

1 HOSTIN - DIRECT
2 (Jury enters courtroom.)
3 THE COURT: Please be seated.
4 As I mentioned earlier, sometimes we take
5 witnesses out of order. We are doing that this
6 afternoon in order to accommodate a medical witness.
7 Mr. McGuinness has consented to interrupt his
8 cross examination and allow that to proceed.
9 You may call that witness, Mr. Bottari.
10 MR. BOTTARI: The Plaintiff calls
11 Dr. Emmanuel Hostin.
12 THE WITNESS: Good afternoon.
13 E M M A N U E L H O S T I N , called as a witness on
14 behalf of the Plaintiff, having been duly sworn,
15 testified as follows:
16 THE COURT: State your full name, spell your
17 last name, and give your business address.
18 THE WITNESS: Emmanuel Hostin, H-O-S-T-I-N,
19 369 Lexington Avenue, eighth floor, New York, New
20 York 10017.
21 THE COURT: You may inquire.
22 MR. BOTTARI: Thank you, your Honor.
23 DIRECT EXAMINATION BY
24 MR. BOTTARI:
25 Q Dr. Hostin, could you briefly give us your

2 the board is the American Board of Orthopedic Surgery.
3 To get Board certified, you have to have been in
4 practice at least two years, maybe three and you collect
5 for a six-month period all of your surgical cases, so
6 this is for surgical practice. You present those cases.
7 They review those cases.

8 In reviewing those cases or in preparing those
9 cases, you also explain any complications you have had
10 which occur and then you have to explain how you
11 corrected them or handled them from a medical standpoint.

12 Then the Board certification is actually an oral
13 examination, so I flew to Chicago where they are
14 headquartered and got grilled a little bit on all my
15 cases.

16 They narrowed it down to a few, maybe it was 25
17 cases to confirm that I was following appropriate
18 practices. Through that, you become Board certified and
19 recertify every ten years, so I have been Board certified
20 since 2005.

21 Q And you recertified in 2015?

22 **A** Correct. There was a year lapse only because I
23 missed the deadline, but the following year, I became
24 Board certified again.

25 Q Do you know what peer reviewed literature is?

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1 professional and educational background?

2 **A** I am an orthopedic surgeon. I went to undergrad

3 at Johns Hopkins University. I did my medical school

4 training also at Johns Hopkins University and did my

5 orthopedic surgery residency at Johns Hopkins University

6 or school -- Medical Institute.

7 Then I did one additional year of sports medicine

8 training called a fellowship at University of

9 Pennsylvania in Philly and became licensed to practice

10 medicine in New York in 2002, when I started practicing

11 as an orthopedic surgeon.

12 **Q** Do you know what the term Board certification

13 means?

14 **A** I do.

15 **Q** Are you what's called Board certified?

16 **A** I am.

17 **Q** What specialty?

18 **A** In orthopedic surgery.

19 **Q** Now, you are the first doctor to testify in this

20 case so could you please tell us what is the significance

21 of being Board certified, are there tests involved?

22 **A** Sure, so Board certification, I guess, simply put

23 is a certain stamp of approval in your field of practice,

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2 A Yes.

3 Q Can you tell us what peer reviewed literature is?

4 A So literature, obviously, it's scientific

5 literature that you're referring to in which studies are

6 performed to decide whether things work or not, simply

7 put.

8 So peer reviewed means that it is reviewed by

9 other doctors, also who usually are Board certified, they

10 should be, and they make sure that the literature or the

11 study was done appropriately and give commentary to

12 support or turn down that literature.

13 Q Have you ever had any articles published in

14 what's called peer reviewed literature?

15 A Yes.

16 Q In the field of orthopedics?

17 A Yes.

18 Q And do you have any what's called hospital

19 privileges?

20 A I do. So I have privileges at Lenox Hill

21 Hospital in Manhattan and also Mount Sinai West in

22 Manhattan.

23 Q Now, what is your particular area of expertise in

24 orthopedic surgery, doctor?

2 Q And if you weren't here today, would you be
3 either seeing patients or operating?
4 A Yes. I usually see patients on Tuesday
5 afternoons where I see my follow-up patients, but also
6 see new patients and potentially book surgeries, yes.
7 Q And how many days a week do you traditionally
8 operate on a weekly or monthly basis?
9 A Two days a week.
10 Q Do you anticipate being compensated for your time
11 away from your office?
12 A Yes.
13 Q And approximately, how much?
14 A \$8,000 for my half day.
15 Q Now, do you know what an MRI is? I'm sure you
16 do.
17 A Yes.
18 Q And what a CT scan is?
19 A Yes.
20 Q Can you tell us what they are good for, what they
21 aren't good for in evaluating orthopedic type injuries?
22 A So CT scan -- CT stands for computed tomography
23 and it's basically an x-ray, but multiple x-rays are done
24 almost in slices and it's mainly used to look at bone.
25 You can see other things like air and sometimes

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2 soft tissue, but it's certainly not as good for those
3 things as it is for bone because it's x-ray beams that
4 are deflected more so by the calcium in bones and there
5 is no calcium in most of the other structures, so it's
6 not very good at looking at those other structures other
7 than bone or some kind of calcified substance.
8 On the other hand, MRI, magnetic resonance
9 imaging, also works in slices, but it actually works as a
10 magnet so it actually acts on the water molecules in
11 various tissues in the body, so in that sense, it's great
12 at looking almost at anything although not as good as for
13 bone because bone doesn't have a lot of water in it.
14 What it does do is differentiate between multiple
15 structures that are all next to each other and based on
16 how much more or less water those structures in the body
17 have, it is able to project pictures, really.
18 They take the energy from the tissues and draw a
19 picture, so to speak, also presented in slices to the
20 radiologist or whoever -- the doctor looking at it, but
21 bottom line, it's great for looking at soft tissue
22 structures.
23 Q And soft tissues could be discs, tears in
24 muscles, tears in ligaments, things like that?

2 disc, cartilage, muscles, tendons, brain tissue, for
3 example, sure.
4 Q Now, did there come a time when someone by the
5 name of Ed Carter became a patient of yours?
6 A Yes.
7 Q When is that and you can refer to your notes and
8 you can actually read from them because your notes have
9 been, with the agreement of counsel, put into evidence as
10 Plaintiff's Exhibit 4.
11 A Great. I brought my notes today. So the first
12 time I saw Mr. Carter was on October 9, 2012.
13 Q Now, did you take what's called -- let me ask
14 you this.
15 What was his chief complaint?
16 A He came to see me about his right shoulder, so he
17 had right shoulder pain.
18 Q Did you take what's called a history from him?
19 A Yes.
20 Q Can you tell us what he indicated to you was the
21 history?
22 A I have noted that he was involved in a motor
23 vehicle accident, a car accident, on July 3, 2012.
24 Q Do you know if there were any x-rays or anything
25 taken on or about that date?

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2 A Yes. He reported to me that he did have x-rays
3 done in the emergency room.
4 Q Did he indicate to you whether or not he sought
5 further medical attention within a couple of days?
6 A Yes. So he a few days later ended up seeing, I
7 think, Dr. Gondre who is the person who eventually
8 referred him to me and was further evaluated and
9 eventually prescribed physical therapy.
10 Q Well, let me ask you this.
11 What do most doctors consider to be quote,
12 unquote, conservative treatment?
13 A Well, it depends on what the issue is.
14 Q Let me ask you this.
15 Is physical therapy usually considered to be
16 conservative treatment to a patient who has an injury to
17 his back, his neck, his shoulder?
18 A Absolutely, yes.
19 Q If someone injures their shoulder, is there a
20 general course of physical therapy that you would
21 normally prescribe?
22 A Yes.
23 Q Depending on the severity of the injury?
24 A Correct, yes.

2 undergone a course of physical therapy?

3 **A** Yes, so what I have noted here based on his

4 report to me was that he had started physical therapy, it

5 seems like just a couple of days after this accident and

6 had been receiving therapy up until he saw me on October

7 9, so about three months later.

8 **Q** What type of complaints did he give to you with

9 regard to his right shoulder?

10 **A** He had difficulty reaching overhead, so reaching

11 above shoulder level and also reaching behind his back

12 and he also had night pain with difficulty sleeping.

13 Those were his complaints.

14 **Q** Is it unusual for someone who has a shoulder

15 problem to have difficulty sleeping on that side of his

16 or her body?

17 **A** No. These are actually all three very common

18 complaints for my patients who have had shoulder

19 injuries.

20 **Q** Now, just in general, if someone has a problem

21 reaching overhead, what, if anything, does that signify

22 to you as a clinician who treats those types of problems?

23 **A** It's a common complaint with several shoulder

24 injuries, but I always have to think about rotator cuff

25 injuries.

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2 The rotator cuff is a group of muscles that

3 attach to the bone and help rotate it and actually hold

4 it in the socket, so the rotator cuff muscle is probably

5 the first thing I think about, but there are also other

6 injuries that may also give similar symptoms.

7 **Q** Let me ask you this.

8 Did I ask you to bring a model of the shoulder

9 here today?

10 **A** Yes.

11 **MR. BOTTARI:** With your Honor's permission,

12 can we have that marked just for identification

13 purposes only and may the doctor explain what he

14 means by the rotator cuff, where it is and how it

15 affects motion going up.

16 **THE COURT:** We will deem it marked. Go

17 ahead.

18 (Plaintiff's Exhibit 5, was deemed marked for

19 identification by the Reporter.)

20 **Q** May the doctor step down? It might be helpful.

21 **THE COURT:** Yes.

22 **A** This is actually a right shoulder model. It

23 shows the shoulder blade and the collarbone here.

24 The rotator cuff muscles that I had mentioned,

2 around the ball or the humeral head, sort of like a shirt

3 cuff. They are in the front, over the top and in the

4 back.

5 The shoulders are a very unique joint in that

6 there is one of the few spots where muscle and tendon run

7 between two bones, so you have the top of the humeral

8 head and the bottom of this bone that you kind of tap on

9 the top of your shoulder called the acromion.

10 Again, getting to the question about difficulty

11 raising your arm, as the arm moves up, that space between

12 the top of the ball and the undersurface of this acromion

13 gets smaller.

14 So anything that's in there that's swollen, so in

15 the normal situation, you would be able to do that, no

16 problem, so in the event that the tendon is swollen or

17 any other tissues in that area, it's going to cause

18 difficulty lifting up the head or the arm and in some

19 cases, if this tendon or one of these tendons is

20 completely torn, you may also have similar problems

21 reaching overhead.

