.

5 THE COURT: So what are you talking about?

6 Aren't you an expert in medicine?

7 Q. Doctor —

8 THE COURT: Excuse me. Where did this term come

9 from?

10 THE WITNESS: He brought it up, not me.

11 THE COURT: You mean he brought up a term that

12 you know what it means?

13 THE WITNESS: Yes.

14 THE COURT: But does it have in any way an

15 implication in your expertise as an orthopedic surgeon?

16 THE WITNESS: For this case, no.

17 THE COURT: For any case. Is that a term you use

18 in your charts or something?

19 THE WITNESS: No.

20 THE COURT: All right, please continue.

21 Q. Isn't that something that is taught in medical school,

22 symptom magnification?

23 MR. HERBERT: Objection.

24 THE COURT: Is that premised on determining the

25 credibility of the patient?

1 THE WITNESS: Yes.

2 THE COURT: All right, that's simple. No doctor

3 or for that matter anybody else is going to be offering an

4 opinion on credibility of an individual. That's not their

5 job. Credibility is for the jury to decide. So I will not

6 permit an opinion on credibility to be given based on

7 someone's expertise.

8 All right, please continue.

9 MR. NEWMAN: I will move on, Judge.

10 Q. Are you aware that Ms. Iovino is a cigarette smoker?

11 A. Hang on. She smokes a pack a week, yes.

12 Q. Did you counsel her to stop smoking?

13 MR. HERBERT: Objection.

14 THE COURT: You may answer.

15 A. I did not.

16 Q. Doesn't smoking have an effect on the healing process

17 of the soft tissue?

18 A. Yes, it does.

19 Q. As far as you know, Ms. Iovino is still a smoker

20 today, correct?

21 A. I don't know. I didn't ask her.

22 Q. Now, you are aware that she was involved in a prior

23 accident in 2008, correct?

24 A. Yes, we mentioned that before.

25 Q. And are you aware that she sustained an injury to her

1 right shoulder?

2 A. Yes, sir.

3 Q. Do you know what kind of injury she sustained?

4 A. The specifics of it, no.

5 Q. I want you to assume hypothetically --

6 MR. NEWMAN: Judge, at this time I offer in

7 evidence the redacted Bill of Particulars from the prior

8 accident.

9 THE COURT: Any objection?

10 MR. HERBERT: May I approach?

11 THE COURT: Sure.

12 (Off-the-record discussion held at the bench)

13 THE COURT: All right, you may continue,

14 Mr. Newman.

15 MR. NEWMAN: I'm sorry, Judge. I offered what's

16 been stipulated into evidence.

17 THE COURT: Sure. What's the date of the

18 exhibit?

19 MR. NEWMAN: February 5, 2009.

20 THE COURT: All right, that document is admitted

21 into evidence by agreement of the parties. It will be

22 Defendant's Exhibit -- we will give it a letter.

23 What letter are we up to?

24 THE CLERK: That's H.

25 THE COURT: That will be Exhibit H. It's in

1 evidence. Would you like it shown to the witness?

2 MR. NEWMAN: Yes, please, Judge.

3 THE COURT: Sure. Why not.

4 (Received and marked Defendant's Exhibit H in

5 evidence)

6 Q. Doctor, please turn to Page 3. It begins at the top,

7 "Jessica Iovino sustained the following injuries." Are we on

8 the same page?

9 A. Yes, sir.

10 Q. Doctor, I want you to assume that Ms. Iovino was

11 involved in an automobile accident on September 1, 2008 for

12 which she sustained injuries and made certain claims in that

13 lawsuit of personal injuries, okay.

14 A. Okay.

15 Q. I want you to assume that as a result of that accident

16 in September of 2008, she claimed she sustained the following

17 injuries, okay, doctor?

