

## PROCEEDINGS

1 THE COURT OFFICER: All rise, jury entering.

2 (Jurors entered the courtroom.)

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

5 You may call your next witness.

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

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

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

13 THE WITNESS: I do.

14 THE COURT CLERK: Please have a seat.

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

17 THE WITNESS: It's Gabriel Dassa, D-A-S-S-A. The  
18 address is 625 East Fordham Road, that's Bronx, New York,  
19 10458.

20 THE COURT: Good afternoon, Doctor.

21 THE WITNESS: Good afternoon.

22 THE COURT: You may inquire.

23 MS. BORDEN: Thank you, your Honor.  
24  
25

Dr. G. Dassa - Plaintiff - Direct

1 DIRECT EXAMINATION

2 BY MS. BORDEN:

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

5 A. Yes, I am.

6 Q. And when did you become so licensed in?

7 A. In 1992.

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

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

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

16 THE COURT: Okay. You may answer.

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

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

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

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

7 Q. All right. And are you board certified?

8 A. Yes, I am.

9 Q. And what are you board certified in?

10 A. I'm board certified in orthopedic surgery.

11 Q. And what is orthopedic surgery?

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

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

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

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1 surgeons in the community do not have comfort with.

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

4 A. Well, I have an affiliation with Medalliance, which is  
5 on 625 East Fordham Road. I just opened up a private office on  
6 Third Avenue in the Bronx, New York. And I'm also affiliated  
7 with an office on the Grand Concourse, 2576 Grand Concourse.

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

11 A. Yes, I do.

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

14 A. I examine patients for both plaintiff and defense.

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

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

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

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

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

5 A. Yes.

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

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

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

14 A. I am.

15 Q. And how much are you being compensated?

16 A. \$6,000.

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

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

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

24 A. Yes, I do.

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

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1 prior to giving testimony here today?

2 A. Yes, I did.

3 Q. And at whose request did you examine him?

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

5 Q. And when did you perform that examination?

6 A. September 22nd, 2011.

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

9 A. Yes, I did.

10 Q. What records did you review?

11 THE WITNESS: May I refer to my report?

12 THE COURT: Yes, you may.

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

19 Q. Who is Dr. Ehrlich?

20 A. Dr. Ehrlich is another orthopedic surgeon.

21 Q. And you work with him at Medalliance?

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

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

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

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

5 THE COURT: Yes.

6 MS. BORDEN: Thank you.

7 MR. LAQUERCIA: May I?

8 THE COURT: Go ahead.

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

6 MR. LAQUERCIA: Thank you.

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

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

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

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

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1 shoulder, right shoulder MRI showed?

2 MS. BORDEN: If I may, your Honor.

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

5 THE WITNESS: That is 9A.

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

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

9 Q. Okay. Thank you.

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

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

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

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

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

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

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

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

Dr. G. Dassa - Plaintiff - Direct

1 of abnormality.

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

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

16 Q. Okay. Thank you, Doctor.

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

19 What surgery was performed on his shoulder in May of  
20 2009?

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

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

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

6 Q. Okay.

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

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

16 A. Yes.

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

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

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

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

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

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

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

25               So in the time of his rehabilitation that he began

Dr. G. Dassa - Plaintiff - Direct

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

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

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

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

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



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1 Q. And what's a better way to tell what's really going on  
2 in the shoulder, the MRI film or --

3 A. Again, the proof is in the difference of Dr. Ehrlich's  
4 findings from actually what's on the MRI studies, because in  
5 interpreting the MRI, the MRI is technology that really has  
6 become so advanced we can get to about 98 percent of accuracy.  
7 But there's still that one to two percent that may be lacking in  
8 perfection, so the best way is to actually go in and assess the  
9 tissues and see them first and see whatever damage you assume  
10 may be there.

11 Q. By the way, Doctor, can you see these sorts of  
12 injuries, the rotator cuff or labral tears on X ray?

13 A. Generally labral tears are not seen on X rays, none of  
14 these soft tissue injuries can be seen on X rays. They're to  
15 evaluate joints and bones as far as alignment and for fractures.

16 Q. Okay. Thank you. And we're done with that for right  
17 now. Thank you.

18 If you could, just describe for the ladies and  
19 gentlemen of the jury what operative intervention Mr. Molina  
20 underwent on his left shoulder?

21 A. So, again, in a similar description, Dr. Ehrlich did  
22 do an arthroscopic operation of his left shoulder. He did find  
23 subacromial impingement syndrome. He also found some arthritis  
24 at the clavicle and acromion, but he did find the type three  
25 SLAP lesion, which was a labral tear, which, again, was

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1 suggestive on the MRI with fraying of the labrum and a partial  
2 tear of the rotator cuff.

3 So, again, that's what I stated, there was a  
4 discrepancy from the MRI films in appearance. Dr. Ehrlich did  
5 not find a complete rotator cuff tear in the left shoulder, he  
6 found a partial tear. So then rather than repairing it, he  
7 debrided the tissue, which is cleaning up the tissue that is  
8 damaged to stimulate bleeding so your body can make scar tissue  
9 to heal it that way. And essentially did a distal clavicle  
10 resection, which if I can show you on the board.

11 THE COURT: Okay.

12 A. This particular space is very narrow in everyone's  
13 shoulder, and the rotator cuff functions to keep this head in a  
14 downward position to create room.

15 And what happens in the case of a rotator cuff injury,  
16 whether it's traumatic or repetitive use type of thing, this  
17 space becomes narrow and the term for that is called impingement  
18 syndrome.

19 So what actually happens is that the rotator cuff  
20 becomes pinched or impinged between this joint and this small  
21 bone, which is called the acromion. So in a procedure to  
22 address that, there's a bur that's inserted into the space that  
23 shaves out the bone and creates space this way, but because of  
24 some of the degenerative findings in his shoulder, which you  
25 will normally find in a 50 year old, he had to actually remove a

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1 piece of this clavicle to alleviate some pressure, because in  
2 despite of the surgery, if he didn't do that, he still would  
3 have had pain related to that joint.

4 Q. Thank you. And I just want to turn your attention  
5 right now to the course of treatment that Mr. Molina had at  
6 Medalliance in regard to his neck and his back.

7 A. Well, the medical record reviewed that was provided to  
8 me, you know, first of all, he did complain to me during the  
9 exam that he was having back pain or lower back pain since the  
10 time of the accident. He had reported that he did receive  
11 several injections to his back. He was receiving interventional  
12 pain management and was having difficulties related to back pain  
13 and radiculopathy, which is pain that shoots down your legs.  
14 And he did have an MRI done of his lumbar spine. He also did  
15 have an MRI of his neck that was requested by the doctors at  
16 Medalliance.

