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2 SUPREME COURT OF THE STATE OF NEW YORK
3 COUNTY OF NEW YORK: CIVIL TERM PART 15
4 ----- X
5 JAMES GREGWARE and EILEEN GREGWARE,
6
7 Plaintiffs,
8 INDEX NUMBER:
9 - against - 108013/07
10 Jury Trial
11 THE CITY OF NEW YORK,
12 BURTIS CONSTRUCTION CO., INC.,
13 ABELARDO DA-SILVA,
14
15 Defendants.
16 ----- X
17 60 Centre Street
18 New York, New York
19 March 15, 2013
20
21 BEFORE:
22 HONORABLE EILEEN A. RAKOWER, Justice,
23 and a sworn jury.
24
25 APPEARANCES:
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48 (Continued on next page.)

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1 Hershman - by Plaintiffs - Direct/Rubinowitz
2 (Plaintiffs' Exhibits 13 through 34 received and
3 marked in Evidence).
4 MR. RUBINOWITZ: We should mark these. These are
5 x-rays of Dr. Hershman?
6 THE COURT: Any objection.
7 MR. RUBINOWITZ: I'm just going to show them.
8 (Whereupon, the jury enters the courtroom.)
9 THE COURT: Good morning, everyone. Come on in.
10 Watch your step as you go. Please sit down. All right.
11 Mr. Rubinowitz, could you call your next witness
12 please.
13 MR. RUBINOWITZ: Thank you, your Honor.
14 At this time, we call Dr. Elliott Hershman to the
15 stand please.
16 THE CLERK: Good morning, Doctor.
17 Remain standing. Raise your right hand.
18 ELLIOTT HERSHMAN, M.D., called as a
19 witness in behalf of the plaintiffs, having been first duly
20 sworn, residing at 2 East End Avenue, New York, New York
21 10075, was examined and testified as follows:
22 THE WITNESS: I do.
23 THE CLERK: Have a seat.
24 THE WITNESS: Thank you.
25 THE CLERK: Could you give us your name, and spell
26 it for us. Elliott, E-L-L-I-O-T-T, Hershman,

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1 Hershman - by Plaintiffs - Direct/Rubinowitz
2 H-E-R-S-H-M-A-N.
3 THE CLERK: And your address.
4 THE WITNESS: Two East End Avenue, New York,
5 New York 10075.
6 THE CLERK: Thank you, sir.
7 DIRECT EXAMINATION
8 BY MR. RUBINOWITZ:
9 Q Dr. Hershman, I'm handing you what is marked Exhibit 21
10 in evidence. These are your records.
11 MR. RUBINOWITZ: Your Honor, as the Court knows,
12 we're calling this witness out of order due to scheduling.
13 Q Dr. Hershman, are you a physician duly licensed to
14 practice medicine in the State of New York?
15 A I am.
16 Q When were you so licensed?
17 A In 1985.
18 Q What I'd like you to do, Doctor, if you would, is to
19 describe your educational background and medical training, and
20 as we proceed I'll fill in as we go.
21 A Sure. I went to undergraduate school at University of
22 Rochester, Rochester New York. And, I stayed there for medical
23 school, and completed medical school in 1979.
24 I was a resident from 1979 to 1984 in orthopedic
25 surgery at Lenox Hill Hospital. That's a five-year residency
26 program.

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1 Hershman - by Plaintiffs - Direct/Rubinowitz
 2 Q What is a residency program?
 3 A Residency program is training to do the care of the
 4 patient that you want to accomplish. So, medical school, you
 5 learn the language of health care, the language of the body
 6 anatomy, physiology, neuroscience, broad overview of medicine,
 7 of the human body, and then you specialize in residency. So,
 8 you could do in internal medicine. You could do general
 9 surgery. You could do neurology.
 10 And, then, after medical school, some people spend
 11 extra training, and that would be a fellowship. So that's
 12 another year.
 13 So my medical school training -- my medical training
 14 included medical school, four years; residency, five years; and,
 15 fellowship, another year. So, that's altogether what three,
 16 four and five is nine and one is ten. So, ten years to become
 17 an orthopedic surgeon with a subspecialty in sports medicine.
 18 And, I guess I was licensed after internship. That's
 19 when you actually formally get your license. But, I started
 20 practicing medicine when I completed all my training, and my
 21 training was done during residency, part of it here in New York.
 22 So, I was at Lenox Hill for my general surgery internship. Did
 23 my residency.
 24 I went to Boston for a while and was at Children's
 25 Hospital to learn pediatric orthopedics.
 26 Q With what institution is that affiliated?