18 A. The following that are listed or are you going to say?

19 Q. Yes, I am going to read them.

20 A. Okay.

21 Q. "Traumatic injury and damage to the right shoulder,

22 including but not limited to rotator cuff tear, multiple

23 ligament, cartilage and tendon tears, multiple chondral

24 fractures requiring surgery which results in permanent and

25 disfiguring scarring, joint diffusion and severe internal

1 derangement, tendonitis, the need for future surgeries and
2 complete shoulder replacement."
3 Doctor, that's a very serious injury, correct?
4 A. Correct.
5 Q. That's a very serious disabling and permanent medical
6 condition, is it not, doctor?
7 A. It could be.
8 Q. And she also claims in that September 8, 2008 accident
9 she sustained traumatic injury and damage to her head including
10 but not limited to closed head injury. A closed head injury is
11 another word for a traumatic brain injury, correct?
12 A. I am not sure if it means a traumatic brain injury but
13 there's certainly injury to the head. I don't know if they are
14 talking about a traumatic brain injury like you have in a
15 football game. I am not sure.
16 Q. That's exactly what I was going to ask.
17 MR. HERBERT: May we approach, Your Honor?
18 THE COURT: Yes, you may. Of course
19 (Off-the-record discussion held at the bench)
20 THE COURT: All right, I thought it appropriate
21 to explain to the jury what a Bill of Particulars is.
22 A Bill of Particulars is a legal document
23 prepared by an attorney in connection with a cause of
24 action that's pending in a court. And what it is, a cause
25 of action pending in a court is commenced by filing a

1 Complaint explaining whatever it is you want to explain is
2 your reason for bringing the action. A Complaint can
3 contain all kinds of allegations and it can be pled
4 inconsistently, meaning it doesn't have to be consistent
5 with itself. It can claim all sorts of things, but it's
6 not proof of anything. It's indicating and giving notice
7 to the other side what they are claiming. And then after
8 that, the notice is given. Then the other side will know
9 how to answer.
10 A Bill of Particulars, all it does is, it gives a
11 further explanation of some of the claims being made, but
12 it proves absolutely none of the claims. So it is a legal
13 document. It is not proof of any specific condition. It
14 is simply an indication of what claims are being made, not
15 what claims can be proven.
16 All right, please continue, counsel.
17 MR. NEWMAN: May we approach again?
18 THE COURT: To the Court?
19 MR. NEWMAN: Yes.
20 THE COURT: Come up.
21 (Off-the-record discussion held at the bench)
22 THE COURT: Please continue, counsel.
23 MR. NEWMAN: Yes, Judge.
24 Q. And she was also claiming as a result of the 2008
25 accident she suffered from post traumatic headaches and post

1 concussion syndrome, correct?

2 A. Yes.

3 Q. And those can be serious and permanent conditions,

4 correct, doctor?

5 A. Yes.

6 Q. She was also claiming significant injuries to her neck

7 as a result of that September 2008 accident, correct?

8 A. I am looking at the injuries, but she is claiming

9 injuries to her neck. That's for sure.

10 Q. C3-4, C5-6 bulges requiring trigger point injections

11 and nerve block surgeries?

12 A. Yes.

13 Q. That's significant, is it not, doctor?

14 A. Yes.

15 Q. And that may well be a permanent injury to her neck as

16 a result of that September 2008 accident, correct, doctor?

17 A. It's possible. We just don't know enough of the

18 claims. It's a very broad thing. I would have to see more

19 information.

20 Q. This is what she is claiming happened to her as a

21 result of the September 2008 accident, correct, doctor?

22 MR. HERBERT: Objection.

23 THE COURT: Well, he can't say that's correct.

24 MR. NEWMAN: I withdraw that.

25 THE COURT: Stop. He cannot claim that that's

1 correct. This is admitted as a Bill of Particulars
2 submitted. I remind the jury that it is not proof of any
3 injury. It is proof of claims that are made. Complaints
4 and Bill of Particulars can be internally inconsistent and
5 it is allowed. It is just what you are telling the other
6 side you are claiming and then you get to the proof at some
7 point later.
8 Please continue.
9 Q. As a result of that accident in September of 2008, she
10 was also claiming serious injuries to her mid back where the
11 thoracic spine is, correct?
12 A. She is claiming injuries to the mid back.
13 Q. "Evidence of abnormal alignment with loss of normal
14 thoracic spine derangement and vertebral subluxation complex",
15 that's what she was claiming in her mid back, correct?
16 A. That is the claim.
17 Q. Subluxation is a twisting of the mid back, correct?
18 A. No.
19 Q. Tell us what subluxation is?
20 A. Vertebral subluxation complex is a chiropractic term.
21 It's not really an orthopedic term. So I never use that. I
22 can tell you what the word "subluxation" means, but I don't
23 believe any orthopedist uses it.
24 Q. All right, I will move on. She is also claiming
25 serious and protracted injuries to her lumbar spine, her low

1 back, as a result of that 2008 accident, correct?

2 A. She is definitely complaining of injuries to the lower

3 back, yes.

4 Q. She is also claiming, again, traumatic injury to her

5 head as a result of that accident with headaches, dizziness,

6 disorientation and --

7 THE COURT: Hasn't that been answered already?

8 THE WITNESS: Yes.

9 Q. I just wanted to say neurological difficulties,

10 correct?