17 Q. Okay. And, Doctor, I am a little concerned about our  
18 time right now, so I would ask that you explain those images to  
19 the ladies and gentlemen of the jury referring to Plaintiff's B,  
20 which is the MRI of the cervical spine, and C, which is the --  
21 9B and 9C. 9C being the MRI images of the lumbar spine and I  
22 just ask that you just briefly show the ladies and gentlemen of  
23 the jury what those studies show?

24 A. Just some background quickly, I'll try to go as fast  
25 as I can. Again, it's the same type of study, it's a photograph

Dr. G. Dassa - Plaintiff - Direct

1 taken with magnetism. And in this particular case, it's slices  
2 taken through the cervical spine taking photographs of the  
3 different tissues.

4 So if I turn your attention to the cervical spine,  
5 this is your brain, and this is the spine or the bones of your  
6 neck from the base of your skull to about to the top of your  
7 shoulders.

8 Now, what's most notable and striking here is that  
9 normally this curve is shaped like a C. So if you look at me  
10 from the side, you can see that this is the particular shape  
11 that the neck wants to be in in a normal position. It's a C.  
12 If you look at the cervical spine here, you can see that that C,  
13 which should be like this, is actually gone. It's reversed.  
14 There's straightening of the C, which means there's a lot of  
15 muscle spasm on this MRI. And when you're looking at the  
16 cervical spine, you're looking at the brain stem here, and there  
17 are seven bones of the cervical spine. So you have C1, C2, C3,  
18 C4, C5, C6, C7, and the spaces in between are the disks which  
19 are these darker structures.

20 Now, in looking at the spinal cord, what are you  
21 looking for? You're looking for abnormalities. If you look at  
22 the spinal cord, which is this gray structure, you can see on  
23 the lower segments, there is space between the bones and the  
24 spinal cord. Okay? You can see clearly here's the gray spinal  
25 cord, here's the bones, this white line is fluid in between the

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1 spinal cord and the bones. As you get into the supracervical  
2 segments, C6, C7, C5, C6 you can see the disks are actually into  
3 the fluid, they're bulging into the fluid and they're actually  
4 on some of these images actually creating pressure on the sack  
5 that holds the spinal cord.

6 So here, this is normal. You can see there's a clear  
7 fluid column, which is represented as white. Here you can see  
8 the fluid is cut off at the C5, C6 and the C4, C5 to a lesser  
9 degree, so that nice white column is being compressed by the  
10 disks that are bulging in the cervical spine.

11 And just for clarification, this is an MRI of the  
12 cervical spine, 9B, and it's dated 1/16/2009 of Mr. Luis Molina.

13 Q. Thank you.

14 A. And then we have the lumbar spine, which is dated  
15 1/26/2009 of Mr. Molina, again, same anatomy, there's your bony  
16 structures, these are your lumbar vertebrae, which would be your  
17 lower back. There's five lumbar segments, 1, 2, 3, 4, 5. This  
18 is your sacrum and your tailbone. And what are we looking at  
19 here? The same type of configuration where you have the spinal  
20 canal, here the gray structure is the spinal cord. And you can  
21 see the disks in between. And at this particular level, which  
22 is L2, 3, it's L1, L2, we do see a significant disk bulge, which  
23 is sticking into that space or fluid. Also, you have one at L5,  
24 S1 where the disk is actually pressing up against the thecal  
25 sack. So you have abnormal placement of the disk. You can

Dr. G. Dassa - Plaintiff - Direct

1 actually see the disk at this level here pressing right on the  
2 nerve root.

3 Q. Thank you. By the way, Doctor, do you see any  
4 degenerative or arthritic changes in the lumbar or cervical  
5 spine of Mr. Molina?

6 A. Again, for a 50 year old, it's highly rare not to see  
7 some degenerative findings. So if you look at the disk,  
8 themselves, you know, you see some irregularity of the facet  
9 joints, which are the joints in the back of the spine. So there  
10 are some age related degenerative changes to both the neck and  
11 the back.

12 Q. All right. And, Doctor, can a patient have some of  
13 these age related changes but still be without pain and have  
14 full range of motion of the neck and back?

15 A. I mean, there are patients who do have age related  
16 changes to the neck and back that have a perfectly normal exam,  
17 so they could have full range of motion.

18 Q. All right. Thank you. Doctor, at this time, I'd like  
19 to turn your attention to the exam that you actually performed  
20 of Mr. Molina just this last September.

21 Can you tell us about what your examination of his  
22 right shoulder revealed?

23 A. Well, we did perform an exam of his shoulders, right  
24 and left shoulders were examined simultaneously. We also  
25 examined his thoracic lumbar spine, which would be the mid and

Dr. G. Dassa - Plaintiff - Direct

1 lower back.

2 So first to address the shoulders, we did do an  
3 inspection evaluation, which is visually looking at the  
4 shoulders, and both shoulders demonstrated previous surgical  
5 scars relative to the surgery that he did have to both  
6 shoulders. And he also was found to have some mild swelling to  
7 both right and left shoulder.

8 We did do a range of motion assessment with a  
9 goniometer. My range of motion assessment reportings were  
10 passive range of motion, with his forward flexion, which is  
11 raising up in front of his body was measured to be 155 degrees  
12 on the right and 160 degrees on the left. And normal is 170.

13 His abduction, which would be raising from the side of  
14 your body up was measured to be 155 on the right, 160 on the  
15 left and normal is 170. His internal rotation, so if I have the  
16 front of my body as an access, would be to turn the shoulder  
17 inwards, that's internal rotation, was measured to be 45 degrees  
18 right, 50 on the left, and 60 is normal.

19 His external rotation, which would be to rotate out  
20 from the body was measured to be 75 right, 80 left, and normal  
21 is 90. And his extension, which would be to bring your arm  
22 back, was measured to be 15 right, 20 left and normal is 30.  
23 And his adduction, which would be to bring your arm across your  
24 body, it was measured to be 25 right, 30 left and 40 is normal.

25 There was a palpatory exam performed, which did

Dr. G. Dassa - Plaintiff - Direct

1 demonstrate some diffuse tenderness, so when you did touch the  
2 shoulders bilaterally, you could elicit some pain. And we did  
3 do an impingement test, which was found to be positive right and  
4 left and normal is negative. So that test is a provocative  
5 maneuver, where you bring the arm up and externally rotate, and  
6 if there's still tightness in the space I described that is  
7 normally narrowed, there would be a solicitation of a response  
8 of pain and clicking, and that was found to be positive in both  
9 shoulders. And his arm drop test was negative right and left  
10 which indicated that at least for the surgical repair done by  
11 Dr. Ehrlich, that portion of the operation worked. We did  
12 measure his thor --

13 Q. Doctor, let me stop you right there and ask you one  
14 question about the loss of range of motion in his shoulders.