22 **Q** You also indicated that Mr. Carter had difficulty

23 reaching behind his back.

24 Can you explain technically why that type of

25 injury?

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2 **A** It's actually very similar also.

3 Again, as you are reaching behind, you are also

4 diminishing that space called the subacromial space, so

5 again, that's a very common complaint with rotator cuff

6 injuries or what's also called impingement, subacromial

7 impingement.

8 **Q** I want you to assume for a moment that there has

9 been testimony that Mr. Carter was in a car accident

10 where he was in the front seat as a passenger and the car

11 was rear ended, he was thrown forward and his right arm

12 was extended and hit the dashboard and his head hit the

13 dashboard.

14 What does that description of the mechanism of

15 injury say to you with regard to the complaints that he

16 has?

17 **A** There is a pattern of injury that's not uncommon

18 from falling out, we call it falling out, on to an

19 outstretched hand.

20 If you fell and you reached out and tried to

21 catch yourself, everyone is protecting their pretty

22 faces, so also in a car, it's not that different.

23 So imagine the arm, the hand to the elbow to the

24 shoulder kind of being jammed up. It's not uncommon to

2 of the rotator cuff that ends up being between these two
3 bones.

4 The other part of the joint that I didn't really
5 talk about is the actually the joint itself, where the
6 ball and socket meet.

7 I can't take it apart from this model, but there
8 is a ring of cartilage around the outer part of the
9 socket called the glenoid.

10 It kind of gives a little more of a deep dish
11 structure to the glenoid because, really, it's almost
12 just like a flat little -- like a tee, like a golf ball
13 on a tee, but also that's another source of injury in
14 that mechanism where the ball kind of slides in an
15 unnatural way over the socket and can kind of rip that
16 labrum off the edge of the socket.

17 The last thing is this biceps tendon can also be
18 pulled as a result of that mechanism.

19 Q And these injuries would be consistent with what
20 you told us about in terms of the injury on the day of
21 the accident?

22 A Yes.

23 Q Did Mr. Carter tell you about a previous shoulder
24 injury when he was lifting weights?

25 A Yes, but I would have to look at my notes.

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2 Q Go ahead.

3 A He did, yes. He had reported that he had hurt
4 that same shoulder lifting weights years prior.

5 Q Did he indicate to you what, if anything, was the
6 treatment that he received at that point in time?

7 A It's something that seemed to go away pretty
8 quickly. He had a Cortisone injection into the shoulder
9 and had no problems after that.

10 Q When doctors use the term asymptomatic, that
11 means no further complaints or no complaints versus
12 symptomatic?

13 A Correct. So symptomatic, he has symptoms of pain
14 or whatever his complaints are and asymptomatic, yes,
15 there are none.

16 Q So he indicated to you what at that point in time
17 with regard to this prior injury?

18 A That he had gotten better after that treatment
19 which included the injection.

20 Q So he came to you for an evaluation, correct?

21 A Yes.

22 Q Now, briefly, I'm going to go through your
23 report.

24 You asked him about his prior medical history,

2 A Yes.

3 Q And he indicated to you he had coronary problems,
4 he had congestive heart failure?

5 A Yes.

6 Q With an injection fracture between 20 and 30?

7 A Yes.

8 Q He indicated that he had a pacemaker or
9 defibrillator implanted in what, 2001?

10 A I think I have here 2011.

11 Q I'm sorry, 2011, and that he had diabetes?

12 A Correct.

13 Q You didn't do any testing with regard to his
14 diabetes, correct?

15 A No, I did not.

16 Q At that point in time.

17 He indicated to you that he did have -- both
18 knees had arthroscopic procedures in 2005 and 2007?

19 A I don't have here documented when it was, but --

20 Q Well, I believe you indicated that he was taking
21 no medications, is that accurate, doctor?

22 A Actually, with looking at the rest of my chart, I
23 mean he had jotted down none, but clearly, from his
24 medical problems, he was taking something, so I wrote
25 down none meaning that he was not taking pain

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2 medications, but clearly and from his later medical
3 records, he was taking a good bit of medication.

4 Q You noted his height and weight, correct?

5 A Yes.

6 Q And he was about 305 pounds at that time?

7 A Yes.

8 Q With regard to his right shoulder, what type of
9 testing did you do, what did you find at that point in
10 time and what diagnosis, if any, did you make?

11 A So I had checked his range of motion.

12 Q Let me stop you right there.

13 Is this range of motion testing that you do, is
14 that standard that all orthopedic doctors and orthopedic
15 surgeons do to a standard set of tests?

16 A They should, yes.

17 Q It's not something you made up?

18 A No, not at all.

19 Q When you say you test his range of motion, what
20 type of range of motion testing of the shoulder do you
21 do, can you explain that?

22 A Sure. May I stand and demonstrate?

23 THE COURT: You may.

24 A So I check forward flexion, basic motions,

2 Q What is normal?

3 A Normal is probably being able to go straight up

4 or maybe a little bit short of that, so 170 or 180 and

5 then I measured 110 for him.

6 Q So let me -- just so we are clear, that's about

7 a 30 percent, 35 percent deficit, something like that?

8 A Yes.

9 Q How about --

10 A And then external rotation, I measure in two

11 positions. External rotation is just going on this way,

12 so I measure it with his elbows close to his body so in a

13 deduction. Normal is 60. His, I measured at 50.

14 And then external rotation with the arm up here

15 in this position, normal is 90 for your average person

16 and I measured 70 in this case.

17 Q Now, are you doing this range of motion by

18 eyeballing or a goniometer?

19 A I usually use a goniometer.

20 Q Can you tell us what that is?

21 A A goniometer is a device used to measure angles,

22 so it has two arms that kind of sit on a little pivot and

23 so this would be a zero angle, relative to this and this

24 would be 90 degrees and it has markings on it so you can

25 measure that.

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2 Q And if he had external rotation of 70, and normal

3 is 90, that would be a 20 or 25 percent decrease in range

4 of motion, that area?

5 A Yes, and -- and I also checked his ability to

6 reach behind his back. I usually don't measure angles

7 with that. I measure the ability how far up you can get

8 behind your back, so usually, I measure the bottom of the

9 shoulder blades as T-7.

10 Again, I use the number of vertebral bodies, the

11 little spinal bones, and based on how far you can reach

12 up, I document that.

13 Q So his was not normal at that point?

14 A It was low so L-5 is just basically above your

15 waistline, I guess, as opposed to --

16 Q T-7 is midback?

17 A Yes, right below your shoulder blades.

18 And then in abduction, his ability to reach out

19 to the side with the arm, with the forearm in this

20 position, normal is about 90, his was a little below that

21 at 80.

22 Q At that point in time, did you review any CT

23 scans or any diagnostic tests?

24 A Yes, I did receive a copy of the report for his

2 Q And what, if anything, did that reveal to you in

3 terms of clinical observations?

4 A That had been performed about three weeks after

5 his accident and it showed AC joint arthropathy, so that

6 his AC joint and --

7 Q Can you point to it on the model?

8 A Absolutely, so the shoulder actually, I will

9 expand on what we talked about earlier, really has three

10 joints, three parts of it that help with motion.

11 One is the ball and socket joint that we talked

12 about that's pretty basic. Most people think about that,

13 but then there is also the acromioclavicular joint.

14 So your collarbone where it actually joins the

15 acromion which is the part of the shoulder blade, the

16 shoulder blade has this little bony projection, you can

17 kind of knock on on top. Then there is the collarbone

18 that attaches there.

19 The third part of the joint is actually your

20 shoulder blade that moves on your rib cage also, so in

21 this case, this joint here, between the collarbone and

22 the acromion had some -- some arthritis, some changes

23 there.

24 Q Let me ask you this.

25 If he got hurt in July, would you expect the

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2 arthritis in the MRI two or three weeks later?

3 A Not as a result of the accident, but yes, it was

4 there.

5 Q Now, you tried to get the MRI from the incident

6 with the weightlifting?

7 A Correct.

8 Q You didn't get that, right?

9 A No.

10 Q Now, someone with his medical history, if you

11 were going to recommend surgery, would you have to get

12 what's called medical clearance?

13 A I would start by saying that with someone of his

14 medical history, I would do a lot to avoid surgery.

15 So one thing that you mentioned in passing which

16 stands out to me and maybe not everybody here is that a

17 normal ejection fracture of the heart is 65 percent, so

18 that's really how much blood the heart pump can basically

19 spit into the arteries or the aorta.

20 His was half of that, so this is a patient that I

21 would really push as much as I can to get better without

22 surgery.

23 Q Well, the physical therapy had been done and

24 didn't really improve, correct?

2 Q So did you see him again after your initial visit
3 in October of 2012?
4 A I did.
5 Q And what was the result, did you again do a
6 physical exam, did he have complaints, tell us?
7 A So I saw him again on December 11, so about five
8 months after his injury. He continued to have pain in
9 his shoulder.
10 I had previously diagnosed him as having post
11 traumatic impingement as I had mentioned earlier, so
12 swelling in between those two bones and AC joint
13 arthropathy. He was painful in that joint on the top of
14 his shoulder.
15 Again, it was post traumatic, not in that the
16 arthritis happened as a result of the accident, but it
17 wasn't painful, it didn't bother him before the accident,
18 but after the trauma, so post traumatic, it was
19 symptomatic, so anyway, he was still having symptoms.
20 I checked his impingement signs --
21 Q Can you tell us, did you do range of motion
22 testing, what did you find?
23 A I did. So his range of motion still was
24 decreased and, in fact, was worse than when I had seen
25 him two months earlier, so instead of this being normal,

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2 instead of the 110 or so that he had during his first
3 visit, now, he was just basically able to reach to
4 shoulder level.
5 His abduction was a little lower by five degrees
6 and now instead of being able to reach to his waist line,
7 he could only reach to his buttock behind his back.
8 Q So he was not really improving, is that a fair
9 statement?
10 A Very fair. He was getting worse.
11 Q And he still complained of pain, correct?
12 A Yes.
13 Q Still had trouble sleeping?
14 A Yes.
15 MR. McGUINNESS: Leading.
16 THE COURT: Yes.
17 Q At that point in time, since we were now five
18 months after the accident, what, if anything, did you
19 recommend to Mr. Carter?
20 A So at that time he had had the previous physical
21 therapy that had not gotten better, so I told him that
22 probably -- I told him that his only option to change
23 his shoulder would be surgery.
24 Q Did he, in fact, agree?