11 A. Yes.

12 Q. So all of those claims she was making as a result of

13 the injuries from that September of 2008 accident,

14 hypothetically, are serious, severe, protracted and permanent,

15 correct, doctor?

16 A. They could be. These are claims. I don't know the

17 actual reality of the claims. As you pointed out before, sir,

18 this is just a claim. I don't know what the truth is about.

19 Q. You testified that someone who has a shoulder surgery,

20 the shoulder is never going to be the same again, correct?

21 A. I said that?

22 Q. Did you say that?

23 A. Did I use those words?

24 Q. I will ask you again. You did the surgery on her left

25 shoulder?

1 A. Yes, sir.

2 Q. Is her left shoulder going to be the same as it was

3 before the accident?

4 A. It's very unlikely that it could be a hundred percent

5 the same.

6 Q. And, hypothetically, if she had this surgery on her

7 right shoulder as a result of the September 2008 accident, her

8 right shoulder was never going to be the same again, correct?

9 A. Within the limits of not knowing what that surgery

10 was, I would say that usually after a person has an

11 arthroscopic procedure it is hard to get a hundred percent

12 result. But I honestly do not know what the right shoulder

13 surgery was, but I can speak clearly about the left shoulder.

14 Q. Right. But she had to have her surgery done to repair

15 a rotator cuff tear, multiple ligament, cartilage and tendon

16 tears and multiple chondral fractures?

17 A. I don't know if that's actually what happened at the

18 surgery.

19 Q. Well, I want you to assume hypothetically that's what

20 it was that occurred as a result of the September 2008

21 accident. She claims she injured her right shoulder, had these

22 injuries and had surgery to address these injuries.

23 A. Correct. I just don't know if she actually had

24 surgery for chondral fractures. That's a very strange word, so

25 I don't know. If you showed me the operative report, then I

1 could clearly tell you what happened. As the judge pointed
2 out, these are claims. I don't know what the reality is. They
3 could be inconsistent.
4 Q. Let's just talk about a rotator cuff tear. That's a
5 serious injury?
6 A. Yes, sir.
7 Q. Arthroscopic surgery addresses the rotator cuff tear?
8 A. Yes.
9 Q. And however the rotator cuff tear was addressed in the
10 surgery is going to result in a condition where the right
11 shoulder is never going to be as good again as it was before
12 that September 2008 accident, correct?
13 A. That's probably true.
14 MR. NEWMAN: Thank, doctor. No further
15 questions.
16 THE COURT: Sir, are you ready?
17 MR. HERBERT: Yes, Your Honor.
18 THE COURT: Wait for Mr. Newman to have a seat.
19 MR. HERBERT: Okay.
20 MR. NEWMAN: Thank you, Judge.
21 THE COURT: You may inquire.
22 REDIRECT EXAMINATION
23 BY MR. HERBERT:
24 Q. Doctor, jumping around a little bit because the
25 testimony got all jumped around, let's stay with the Bill of

1 Particulars for a second from the 2008 accident. Can you show
2 me anywhere on this document where Ms. Iovino signed this
3 document, doctor?
4 MR. NEWMAN: Objection.
5 A. I will let you know in a second.
6 MR. NEWMAN: Objection.
7 THE COURT: It's admitted by stipulation of
8 counsel. Why don't counsel tell me, did the plaintiff sign
9 it?
10 MR. NEWMAN: It's verified by --
11 THE COURT: Is that yes, no?
12 MR. NEWMAN: No, Judge.
13 THE COURT: There is no dispute that the
14 plaintiff didn't sign it. It was prepared by her attorney.
15 Q. Can you show me any medical records attached to this
16 Bill of Particulars from 2008, any medical records, any medical
17 evidence?
18 A. No.
19 Q. So these are attorney's words written for a claim,
20 correct?
21 A. That's right.
22 Q. Have you seen any prior 2008 medical records by
23 counsel?
24 A. No, sir.
25 Q. Have you seen any prior 2008 records regarding any of