15 How would you quantify that?

16 A. Well, you know, I think that, you know, he has some  
17 motions that are mildly restricted, some motions significantly  
18 restricted. I think if you take into account the shoulder range  
19 of motion, you have to look at all the motions collectively.  
20 They didn't singularly affect your function, they all work with  
21 each other. So I would say that he has a moderate restriction  
22 to the right shoulder and to a lesser degree to the left  
23 shoulder.

24 Q. Okay. Thank you. And could you please tell the  
25 ladies and gentlemen of the jury about your findings with regard



Dr. G. Dassa - Plaintiff - Direct

1 to his lumbar spine?

2 A. Again, the findings were basically assessed the same.  
3 with a range of motion assessment. His ability to flex forward  
4 at the waist was measured to be 55 degrees and normal is 90.  
5 His ability to extend back was measured to be 25 degrees and  
6 normal is 30. And his lateral bending, which is bending to the  
7 sides at his waist was measured to be 20 and normal is 40. And  
8 his ability to rotate right and left is measured to be 25 and  
9 normal is 30. There was muscle spasm, so when his back was  
10 palpated or touched, his muscles were found to be in spasm and  
11 hard from L1 to L5, and he also had a positive straight leg  
12 raising test on the right side at 20 degrees.

13 Q. What does a positive straight leg test mean?

14 A. Well, the findings of a straight leg test being  
15 positive is suggestive of a pinched nerve. It represents  
16 sciatic irritation or inflammation. The sciatic nerve becomes  
17 inflamed when there is a herniated disk or pressure on the nerve  
18 in the spine, so when you stretch it by performing a straight  
19 leg maneuver and get the appropriate response to that, that  
20 would be a positive test, that would indicate sciatic or a  
21 pinched nerve in the lumbar spine.

22 Q. Okay. And what is the -- how would you quantify those  
23 reduction in ranges of motion you just told us about for the  
24 lumbar spine?

25 A. Again, if you take the numbers individually, his

Dr. G. Dassa - Plaintiff - Direct

1 ability to flex was almost 50 percent reduced, you know, whereas  
2 the extension was only five degrees less than normal. And,  
3 again, the lateral bending was 50 percent reduced and the  
4 rotation was only five degrees less than normal.

5 So as a collective assessment, it would be a moderate  
6 restrictive range of motion, but he does have severe restriction  
7 and reflex in lateral bending.

8 Q. And, Doctor, what was your impression based on your  
9 review of the records and your examination of Mr. Molina?

10 A. Well, again, it was listed in my impression it was  
11 bilateral traumatic internal derangement status post bilateral  
12 shoulder bulge persistent orthopedic impairment of the right and  
13 left shoulder. I think it was also lumbar radiculopathy that  
14 was noted on my physical exam, lumbar disk displacement based  
15 upon the review of records and, again, just multi-ligamentous  
16 injury to the lumbar spine, which was representative of a lumbar  
17 sprain.

18 Q. I know you told us what the distal placement was when  
19 you showed us the film, but what is radiculopathy?

20 A. Radiculopathy is a term that describes the referral or  
21 radiation of pain down an extremity. So if you have a neck  
22 injury and you have a disk that causes a pinched nerve -- the  
23 referred pain or numbness or tingling that may shoot down the  
24 arm with that condition is called radiculopathy.

25 In the case of the neck, it's cervical radiculopathy.

Dr. G. Dassa - Plaintiff - Direct

1 In the instance of a lower back disk herniation or a pinched  
2 nerve, you have pain that shoots down the leg, so that would be  
3 a lumbar radiculopathy. So it's just a descriptive term of  
4 referred pain or numbness and tingling down an extremity that  
5 correlates usually with the disk displacement.

6 Q. Okay. Doctor, do you have an opinion to a reasonable  
7 degree of medical certainty as to what the cause of Mr. Molina's  
8 right shoulder injury was?

9 A. Yes.

10 Q. What is that?

11 A. Again, my opinion is the fall that occurred and the  
12 incident that was described on the corrected date which was  
13 November 16th, 2008.

14 Q. And what is the basis of that opinion?

15 A. Well, essentially, you know, you're dealing with a  
16 functional gentleman who is working, performing heavy labor.  
17 Had this fall, had objective finding of acute injury to the  
18 shoulder, you know, in the face of some degenerative finding,  
19 but he was a functional laborer, and had no prior history of  
20 treatment or complaints to the right shoulder that I viewed.

21 So the only pertinent information that I saw that was  
22 related to a right shoulder injury was this fall. And, you  
23 know, if you have a person that's functional without complaints  
24 of right shoulder pain, there is a described incident and now  
25 they are dysfunctional and they continue to be dysfunctional,

Dr. G. Dassa - Plaintiff - Direct

1 the only reasonable conclusion I can draw is that the history of  
2 his falling down the stairs or falling on the stairs caused the  
3 injury to his right shoulder.

4 Q. Okay. And I just want to clarify something. I think  
5 you said he had some acute injuries that Dr. Ehrlich noted in  
6 the operative report, but he also had some degenerative finding  
7 in the right shoulder; is that correct?

8 A. Yes.

9 Q. And those were preexisting arthritic conditions?

10 A. Well, again, he's 50 years old. There's no 50 year  
11 old around that doesn't have some baseline arthritis. Most  
12 people have some arthritic finding and they have no symptoms.  
13 If you look at his MRI, his MRI showed some changes you would  
14 see with aging in a 50 year old shoulder.

15 Along with those, there were findings of acute injury  
16 of torn tissues and tissues that were separated, that he could  
17 not function as a laborer if he had them as a preexisting  
18 condition. Because you can't do heavy work with a labral tear  
19 and a complete rotator cuff tear, it's just not functionally  
20 possible. He would be seeking treatment for significant pain in  
21 the face of those conditions.

22 So he had degenerative findings, again, you know,  
23 arthritis it's on his MRI of his AC joint, acromion clavicular  
24 joint, the little joint I described, so that's what was there  
25 preexisting to the fall.

Dr. G. Dassa - Plaintiff - Direct

1 Q. All right. But somebody could perform heavy manual  
2 labor with the amount of arthritis he had, correct?

3 A. Yes.

4 Q. Doctor, do you have an opinion to a reasonable degree  
5 of medical certainty as to what the cause of the left shoulder  
6 injury that you've been explaining to us was to Mr. Molina?