2 Q Did you also have to do what's called medical
3 clearance with regard to Mr. Carter?
4 A Yes, so part of the discussion was that -- any
5 surgery for him would be risky, given his heart
6 condition, so that there were risks of having the
7 surgery.
8 I took this very seriously and, obviously, he did
9 as well and he would have to see his heart doctor and his
10 other doctors to basically make the surgery as safe as
11 they could in terms of any adjustments of medications, et
12 cetera.
13 Q Did there come a time in January of 2013 when, in
14 fact, you did perform the surgery on his shoulder at
15 Lenox Hill Hospital?
16 A Yes.
17 Q And you can refer to your operative report.
18 A Right. So the surgery was on January 21, 2013.
19 Q Can you tell us what a pre-op diagnosis is?
20 A Preoperative diagnosis is basically a diagnosis
21 you have made before the surgery, so the reason why the
22 patient required the surgery and why you are there.
23 Q Can you tell us what a post-op diagnosis is?
24 A So the postoperative diagnosis, post-surgery or
25 postoperative, after the surgery, once you have more

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2 information, i.e., what you found at the time of the
3 surgery, then you can prepare postoperative diagnosis,
4 you know it now. You have that information, so that's
5 the diagnosis given everything you found at the time of
6 surgery.
7 Q Well, let me ask you this, on the CT scan, did it
8 show any tearing of the labrum or any tearing of the
9 rotator cuff or any tearing of any other parts of the
10 shoulder that you saw?
11 A No, it didn't, and I wouldn't expect a CT scan to
12 show those items.
13 Q Tell us why, I know you briefly described --
14 A We talked about it earlier, so again, it doesn't
15 look at soft tissue and it doesn't look at the rotator
16 cuff or at the labrum or those other structures.
17 They are seen almost as small mild shadows that
18 you can't really make interpretations of, not enough to
19 make that kind of diagnosis.
20 Sometimes, previously, before the days of MRIs,
21 they used to inject dye into a shoulder and take a CT
22 scan or an x-ray and if that dye leaked out, then there
23 was an inference that yes, there is a tear, but even that
24 tear has to be a full thickness tear, it has to be

2 Q You used the term full thickness tear.
3 What is the difference between a full thickness
4 tear and a partial tear?
5 A I usually tell my patients that imagine the
6 tendon, let's look at this tendon, as having a certain
7 thickness to it and I actually use the description of a
8 sandwich, let's say, and then we can talk about slices of
9 bread and whatever floats your boat in between the slices
10 of bread.
11 So let's call it salami and so a partial --
12 let's say a full thickness tear goes through the whole
13 sandwich. It goes through the bread, through the meat
14 and through the second slice of bread.
15 That full thickness tear could be small, it could
16 only be -- let's say if this is the tendon, it could go
17 through one finger's worth or all fingers and be a very
18 large tear, but full thickness goes through the whole
19 sandwich.
20 A partial thickness tear would only go through
21 something less than the full sandwich. It might be one
22 slice of bread or the bread and the meat, or even -- it
23 could be up to 80 percent thickness, so through half the
24 second slice of bread, but it doesn't go all the way
25 through. It's not full thickness.

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2 Q When you did your surgery, doctor, on
3 Mr. Carter's right shoulder, did you find any tears?
4 A I did.
5 Q How many tears did you find?
6 A I found a partial tear of the rotator cuff tendon
7 and then I found two tears of the labrum, so that's the
8 -- kind of the cartilage structure around the socket.
9 Q Do you have an opinion with a reasonable degree
10 of medical certainty -- I want you to assume that
11 Mr. Carter's shoulder was asymptomatic prior to July 3,
12 2012.
13 A Okay.
14 Q Do you have an opinion within a reasonable degree
15 of medical certainty as to whether the tears that you
16 found in his shoulder were as a result of the accident of
17 July 3, 2012?
18 MR. McGUINNESS: Objection.
19 THE COURT: Overruled.
20 A I do have an opinion.
21 Q What is that opinion?
22 A That they were caused by the accident in which he
23 was involved on that date.
24 Q Now, just briefly, you said you found a superior

2 A Yes.
3 Q Can you show us on the model and what does that
4 affect in terms of motion, if it's possible?
5 A Yes, so, it's actually tough on this model, but,
6 again, we talked about the socket, so I can't take the
7 ball out of the way, but the socket, we look at it almost
8 like a clock face and it's kind of oval in shape.
9 We talk about the superior here or the top part
10 of the labrum or the bottom or inferior and then anterior
11 and posterior, so front and back.
12 So in this clock face, he had a tear at the top
13 of the shoulder and the front of the shoulder, so two
14 separate labral tears.
15 In terms of motion, it's through pain and
16 inflammation that the motion is restricted, but you could
17 theoretically have a labral tear and have good motion of
18 your shoulder.
19 Q Well, does the motion deficits that he exhibited
20 to you when you examined him correlate to the tears that
21 you found in the surgery?
22 A I would actually submit that the range of motion
23 deficit more closely is a result of the rotator cuff tear
24 so the third tear that he has, but the labral tears
25 certainly completely impacted in terms of inflammation

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2 and pain.
3 Q But taken together, all of those tears didn't
4 help him, right?
5 A No, not at all.
6 Q It limited his range of motion?
7 A Yes, again, the limitation on lifting came
8 through a couple of different mechanisms. One is from
9 the rotator cuff tear and the subacromial inflammation,
10 but then further pain with that motion also kept limiting
11 him and that's why it kept getting worse.
12 Q I'm going to briefly go through your operative
13 report, if you can, go to Page 2, so you can tell the
14 jury and the Court what you did, when you made the
15 incision.
16 Why don't you start at the top where you used a
17 number 11 blade, tell us what you did?
18 A Sure. So an arthroscopy basically uses a small
19 camera or arthroscopy which we insert into the joint and
20 while looking there, we are able to insert other small
21 instruments through other incisions, so we are doing this
22 through the skin rather than a big open incision.
23 So I started with a posterior incision, so I made
24 my first incision, inserted the camera and was able to

2 socket that I showed you on the model. We started there
3 and I just take an initial look at the structures I find.
4 So I found that the cartilage inside the joint
5 was fine, there was no evidence of arthritis in the main
6 part of his joint but there were tears of the labrum that
7 I found as I described to you at the top and in the front
8 of the joint. The biceps tendon was okay.
9 Q Doctor, let me stop you for one second.
10 Did I ask you to bring with you color -- did you
11 take intraoperative photos?
12 A I did.
13 Q On this iPad, are these copies of your
14 intraoperative photos?
15 A They are.
16 Q Would it be helpful if you used this to show the
17 jury what you did, again, if you can step off. I have
18 shown this to counsel.
19 MR. McGUINNESS: Is there some way to
20 designate what specific photo on the panel?
21 THE WITNESS: I will call them out if you
22 like.
23 MR. BOTTARI: It's the grid, one, two, three,
24 four, five, six, seven, eight, nine.
25 THE COURT: Later on, we're going to have

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1 HOSTIN - DIRECT
2 them duplicated and they will be labeled.
3 A So there is 9, 18, and 22 in total. I will try
4 to give the number.
5 So this initial look is -- remember, the camera
6 is probably about the size of a pen in terms of diameter,
7 in terms of the diameter, so you can only see so much in
8 any one particular time, so you don't get the whole
9 overall picture all at once.
10 Here is the ball or the edge of the ball and here
11 is the top of the socket, so imagine the socket is that
12 clock face or that oval clock face.
13 So here is the top part and some of these little
14 scraggly tissue here is part of the tear and then there
15 is this tear over here which should be attached to this
16 structure.
17 Q Which plate are you pointing to?
18 A That was picture number 1.
19 Also, then picture number 3, again, kind of a
20 more central look, so here is the ball, here is the
21 socket on the bottom. This is all cartilage, so if you
22 eat chicken, opened up like a chicken joint, the white
23 cap at the end of the bone, that's cartilage and we have
24 similar cartilage, so that looked good.

2 of coming in between the two bones. This is actually the
3 biceps tendon coming in which I mentioned as normal.
4 Q Can you refer to the grid on the chart so we know
5 what we are talking about?
6 A The biceps tendon normal image is image number 5
7 and then in image number 9, this is actually a picture
8 of, again, here is the ball, here is the socket here,
9 here is the torn labral tissue.
10 This is sort of one of these instruments that we
11 use. It's actually kind of a rotary tool, a rotary tool
12 that turns, has some teeth and is able to grab the tissue
13 and then it has a suction device on the other end that
14 brings whatever we debrided off out of the joint.
15 Q What do you mean by debrided?
16 A Cleaned up, so you remove the stuff that you
17 don't want, so you can tell your kids to debride the crap
18 out of their room.
19 This is picture number 13, so here is the top
20 part of the glenoid -- actually, this is a great shot,
21 with the biceps, the normal biceps coming in, but the
22 superior labrum is here.
23 You can see it's very ratty, we cleaned up part
24 of it but still had to smooth it out a little bit more.
25 I am also demonstrating in that same picture that

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2 there is some separation between that top labrum from the
3 bone, this is another component of the tear.
4 Then up top, so image 17, now, I'm in the
5 subacromial space, rather than being inside the joint
6 where I would be between the socket and the ball, I am up
7 in this space now.
8 We can actually take the camera out and then
9 insert it through the same initial incision, but now into
10 another space on the top of the shoulder -- the top of
11 the rotator cuff and there was a tear there, you could
12 see this hollow here, that's the image --
13 MR. McGUINNESS: Which image?
14 A Same image I called out which I think was 17.
15 Again, that same instrument, the shaver, coming
16 in to remove the loose stuff, but the remainder of the
17 tendon was okay so I left that behind.
18 Then the last thing that we did which is also
19 standard for this type of problem is the resection of the
20 distal clavicle, so that's going to be images 19 --
21 Q Can you define resection?
22 A I'm going to in a second. 19 to 22.
23 So with these issues, remember the one I
24 mentioned between the collarbone and the top of the

2 the joint when all else fails is to actually remove a
3 part of the bone, so that the two bones don't touch
4 anymore.

5 This is a very accurate model. There are two
6 ligaments that actually hold the collarbone in place, so
7 even by removing that bit of bone -- I didn't want to
8 freak you out, by removing that sliver of bone, you avoid
9 the contact between these two bones, but it still remains
10 stable there.

11 So this is the end of the collarbone, so this
12 little -- actually, it looks like an English muffin,
13 like Thomas' English muffin, like nooks and crannies,
14 that's the end of the bone after we have resected that
15 bit, so -- that's it. Again, that's 19, 20, 21 and 22.