1 the injuries that were claimed that were just in the Bill of
2 Particulars?
3 A. No, I have not.
4 Q. In your opinion with your work experience testifying
5 as an orthopedic surgeon and your past testifying, if there was
6 a prior injury, a prior problem that the other counsel wanted
7 to you see that would influence this case, wouldn't the other
8 counsel bring that to your attention, doctor?
9 MR. NEWMAN: Objection.
10 THE COURT: Sustained. Do not answer that.
11 Q. Did counsel -- have you seen any medical evidence to
12 contradict anything you said so far today or last week
13 regarding Ms. Iovino?
14 A. Absolutely not. I have seen nothing that would
15 contradict anything I said regarding her left shoulder.
16 Q. Thank you, doctor.
17 Now, doctor, you stated in one of your reports -- I
18 believe it was dated August 26, 2013?
19 A. Yes.
20 Q. You stated that she has difficulty with stressful
21 types of activities. Do you see that, doctor?
22 A. Yes, I do.
23 Q. Now, I want to you assume that in February of 2013,
24 approximately, a year and a half after the accident, Ms. Iovino
25 saw one of the defendant's doctor's for examination.

1 MR. NEWMAN: Objection.

2 Q. And during that examination --

3 THE COURT: Sustained.

4 Q. Now, doctor, I want you to assume that another doctor

5 stated that Ms. Iovino had difficulty with her activities with

6 life. Would that be consistent with your medical records?

7 MR. NEWMAN: Objection.

8 THE COURT: Sustained.

9 Q. Doctor, you are an orthopedic surgeon, correct?

10 A. Yes, sir.

11 Q. You are not a physical therapist?

12 A. No.

13 Q. You are not a chiropractor?

14 A. No.

15 Q. You perform surgeries, correct?

16 A. Yes.

17 Q. You see patients?

18 A. Yes.

19 Q. Now, it's consistent when you treat as an orthopedic

20 surgeon that you don't treat every single day or every single

21 week, correct?

22 A. Yes.

23 Q. How do patients normally treat with an orthopedic

24 surgeon?

25 MR. NEWMAN: Objection.

1 THE COURT: Could you say that a little slower?
2 MR. HERBERT: I'm sorry, Your Honor.
3 THE COURT: Say it again.
4 Q. You are an orthopedic surgeon, correct?
5 A. Yes, sir.
6 Q. And you are not a physical therapist?
7 A. I am not.
8 Q. How do patients treat with an orthopedic surgeon?
9 A. When they come to an orthopedic surgeon, they come
10 with a specific complaint. That's why they go to the
11 orthopedist. It's not about total body wellness, diabetes,
12 blood pressure. It's about, "My shoulder hurts, my knee hurts,
13 my back hurts." And it's my job, so to speak, to take a
14 history from that patient to find out when this problem
15 started, what caused the problems, are there any associated
16 problems that could affect this patient. And then I do a
17 physical examination and then I hopefully have some
18 radiological help like an MRI. Or if I don't have the testing
19 that I need before rendering a clarity in terms of what to do
20 next, I will send the patient for that test, commonly an MRI
21 test.
22 But if that's available to me, and I did my physical
23 exam, and I did my history and I have come to a conclusion, I
24 will then prescribe treatment for that problem. That treatment
25 could be non-operative, injection, therapy or it could be

1 operative. So the orthopedic surgeon does not focus on, you
2 know, "Let's come back three times a week for therapy. What
3 did you do today, what did you do yesterday?" It's more of,
4 "Do you have a problem that needs a surgical treatment or do
5 you not? If you do not, then let me make sure you are getting
6 the proper non-operative treatment, meaning I want you to go to
7 this therapist. Or if you are already going to therapist,
8 continue with your treatment." And then I see the patient back
9 from time to time to see progress because sometimes a
10 non-operative course of treatment fails and then that patient
11 becomes an operative candidate.
12 Q. Counsel mentioned repetitive injury. I want you to
13 assume in this case Ms. Iovino is, approximately, 35 years old.
14 How does age deal with repetitive injuries and --
15 MR. NEWMAN: Objection.
16 THE COURT: Did you complete the question?
17 MR. HERBERT: Almost. No, Your Honor.
18 THE COURT: You didn't? All right, finish the
19 question. I see there is an objection.
20 Q. How does age in your opinion deal with a repetitive
21 injury?
22 THE COURT: You may answer that.
23 A. Okay, the concept of a repetitive injury is almost
24 clear just by listening to the words, "repetitive injury". So,
25 in other words, you can develop an injury just from repetitive