7 A. I do.

8 Q. And what is that?

9 A. Again, my opinions are really based upon my review of  
10 Dr. Ehrlich's treatment with the patient. His left shoulder  
11 symptoms were really coincident to the performance of the  
12 surgery and the fact he had a useless right arm for several  
13 months. I believe it was represented to an overuse syndrome to  
14 the left shoulder and, again, that was born out in Dr. Ehrlich's  
15 records, so I had to concur with an assessment it was really a  
16 compensatory overuse of the left shoulder that lead to the  
17 condition of the left shoulder.

18 Q. And, Doctor, do you have an opinion as to a reasonable  
19 degree of medical certainty as to what the cause of Mr. Molina's  
20 lumbar spinal injuries that you've been testifying to here today  
21 are?

22 A. Again, I think the disk displacements are causally  
23 related to the fall. He did describe falling directly on his  
24 back on a hard stair. I don't think the degenerative findings  
25 have anything to do with this accident, but I do believe the

Dr. G. Dassa - Plaintiff - Direct

1 disk herniations are related to this accident.

2 Q. All right. And do you have an opinion to a reasonable  
3 degree of medical certainty as to what the cause of Mr. Molina's  
4 cervical injuries that you've been testifying to here today are?

5 A. I do.

6 Q. And what is that?

7 A. My opinion is, again, that's based upon the lack of  
8 historical details pertinent to treatment to neck and back  
9 conditions and having neck pain prior to this, so that the only  
10 reasonable history that is present is the fall, so I would have  
11 to attribute the falls to the neck issues, as well.

12 Q. Okay. And are you aware if Mr. Molina has been  
13 continually treating for his lumbar spinal injuries?

14 A. Yes.

15 Q. And did you review some MRI films of the lumbar spine  
16 that were taken a year after those films that you first showed  
17 the jury?

18 A. Yes.

19 Q. And I would ask that you explain to the ladies and  
20 gentlemen of the jury the findings on MRI on January 27th, 2010?

21 MR. LAQUERCIA: What's the exhibit number?

22 MS. BORDEN: This is 10A. .

23 MR. LAQUERCIA: I had previously objected to 10A.

24 MS. BORDEN: Right.

25 MR. LAQUERCIA: I'm objecting to 10A.

Dr. G. Dassa - Plaintiff - Direct

1 THE COURT: Overruled.

2 MR. LAQUERCIA: Can I make an argument at side  
3 bar?

4 THE COURT: Side bar.

5 (Whereupon, there is a discussion held off the  
6 record at the side bar among the Court, defense counsel  
7 and plaintiff's counsel.)

8 Q. Doctor, if you could please explain to the ladies and  
9 gentlemen of the jury what these findings in the lumbar spine  
10 showed a year after those first films that we looked at earlier  
11 this afternoon?

12 A. In a similar comparison, you can see this is the  
13 spinal column, this is the spinal cord, you can see it on  
14 several views, again, slicing from the outside to the inside of  
15 the spine and then back to the outside to look at the nerve  
16 roots. And, in essence, you have the 1, 2, 3, 4, 5 lumbar  
17 vertebra, which are the bones, you have the disks that are in  
18 between the bones, and, again, for me to have you understand the  
19 affect of what's going on here, you can see the white space  
20 between the bones and the spinal cord.

21 The spinal cord is this dark structure. Here is the  
22 disk space. This column in a normal spine will have the fluid  
23 completely patent, meaning it's fully open. You would see a  
24 continuous white space or white line, which represents the fluid  
25 that surrounds the spinal cord.

Dr. G. Dassa - Plaintiff - Direct

1           As you go down the lumbar spine and most notable you  
2       can see at L12, which is if you go, this is the fifth, this is  
3       the fourth, three, two, one. L1, 2, you can see the disk is  
4       actually herniated past the bones into the fluid and it's  
5       actually pressing on the nerve root in this particular location.  
6       If you have bulges of disks to lesser degree at L3, 4, actually  
7       L2, 3, but notable here at L5, S1, you can see the disk is  
8       actually closing off that fluid completely, so that's another  
9       disk herniation at L5, S1.

10           Q.   Thank you, Doctor.

11                   Now, I think I just want to clarify something. I  
12       think you told us on the MRI's from January of 2009, that there  
13       were bulges in the lumbar spine, but now in January of 2010,  
14       they are herniation; is that correct?

15           A.   Well, I think that at the L5, S1 level, if you look at  
16       the radiologist's interpretation, he interpreted the L5, S1 as a  
17       bulge as well as the L1, 2 level. My review of the films, I  
18       believe that the L5, S1 was a small herniation, which now on  
19       this film is a large herniation, and the L1, 2, was a disk  
20       bulge, which is now a disk herniation.

21           Q.   Okay. And do you have an opinion to a reasonable  
22       degree of medical certainty as to what the cause of that L5, S1  
23       herniation was?

24           A.   Well, as you look at the anatomy of disks, the only  
25       analogy I can give you is the comparison of a jelly doughnut.



Dr. G. Dassa - Plaintiff - Direct

1 You know, if you bite into a jelly doughnut, the jelly will  
2 squirt out the side, and why, because it breaks through the wall  
3 of the doughnut, and that's the equivalent of a disk herniation.

4 In order for the jelly to come out of the doughnut, it  
5 has to rip through the wall of the doughnut. In order for a  
6 disk to be herniated you have to go through the wall of the  
7 disk. So the disk has a connective tissue wall and a center  
8 fluid containment and with injuries or pressure. You can have  
9 that disk pushed through the wall to have a bulge you have to  
10 tear the wall. It's an incomplete tear. I believe that, you  
11 know, as disks become injured, the course of normal functions  
12 like just sitting in a chair which increases the disk space  
13 pressure can advance a disk bulge to a disk herniation.

14 So I believe the advancement of a bulge to a  
15 herniation or small herniation to a large is just a normal  
16 progression of the injury that had occurred.

17 Q. All right. And then initial bulge or herniation you  
18 believe to be caused by the accident of November 16th, 2008?

19 A. Yes.

20 Q. All right. What is his prognosis, Mr. Molina's  
21 prognosis for his right shoulder?

22 A. I think that the type of repair that he had with  
23 suture anchors and, you know, he's absolutely not a person who  
24 is going to be able to perform strenuous activity with the right  
25 arm. I think that his prognosis is guarded from that

Dr. G. Dassa - Plaintiff - Direct

1 perspective. I think he's highly susceptible to retearing his  
2 rotator cuff.