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1 Hershman - by Plaintiffs - Direct/Rubinowitz
 2 A It's part of the Harvard Health Care System, part of
 3 the Harvard Medical School system. I did pediatrics there.
 4 And, then when I finished my residency I went to
 5 Cleveland, Cleveland, Ohio, an esteemed city, and I was at the
 6 Cleveland Clinic for a year, and had a ball there actually. It
 7 was a fellowship in sports medicine, just what I wanted to do.
 8 I I participated in care for the professional athletes out
 9 there, the Cleveland Browns, the Cleveland Cavaliers, focussed
 10 in specifically on knee things. Some new, innovative things
 11 they were doing knee surgery in 1984 and '85.
 12 And then when I finished there, I came back and went
 13 into practice back at Lenox Hill Hospital where I started --
 14 Q If I could just stop you for one moment. You glossed
 15 over the Cleveland Clinic. What is that?
 16 A The Cleveland Clinic is a world renown, actually,
 17 institute that is on a cutting edge of healthcare. People from
 18 all over the world come there as patients. People from all over
 19 the world come there to work there because they attract
 20 wonderful clinicians, researchers, educators. And having
 21 trained here in New York for five years, I wanted to get another
 22 view of of sports medicine and orthopedic surgery, and I wanted
 23 to go to one of the leading institutions in that, in the world.
 24 So, I actually went to Cleveland for a year to accomplish that.
 25 Q You mentioned there were certain innovations at the
 26 Cleveland Clinic. What specifically are you talking about?

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1 Hershman - by Plaintiffs - Direct/Rubinowitz
 2 A When I was a resident in orthopedic surgery at Lenox
 3 Hill, I learned techniques of ligament reconstruction that
 4 involved using tissues from one part of the body to replace
 5 tissues that were damaged in another part of the body. And, in
 6 those days, the focus was not so much on an anatomic restoration
 7 of ligaments.
 8 So, I mean, if you want too fast forward to 2013, our
 9 big focus now is on if you injure a ligament, you want to
 10 replace it with a piece of tissue that is exactly similar to the
 11 damaged tissue and want to put it exactly where the damaged
 12 tissue was. Makes sense.
 13 Well, in 1984, that's not what was happening. And
 14 people were actually removing tendons to replace ligaments, and,
 15 you know, sacrificing parts of a joint to replace other parts of
 16 a joint.
 17 And, when I was a resident, I actually thought that it
 18 didn't make a lot of sense to me to do that because you are
 19 weakening another part of the joint. And, I had heard, over in
 20 Europe, that they were starting to do these newer techniques,
 21 and they were bringing it to America, particularly in Wisconsin,
 22 Cleveland, down in Georgia, a few different places, and that's
 23 one of the reasons I actually went to the Cleveland Clinic, to
 24 learn this technique for transferring tissues from other places,
 25 not sacrificing, and then anatomically placing the positioning
 26 tissue to replace damaged structures. And, I brought that back

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1 Hershman - by Plaintiffs - Direct/Rubinowitz
 2 to New York from Cleveland and started doing that here in
 3 New York in 1985.
 4 Q Now, Doctor, when you came back to New York, did you
 5 continue at a specific institution?
 6 A I continued at Lenox Hill Hospital, and I've been at
 7 Lenox Hill Hospital ever since.
 8 Q Tell the Court and jury what your position is with
 9 Lenox Hill Hospital presently?
 10 A Right now I'm Chairman of the Department of the
 11 Orthopedic Surgery at Lenox Hill, and I also Director of the
 12 Residency Program, that's the training program for the young
 13 doctors. So, the teaching program.
 14 Q For how long have you been involved in teaching
 15 residents in your trade, orthopedics?
 16 A Well, actually, you -- in medicine, medicine is very
 17 much like an apprenticeship. So, even when you are a resident,
 18 as you move up the ladder every year, you are teaching the
 19 residents below you.
 20 So, you start out this culture of educational learning.
 21 I think that's how we promote healthcare and good medicine
 22 because we're always asking each other questions, always
 23 thinking about about ways to move things forward for our
 24 patients.
 25 And, I really always loved teaching. So, when I went
 26 to the Cleveland Clinic and then I returned to to Lenox Hill,

1 Hershman - by Plaintiffs - Direct/Rubinowitz
2 they actually gave me a position, it was called Basic Science
3 Coordinator. But, basically that meant I was responsible for
4 making sure all the residents learn the basic science of
5 orthopedic surgery. So, what do bone cells do? What do
6 cartilage cells do? What do ligaments do? What do muscles do?
7 And that's how I started formally teaching the residents when I
8 returned from Cleveland.

9 Then, after being Basic Science Coordinator for a few
10 years, they promoted me to Residency Coordinator. Then I became
11 Vice Chairman of the department. And then, about a few years
12 ago, about five years ago, they made me Chairman of the
13 department. So I'm running the show now.

14 Q Doctor, are you board certified in the fields of
15 orthopedics?

16 A I am.

17 Q When were you board certified, Doctor?

18 A I think it was 1986. That was I think the year I was
19 first board certified.

20 Q What does it mean to be board certified first of all?

21 A Okay. Board certified is a process that we go through
22 to show our ability to practice the field that we want to
23 display competence. It's about competency. Are you competent
24 to practice medicine in the field you desire.

25 So, if you told me you were having chest pain today,
26 truthfully, I wouldn't really don't know much to do. I have a

1 Hershman - by Plaintiffs - Direct/Rubinowitz
2 that he knows his stuff. So, every ten years I've taken an exam
3 again, and I've done that twice now. I've been recertified two
4 times. Last one about three years ago.

5 And, now I did it in the fashion that we do it where we
6 bring our own cases. I send a list of my hundred operations,
7 let's say. And, the doctors in Chicago, that's where it is,
8 they pick five cases, and they bring your case, and then they
9 look at it. And, they always bring -- they always pick the
10 cases that you always have the hardest trouble with, most
11 challenging case, the ones that have very complications and this
12 and that because medicine is like that. Nothing is always
13 perfect.