16 Again, different angles just because I have to
17 remove a pretty -- I have to know how much I am
18 resecting.

19 After I resected it, I insert a small cannula, a
20 little tube which I know the size of and that helps me
21 measure and make sure I remove the appropriate amount.

22 Q Doctor, how much did you remove?

23 A Ten millimeters, so a centimeter of the bone, a
24 little under half an inch.

25 Q Have you basically told us what you did during

2 remove a little bit of the bottom of this bone, the
3 acromion, so that's called an acromioplasty.

4 So by making the space bigger and removing the
5 swollen tissue from that space, we allow for more motion
6 again or, hopefully, for pain free motion after
7 appropriate therapy.

8 Q Now, after you finished with this operation, what
9 is generally the recovery time for a person who had an
10 operation like Mr. Carter?

11 A With appropriate therapy and coaching, probably
12 about three to six months, depending on the person.

13 Q Is the rehab for shoulder surgery pain free?

14 A No.

15 Q Can you describe what a general rehab for
16 shoulder surgery entails?

17 A A surgery -- so we are operating in this case
18 for someone who has had trauma to the shoulder, trauma,
19 injury, et cetera, but surgery is really, in essence, a
20 controlled trauma, so it's not normal to have these
21 instruments in your shoulder, so it causes swelling in
22 and of itself.

23 The shoulder is very unique amongst other joints,
24 let's say, just compared to the knee, that it can really
25 generate a lot of inflammation after these surgeries, so

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2 your operation in the last few minutes?

3 A Yes. We actually trimmed -- I skipped one other
4 part. So, also, the other issue with impingement, we
5 talked about impingement, so when you lift the arm up, it
6 kind of pinches that space.

7 So there are two ways to resolve that. One is to
8 remove anything swollen that's not necessary, so part of
9 what causes impingement is bursitis.

10 If you ever heard of term bursitis, the bursa is
11 kind of a general structure that we have in multiple
12 parts of our bodies and I call it God's natural WD-40 so
13 it's kind of a flat tissue.

14 Imagine putting a little mineral oil inside a
15 balloon and just letting it stay flat. You can imagine
16 that that's very slippery and it would keep things from
17 rubbing against each other.

18 In the event of trauma or injury, that bursa can
19 become swollen and irritated and so that's part of what
20 causes the inflammation in this space that we talked
21 about, so we do two things to help that.

22 So I removed the bursa, so, again, that little
23 shaver instrument we insert in there, we remove the
24 bursa, but we also take that other instrument, the burr

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2 getting the shoulder moving right away is very important.

3 Specifically, what does the therapy entail,
4 moving the shoulder, both -- sometimes with a passive
5 machine, imagine a chair that has a little outrigger --
6 little motor that you attach to the arm, you press a
7 button and it kind of helps move it to keep it from
8 getting stiff.

9 Therapists keep you moving. You move it in all
10 directions, so not just to scratch your head, but you
11 have to get your arm above your head.

12 He restores your range of motion, but once you
13 got your motions a little bit better, you have to restore
14 strength. You do a little strengthening, let's say,
15 lifting weights or pulling or pushing against bands for
16 resistance.

17 Q Let me ask you this, did Mr. Carter have any sort
18 of follow-up visits with you, doctor?

19 A He had a couple. After the surgery, I saw him
20 -- so the surgery was January 21, 2013. Then I saw him
21 on February 5, 2013.

22 Things looked appropriate so the incisions that I
23 had made looked like they were healing appropriately and
24 I gave him a prescription to begin physical therapy and

2 Q Did he, in fact, see you in the next four weeks
3 as you requested?
4 A No.
5 Q By the way, at the February 5, 2013 visit, did
6 you do any range of most testing or too soon to do it?
7 A You know, I do a little bit of testing and I
8 get an idea in my head of where this patient is headed.
9 In terms of someone who has full range of motion
10 a week or two after surgery, I don't worry about too much
11 and then patients who are very stiff and hesitant to even
12 move, I read him the riot act and explain the importance
13 of getting the shoulder moving, so yes, I do a little bit
14 although I don't normally document it.
15 Q Did you see him again at some point in time over
16 the next year or so?
17 A Yes. I saw him again on April 8 of 2014.
18 Q At that point in time, did you examine him?
19 A I did.
20 Q What, if anything, did your examination show?
21 A So I always check the AC joints, so when we
22 remove that part of clavicle, I check that area. He was
23 not tender there, and I checked his range of motion which
24 was better than before his surgery, but not normal.
25 Q Let me ask you this, the forward flexion that you

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2 had when you originally saw him was 110 and 95, correct?
3 A Yes.
4 Q When you saw him April 8, 2014, which was
5 approximately fifteen months after the accident -- after
6 your surgery, doctor, what did the forward flexion
7 measurement show?
8 A He had forward flexion of 120, so that's 90, it
9 was about 120.
10 Q Normal is 170, 180, that's what you said?
11 A Correct.
12 Q So in your opinion within a reasonable degree of
13 medical certainty is his range of motion with regard to
14 forward flexion of his right shoulder, is that decreased
15 permanently?
16 MR. McGUINNESS: Objection, your Honor.
17 THE COURT: Overruled.
18 A It is my experience if this is the range of
19 motion a year after, a year or after surgery, that that's
20 what they are going to get. It's permanent.
21 One could try further surgery to try to advance
22 range of motion. There are various ways to do that, but
23 without that, this is permanent.
24 Q And that's about -- 170 or 180 is normal, that

2 A Approximately, yes.
3 Q With regard to abduction, you found 90?
4 A Yes.
5 Q How does that relate to normal?
6 A That's normal.
7 Q With regard to internal rotation, he was now at
8 L-4, that's up one on the back?
9 A A little bit more above his waist, but not quite
10 normal, although I will admit I usually compare it to the
11 other side and I don't have his other readings there, but
12 that's not -- that's diminished.
13 Q That would be permanent at this point in time?
14 A Yes.
15 MR. McGUINNESS: Objection.
16 THE COURT: Overruled.
17 Q And with regard to external rotation, you found
18 what, 50 degrees at normal being 80?
19 A No, so that is -- my external rotation, I
20 measured in two rotations, the elbow down and elbow up,
21 so the elbow down normal is 60, his is at 50. With the
22 elbow up here, normal is 90 and he was at 80.
23 Q So he has some slight diminution, less than --
24 A In rotation, yes.
25 Q And that also would be permanent at this point in

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2 time, about a year out?
3 MR. McGUINNESS: Objection.
4 A Yes.
5 THE COURT: Overruled.
6 Q Doctor, do you have an opinion with a reasonable
7 degree of medical certainty given your examination of
8 him, Mr. Carter, two times before your surgery, given the
9 history of the accident as told to you, given the
10 mechanism of injury, given the complaints he expressed to
11 you, was he unable to perform his usual and customary
12 duties in the three months out of the six months after
13 July 3 of 2012?
14 MR. McGUINNESS: Objection.
15 THE COURT: Overruled.
16 A He had significant disability in the shoulder so,
17 yes, he came to see me three months after the surgery --
18 excuse me, after the accident and was debilitated at that
19 time and I continued to see him for another almost three
20 months until he had surgery and he was even further
21 debilitated, so certainly, that was more than ninety
22 days, so, yes, he did have great difficulty and could not
23 do normal activity with that shoulder.
24 Q When you say normal activity, just so the jury

2 A So things -- activities of daily living, for
3 one, things like reaching behind your back, getting a
4 wallet out of your pocket, getting a dish out of the
5 cupboard, sleeping without having to do gymnastics to
6 find the right position and then lifting, just lifting
7 anything above shoulder level, those are other things
8 that are very difficult with these type of injuries.

9 Q Given the findings that you made on your
10 follow-up exam in April of 2014, would those type of
11 things be permanent at this point in time?

12 MR. MCGUINNESS: Objection.

13 A Can you repeat?

14 Q Sure. Given the findings that you made in April
15 of 2014, were those range of motion and some activities
16 of daily living be limited on a permanent basis?

17 MR. MCGUINNESS: Objection.

18 THE COURT: Overruled.

19 A Yes.

20 Q And all of the opinions that you have given us
21 here today are within a reasonable degree of medical
22 certainty?

23 A Yes.

24 Q Can you give us one last time, the basis of your
25 opinions?

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2 A Again, this is a gentleman who before July 3 of
3 2012 had a prior injury, but was better and was normal up
4 until July 3. He was asymptomatic.

5 After July 3, 2012, and until he saw me and even
6 beyond that, he continued to be symptomatic in the
7 shoulder, just from a time standpoint, this was just
8 after the accident, it was clearly a result of the
9 accident.

10 Then as we mentioned beyond that, his range of
11 motion has not increased beyond 120, forward flexion, a
12 year and a few months after the surgery and as I
13 mentioned, I have been doing this for a long time and
14 that's kind of the end of the road. It's not going to
15 improve any further without very aggressive measures.

16 Q Do you have an opinion as to whether he may need
17 pain medication in the future because of the injuries to
18 his shoulder?

19 A I do.

20 Q What is that?

21 A This is definitely something that will require
22 anti-inflammatories intermittently.

23 Hopefully, he has not gotten into opioids for
24 this as it is chronic so I hate to put patients on

2 I recommend.

3 MR. BOTTARI: I have nothing further.

4 THE COURT: We will take a ten-minute recess.

5 Don't discuss the case.

6 (Jury exits courtroom.)

7 (Recess taken.)

8 (Jury enters courtroom.)

9 THE COURT: Please be seated. You may
10 continue.

11 MR. MCGUINNESS: Thank you, your Honor.

12 CROSS EXAMINATION BY

13 MR. MCGUINNESS:

14 Q Dr. Hostin, my name is Dennis McGuinness. We
15 have never met before today?

16 A No.

17 Q What I would like to do for the jury is maybe
18 define some terms and some concepts for them.

19 You are familiar with something called an
20 objective finding?

21 A Yes.

22 Q And objective means it's something that you can
23 see, you can feel, you can determine through the use of
24 your own senses?

25 A Correct.

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2 Q You can determine its existence, you can verify
3 it is there, completely independent of anything that the
4 patient tells you?

5 A Correct.

6 Q For example, if there is a deformity, you can see
7 that; if there is bruising or ecchymosis, you can see
8 that; if there is swelling, you can see that, correct?

9 A Yes.

10 Q And there is some testing that's done that's
11 generally regarded as objective, I'm trying to keep this
12 in lay terms, an x-ray, that's an objective test,
13 correct?