3 So it's a really careful type of future for him with  
4 the right arm. And I think that the expected outcome is not  
5 predictable. He may be okay, as far as not having further  
6 injury he may not, he may require additional treatment depending  
7 if the tear breaks down, but even in the best case scenario, I  
8 don't believe he would be able to do strenuous activity with the  
9 right arm.

10 Q. Is that loss of range of motion that you found on  
11 examining his right shoulder, do you believe that's permanent?

12 A. Yes, I do.

13 Q. And why is that?

14 A. Well, he was injured in 2008, he had surgery in 2009,  
15 you know, you're almost three years now. I mean, really you're  
16 probably at your maximum range of motion at about a year to 15  
17 months after an injury or surgery, so I think what you're seeing  
18 in his right shoulder is what he's going to have and sadly the  
19 same goes for the left shoulder, as well.

20 Q. All right. I want you to assume for purposes of this  
21 question Mr. Molina told the ladies and gentlemen of this jury  
22 he experiences daily pain in his right shoulder, in his left  
23 shoulder and in his lower back.

24 Is that testimony -- would that testimony be  
25 consistent with the injuries?

Dr. G. Dassa - Plaintiff - Direct

1 A. I think so, yes.

2 Q. Okay. And what is his prognosis for the cervical  
3 spine at this point, his neck?

4 A. Again, you know, I think it's probably fair. I didn't  
5 really get into specific addressing of his complaints for the  
6 neck, because he was really complaining mostly of the lower  
7 back. Based upon an MRI reviewed and his level of complaint I  
8 would say it's a fair prognosis.

9 Q. And what about his prognosis right now for his lower  
10 back?

11 A. At his current level of functioning and what I see on  
12 the MRI, I believe his prognosis is poor.

13 Q. Okay. Is he indicated for any further medical  
14 treatment for either of his shoulders right now?

15 A. I don't think, you know, beyond intermittent  
16 conservative treatment, physical therapy for exacerbation or  
17 increase of pain symptoms. Beyond that, I don't think anything  
18 orthopedically at least from a surgical perspective is  
19 necessary, because the more surgery you do, the more scar tissue  
20 created, the more dysfunction you create.

21 I think although his range of motion is not normal, he  
22 does maintain something that is reasonable. Less than what he  
23 has if he did have additional surgery and lost more motion, he  
24 would be completely dysfunctional, so unless there's an MRI that  
25 shows another rotator cuff tear or something that absolutely

Dr. G. Dassa - Plaintiff - Direct

1 indicates the need for surgery, that surgery should be  
2 entertained at this point.

3 Q. What about for his lumbar spine, is he indicated for  
4 any further treatment for his lumbar spine right now, his low  
5 back?

6 A. I know he's seeing Dr. Olsewski over at Montefiore  
7 Medical Center. I know that there were a conversations  
8 according to his history to me regarding possible surgery to his  
9 lumbar spine. You know, the medical history indicates that he's  
10 exhausted non-surgical treatment. It would be the next logical  
11 step in an assessment for spine surgery. I mean, given what he  
12 has on his MRI, plus the fact that his MRI's have shown some  
13 progression, you know, it's not unreasonable to suggest he is a  
14 surgical candidate for the lower spine.

15 Q. Do you think he needs spinal surgery?

16 A. Again, based upon the historical details, his response  
17 to treatment, I believe he's a candidate for spine surgery.

18 Q. What is that cost associated with the spinal surgery?

19 A. You know, it's variable, it depends on if there's just  
20 discectomy done, fusions done, you know. I think it ranges  
21 between 50 and \$80,000, which includes the hospital stay and the  
22 rehabilitation. You know, if there's a normal fusion done, that  
23 would entail a short time in the surgical intensive care unit to  
24 monitor his spinal cord function before they would discharge  
25 him, so it can be rather costly, but, again, it would depend on

Dr. G. Dassa - Plaintiff - Direct

1 what the surgeon is recommending to do.

2 Q. And do you have an opinion as to a reasonable degree  
3 of medical certainty as to the permanency of his lower back  
4 injury?

5 A. Yes, I do.

6 Q. And what is that?

7 A. I believe, you know, you're not going to reverse the  
8 changes that you see on MRI. Even if you did surgery, you're  
9 manipulating the anatomy to make him have less pain, so whatever  
10 is done for him surgically would not restore him to normal, so  
11 whatever consequential injuries he has, I believe it's going to  
12 result in permanency.

13 Q. Okay. And do you know -- do you have an opinion as to  
14 a reasonable degree of medical certainty as to whether  
15 Mr. Molina would be able to perform any sort of manual labor at  
16 this time?

17 A. I do.

18 Q. And what is that?

19 A. I don't think he's fit for manual labor.

20 Q. Okay. Do you think that he could ever be fit for  
21 manual labor in the future?

22 A. In my opinion, no.

23 MS. BORDEN: Thank you, very much, Dr. Dassa.

24 CROSS-EXAMINATION

25 BY MR. LAQUERCIA:

Dr. G. Dassa - Plaintiff - Cross

1 Q. Good afternoon, Doctor. Would you mind if I remove  
2 this exhibit?

3 A. Not at all.

4 Q. Now, Doctor, you just recently saw the plaintiff in  
5 this case, correct?

6 A. That's correct.

7 Q. You're not treating him at this particular time?

8 A. I am not.

9 Q. When you examined him, it wasn't for the purposes of  
10 taking him on as a new patient so you could treat him?

11 A. That's correct.

12 Q. Before you took the stand, you said you reviewed a  
13 number of records.

14 Did you also in those records review the hospital  
15 record for Westchester Square Medical as to what the plaintiff  
16 claims happened to him?

17 A. I did review those records, but after the report was  
18 prepared --

19 Q. But you did review them?

20 A. Yes.

21 Q. And you agree with me the plaintiff said that he fell  
22 on steps, right?

23 A. Yes.

24 Q. All right. And I believe the records and other  
25 reports that were given or rather were made about the

Dr. G. Dassa - Plaintiff - Cross

1 plaintiff's accident speak to his hitting his right shoulder  
2 against the rail, correct?

3 A. Yes.

4 Q. All right. Now, you have never been asked the  
5 question, hypothetical or otherwise, as to whether that type of  
6 impact, that is a man who slips and falls on a staircase and  
7 hits his back against steps and his right shoulder, against a  
8 rail, would cause the injuries that he complained of, correct?  
9 I mean, today, you have haven't been asked?