1 over and over again use of a particular body part to do a
2 particular job, whether it's lifting heavy weights, moving
3 furniture. People can get carpal tunnel syndrome, problems
4 with nerves, just from long term typing and moving the wrist.
5 So by definition the longer a person is doing something
6 repetitive, the more likely it is for a person to develop a
7 repetitive injury problem.
8 So the younger the patient is the less likely they
9 have had enough time to develop a repetitive injury. So
10 someone who is 60 is more likely to develop a repetitive injury
11 from the same. If they started doing that action when they
12 were 30, the chances are at 35 they are less likely to have
13 developed it than if they were 60 doing it over the course of
14 so many years. So that's the concept of how age fits in. At
15 35 Ms. Iovino is still a very young person and is less likely
16 as opposed to someone who would be 55 or 60 doing the same
17 thing over all of those years to have developed a problem.
18 Q. I want you also to assume that Ms. Iovino is an
19 administrative assistant, clerical work, typing, filing,
20 working with a vice president. How does someone's job affect
21 an injury?
22 MR. NEWMAN: Objection.
23 THE COURT: You may answer.
24 A. Are you asking about the development of an injury or
25 making whatever injury worse?

1 Q. Making it worse.

2 A. Okay. So, number one, obviously if you have a torn
3 rotator cuff which would make it hard to lift, push, pull and
4 throw, that would be a more difficult situation when you are
5 doing that type of work. If you are doing typing, you can type
6 very well with a rotator cuff tear. I am not saying it's
7 comfortable, but you can certainly type. But if you had to be
8 lifting things onto the top shelf, you probably would have a
9 great deal of difficulty doing it. So if she is doing clerical
10 work, then a clerical work situation, if it does not require
11 lifting and repetitive pushing and pulling, is probably
12 something the patients can do with some difficulty. But if
13 they are doing pushing, pulling, lifting, that kind of job
14 would be very difficult to do.

15 Q. Counsel mentioned earlier in your op report 31
16 minutes. That 31 minutes represents the operation taking
17 place, the surgery, correct?

18 A. That's the actual operative time. The patient was in
19 the room, as I said, for about an hour.

20 Q. Isn't it true, doctor, that an MRI is one piece of the
21 puzzle used to diagnose a problem?

22 MR. NEWMAN: Objection.

23 THE COURT: Stop leading. Sustained.

24 Q. How is an MRI used with your treatment of a patient,
25 doctor?

1 MR. NEWMAN: Improper redirect also.
2 THE COURT: May I have counsel at the bench for a
3 moment, please.
4 (Off-the-record discussion held at the bench)
5 THE COURT: Mr. Herbert, you may continue.
6 Q. Doctor, how does an MRI fit into your diagnosis and
7 treatment of a patient of yours?
8 A. That's a very important point that is something that
9 needs clarification. An MRI is only one of the -- I will use
10 the word -- weapons a doctor has to use in the fight against
11 patient's problems. So, for instance, if a patient comes in
12 with a history and physical examination that basically their
13 shoulder is having difficulty and the MRI then supports that
14 diagnosis, that's a very helpful tool. But what happens if the
15 patient has a lot of pain and on examination has a lot of
16 limitation and the MRI is negative, okay? Do you just say,
17 "Well, since the MRI is negative, there is nothing wrong with
18 you, just go home", if the patient says, "I have been
19 complaining for months, I can't do this, I can't do that".
20 And that happens very commonly. And I always try to explain
21 that in medicine, medicine is not just about technology. If it
22 was just about MRI's, then why should I bother seeing the
23 patient?
24 MR. NEWMAN: Objection. Can the doctor answer
25 the question without making a speech?

1 THE COURT: Sustained. Take some control,
2 Mr. Herbert.
3 MR. HERBERT: Okay.
4 Q. What part is the MRI when you treat patients compared
5 to your diagnosis, how does it play into it?
6 A. The MRI report can either support a conclusion or it
7 does not support a conclusion, but it's only one weapon. So
8 that if the patient -- if the patient has -- if the MRI says
9 the patient has a torn rotator cuff but the patient is using
10 their arm fully, then we ignore the MRI because the patient is
11 having no complaints. You don't operate on a patient that has
12 no symptoms. Similarly, in reverse, if the patient has
13 terrible symptoms and the MRI is negative, you don't dismiss
14 the patient. The MRI is one weapon. History, physical
15 examination are still the most critical thing in a doctor's
16 armamentarium.
17 THE COURT: In a doctor's what?
18 THE WITNESS: Armamentarium.
19 THE COURT: You can tell us what that means.
20 That's not an SAT word and I don't know what it means.
21 THE WITNESS: It simply means it is one weapon in
22 an arsenal of weapons, an armamentarium in a large group of
23 weapons that we have at our disposal to try to come to the
24 right diagnosis and the right treatment.
25 Q. Thank you, doctor.