14 A Yes.

15 Q CT scan, that's considered to be an objective
16 test?

17 A Yes.

18 Q An MRI, similarly, is considered to be an
19 objective test?

20 A Yes.

21 Q I mean, some radiologists may read things a
22 little bit differently and there, you are talking about
23 something called interobserver variability?

24 A Yes.

2 at something, see the same thing, but call it something
3 different?

4 A Agreed.

5 Q And you are aware that there is some effort
6 between radiologists to standardize the language that
7 they use based on findings, correct?

8 A Yes.

9 Q Now, you contrast things and reject things that
10 are subjective, it's completely the opposite, a
11 subjective complaint, let's say the patient says, I feel
12 numbness, you can't verify that it exists independent of
13 what the patient tells you, correct?

14 A I don't know that that's a great example, but
15 there are EMGs that measure lack of feeling but --

16 Q That's an objective test for lack of feeling, but
17 the statement that the patient makes, that's purely
18 subjective?

19 A Correct.

20 Q Similarly, if a patient says, I feel pain, you
21 can't verify its existence independent of what the
22 patient tells you, you are entirely dependent on the
23 patient's word?

24 A Correct.

25 Q You are entirely dependent on the patient's

2 passive range of motion numbers that I am giving you.

3 Q In all cases where you are manipulating the
4 patient?

5 A That's how I do it, yes.

6 Q You don't just simply ask them to raise their
7 hands or lift their hand, you are actually moving it?

8 A I am.

9 Q So the jury understands, if you ask a patient to
10 do something and they go, well, I can move it this far,
11 that's dependent somewhat on the patient's effort?

12 A Yes.

13 Q If they move it far, I can't move it any further
14 because it hurts, that end point is subjective?

15 A I completely agree.

16 Q So active range of motion testing is subjective,
17 correct?

18 A Yes.

19 Q Passive range of motion is generally regarded to
20 be objective?

21 A Correct.

22 Q Now, you talked about normal values. That's for
23 the population at large, correct?

24 A Yes.

25 Q In order for you to determine that a specific

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2 perception?

3 A Yes.

4 Q You are entirely dependent on their motivation?

5 A Yes.

6 Q Now you talked about doing range of motion
7 testing?

8 A Yes.

9 Q And there is basically two types of range of
10 motion testing, active range of motion testing and
11 passive range of motion testing, correct?

12 A Yes.

13 Q And active is from the standpoint of the patient,
14 active range of motion testing, the patient is active;
15 passive range of motion testing, the patient is passive,
16 correct?

17 A Well, I will -- just to clarify, active means
18 yes, they are using their muscles to move their arm.
19 Passive means that the examiner -- I as the examiner am
20 moving their arm.

21 Q With passive range of motion, normally, when you
22 do range of motion testing for, let's say, range of
23 motion of a shoulder, neck or back, you use active range
24 of motion, correct?

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2 patient has lost something, you need to know what their
3 baseline range of motion was, correct?

4 A Within reason, so there are some range of motion
5 that are so much an outlier that it has to be abnormal or
6 diminished, but yes, the ideal situation is for me to
7 know --

8 Q What it was before?

9 A What it was before.

10 Q And you mentioned earlier that you liked to do
11 both sides of the body?

12 A Correct.

13 Q Because that's an indication of what their
14 baseline is?

15 A Yes.

16 Q And you weren't able to do that for Mr. Carter?

17 A Well, you know what, I know I did it, I just
18 didn't record it, but my norm is to measure both at the
19 same time. I'm not sure why I didn't record it.

20 Q But when you do that, when you do range of
21 motion, I mean, the whole idea, you can have a patient
22 whose base normal may be 170, 180, but because of
23 conditions, wear and tear, whatever else is going on in
24 their lives, their baseline could be 150?

2 Q You are talking about degrees, you got 360
3 degrees in a circle in 60 minutes, so each little minute
4 tick mark is six degrees, right?
5 A Okay.
6 Q So when you talk about a 10 degree loss, you are
7 talking about less than the difference between 12:00 and
8 12:02 which would be 12 degrees?
9 MR. BOTTARI: Objection.
10 THE COURT: Sustained.
11 Q It's simple math.
12 A I'm sure those are 12 degrees there, yes.
13 Q You talked a little bit about arthritis and
14 joints. Can you explain to the jury what arthritis in a
15 joint is?
16 A Arthritis is the loss or damage to cartilage,
17 that white cap that I showed you in the pictures, within
18 a joint, so such that the bones or the pressure now
19 between the bones is not diminished by that cartilage
20 anymore and there is increased pressure between the
21 bones.
22 Q Now, there are two different kinds of cartilage.
23 One is hyaline cartilage and that's the cartilage that
24 you would find like in the chicken leg?
25 A Yes.

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1 HOSTIN - CROSS
2 Q And it's also the same kind of cartilage that you
3 find on the humeral head?
4 A Yes.
5 Q It's the same kind of cartilage that you would
6 have in the AC joint, there is actually normally
7 cartilage in there?
8 A There is some cartilage there.
9 Q And it's actually a joint, there are ligaments
10 which are bone to bone connections, they form a capsule
11 around it, correct?
12 A Yes.
13 Q And there is actually fluid in there to
14 lubricate, synovial fluid within the joint?
15 A Yes.
16 Q And what happens over time is as this joint works
17 or as we age, the cartilage wears away; is that correct?
18 A Yes, that's right.
19 Q And as it wears away, we can develop arthritis or
20 arthrosis or bone spurs as a result of the wearing away
21 of the cartilage?
22 A Are you speaking specifically of the AC joint in
23 this instance?
24 Q Well, yes.

2 over time, some of that cartilage may wear, but the thing
3 that I would add is that it's very, very common for a
4 patient in their studies, whether it be a CT scan or MRI,
5 to see arthritic changes or things that are called
6 arthritis in that joint, but it is much less common for
7 that joint to actually be symptomatic.

8 So although those changes may be present, I see
9 them all the time in these reports in patients who have
10 no symptoms in that area and so it's very common,
11 especially in that particular joint, to have a patient
12 who has zero symptoms with x-ray or CT or even MRI
13 evidence of arthritis in that joint.

14 Q Similarly, I mean, they have done studies of
15 cadavers where a hundred percent of the cadavers have had
16 rotator cuff tears on one side of their body and seventy
17 percent of them have rotator cuff tears on both sides of
18 the shoulders, correct?

19 A Yes.

20 Q I mean, these are people in the sixth decade of
21 life, in their fifties, who have never had any injury to
22 their shoulder, correct, no history?

23 A They are dead.

24 Q I know they're dead now.

25 A How do we know?

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2 Q Presumably, there is a medical chart that
3 followed them with them, correct?
4 A I don't know the exact detail of that particular
5 study. There are certainly studies that show, yes, in
6 patients who have been deemed asymptomatic, they have
7 pathology, but I'm not sure that I can comment any
8 further on that study.
9 Q To some extent, we are all going to get them?
10 A To a certain extent, but at the same time, I
11 don't have a door where everyone coming off the street
12 comes in to see me, not everybody has that kind of
13 pathology that they require medical care.
14 So yes, we are all going to degenerate to a
15 certain degree, but I wouldn't say everybody comes up
16 with arthritic knees or shoulders.
17 Q I'm not saying everybody goes and sees a doctor.
18 A Right.
19 Q But the studies indicate that we're going to have
20 them and may never see a doctor, fair enough?
21 A I'm not sure that I would agree with that
22 conclusion from that study especially without having
23 looked at it.
24 Q When you've got this formation of bone that

2 are talking about a process that takes years, decades,
3 correct?
4 A Maybe not decades, but it can be years.
5 Q Several years?
6 A Okay, yes.
7 Q I mean, it's not going to occur in the 21 days
8 between the accident and the -- when the CT scan was
9 done here?
10 A I completely agree with that.
11 Q In all probability, that CT scan would have
12 looked the same if it was taken the day before the
13 accident?
14 A I agree.
15 Q You've got -- you have Mr. Carter's report in
16 your file, you had an opportunity to review it?
17 A I have it right here. It specifically says mild
18 DJD.
19 Q Degenerative joint disease --
20 A Yes.
21 Q -- of the AC joint, acromioclavicular joint?
22 A Yes.
23 Q They don't find any soft tissue swelling?
24 A It says no soft tissue masses are present.
25 Q But they don't find any indication of swelling or

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2 that this is larger or there is any edema there?
3 A It says no soft tissue masses are present, yes.
4 Q But you know when they do the image, you know
5 pretty much, they are looking at the whole thing in the
6 absence of a statement of a finding as the swelling is
7 usually pretty indicative that it wasn't there?
8 MR. BOTTARI: Objection.
9 Q Correct?
10 THE COURT: He can answer that, if you can.
11 A Yes, you know, I will be honest with you, so part
12 of training in orthopedic surgery in general is to also
13 review studies, and I often review studies and find
14 things that are not commented on by the radiologist for
15 whatever reason.
16 Now, I will admit, I didn't look at this
17 particular study because what I was interested or what I
18 was concerned about I knew would not be demonstrated in
19 this study, but just maybe radiologist X, in this case,
20 Michael Hughes, didn't mention anything or didn't mention
21 a particular thing doesn't mean to me that it doesn't
22 exist. I just -- so I wouldn't --
23 Q At the same time, you didn't ask for the study to
24 read it yourself or ask for a reread as to anything,

2 A Correct, but, again, I'm seeing the patient,
3 whether there is swelling on the CT scan three months
4 before he saw me wouldn't change how I would treat the
5 patient.
6 Q I agree, you are here and now, you're doing --
7 A Yes.
8 Q When you -- you talked about one of the -- the
9 differences between CT scans and MRIs, one thing the CT
10 scan is good for is detecting iron or blood, correct?
11 A It can if there is a hemarthrosis in the joint.
12 Q Or --
13 A It's not great, but it may show some slight
14 differences within the capsule if there is blood, for
15 example.
16 Q But it's better than an MRI for detecting blood,
17 for example, someone has a stroke and there is a bleed in
18 their brain, give them a CT scan to determine whether or
19 not there is a bleed?
20 A I don't agree with that.
21 Q You don't?
22 A No. I think that when you're looking for
23 expansion -- they infer things, so there is hollows, so
24 the big contrast between parts of the brain, the soft
25 tissue and the lacunae and a bleed, it's just going to

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1 HOSTIN - CROSS
2 look different and for their purposes, the CT scan is
3 better, but I don't know that that means it's better at
4 looking at iron or so, but --
5 Q But one of the first things you should do with
6 someone who has a stroke is to determine whether there is
7 an intracranial bleed?
8 A Yes, but that's not to say that the CT scan is
9 looking at blood per se. It's looking at blood's ability
10 to move the soft tissues and expand, so it's looking for
11 an expanse of a lesion and not at blood per se and so,
12 that could be tumor, it could be blood, it could be
13 edema.
14 Q Fair enough. When you -- one of the things you
15 talked about, you talked about a hemarthrosis.
16 We have got blood going all through our body, but
17 we don't find blood in joints; is that correct, normally?
18 A Normally, no.
19 Q When you do surgery, one of the things that you
20 try real hard to do is maintain what you call meticulous
21 hemostasis, right?
22 A Okay.
23 Q You don't want blood where it's not supposed to
24 be?