10 A. That specific mechanism that you described?

11 Q. Yes.

12 A. It wasn't asked me in that way.

13 Q. So can we assume that that specific mechanism is the  
14 basis of any of your opinions given here today, that is  
15 specifically --

16 MS. BORDEN: Objection.

17 Q. -- that is specifically what the plaintiff testified  
18 in this court happened to him, that he fell, rather he slipped,  
19 his feet went out from under him, and he hit his back on steps  
20 and shoulder on the rails, correct?

21 MS. BORDEN: Objection as to the characterization  
22 of testimony.

23 THE COURT: If the doctor understands the  
24 question, he can answer it.

25 A. I don't understand the question.

Dr. G. Dassa - Plaintiff - Cross

1 Q. Well, Doctor, you've given opinions here today, but  
2 you were never asked the specifics about the testimony that was  
3 given in this court as to how the accident occurred, correct?

4 A. I mean --

5 Q. Yes or no, correct?

6 A. Today -- again, I know the details that you're  
7 describing. It was communicated to me by the patient. Was the  
8 counsel's direct examination did she go through that in detail?  
9 No, she did not.

10 Q. No. So you agree with me you've never been asked  
11 whether or not an accident such as this, that is where a person  
12 slips with his feet out descending stairs at no particular speed  
13 could cause a tear of the supraspinatus and the labrum?

14 A. I was not asked that in that way, no.

15 Q. And the same thing in terms of his hitting his back  
16 against the steps.

17 The testimony in this courtroom is that when he  
18 slipped, he fell down on the steps, he fell backwards as he was  
19 descending the staircase; is that correct?

20 A. That's correct.

21 Q. Now, can you tell the jury what a trauma is, a  
22 traumatic injury?

23 A. A traumatic -- what is traumatic --

24 Q. What a traumatic injury is?

25 A. Well, basically trauma is an event that causes or



Dr. G. Dassa - Plaintiff - Cross

1 inflicts tissue damage or injury to the body.

2 Q. All right. Now, in any of the reports that you read  
3 or any of the statements that were taken of the plaintiff  
4 describing how he was hurt, what is your understanding of the  
5 trauma that would cause the tears that you say were repaired,  
6 and we know according to the operating report, repaired to the  
7 right shoulder of the plaintiff by Dr. Ehrlich?

8 A. I think the cause of the trauma was the fall he  
9 sustained on the steps.

10 Q. And it was hitting his right shoulder, hitting the  
11 rail, handrail caused the tear?

12 A. Again, in specifics, if a person falls, I mean, that  
13 is one of the components that could have caused the injury is  
14 striking the shoulder. Also, he had described trying to catch  
15 himself, and had a wrenching of the shoulder before he struck  
16 the shoulder.

17 So there's several components of what he describes to  
18 me as his fall.

19 Q. Tell me where in the report, the hospital report for  
20 Westchester Square there's any mention written by any triage  
21 nurse or treating doctor when he was examined the day after the  
22 occurrence where he said he wrenched his shoulder?

23 A. Again, I didn't see any of that in Westchester Square.

24 Q. And as you sit here today, because you reviewed all of  
25 the medical reports, Medalliance and all that stuff and

Dr. G. Dassa - Plaintiff - Cross

1 Surgicare and all that stuff, is there any place written where  
2 he said he wrenched his shoulder while he was falling as he was  
3 holding onto the rail of this staircase?

4 A. Specifically I didn't see in anything else.

5 Q. So what you just said, anything else, how something  
6 could make a tear like that would be a general hypothetical that  
7 it is possible that if a person is holding onto something and if  
8 he wrenches his shoulder, he could have a tear such as that, but  
9 as far as you know, there's never been any person, any medical  
10 practitioner, nurse, doctor, or surgeon who has ever written  
11 down anywhere that that's how this occurred; is that correct?

12 A. That's incorrect.

13 Q. Where is it?

14 A. Because I examined the patient, took a history, that's  
15 the history he provided to me.

16 Q. Can I ask you, may I interrupt, where in your notes  
17 does it show you wrote down that he told you that he wrenched  
18 his shoulder while holding onto the rail?

19 A. Again, I just recently saw him, so I have an  
20 independent recollection of that. I did not put those specific  
21 details in my report.

22 Q. I'm sorry. Would you not agree with me that writing  
23 down what would be the trauma that actually occurred, that  
24 actually happened and actually caused this accident would be a  
25 very material factor for you in establishing how this man

Dr. G. Dassa - Plaintiff - Cross

1 suffered the injury that you said was treated by Dr. Ehrlich?

2 A. I agree with you, and I did state that he had a slip  
3 and fall. Again, when people fall, it's not very accurate as  
4 they would describe the entire history of the fall. What he did  
5 describe to me in the space where I'm seeing him as a medical  
6 expert, I wasn't providing treatment for him.

7 If you look at Dr. Ehrlich's notes, he does speak to  
8 the fall, slip and fall as being a causative agent for it.  
9 There's no other pertinent history other than this fall as far  
10 as the specific whether he twisted to the right or twisted to  
11 the left, if he tumbled, he fell down. And that's significant  
12 enough history correlating with his MRI finding that allows me  
13 to draw those conclusions.

14 Q. All right. Now, you're drawing conclusions knowing  
15 that Dr. Ehrlich is not going to testify about what he found and  
16 what his reasons are as to why this person needed the surgery,  
17 correct?

18 MS. BORDEN: Objection.

19 THE COURT: Sustained.

20 Q. Well, do you know if Dr. Ehrlich is going to testify  
21 to what you said he made his findings were?

22 MS. BORDEN: Objection.

23 THE COURT: You can answer that.

24 A. I know Dr. Ehrlich is not testifying.

25 Q. Okay. So, Doctor, one of the things I didn't see in

Dr. G. Dassa - Plaintiff - Cross

1 your report or two things, the height and weight of the  
2 plaintiff in this case, correct?

3 A. That's correct.

4 Q. Would you agree with me that a person's height  
5 relative to a person's weight is significant with regard to  
6 degenerative changes in the person's spine from the cervical  
7 spine on down?

8 A. Yes.

9 Q. All right. Indeed, would you agree with me that the  
10 spine is carrying the upper half of the body and all of the  
11 weight of the body?

12 A. Yes.

13 Q. Okay. Now, do you know the height of the plaintiff?

14 A. I don't.

15 Q. Did you think it was significant to take the height of  
16 the plaintiff?

17 A. No.

18 Q. In any of the report, did you happen to see the height  
19 of the plaintiff being five-foot nine?

20 A. No.

21 Q. What about the weight of the plaintiff? Did you know  
22 that it's reported in the hospital reports that his weight was  
23 approximately 250 pounds, more or less?

24 A. I do recall seeing that.

25 Q. Now, would you agree with me that that places the

Dr. G. Dassa - Plaintiff - Cross

1 plaintiff in the category of being overweight?