14 And you bring your cases, and you have to describe what
15 you did, what the thinking process was.

16 And, then if you are -- if they accept what you do,
17 they recertify you.

18 The rate of certification and passing the board exam
19 probably is about 90 percent for first-time takers for the
20 written exam, and probably a little bit higher on the oral
21 exams, probably about 95 percent.

22 So, the story is everybody does not pass. And -- but,
23 fortunately, on all three of my occasions I did.

24 Q Did you actually contribute to the board exam itself?

25 A I did years ago, yes.

26 Q Doctor, while I focus on your medical organizations and

1 Hershman - by Plaintiffs - Direct/Rubinowitz
2 little bit of knowledge left over from medical school, but I'm
3 really not so competent in cardiology, and I wouldn't profess to
4 be that.

5 But, I'm competent in orthopedic surgery. And why?
6 Because there are a group of my peers, my other orthopedic
7 surgeons, who put together an exam, and actually many of us
8 contribute questions for the exams.

9 And its -- it's a two-step process. So, when you first
10 start out, right after residency, you take a written exam,
11 multiple choice, and you have to pass that.

12 And, then in those days you had to practice for two
13 years. And, then once you practiced for two years, you sat with
14 a group of doctors just like this, I sat over here, and two
15 orthopedic surgeons sat over there, and they put up cases, and I
16 had to look at the X-ray and look at the MRI and make a
17 diagnosis in front of these two people, tell them what I do,
18 tell them what the potential complications were, tell them what
19 I thought the outcomes might be. Talk about a stressful
20 situation.

21 And, they've changed it over the years actually because
22 they felt it was too stressful for the young doctors. Anyway, I
23 was board certified back then right after residency.

24 And, now we want to continue to show that we're
25 competent, particularly to the public. You want to know that
26 your doctor is competent, that you are going to a good doctor

1 Hershman - by Plaintiffs - Direct/Rubinowitz
2 background, which I want to do, are you affiliated with any
3 sports teams?

4 A I am.

5 Q Please explain that?

6 A So, my specialty is sports medicine. In sports
7 medicine, I'm involved in the care of athletes. So, I take care
8 of lots of young people during variety of sports things, and I
9 take care of recreational athletes as well people, who are just
10 active as part of day-to-day living.

11 One of the other things I do is I take care of
12 professional athletes. And for 25 years or so, I've been the
13 team orthopedic surgeon for the New York Jets. And my role
14 there is I attend the games. I see players when they're
15 injured. I examine them. I talk to them. Make a diagnosis.
16 Sometimes we could get an X-ray. We have X-ray right there. We
17 make a determination whether it's proper for them to go back
18 into the game, not go back into the game. Do we need an MRI?
19 Are they going is to need surgery? Are they out for the season?

20 And, I've been doing that for the Jets this whole --
21 all these years since I actually came back from Cleveland.

22 There also was about a brief ten years where I also
23 took care of the New York Islanders, the hockey team out on Long
24 Island. As things got busy, and this and that, I wanted to be
25 chairman of my department, and we kind of agreed that I wouldn't
26 do that anymore.

1 Hershman - by Plaintiffs - Direct/Rubinowitz
 2 Q Doctor, are you also involved with Hunter College in
 3 any way?
 4 A I am the orthopedic surgeon for Hunter College. So, at
 5 Hunter College we have lots of athletes across all the
 6 intercollegiate sports, wrestlers, volleyball, basketball, and
 7 I'm the orthopedic for them as well.
 8 Q What medical organizations are you part of of?
 9 A A number. I am a member of the American Academy of
 10 Orthopedic Surgery. That's the organization that most
 11 orthopedic surgeons belong to.
 12 I'm a member of the American Orthopedic Society for
 13 Sports Medicine. That's the AOSSM, that's the group that I
 14 participate the most in. It is a sports medicine group. So, we
 15 all talk the same language or discuss the same things. It's
 16 sort of like everyone has an interest, and you go where
 17 everybody knows your name, that kind of thing. That's my sports
 18 medicine group.
 19 I'm also in a group of educators, that is the American
 20 Orthopedic Association, AOA, and we talk about how to teach, how
 21 to, how to transmit, you know, what we're learning and what
 22 we're doing to young doctors and other doctors also because, if
 23 we're doing cutting edge things, we need to teach all the other
 24 orthopedic surgeons, you know, across the world what we're
 25 thinking and discuss it. Are we doing the right thing? What is
 26 another approach to this? How else could we look at this

1 Hershman - by Plaintiffs - Direct/Rubinowitz
 2 Q Doctor, are you involved in research in addition to
 3 your duties as chairman of the department?
 4 A Well, it's part of trying to continue to improve
 5 healthcare and medicine and orthopedic surgery and quality of
 6 life for people, I do do research.
 7 One of the biggest projects I'm working on is the
 8 project with some people in Europe where we're actually trying
 9 to create an artificial meniscus. Right now there is no
 10 meniscus. If you tear your meniscus and have a bad meniscal
 11 injury, and over time you could get osteoarthritis, that's
 12 generally what happens, and we generally don't have a good
 13 replacement for that. And people go on to get arthritis.
 14 There's a company called Active Implant, I'm a consult
 15 there. We've working on developing an artificial meniscus. I
 16 do research in that area.
 17 I do research on some knee ligaments. The residents
 18 and I do research together, with the fellows, and we present
 19 present our information at various meetings.
 20 Q Give us me a sense of how many publications you have in
 21 your field.
 22 A I'm not sure. Perhaps, I don't know, fifty, sixty,
 23 something like that.
 24 Q In addition to those publications, Doctor, do you
 25 present at various lectures within your field?
 26 A I do. You know I give talks at meetings and present