2 Specifically, meticulous hemostasis, so when we are doing
3 an arthroscopy, one thing I may not have mentioned, it's
4 done with water.

5 You're looking at items, so you can imagine if
6 you had any bleeding in there, you can't see, you can't
7 do the procedure, so we need hemostasis.

8 We do different things to maintain that including
9 increasing the pressure of the water. We decrease the
10 patient's blood pressure sometimes, ask the
11 anesthesiologist to do that, so those things kind of keep
12 the blood at bay.

13 When we do an open surgery, the reason for
14 hemostasis is not that the blood is unhealthy to the
15 joint, but you don't want to leave after you have done
16 your surgery and have things continue bleeding in there.

17 Q That's right.

18 A So it's more so that you don't have problems
19 afterwards, not that the blood itself is poisonous or
20 something to the joint, sir.

21 Q But it is inflammatory to a joint?

22 A It can be to a certain degree, but, again, it's
23 not a dangerous thing.

24 For example, if I have a patient who comes in, in
25 the standard of care, if a patient comes in with blood in

2 and adhesions, correct?

3 A Again, these adhesions and scar tissue come from
4 the trauma and the torn tissues, not the fluid or the
5 blood.

6 Q You're saying that scar tissue isn't a reaction
7 to the irritant of blood in the joint?

8 A Well, for example, if I took blood out of a
9 patient's arm and I inject it into the joint, that's not
10 going to cause an inflammatory response.

11 In fact, it's a treatment that we use for things.
12 People are taking blood out of patient's arms, it's
13 called RPR, and injecting it into the joints to treat
14 arthritis, so I kind of disagree with your statement.

15 It's not the blood per se. It's the trauma.
16 It's the tears that occurred.

17 Q Now, you talked about the -- just to kind of
18 clarify a couple of things, the bone in the upper arm,
19 that's the humerus?

20 A Yes.

21 Q And at the top of it, the ball, that's what's
22 called the humeral head?

23 A Yes.

24 Q Now, you talked about the shoulder blade?

25 A Yes.

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2 the joint, the correct treatment is not necessarily to
3 pull the blood out as if oh, my God --

4 Q I'm not suggesting that.

5 A Okay.

6 Q What I'm saying, there is an inflammatory cascade
7 that happens when you get some blood in the joint,
8 correct?

9 A I would submit to you that the inflammatory
10 process has happened because of whatever trauma that
11 happened that causes blood to be in the joint.

12 So blood in the joint usually comes because
13 something is torn and so the blood -- but sometimes,
14 it's not blood. Sometimes, it's fluid, and serous fluid
15 brings inflammatory cascade -- I can't remember the
16 terms, markers, but it's not necessarily blood itself.
17 It's in the fluid.

18 Q But one of the things, let's say you have serous
19 fluid that does enter the joint, it wouldn't be uncommon,
20 let's say, over the time of an injury over the next hour
21 or two hours to have a joint become very swollen and
22 painful over a period of time, correct?

23 A It can, yes.

24 Q Now, the other problem is serum or blood, if it

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1 HOSTIN - CROSS

2 Q And that's the scapula?

3 A Yes.

4 Q And on the side of the scapula is a small like
5 you said like a T, that's called the glenoid?

6 A Yes.

7 Q That's lined with hyaline cartilage?

8 A Yes.

9 Q Around the glenoid is fibrocartilage, correct?

10 A Called the labrum, yes.

11 Q Labrum, but it's made up of fibrocartilage, there
12 are actual fibers around?

13 A Yes.

14 Q And when you did your surgery and you had
15 examined him, what you found was, you didn't find any
16 tear where this was broken completely loose and you have
17 to go with anchors and reattach it to the bone, correct?

18 A Yes, if it was completely detached.

19 Q But you didn't find that in Mr. Carter's case?

20 A No.

21 Q You were able to go in there with a shaver and
22 whisk away the broken fibers?

23 A Well, I don't know that I would say whisk away.

24 Q Debride?

2 Q Fine, but use a rotary device and you remove
3 them, fair enough?
4 A Yes, yes.
5 Q Similarly, when you examined the bursal surface
6 of the rotator cuff, it wasn't a through and through
7 attachment?
8 A Detachment.
9 Q Or through and through tear, there were fibers
10 there and you debrided them using the same burring
11 device?
12 A Yes.
13 Q You didn't have to go in there and surgically
14 repair the rotator cuff itself?
15 A Yes, I didn't have to reattach.
16 Q Or stitch it up or reattach it or something like
17 that?
18 A Yes.
19 Q Now, you can have labral tears by wear and tear,
20 correct?
21 A They look different. They are not -- but yes,
22 you can.
23 Q You can have labral tears happen by fraying, wear
24 and tear by fraying?
25 A Yes, there are different types of tears, that's

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1 HOSTIN - CROSS
2 one type of tears.
3 Q And you can have rotator cuff tears that develop
4 over time without trauma, correct?
5 A They can, yes.
6 Q Now, you mentioned taking a history from
7 Mr. Carter, is taking history important?
8 A It's probably more important for you than it is
9 for me, but it's important.
10 Q I mean, you want to be reasonably thorough?
11 A Yes.
12 Q And I mean, you want to look at things like --
13 you want to know when the onset of complaints were?
14 A Yes.
15 Q You want to know if he has prior treatment?
16 A Yes.
17 Q You want to know if there is prior injuries,
18 prior surgeries?
19 A Yes.
20 Q You want to know his prior medical history, other
21 comorbidities or other illnesses that may impact your
22 decision in care?
23 A Yes.
24 Q You want to know whether or not there are other

2 A Yes.
3 Q Those items are important, are they not?
4 A Yes, although, again, I would state that if I was
5 very -- this gentleman came to me for a shoulder pain
6 and shoulder injury and, for example, the fact that he
7 hurt his neck and back in that same injury, I record,
8 but, for example, it may not be so important, other than
9 potentially maybe his neck can contribute to his shoulder
10 pain, but other than that, not crucial.
11 Q But it's not part of your bailiwick, he was
12 seeing you for the shoulder?
13 A Correct, but you're asking me about history and
14 you are including other things that may -- for example,
15 the day, July 3, to me is not a crucial date.
16 It's more crucial to what's going on here, but
17 the fact that yes, he hurt himself five months, six
18 months -- I'm sorry, three months before he saw me,
19 okay, it hasn't been going on for twenty years or five
20 years, yes, that's important, but --
21 Q Fair enough.
22 A The history is important, yes.
23 Q One of the things you mentioned earlier and one
24 of the things that you would explore in the history is
25 the mechanism of injury, correct?

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1 HOSTIN - CROSS
2 A I didn't explore it more than he was in a car
3 accident.
4 Q So the jury understands, what the mechanism of
5 injury is, basically, how the forces in the world around
6 us acted on the body part to bring about a cause and
7 injury, correct, in simple terms?
8 A Could you repeat the question?
9 Q One thing you're here to answer, just how did the
10 forces that were involved impact the body to bring about
11 or produce an injury?
12 A Yes, that's sometimes a question.
13 Q I'm keeping it in lay terms.
14 A Yes.
15 Q I mean, you know, even though -- you know that
16 if you have certain x-ray findings, even though you may
17 not be able to image the soft tissue, by knowing the
18 mechanism of injury, you know that there are certain soft
19 tissue injuries that would be associated with a
20 particular x-ray presentation?
21 A Yes, and also based on my physical exam, and I
22 would argue with you also that whether this gentleman
23 came to me after a car accident or because he fell down
24 the stairs at his home, I'm still presented with --

2 A -- with his shoulder which hurts and has specific
3 exam findings and I am also handed these CT findings and
4 so, again, the actual mechanism, although sometimes
5 helpful, wasn't that helpful to me in terms of treating
6 him.
7 Q Okay. You're not -- most of the time, doctor,
8 you don't care how and why, you want to just treat the
9 patient, get him better?
10 A Yes. I care a little bit, but yes, but I'm
11 treating the patient and his shoulder today.
12 Q And only in a medical/legal situation do you get
13 involved in the causation issue?
14 A Correct.
15 Q Is part of -- to get into medical school, there
16 are certain prerequisites that you had to take,
17 undergraduate?
18 A Yes.
19 Q You took cases and took courses in basic physics?
20 A Yes.
21 Q Solids, mechanics, properties and materials,
22 things like that?
23 A Yes.
24 Q Your undergraduate degree, is it in engineering?
25 A No.

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1 HOSTIN - CROSS
2 Q Is it in pre-med?
3 A Chemistry.
4 Q Bit of a hard science, but you had to take all
5 this course work?
6 A I did.
7 Q And you are familiar with something called
8 inertia?
9 A Yes.
10 Q And that's the tendency of something -- that's a
11 tendency of a body in motion remaining in motion?
12 A Right.
13 MR. BOTTARI: Objection.
14 THE COURT: I will allow it.
15 Q And a body at rest will remain at rest?
16 A Yes.
17 Q I want to kind of make a visual for the jury. If
18 you're in a car and you are the occupant of the car --
19 A Yes.
20 Q -- and the car strikes a fixed object, the car
21 stops, the seat stops, the body goes forward relative to
22 the car?
23 A If he hits an object.
24 Q Right, hits a fixed object.

2 Q And if you are sitting in an airliner, at the end
3 of a runway and the pilot advances the throttle and the
4 engine revs up and forces from the rear, the plane
5 accelerates, the seat accelerates, the relative motion of
6 the torso is backwards into the seat, correct?
7 A Okay.
8 Q Do you agree?
9 MR. BOTTARI: Objection.
10 Q It's just the law of physics.
11 A But you're not finishing, so there is -- you've
12 also got to think about equal and opposite reaction, so
13 just the same way it goes back into the seat, there is a
14 motion that pushes that person away from the seat.
15 Q And it's the reform -- it's the reform force of
16 the foam in the seat or the metal frame of the seat,
17 correct?
18 A Sure, so --
19 Q All right. Well, now, what do you know about
20 Mr. Carter's accident other than it was a rear end
21 accident?
22 A Nothing.
23 Q Do you know anything about the forces involved or
24 the speeds involved?
25 A No.