2 A. For his height, yes.

3 Q. And would you agree with me, too, that being  
4 overweight would be more than a normal spinal column could  
5 handle in day-to-day work that a person does, correct?

6 A. Can you repeat that?

7 Q. Would you agree with me that being overweight would  
8 put more than the normal strain on the spinal column?

9 A. Again, if you're heavier than what you should be for  
10 your height, it's more stress across all your joints.

11 Q. And those little things you talked the about, the  
12 disks, you talked about thinking about a jelly doughnut, you  
13 squeeze, what have you.

14 Well, isn't it true, Doctor, that if you're working as  
15 an operation engineer, which the plaintiff testified that he  
16 did, that the twisting and turning and lifting with extra weight  
17 on your body would be an added stress and/or compressor on all  
18 of the disks in the body?

19 A. Yes.

20 Q. All right. And when a person gets to middle age, any  
21 person, isn't it true that there is typical arthritic changes  
22 that occur just from aging, correct?

23 A. Yes.

24 Q. Couple that with a person's weight, wouldn't you agree  
25 with me that the plaintiff's weight, itself, gives -- has given

Dr. G. Dassa - Plaintiff - Cross

1 rise to the degenerative changes found in the X rays at  
2 Westchester Square Medical?

3 A. I think it's a combination of his occupation, it's a  
4 combination of the weight, it's a combination of his function  
5 for 50 years.

6 Q. And all of these things happening before this fateful  
7 night when he slipped and fell going down the stairs, correct?

8 A. Yes.

9 Q. All right. So essentially, it's cumulative, correct?

10 A. If you're speaking of the degenerative changes, yes.

11 Q. Yes, sure. And that would be neck, back, lower spine,  
12 the whole thing, correct?

13 A. The whole thing.

14 Q. Now, if you were to please compare the operative  
15 reports of Dr. Ehrlich, which are now in evidence that you  
16 referred to, the first one for the right shoulder. The  
17 postoperative diagnosis shows right shoulder traumatic  
18 subacromial impingement, correct?

19 A. Yes.

20 Q. Supraspinatus tear and rotator cuff surgery?

21 A. Yes.

22 Q. Now, if you would like at the second report, which was  
23 done years after the occurrence, date of operation 21st of  
24 October in 2010, the postoperative diagnosis was left shoulder  
25 subacromial impingement with no mention, whatsoever, of trauma,

Dr. G. Dassa - Plaintiff - Cross

1 correct?

2 A. Yes.

3 Q. Now, Doctor, assume that the testimony has been that  
4 since February of 2009, the plaintiff hadn't done any work. He  
5 hadn't returned to his job since that time, he hadn't worked any  
6 other place, and he's essentially testified as I understand it  
7 that he's been at home.

8 Now, you were given an opinion that the surgery for  
9 the left shoulder was because of excessive use in wear, correct?

10 A. Yes.

11 Q. Now, do you have a history that you took of this  
12 plaintiff before you did your report, before you came here today  
13 about what exactly he did do if he wasn't working that would  
14 create such excessive tear that it would create as Dr. Ehrlich  
15 said left shoulder subacromial impingement? What happened?

16 A. Well, again, as I described before, with a rotator  
17 cuff tear and labral tear that is repaired, you can absolutely  
18 not move your arm for three months, your arm has to stay in a  
19 sling, which means even to do any type of activity of daily  
20 living, normal hygiene, having to care for himself, reach for  
21 things in the house, you know, if you're solely dependent upon  
22 one extremity, you can just with that activity incite the kinds  
23 of findings that Dr. Ehrlich found on those -- on his operative  
24 report.

25 Q. After patients are released from hospitals, they're

Dr. G. Dassa - Plaintiff - Cross

1 given instructions, correct?

2 A. Yes.

3 Q. After surgery.

4 And they're told to take medication, analgesics to  
5 stop the pain and to mind what they do.

6 Do you know of any instructions that were given by Dr.  
7 Ehrlich or any other treating physicians after the first surgery  
8 telling him that he had to care and watch how he used his left  
9 hand and arm?

10 A. General. I did not specifically see Dr. Ehrlich's  
11 postoperative instructions, but his standard, it is standard of  
12 care even when I do rotator cuff surgery, there is absolute  
13 prohibition of raising your arm above shoulder height actively.

14 Q. The left arm, you're talking about any instruction to  
15 the left arm to protect the left arm for overuse, so that you  
16 would be required to go in and have the impingement surgery?

17 A. Again, no, there's -- it's not practical, because you  
18 need to have some arm to care for yourself. So, again, most  
19 patients don't develop overuse, but there are certain  
20 preexisting conditions in his shoulder that made him susceptible  
21 to that.

22 Q. I see. And would those preexisting conditions of his  
23 shoulder be the fact he had arthritis in that left shoulder?

24 A. I think that's one component of it, yes.

25 Q. I think arthropathy, doesn't that speak to having



Dr. G. Dassa - Plaintiff - Cross

1 degenerative condition in the left shoulder?

2 A. Yes.

3 Q. And would you agree with me that the shoulders are  
4 bilateral, correct?

5 A. Yes.

6 Q. And people, whether they work, whether they're at  
7 play, whether they're sleeping, they're going to use both of  
8 their shoulders bilaterally constantly, correct?

9 A. Yes.

10 Q. So would you agree with me that if someone was going  
11 to have arthropathy in the left shoulder, there had to be  
12 already preexisting arthropathy in the right shoulder, as well?

13 A. Yes.

14 Q. Okay. I believe you testified, Doctor, that the  
15 plaintiff would have a fair prognosis for cervical spine, that  
16 is the neck?

17 A. Yes.

18 Q. Okay. And I believe you testified that he would have  
19 a moderate restricted range of motion, correct?

20 A. Yes.

21 Q. All right. Now, with regard to the work that he could  
22 do, all right, I believe you testified the Plaintiff could --  
23 cannot do strenuous activity because of your findings; is that  
24 right?

25 A. Yes.

Dr. G. Dassa - Plaintiff - Cross

1 Q. But doesn't that also mean he can't do other work that  
2 is not strenuous?

3 A. Again, it would depend upon --

4 Q. Yes or no?

5 A. It depends. It's not a -- I can't answer that  
6 question yes or no. It's not a yes or no answer. I mean it's  
7 job description dependent.

8 Q. All right. Job description dependent.

9 So in the universal possibilities of probabilities of  
10 jobs out there, are there not jobs that do not require strenuous  
11 activity?