1 Hershman - by Plaintiffs - Direct/Rubinowitz
 2 problem? And that's how we advance medicine.
 3 Q Doctor, are you on the board of directors of any of
 4 these organizations?
 5 A Currently, no. I was on the board of directors for the
 6 American Orthopedic Society of Sports Medicine for a while, I
 7 was program chairman. These things kind of ebb and flow. You
 8 have terms of three years or four years. You come on, you go
 9 off, and things like that you.
 10 Q Were you involved with the National Football League in
 11 that regard?
 12 A The National Football League I wear a few hats at the
 13 National Football League. So, in addition to being team
 14 orthopedic for the New York Jets, I'm also chairman of a group
 15 of doctors and researchers and Ph.D. people, athletic trainers,
 16 that study injury in the National Football League, and it is a
 17 group called, excuse me, the Injury and Safety Panel.
 18 So, we've been working for about 20 years or so on
 19 trying to reduce injuries in in football. And, many of the
 20 things that we have discussed and talked about have been
 21 implemented in sports over the years.
 22 So, for example, one thing I focus on is knee injuries
 23 and what happens on turf, which is the synthetic material, and
 24 grass. You may have heard some where that they're more injuries
 25 on turf than grass. That's our work. We publish that data.
 26 So, that comes from the NFL Injury and Safety Panel.

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 2 papers and participate in studies with people.
 3 So we have, for example, a group of orthopedic
 4 researchers that are looking at why people re-tear their knee
 5 ligaments.
 6 Let's say you have a knee operation. I think it goes
 7 swimmingly. I'm the surgeon. You go out and play soccer two
 8 years later. You tear it again. Why is that? Well, and can
 9 you been okay? So, now you are having a second operation.
 10 So, these injuries, for example, are not so common.
 11 And, for a single researcher to get a lot of these injuries,
 12 since it's only three percent of all your patients, that you
 13 operate on, the numbers are small. But, in research numbers are
 14 the power. So, the more patients you have, the more powerful
 15 the data.
 16 So, if you want to do a study, for example, on high
 17 blood pressure, you include thousands of people. You get 10,000
 18 people, Framingham Study, thousands and thousands of people.
 19 Then you get clinically significant data.
 20 In orthopedic surgery, as you get you dive deeper and
 21 deeper into things, so the knee ligaments tear, knee ligament
 22 surgery, now a re-tear, it gets smaller and smaller the number
 23 of patients you see. So, for example, we have to do a combined
 24 study. So, myself and fifty other surgeons across America, we
 25 formed a group to study this particular injury, and we publish
 26 our information from that. We actually call it MARS, like the

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2 planet. It stands for Multicenter ACL Revision Surgery Study.
3 It's an NIH research group.
4 Q If I may, the National Institutes of Health?
5 A I'm sorry, National Institutes of Health, yes. And you
6 could actually look at the information that we're gathering
7 online. You could to the NIH website.
8 MR. RUBINOWITZ: Your Honor, at this time, I tender
9 Dr. Hershman as an expert in this field.
10 THE COURT: Not necessary, but thank you.
11 Q Doctor, what I'd like to do, with the Court's
12 permission, is have you come down. I want to briefly review
13 some of the anatomy we're going to be speaking about.
14 MR. RUBINOWITZ: Your Honor.
15 THE COURT: Go ahead.
16 Q Doctor, I'm going to show you first what has been
17 marked in evidence as Plaintiffs' Exhibit 22. It is a Netter
18 illustration, a Dr. Netter illustration of the knee, correct?
19 A It is.
20 Q Doctor, here is what I'd like to you do with this.
21 What I'd like you to do is to educate us first on the knee
22 joint. Tell us about the knee joint in general.
23 A Sure.
24 MR. BAXTER: Hold on.
25 THE COURT: Everybody, feel free to move around so
26 you could see. Any place you could see.

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2 MR. RUBINOWITZ: Everybody could see you there and
3 you are not blocking everyone.
4 THE COURT: It's always easier for the reporter if
5 you could see the speaker.
6 A So, the knee, right. The knee. What does the knee do?
7 Everybody has a knee so everybody should know what the
8 knee does. It bends. So, it's a little bit like a hinge. But
9 it's a little more than a hinge because, in addition to bending,
10 it also has some rotation.
11 Q And, Doctor, I'm going to show you the demonstrative
12 exhibit as well of the knee.
13 MR. BAXTER: I'm sorry, could we get that number.
14 THE COURT: That is actually not marked.
15 MR. RUBINOWITZ: It's just for demonstrative
16 purposes.
17 THE COURT: Okay.
18 MR. RUBINOWITZ: If you want me to, I could mark
19 it.
20 MR. BAXTER: I saw a sticker on it. Just want to
21 make sure.
22 THE COURT: No, it's just a model of a knee.
23 MR. BAXTER: Yes.
24 THE COURT: Go ahead.
25 A So, the knee bends. It also has a little bit of actual
26 rotation. So it does this too. Okay.