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2 Q Did you ever see any photographs of the property
3 damages of the vehicles involved?
4 A No, I did not.
5 Q Now, the history that a patient gives you, that's
6 purely subjective, correct?
7 MR. BOTTARI: Objection.
8 THE COURT: Sustained as to form.
9 Q Generally, a patient's history is subjective?
10 MR. BOTTARI: Objection.
11 THE COURT: Sustained.
12 Q Did you obtain any objective information from
13 Mr. Carter concerning his history?
14 A He told me that -- he described his accident as
15 his being rear ended.
16 Q But now, him telling you, you didn't verify that?
17 A I don't have a videotape of the accident.
18 Q So what he told you was purely subjective?
19 A I wouldn't use that word.
20 Q You are relying on -- you relied on what he has
21 told you?
22 A I relied on his history of the accident.
23 Q And you would agree some patients are good
24 historians, some patients are bad historians?

2 Q Let me ask you this, if an injury to a
3 collarbone, a fracture to the bone, disruption of the
4 bone, in your experience, is that immediately painful,
5 mandatorily painful?
6 A Of a fracture of a collarbone?
7 Q Yes.
8 MR. BOTTARI: Objection.
9 THE COURT: You can answer it.
10 A Yes.
11 Q It's not going to show up over time, it is at the
12 moment it happens?
13 A If it's displaced. I mean, every once in a
14 while, you are surprised by what's a stress fracture, but
15 for your average person, yes.
16 Q And when you do have pain from a fracture, it's
17 going to be localized, it's going to be generally at the
18 point of the fracture?
19 A Not always, but it's going to be close to that.
20 Q When you first saw Mr. Carter and he told you he
21 was in a car accident, did he tell you that as a result
22 of this rear end collision, that he hit his head on the
23 dash and slammed his right arm into the dash?
24 MR. BOTTARI: Objection.
25 THE COURT: Overruled. You can ask him

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2 whether that's what he was told.
3 A I don't have that detail written down, so I don't
4 recall that.
5 Q He never told you that?
6 A I can't say that he never told me that. I can
7 say that I don't have it in my note and I can say that he
8 didn't write it down in his intake form.
9 Q Based on inertia, you agree that's somewhat
10 inconsistent with a rear end collision?
11 MR. BOTTARI: Objection.
12 THE COURT: Sustained. That's a question for
13 the jury.
14 A Can you repeat that?
15 MR. BOTTARI: You don't have to answer it.
16 THE COURT: You don't have to answer it.
17 Q Now, if we could turn, if we could, when he gave
18 you the history, he told you that he had -- his initial
19 complaint was pain in his right shoulder?
20 A I wouldn't say that that's what he told me. He
21 came to me with right shoulder pain and he told me
22 that -- the questions that I asked and so I asked
23 specific questions.
24 So my intake form says describe your injuries

2 you as a result of the accident, and I asked him to mark
3 or circle what applies and he checked his shoulder.
4 Now, I had a discussion with him, so he hurt his
5 shoulder in that accident. I don't know that he said
6 that his initial complaint was of shoulder pain. I think
7 that's stretching what I just told you, but that's the
8 information that I have.
9 Q But that's the level of the information that you
10 gathered?
11 A Yes.
12 Q Now, he told you that he went to the emergency
13 room and x-rays were taken, correct?
14 A Yes.
15 Q He told you those x-rays were negative for a
16 fracture?
17 A Yes.
18 Q And he brought with him a copy of his CT scan?
19 A Yes.
20 Q Or --
21 A The report.
22 Q There is no indication of any kind of blood or
23 bleed on the report, correct?
24 A No.
25 Q Is that correct?

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1 HOSTIN - CROSS
2 A Yes, there is no indication of blood in the
3 report.
4 Q Now, he told you that he had problems sleeping,
5 if you take your arm and you sleep on your upper arm or
6 on your shoulder, you are basically forcing that arm in
7 180 degrees of abduction, correct?
8 MR. BOTTARI: Objection.
9 THE COURT: If he can answer it.
10 A I wouldn't call it 180.
11 Q Close?
12 A But more abduction than I would recommend, yes.
13 Q That could be painful, right?
14 A It can be.
15 Q This is a very common problem with people with
16 impingement in the shoulder, correct?
17 A Again, so there are people who sleep that way and
18 are able to, but if you have impingement or have hurt
19 your shoulder, it is pretty difficult to sleep like that.
20 Q But there are people who have that and have never
21 been in an accident, correct?
22 A Have what?
23 Q Have a problem sleeping and never been in an
24 accident, correct?

2 never been in a car accident?

3 Q Never injured their shoulder?

4 A In some cases, yes.

5 Q You made an effort to locate the MRI that he had

6 from the prior weightlifting incident, correct?

7 A Correct.

8 Q And he was not able to describe for you the

9 doctor who treated him or the facility he went to or

10 where the imaging was done?

11 A Correct.

12 Q I mean, these things, you asked for, you would

13 have liked to have reviewed before you treated him

14 further?

15 A Again, what I mentioned earlier is, I have a

16 patient before me and I'm treating him now. The request

17 was made just because he is a very sick guy and I really

18 wanted to avoid surgery, if I could.

19 I thought maybe the MRI information would

20 actually help me not do the surgery, although I didn't

21 have it, but he continued to be symptomatic and as I tell

22 my trainees sometimes, you treat the patient, not the

23 imaging.

24 Q Not the film, right. But it is, again, his

25 complaints, they were subjective, correct?

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2 MR. BOTTARI: Objection.

3 THE COURT: Sustained.

4 Q He continued to complain of pain, correct?

5 A Yes, but he also had decreased range of motion

6 and objective measures of shoulder issues, shoulder

7 problems.

8 Q And you don't know how long he had it, it's just

9 by virtue of him telling you that it occurred at the

10 accident that you infer it came from the accident,

11 correct?

12 A Partially. I also have no -- there is no

13 records showing that he has had previous care for his

14 shoulder other than the remote injury, but I have not

15 been shown anything in terms of treatment for his

16 shoulder before this incident.

17 Q But then again, he was unable to provide you

18 those records, correct?

19 A Correct.

20 Q And not having those records doesn't mean that it

21 didn't happen, correct?

22 MR. BOTTARI: Objection.

23 THE COURT: He can answer that.

24 A I would agree with that.

2 thing that you -- I believe you indicated that you

3 examined was the glenoid humeral joint?

4 A Yes.

5 Q And that's where you found a tear, the two tears,

6 one in the superior labrum, one in the anterior labrum?

7 A Yes.

8 Q These are two separate discreet tears, you showed

9 them in the photograph, these were fibrous, like the

10 fibers were broken down, correct?

11 A It was more than that, but that's just what I

12 captured in that image.

13 Q You were able to debride them with the shaver?

14 A Yes, correct.

15 Q I believe that you also used a laser to ablate

16 them?

17 A I don't -- I don't like when people use the word

18 laser, but it's just joking a little bit, but I have a

19 lot of patients who call this laser surgery and we

20 haven't used lasers for these type of surgeries since the

21 nineties, but it's a thermal ablation wand, it's kind of

22 a heat wand, but yes, we use that.

23 Q I didn't -- it's kind of like if you have a

24 thread hanging from your shirt or your suit and you --

25 rather than pull it out and pull the whole thing out, you

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1 HOSTIN - CROSS

2 put a lighter or match to it and it kind of scorches it

3 off, not that simple, I'm trying to keep it in lay terms?

4 A I wouldn't describe -- the thread indicates that

5 it's a nothing thing, so when you're done --

6 Q Not at all.

7 A -- you're back to a normal labrum, so --

8 Q The tissue is gone, you're not -- it was there,

9 if it was broken down because of fraying, you want to

10 smooth it out where it doesn't interfere with bone

11 movement?

12 A Correct.

13 Q Not suggesting that it's going away, but there

14 are multiple causes for it.

15 Now, you also removed a number of adhesions?

16 A Correct.

17 Q And there were several of them, right?

18 A Well, yes, think of it almost as a sheet, not

19 like an adhesion here and another one there, but several

20 in this area.

21 Q And they can restrict motion too?

22 A Absolutely, and that's what I was alluding to

23 earlier, so how a labral tear can restrict motion, unless

24 it's an entire labrum coming off, the irritation and you

2 fluid in the joint, but from the trauma of the torn
3 labrum and this is exactly why over time following the
4 accident, he continued to have loss of range of motion as
5 these adhesions developed further and further from the
6 intra-articular trauma, the labral tears.

7 Q But after you did -- you also examined the AC
8 joint capsule --

9 A You know what --

10 Q -- and you looked at the end of the clavicle and
11 you found that the end of the clavicle had been damaged?

12 A No --

13 Q If you would, read your report on that, doctor,
14 your operative report, first line, last paragraph.

15 Next, attention was directed towards the distal
16 clavicle, this was found to have been injured.

17 A Yes, but I think you are misinterpreting this.

18 The distal clavicle or the AC joint was found to
19 be injured before the surgery started. That's why it's
20 in my preoperative diagnosis, the AC joint arthropathy.

21 So when I -- I think the sentence is misleading,
22 but the point was, we have an injury to the AC joint and
23 that's why I directed myself to the distal clavicle
24 because I'm going to remove and that was the preoperative
25 plan, not based on what I found at surgery.

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2 Q So you're saying that it was arthritic and not
3 injured?

4 MR. BOTTARI: Objection.

5 THE COURT: Overruled.

6 A No. What I'm saying was that the treatment was
7 not based on what I found at the time of surgery. The
8 plan was to remove the distal clavicle preoperatively.

9 Q I understand, but while you are evaluating the
10 distal clavicle is when you made the observation and when
11 you did -- you wrote the report, probably dictated it
12 after the surgery?

13 A I did.

14 Q And that was a finding that you noted during the
15 course of the surgery?

16 A One thing, again, I'll make you familiar with
17 this, the AC joint is a very tight joint, you can't fit
18 the camera inside the joint, and so, you can't look at
19 the end of the clavicle until you have already cut it so
20 now you could fit your camera in.

21 You can remove a little bit of the acromion and
22 see an edge of it, but, again, the plan was to remove the
23 distal clavicle.