1 Doctor, counsel brought up the hospital records on
2 cross-examination. What's the difference between an X ray and
3 an MRI, doctor?
4 A. An X ray is a radiological study that loses actual
5 radiation and it penetrates through soft tissue and bone. It
6 gives an image on the other side of the beam so that there is a
7 film, let's say, in the back of the shoulder. The beam comes
8 to the front and it shows you basically bones. It just shows
9 you pictures of bones. It doesn't show you anything, soft
10 tissue, arteries, nerves, brain tissue, cartilage, it shows you
11 none of those things. An MRI is absolutely zero radiation.
12 It's a magnetic. It has a radiation that's not harmful. It is
13 a magnetic device and it can image with great clarity soft
14 tissues. The problem is the ability of the reader to interpret
15 those images.
16 Q. Now, the hospital records, was there any MRI test
17 taken?
18 A. Extremely rare but there's an MRI that --
19 THE COURT: That's a yes or no question.
20 THE WITNESS: So I don't know.
21 THE COURT: That should be your answer.
22 THE WITNESS: Yes, sir, I don't know.
23 Q. What part of the hospital records was part of your
24 diagnosis and treatment on Ms. Iovino?
25 A. Zero.

1 Q. But looking at the hospital records, would the
2 hospital records be consistent with Ms. Iovino's injury?
3 MR. NEWMAN: Objection.
4 THE COURT: You may answer that.
5 A. What's consistent is --
6 THE COURT: Please identify the exhibit for the
7 hospital record you are referring to.
8 MR. HERBERT: Can I approach the witness?
9 THE COURT: You don't have it in front of you?
10 MR. HERBERT: I believe the witness does, Your
11 Honor.
12 THE COURT: Please give that hospital record to
13 counsel.
14 COURT OFFICER: Which hospital record are you
15 indicating?
16 MR. HERBERT: Coney Island.
17 Q. Looking at what's been marked as an exhibit in
18 evidence --
19 MR. HERBERT: It is actually not labeled, Your
20 Honor.
21 THE COURT: It's part of the doctor's chart. Is
22 the doctor's chart in evidence?
23 MR. HERBERT: Yes, Your Honor.
24 THE COURT: Including that record.
25 MR. NEWMAN: The Coney Island record is Exhibit

1 1.

2 THE COURT: Exhibit 1. Let's take Exhibit 1 in

3 evidence and give it to the doctor.

4 A. What is consistent is that the patient complained

5 about pain in her extremity. That's what consistent.

6 Q. By "extremity", you mean the arm, doctor?

7 A. Yes, left upper extremity.

8 MR. HERBERT: Thank you, Your Honor. I have no

9 further questions.

10 THE COURT: Counsel.

11 RECROSS EXAMINATION

12 BY MR. NEWMAN:

13 Q. Doctor, Ms. Iovino didn't injure her left rotator cuff

14 in this accident, correct?

15 A. She developed an impingement problem as a result of

16 the accident and that is a rotator cuff issue.

17 Q. Was the rotator cuff torn in this accident?

18 A. No, sir.

19 Q. And you didn't do any kind of repair -- withdrawn.

20 MR. NEWMAN: Thank you. I have no further

21 questions.

22 MR. HERBERT: No further questions, Your Honor.

23 THE COURT: Thank you. You may step down at this

24 time and you are free to go.

25 THE WITNESS: Thank you, sir. Do I leave all of

1 my records here?

2 THE COURT: Let's take a moment. I want to

3 confer with counsel about scheduling. So can you give me

4 about five minutes, jurors?

5 Follow the officer. Don't discuss the case.

6 Keep an open mind. Form no judgments.

7 COURT OFFICER: Jury exiting.

8 (At this time, the jury left the courtroom)

9 THE COURT: All right, did we admit the doctor's

10 records in evidence?

11 MR. HERBERT: Yes, Your Honor.

12 THE COURT: All right, so I guess we keep it

13 then.

14 MR. HERBERT: Yes, Your Honor.

15 THE COURT: Which would mean he has to get it

16 back eventually, sooner rather than later.

17 MR. HERBERT: Yes, Your Honor.

18 THE COURT: So I may have to put the onus on one

19 of you to copy it and give him back the original.

20 We will need to keep the records momentarily. I

21 will have plaintiff's counsel return the original file to

22 you in due course. You can work that out later. You are

23 free to go.

24 (WITNESS EXCUSED)

25 THE COURT: What's the next order of business?