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2 Because the knee is essentially a rounded is surface on
3 the top okay, which is up here.
4 The femur bone.
5 So, you have the thigh bone, which connects at the
6 knee, to the tibia bone, which is your shin bone.
7 Q Would you just point out for us on you what you're
8 talking about.
9 A So, shin bone, femur bone, and in between is your knee.
10 And, you know that old song, the knee bone is connected
11 to the thigh bone, that's the ligaments theme song. That's what
12 that actually is because the ligaments connect the bones.
13 And, if you don't have ligaments, your bones just kind
14 of wobble around. So, when you injure your ligaments, you feel
15 your knee has laxity, looseness or laxity to it. And, people
16 tell me, when I take a history, they feel instability. That's
17 what they complain of. Medically that's laxity.
18 And, so what is happening? Well, anatomically the knee
19 is actually held together the two bones, the main two bones, the
20 femur and the tibia by four ligaments.
21 Q If I may, Doctor, when you say the tibia, is that one
22 and the same as the shin bone?
23 A Shin bone.
24 Q It's the tibia.
25 A Thank you. The tibia. So the shin bone, the tibia.
26 The femur bone, the thigh bone.

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2 So, the four ligaments, the four main ligaments that
3 connect the femur, which is the top of the knee, to the tibia,
4 which is the bottom of the knee, are ligaments on the side,
5 okay. So, there's on each side of the knee -- so, on the
6 outside of your knee is one ligament. So, this connects the
7 thigh bone to the fibula the little bone.
8 And, then on the inside is the collateral ligament.
9 Okay, the medial, MCL, the medial collateral ligament, which
10 connects the femur to the tibia on that side.
11 So, what does this do? This ligament, right here,
12 prevents motion this way.
13 Q When you say this ligament, for clarity, you are
14 referring to the medial collateral ligament?
15 A Medial collateral ligament, one of the four ligaments.
16 So, you have the femur bone, the tibia bone. The bones
17 would do this if it wasn't for a ligament on the side here.
18 Q Indicating moving?
19 A The MCL.
20 Q And, which way are you suggesting the force is going
21 right now?
22 A The force here, this is where the femur is rotating
23 this way. Okay, so --
24 Q When you say this way?
25 A This is valgus. The force is actually called in
26 medicine, they call it valgus. They have a name for this. This

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 2 is called valgus. So, it's actually moving valgus, means away
 3 from the midline. So this is a valgus movement.
 4 You see how this stretches out when you do this.
 5 Okay, so, in your body it doesn't -- it stretches out a
 6 little bit, and then it stops. So, that holds your knee in
 7 place. It doesn't move any farther.
 8 If you have a force going this way, this is actually
 9 call varus.
 10 Q Indicating the opposite way?
 11 A The opposite way.
 12 The lateral, the outside, lateral means outside.
 13 Medial means inside. So, medial. Lateral. Medial.
 14 Lateral.
 15 So, the lateral collateral ligament LCL prevents motion
 16 this way.
 17 Now, the lateral collateral ligament is a little
 18 different from the medial collateral ligament, why? Because the
 19 medial collateral ligament attaches from the femur to the tibia,
 20 the two main bones.
 21 There's actually another bone that's part of the knee,
 22 a third bone, and that is the fibula. That's the little bone
 23 that runs down the side of your leg and in between your ankle
 24 and your knee. It's a small little bone. Lots of muscles
 25 attach to it.
 26 But, what is important for the knee is the lateral

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 2 collateral, the outside ligament attaches to it right over.
 3 Here is the lateral collateral ligament, attaching to
 4 the fibula. Fibula head right here, that is what we actually
 5 what we call it, on the outside of your knee.
 6 So, two ligaments, one on each side of your knee, those
 7 are half the ligaments, okay. And they prevent sort of side
 8 motion, okay. That's what they do.
 9 Then you have ligaments inside your knee. Now, these
 10 you can't touch. You can't feel them. You can't see them.
 11 They're deep in the middle of your knee. And they're called the
 12 cruciate ligaments.
 13 And if you read the sports pages, you hear about them
 14 all the time because you hear about people who tear their ACL.
 15 MR. BAXTER: Objection, objection.
 16 THE COURT: I'll allow it. Go ahead.
 17 A You hear about people who injure their ACL
 18 participating in sports.
 19 And these are the ligaments. Okay. They cross.
 20 Cruciate means cross, okay. Cruciate means cross.
 21 One is in the front; that is anterior.
 22 One is in the back; that is posterior.
 23 So, here you see them on this illustration crossing.
 24 In the front is the anterior cruciate ligament.
 25 In the back is the posterior cruciate ligament.
 26 And, by their location, they prevent front and back