24 There is no surgery in which we examine the

2 resect it because by the fact that you're looking at the
3 end of the clavicle, you have already kind of screwed
4 that joint up.

5 So if you're not planning on removing it, you
6 shouldn't be looking at it, so I think that sentence, I
7 think you misinterpreted that sentence.

8 Q Okay, it says what it says.

9 A I'm sorry?

10 Q It says --

11 A Well, it says, this was found to have been
12 injured.

13 Q I mean, I didn't write it, you did?

14 A Correct. Preoperatively.

15 Q You didn't write this preoperatively?

16 A Found is a past tense word. I found
17 preoperatively that this was injured.

18 Q It doesn't say preoperatively?

19 A No, it doesn't.

20 Q And in the context that it's while you're looking
21 at -- what you actually say, your attention is directed
22 towards the distal clavicle, this was found to have been
23 injured, so it's in that context, you are actually --
24 you're looking at the distal clavicle, I'm not going to
25 argue, but these are your words, you wrote it?

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2 A I understand, maybe it was poorly worded, but I'm
3 glad I could explain it to you.

4 Q Not a problem, not a problem.

5 One thing that you do is you indicated you used a
6 burr and you smoothed out the underside, if I could?

7 A Yes, please.

8 Q This being the AC joint here?

9 A Yes.

10 Q You smoothed out the underside of the acromion?

11 A Yes.

12 Q Did you also -- there is this ligament here?

13 A Correct.

14 Q That's the coracoacromial ligament?

15 A Yes.

16 Q You removed that as well, you took it down?

17 A I elevated it off the acromion, yes.

18 Q And that's to allow more space for the rotator
19 cuff to pass underneath it or at least a portion of the
20 rotator cuff to pass underneath it?

21 A Yes.

22 Q To create even more space, you removed about 10
23 millimeters, about 25.6 millimeter, .4, .6 millimeters to
24 an inch?

2 Q Ten millimeters?
3 A Ten millimeters, and that's not the same space
4 that we are creating, so one was the subacromial space to
5 give more room for the rotator cuff --
6 Q Right.
7 A -- and in that case, the second case for the
8 distal clavicle, that was to --
9 Q Separate the two bones so they don't rub against
10 each other?
11 A Yes.
12 Q Sometimes, that's called a Mumford procedure?
13 A Yes.
14 Q But the whole idea is to stop the -- I mean aside
15 from fixing the tears or debriding --
16 A Debriding them.
17 Q Debriding the tears, debriding the rotator cuff
18 tear, the main alteration you did on Mr. Carter was you
19 removed -- you increased the subacromial space, correct?
20 A Yes.
21 Q And you removed the distal clavicle so the two of
22 them aren't rubbing together?
23 A Yes.
24 Q And you would agree that the degenerative disc
25 disease, all be it the report was mild, those two

2 joint, not because he had the mild AC joint arthritis on
3 the CT scan, but because he had symptoms there that
4 didn't get better with conservative measures.
5 Q And the only information you had when I believe
6 you told the jury earlier that this is similar to a fall
7 on an outstretched arm, correct?
8 A What do you mean that's the only information I
9 had?
10 Q Slamming his right arm into the dash, if that, in
11 fact, happened creates the mechanism of injury?
12 A You used the term the only information I had, I'm
13 not sure --
14 Q The only history information you had about the
15 happening of the accident --
16 A Okay.
17 Q -- was that this was a rear end collision?
18 A Yes.
19 Q And the mechanism of injury that you described to
20 the jury earlier was that this injury could only be
21 caused by someone slamming their arm or not only, but one
22 of the mechanisms of injury would be that someone is
23 falling on an outstretched arm?
24 MR. BOTTARI: Objection.
25 THE COURT: Sustained.

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2 procedures were basically oriented to alleviate that
3 problem, correct?
4 MR. BOTTARI: Objection.
5 THE COURT: Sustained.
6 Q Do those two procedures, the acromioplasty and
7 the Mumford portion of it, do they give extra space --
8 do they alleviate the symptoms of the impingement in
9 Mr. Carter's case, they are intended to?
10 A Yes, and the -- the reason the procedures were
11 necessary were not because the CT scan shows that there
12 is mild AC joint DJD, degenerative joint disease, that's
13 one, and the impingement is the second other procedure in
14 quotes that you mentioned, again, it didn't occur because
15 he had some -- or it wasn't performed because he had
16 impingement that preexisted his injury.
17 The impingement, it's sort of a back-up
18 procedure. It's something that often is done when you do
19 a bursectomy, when you're cleaning out the subacromial
20 space. It further guarantees or allows that this is
21 going to be successful.
22 Some surgeons doesn't do the acromioplasty, for
23 example, and rely -- it just leaves less room for error,
24 so to speak, and the distal clavicle resection was a

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1 HOSTIN - CROSS
2 Q You mentioned earlier about falling on an
3 outstretched arm?
4 A Yes.
5 Q And that was a mechanism of injury you believe
6 was the mechanism of injury in Mr. Carter's case?
7 MR. BOTTARI: Objection.
8 THE COURT: Sustained.
9 Q What was the mechanism of injury for Mr. Carter?
10 A He was rear ended.
11 Q And thrown into the dash?
12 A This was information I learned recently, but what
13 I was advised was that he was in a rear end collision.
14 Q So all the questioning about falling on an
15 outstretched arm didn't mean anything, you didn't have
16 any basis to say that that was the mechanism of injury
17 here?
18 MR. BOTTARI: Objection.
19 THE COURT: Sustained.
20 Q You testified earlier that something about
21 falling on an outstretched arm, are you saying that was
22 the result of rear end contact?
23 MR. BOTTARI: Objection.
24 THE COURT: I will sustain it as to form.

2 Honor.
3 THE COURT: Sustained as to form.
4 Q When you told the jury earlier and you spoke
5 about it being similar to -- striking the arm is similar
6 to falling on an outstretched arm, was that your belief
7 that that was the mechanism of injury in this case?
8 MR. BOTTARI: Objection.
9 THE COURT: Can you answer that question?
10 Q Yes or no.
11 A I was asked the question that -- I believe the
12 question was, assuming that his arm was out against the
13 dashboard when the collision occurred, could that be a
14 mechanism of injury and given that scenario, I said yes
15 and then I compared it to another common mechanism and
16 then went on to explain that.
17 Q I mean, there is no evidence in this case or has
18 ever been presented to you that there was a direct blow
19 or direct contact to the point of the shoulder, correct?
20 A Again, I was given this information --
21 Q But you know of no evidence of that?
22 A No.
23 Q Is that correct?
24 A I have no evidence of that.
25 Q You have no evidence of any swelling or bruising

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1 HOSTIN - REDIRECT
2 or ecchymosis, any kind of direct injury to the point of
3 the right shoulder, correct?
4 A I don't have that information, no -- correct.
5 MR. McGUINNESS: Thanks, doctor.
6 THE WITNESS: Thank you.
7 THE COURT: Counsel?
8 MR. NASTRO: Nothing further, your Honor.
9 THE COURT: Anything further?
10 MR. BOTTARI: Just briefly, your Honor.
11 REDIRECT EXAMINATION BY
12 MR. BOTTARI:
13 Q Doctor, one of the things you mentioned before
14 was, quote, unquote, clinical correlation; am I right?
15 A Yes.
16 Q You did not see any prior MRIs?
17 A Correct.
18 Q And you were not aware of any information ever
19 that anyone had showed you either today or before today
20 about prior injuries to this gentleman's right shoulder;
21 am I correct?
22 A Well, he had the one injury --
23 Q Other than the weightlifting injury?
24 A Correct, no other evidence or history of other

2 Q Now, you were asked if there were what was called
3 full thickness tears; am I right?
4 A Yes.
5 Q There were no full thickness tears when you went
6 in there, into his shoulder, correct?
7 A That's correct.
8 Q By the way, have you ever heard the term gold
9 standard with regard to MRI or arthroscopies or CT scans?
10 A Yes.
11 Q What is the gold standard?
12 A So the concept of a gold standard is think of the
13 following, so imagine an MRI and it's a new test, I mean,
14 we get new stuff all the time.
15 At that time, okay, we got this funky new thing,
16 we can put a magnet on people and get these pictures and
17 the question is, well, is this really -- is this
18 really -- what do we see with this picture, how do we
19 know this means anything.
20 You have to compare it to what's called the gold
21 standard and for MRIs, in particular, when it comes to
22 soft tissue injuries in the joint or around the joint,
23 the gold standard is arthroscopy, so there is tests,
24 there is studies.
25 We talked about literature that basically says,

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1 HOSTIN - REDIRECT
2 okay, this is what we found on MRI and this is what was
3 found at the time of surgery. This is the gold standard.
4 This is what we compare ourselves to.
5 Then we say the MRI, okay, it's very close, 98
6 percent is often the number that's used. This correlated
7 with what was found at the time of the surgery, that's
8 the gold standard.
9 Q So the surgery is the gold standard?
10 A The findings at the time of surgery.
11 Q Because you are actually in his shoulder?
12 A I'm right there.
13 Q You are actually seeing the tissue?
14 A Correct.
15 Q You are aware of studies that show false positive
16 or false negatives with regard to MRIs, correct?
17 A Yes.
18 Q That's what you're talking about?
19 A Yes.
20 Q You're in the shoulder. So can partial thickness
21 tears cause pain?
22 A Absolutely. They actually, ironically, are very
23 often more painful than full thickness tears in some
24 cases.

24 Q But a degree is a degree?

2 different.
3 MR. McGUINNESS: Thank you, doctor.
4 MR. BOTTARI: Nothing further.
5 THE COURT: Thank you, doctor. You can step
6 down.
7 MR. BOTTARI: You can take your file. Don't
8 take what was marked in evidence.
9 THE COURT: It is late enough that we can
10 break for tonight. I do have some other matters on
11 tomorrow morning, so I'm going to ask you to come in
12 at about 10:15 or 10:30 and we will continue with
13 Mr. Carter's testimony and then we will have a
14 medical witness in the afternoon.
15 Enjoy your evening. Don't discuss the case.
16 We will see you at 10:15.
17 MR. BOTTARI: The witness in the afternoon is
18 1:30.
19 THE COURT: We are getting a late start in
20 the morning, but we will get an early start in the
21 afternoon, we will start at 1:30 tomorrow afternoon.
22 Adjust your plans if necessary.
23 MR. BOTTARI: Thank you, Judge.
24
25 oOo

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