12 MS. BORDEN: Objection.

13 THE COURT: Overruled. You can answer.

14 A. Are there jobs?

15 Q. Are there jobs that do not require strenuous?

16 A. Yes, there are.

17 Q. So in so far as the plaintiff might qualify to do a  
18 non-strenuous job, he would be able to do that job and he would  
19 not be considered to be disabled from that kind of job, correct?

20 A. Again, it's job description dependent because the  
21 issue is not only strenuous activity.

22 Q. You said? I'm sorry?

23 A. Strenuous activity was really specifically addressed  
24 to his going back to work as a laborer. I don't feel he's  
25 functionally capable or should be doing that. There are other

Dr. G. Dassa - Plaintiff - Cross

1 issues when it comes to working that you have to assess when it  
2 comes to a lumbar spine condition. Even assume that sitting  
3 down in a chair is a position of -- that's a good position for a  
4 person with a disk herniation, it's actually the worst position  
5 for a disk herniation, so when I say it has to be job  
6 description dependent, will there be reasonable accommodations  
7 made for the patient to limit his sitting not more than 20  
8 minutes at a time, to have him get up, move around, will there  
9 be accommodations for him possibly to be able to lay down during  
10 the course of the day, because that's the only position that  
11 adequately releases pressure on the disk spaces.

12 So is it in the hypothetical conceivable that he can  
13 do some type of work, yes, but it's job description dependent.

14 Is there a job out there that will allow him to do  
15 non-strenuous work, say, within the guideline of not sitting for  
16 prolonged period of time, allow him to lay down and conceivably  
17 allow him to work on medication he has to currently take for  
18 pain, again, I wouldn't have a person doing sedentary work in my  
19 office under those conditions.

20 Q. All right. You'd agree with me, though, that if a  
21 person can do not strenuous work, he's not totally disabled?

22 A. By definition, if you can do some type of work, you're  
23 not totally disabled.

24 MR. LAQUERCIA: Nothing further. Thank you,  
25 Doctor.

Dr. G. Dassa - Plaintiff - Cross

1 MS. BORDEN: I just have one quick follow-up.

2 REDIRECT EXAMINATION

3 BY MS. BORDEN:

4 Q. Doctor, you were asked about the degenerative changes  
5 in Mr. Molina's neck and back being cumulative in nature.

6 I would just like you to clarify for the ladies and  
7 gentlemen of the jury, what was degenerative in his neck and  
8 back versus what was traumatic as you read on the MRI's?

9 A. Well, you know, again, there were findings of the  
10 joints, the facet joints, the small joints of the spine, the  
11 vertebral bodies, there's some irregularities, which is basic  
12 wear and tear of the joint. There was some osteophyte  
13 formation.

14 These are all things that occur over time, and if you  
15 want to get into the specifics of his weight and the type of  
16 work that he did, you would normally find that in a person  
17 that's overweight that does strenuous work. There are other  
18 things in the spine like disk herniations, again, you have to  
19 tear tissue to have a disk herniation. You don't generally see  
20 disk herniations just with arthritis. Usually you'll see it  
21 with the trauma superimposed upon a preexisting condition like  
22 degenerative changes, and in this particular case, the only  
23 trauma that, again, is suggestive is the fall.

24 So, you know, in my opinion, and reviewing the MRI,  
25 there's unquestionable degenerative finding, but there are also

Dr. G. Dassa - Plaintiff - Redirect

1 disk injuries that, again, if you told me he had no history of  
2 trauma, that I can say yes, everything there is from preexisting  
3 problems, but you had a functional person that did a strenuous  
4 occupation up until this event, and now he's not capable of  
5 doing that.

6 So there was some event that occurred to cause those  
7 changes in his spine that were not degenerative, that's the  
8 basis of my conclusions.

9 Q. And those bulges and herniations that you found, you  
10 believe those are traumatic in nature, correct?

11 A. Yes.

12 MS. BORDEN: Thank you. No further questions.

13 MR. LAQUERCIA: Nothing further.

14 THE COURT: You may step down. Thank you,  
15 Doctor.

16 (Whereupon, the witness was excused.)

17 THE COURT: Okay, ladies and gentlemen, we're  
18 going to break at this time. I remind you, do not discuss  
19 the case among yourselves, do not allow anyone to discuss  
20 the case with you. Do not do any independent research.

21 I'll see you back here tomorrow morning, 10:00.

22 THE COURT OFFICER: All rise, jury exiting.

23 (Jurors exited the courtroom.)

24 MR. LAQUERCIA: Good night, your Honor.

25 THE COURT: Okay. Good night.

(Whereupon, court is recessed and the case  
adjourned to Tuesday, October 25, 2011 at 10:00 a.m.)

TRANSCRIPT OF PROCEEDINGS,  
DATED OCTOBER 25, 2011 [A-274 - A-325]

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SUPREME COURT OF THE STATE OF NEW YORK

COUNTY OF BRONX: CIVIL TERM PART 1A-29

-----X

LUIS MOLINA,

Plaintiff

Index No.

-against-

303734/2009

THE NEW YORK CITY TRANSIT AUTHORITY,

Defendant.

-----X

851 Grand Concourse  
Bronx, New York 10451  
October 25, 2011

B E F O R E:

HON. ROBERT E. TORRES, JSC, and a jury of six plus  
two alternates.

A P P E A R A N C E S:

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JANET CAMPOLO, RPR  
Senior Court Reporter

## PROCEEDINGS

1 (Whereupon, cleaning records were marked  
2 Defendant's exhibits B and C for identification.)

3 THE COURT: On the record, please.

4 MR. LAQUERCIA: If it please the Court, good  
5 morning, your Honor.

6 THE COURT: Good morning.

7 MR. LAQUERCIA: On behalf of the defendant, New  
8 York City Transit Authority, I had marked for  
9 identification a series of documents stapled together which  
10 purport to be and which will be offered as the summer and  
11 winter schedules in the year 2008 for several subway  
12 stations, one of which is Hunts Point Avenue station where  
13 plaintiff's accident occurred.

14 I have -- I received a subpoena, what purported  
15 to be a subpoena by counsel seeking documents, cleaning  
16 schedules and what have you, and I was told by Mr. Gerald  
17 Fraizer, F-R-A-I-Z-E-R, who is the claims manager for  
18 County of Bronx just last evening in front of 130  
19 Livingston Street about 6:30 p.m., that this is all that  
20 they have. That is all that's kept as a record.  
21 Mr. Fraizer is in the court and he will be in court at  
22 10:00 today, if not, unless I'm mistaken, but certainly if  
23 it's necessary and you need a further foundation for these  
24 things, we can offer this subject to connection.

25 Outside or actually in the courtroom today