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 2 motion. Okay. Front and back motion. So that's what they
 3 prevent.
 4 The ACL, anterior cruciate, prevents front motion.
 5 PCL prevents back motion.
 6 So, those are the four ligaments of the knee:
 7 Medial collateral, on the inside. Lateral collateral
 8 on the outside. ACL and PCL in the central part.
 9 The femur is covered by articular cartilage. That's
 10 another part of the joint. You've all seen that.
 11 Everybody eats chicken, turkey. Any vegetarians here?
 12 It's a rhetorical question.
 13 The white stuff on the end of the bone, that's
 14 articular cartilage, okay, and that's what your joints glide on.
 15 That's what your joints glide on.
 16 So, when you bend your joints, because you have smooth
 17 articular cartilage, that's why it doesn't hurt. It's nice and
 18 smooth. It's actually less friction than ends an ice skate on
 19 ice. It really glides. That's that white stuff when you break
 20 a chicken leg or turkey leg. That's the articular cartilage.
 21 Every joint in your body in all animals, every moving
 22 part has articular cartilage covering it. Same thing on the
 23 bottom on the tibia. That has articular cartilage also.
 24 What is unique about the knee is that it has two little
 25 fibrocartilage pads in addition to the articular cartilage to
 26 help pad the joint. Those are the menisci.

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 2 You ever heard someone has a torn meniscus, that's this
 3 little pad right here. There's one on the inside, and on one on
 4 the outside. It's on the inside, medial collateral ligament is
 5 on the inside. Medial meniscus is on the inside.
 6 (Continued on following page).
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 2 A On the outside, the lateral collateral meniscus,
 3 lateral meniscus, okay, and they all work together to
 4 prevent motion of the joint, particularly the ligaments
 5 and to prevent wear and tear, and to allow motion to the
 6 articular cartilage and the meniscus.
 7 There's also another part to the knee, that's
 8 a fourth bone in the knee, and that's the patella.
 9 What is another name for your patella? Your
 10 knee cap, okay. Everybody knows about the kneecap.
 11 That's also part of your knee. It's actually an
 12 interesting bone, the knee cap. It's a sesamoid
 13 bone.
 14 What's a sesamoid?
 15 A sesamoid bone is a that's within a tendon,
 16 so it's actually, part of the thigh muscle, so you
 17 have your thigh muscle that actually attaches down on
 18 the tibia here, so thigh muscle, that's called the
 19 quadriceps. Thigh muscle goes all way, attaches to
 20 the tibia. What does that do? It actually
 21 straightens out your knee. The ligament theme song,
 22 the knee bone connects, those are ligaments, they
 23 connect bone to bone.
 24 Then we have tendons. We have tendons.
 25 Those connect muscles to bones, so here we have, for
 26 example, a tendon in front of the knee, and within

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 2 that tendon is the fourth bone of the knee, the
 3 patella, so you have quadriceps muscle, patella,
 4 patella tendon attaching down to the tibia, so we
 5 have muscles that move the joint, ligaments that
 6 prevent abnormal motions, pads that help prevent wear
 7 and tear, and that's pretty much the basic anatomy of
 8 the knee.
 9 Q Now, before we leave the knee, doctor, what I
 10 would like you to do, I would like you to focus on
 11 vascular function. For example, if we start with the
 12 meniscus --
 13 First of all, what is vascular function?
 14 A Okay. I'm just going to take a sip of water.
 15 Thank you.
 16 Q By the way, doctor, before I start, have you
 17 appeared in Court before?
 18 A I have appeared twice before in Court.
 19 Q All right. Take your time. If you need some
 20 water, let us know. If you need a break, let us know
 21 that.
 22 A Okay. Thank you.
 23 Q Let's focus on vascular function. What is that?
 24 A Well, vascular, let's just talk about
 25 vascularity.
 26 Let's say that, okay, so everything in your

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 2 body in one way other another is alive. Everything
 3 has cells. Cells are the building blocks of all the
 4 parts of the body, so the liver has liver cells.
 5 Your kidney has kidney cells. Muscles have muscle
 6 cells. Bones have bone cells. Bone is alive, okay.
 7 Bone is alive. Bone has lots of cellularity.
 8 If you break your bone, it bleeds, okay.
 9 Remember, bone marrow? That's where all the
 10 bone elements, the blood elements come from, so if
 11 you want to make cells, it actually comes from your
 12 bone marrow, so bone is alive, and in the knee, we
 13 have the bones that are alive, so they have bone
 14 cells, osteoblasts. Osteoblasts we call them. We
 15 have the ligaments, therefore, collagen and
 16 fibroblast, okay, so those fibroblast cells,
 17 osteocytes, osteoblasts. We have collagen, which is
 18 like the little ropes that -- microscopic ropes that
 19 form all the little structures in the knee holding
 20 things together. Then we have the fibrocartilage
 21 pads, the menisci. What is unique about them,
 22 because they're in you're knee, they don't have much
 23 vascularity. If you look microscopically at bone,
 24 ligaments, bone and ligaments, they have little
 25 vessels like arteries become arterials, these veins
 26 become venals, so if you look under the microscope,

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 2 you see these little blood vessels. When you get to
 3 certain parts of the body, those vascular elements
 4 become scant. You don't see them very much.
 5 Q Scant?
 6 A Scant. Uncommon, not well seen, not frequently
 7 seen, so if we look at the meniscus, for example, the
 8 meniscus is the shape of a seed that sits between the two
 9 bones, and only at the periphery is the blood supply,
 10 only 1 or 2-millimeters. The rest of it is avascular.
 11 It actually gets nourishment by a process called
 12 effusion.
 13 Q When you say avascular, does that mean without
 14 blood supply?
 15 A Without blood supply to the majority of the
 16 meniscus.
 17 Also, articular cartilage, another part of
 18 the knee, the white stuff covering the bones, doesn't
 19 have a good blood supply.
 20 What's the implication for that? What's the
 21 implication for tissues that don't have good blood
 22 supply?
 23 Poor healing.
 24 If you get a cut, if you get a cut, you
 25 scrape your arm, what happens? Everyone knows. It
 26 bleeds. Blood brings in the cells that heal, right.

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 2 The two ends of the bone, the two ends of the skin,
 3 the two edges have to get near each other, you got a
 4 clot. You get a clot.
 5 How does blood go from being liquidy to
 6 solid, right? The proteins act to make the blood
 7 solid, okay, and you get a clot, and that brings in
 8 healing.
 9 Well, articular cartilage and meniscus, that
 10 doesn't happen, so Henry Menken was a surgeon up at
 11 Mass General many years ago showed that if you had
 12 damage to the articular cartilage, it doesn't heal.
 13 It doesn't heal. It only can heal if you get sort of
 14 a full friction lesions down to the bone where
 15 there's blood that can bring in blood cells. Even
 16 then, the process is not very good, so what's unique
 17 about the knee, and some other parts of the body,
 18 around the shoulder, and some other joints, some of
 19 these elements that have cartilage have poor
 20 vascularity, and hence, poor healing qualities.
 21 Q Doctor, what is the retinaculum?
 22 A The retinaculum is a specialized structure that's
 23 in the knee, not one of the major structures like the
 24 ligaments, or the meniscus, but is an important structure
 25 nonetheless, and it holds your knee cap, your patella in
 26 place, okay so, your knee cap can slide back and forth

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 2 this way, and the retinaculum is some tissue on each side
 3 that prevents it from going this way, that's this
 4 retinaculum, and from going this way, that's that
 5 retinaculum.
 6 Q That you are talking about lateral to medial?
 7 A Yes. Actually, we know now in the past years
 8 we've been talking about little ligaments that are
 9 actually within the retinaculum, but when we talk about
 10 the retinaculum as the whole structure, that keeps the
 11 kneecap centered, keeps the kneecap centered. You can
 12 see why it should be centered because, actually, if you
 13 look, I don't know if you can see -- I'll show you,
 14 there's like a V. There's like a V here. That's in the
 15 femur, this little groove. You can see it up here, this
 16 little groove, it's called trochlear, and the trochlear
 17 is the seat for your knee cap. The trochlear is a seat
 18 for kneecap, so the kneecap sits in the trochlear, so
 19 when you flex and straighten your knee, when you bend and
 20 straighten your knee, that kneecap sits in there right in
 21 that trochlear, and if you have weakness of your
 22 retinaculum, the kneecap can slide to the sides, and
 23 that's what happens when people have kneecap instability,
 24 another problem of the knee, and once in a while we have
 25 to actually tighten up the retinacular because the
 26 kneecap is sliding too much.

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 2 Q Doctor, you refer to the word subluxation.
 3 What is that?
 4 A Subluxation by definition means part of a joint
 5 that's out of place. That's all it means, part of a
 6 joint. It's a big word. All it means is part of a joint
 7 is out of place, and partially out of place, okay,
 8 because everyone knows what completely out of place is,
 9 dislocation, so dislocation means completely out of
 10 place, so we had to come out with something -- not me,
 11 but many years ago, partly out of place, and that word
 12 was subluxation.
 13 Q Doctor, when we speak about terms such as
 14 arthritis, where in the body would arthritis be found?
 15 A Well, arthritis can be found in joint, number
 16 one, and in any joint in your body, so you can get
 17 arthritis anywhere. You can get arthritis in your TMJ
 18 joint, arthritis in your neck. Any place there's a
 19 joint, a moving part, bone and cartilage, you can get
 20 arthritis.
 21 Q Doctor, just to clarify, when you used TMJ,
 22 temporomandibular joint is what you are talking about?
 23 A Yes. I'm sorry, the temporomandibular joint.
 24 Q That's not involved in this case.
 25 I want to draw us back here.
 26 A In the knee, in the knee, any of the articular

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1 Hershman Direct - Rubinowitz
 2 surfaces can get arthritis, so any articular surface you
 3 can arthritis. You can get arthritis on the femur. You
 4 can get arthritis on the tibia. You can get arthritis on
 5 the patella, so any of the surfaces you can get arthritis
 6 in. Sometimes you can get arthritis in one of the
 7 parts. Often you get arthritis in all the parts.
 8 Depends on what is creating the arthritic process.
 9 Q Doctor, when we talk about a term such as
 10 osteoarthritis, what is that?
 11 A Osteoarthritis is many things.
 12 One thing it is, is it's you use the word for
 13 the process where joints break down, so where
 14 cartilage is lost, the cushion is worn out, the bones
 15 get closer together because the cushions are wearing
 16 out, and the patient has pain, but osteoarthritis is
 17 the process -- excuse me, where the cartilage wears
 18 down.
 19 Q All right, thank you, doctor.
 20 What I want you to do now is, I want you to
 21 put up another anatomic exhibit, Exhibit 23 in
 22 evidence, and I would just ask you if you would
 23 explain to us, what is Exhibit 23?
 24 A This is an illustration of the pelvis, and many
 25 of the structures around the pelvis, so the pelvis is the
 26 bones here at the your waist, and there are many organs

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2 that are inside the pelvis.
3 As an orthopedic surgeon, we take care of the
4 pelvic bones and some of the ligaments around the
5 pelvis. The pelvis is -- going back to that sort
6 of the song of the bones being attached to each
7 other, the thigh bone, or the femur comes up and
8 attaches to the pelvis, so your hip, your hip joint
9 is at your pelvis.
10 You also have in the pelvis a joint in the
11 front, a pubic symphysis. That's a joint that widens
12 when women have children. The pelvis opens slightly
13 to allow the fetus to go down the birth canal, so
14 that widens a little bit. That's a little joint in
15 the front here.
16 Around the back is the sacrum. That's part
17 of the pelvis sort of structure, and in the front, we
18 have two structures called the rami, the superior and
19 inferior rami.
20 Q Would you just point out, doctor, where the
21 superior pubic rami are?
22 A It's this sort of the bridge across, across the
23 front of the pelvis. That is the superior, that is the
24 top, and this is the inferior, that is the bottom.
25 Around this area is the bladder, it's right
26 behind here. There's a lot of arteries and veins

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2 that pass through here. There are some nerves that
3 also come around through here. A lot of the lower
4 parts of the bowel pass through that area to the
5 floor of the pelvis back there. There are lots of
6 muscles, and -- a lot of muscles.
7 Q And, doctor, are there -- I'm sorry -- are
8 there peripheral nerves that surround every square inch
9 of the body?
10 A Well, there are peripheral nerves on the surface
11 of your entire body. That's why you feel things.
12 Q Doctor, what I would like to do next, I would
13 like to focus on what has been marked as Plaintiffs'
14 Exhibit 24 in evidence. Let's put this up briefly.
15 I would just ask you to explain what is
16 Exhibit 24 --
17 A This is an illustration.
18 Q -- in evidence?
19 A Of the bones of the shoulder girdle, the bones of
20 the shoulder girdle.
21 Q And, doctor, is there another joint affiliated
22 with the shoulder girdle?
23 A Well, the shoulder has a number of joints. Just
24 like the knee has some joints, the shoulder has some
25 joints.
26 There's the major of the shoulder that we

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2 think about is the joint called the glenohumeral
3 joint, okay, so the bones of the shoulder are the
4 scapula, which is your shoulder blade, so the
5 shoulder blade, scapula, and then the other part of
6 the shoulder, the shoulder joint, the humerus, that's
7 your arm bone, and the articulation of the joint
8 between those is called the glenoid, which means the
9 socket of the shoulder, and the humerus, which is the
10 head, and they allow motion of the shoulder.
11 Shoulder is different than the knee.
12 Shoulders are really different than the knee.
13 The knee allows pretty much bending, right,
14 just bending.
15 Shoulder, you can do lots of things with your
16 shoulder; actually, all kind of things.
17 Q Does it have a greater range of motion than the
18 knee joint?
19 A Yes, it has a greater range of motion than the
20 knee joint. That's because the socket is very shallow,
21 and the head has lots of articular cartilage, a lot of
22 white stuff, a lot of articular cartilage in the shoulder
23 joints here with the glenoid, but the glenoid is kind of
24 shallow, so it allows your shoulder to do lots of things,
25 lots of motions, and because of that, the soft tissue
26 structures around that are very important; the rotator

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2 cuff, which is not illustrated here, but parts of muscles
3 and tendons that work in the shoulder, and some
4 ligaments, and also a labrum, which is a soft tissue
5 structure that tends to also keep the head in place.
6 Q Would you show us where the labrum would be
7 located, doctor?
8 A The labrum would be along the edge of the
9 glenoid, the bony part.
10 There's also another part of the shoulder
11 called the AC, acromioclavicular joint, which is
12 another part of the shoulder. That's up here at the
13 top. That's between the clavicle, and acromion, so
14 there's a few different joints that make up the
15 shoulder joint.
16 Q Okay. Doctor, finally, I'd just like to show you
17 what is marked Exhibit 25 in evidence.
18 If you could, doctor, would you just explain
19 what that is, please.
20 A Oh, this is another illustration of the chest
21 wall. This is your chest. This is, essentially, with
22 the skin removed, so this actually shows the various
23 muscles, bones, cartilage structures of the chest, shows
24 some of the blood vessels that travel through that area,
25 so what you see is in the front here the sternum, which
26 people call the breast bone. You see all the ribs. They

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2 go about along here. Ribs are protection for your lungs,
3 and heart. They sit inside your chest cavity, and the
4 ribs are protection for them. That's what the ribs do.
5 They also have muscles, so the muscles help
6 when you take a breath, your lungs expand, and
7 they're in between the ribs. There's some external
8 muscles that help that, too.
9 And then, there are muscles that attach
10 around the chest that help guide the shoulder to work
11 because your muscles have to be anchored to
12 something. Here's your shoulder up here, and your
13 chest works to anchor some of those muscles that
14 function for your shoulder.
15 These are the vessels that travel from your
16 heart, which is not seen, but it's inside there, to
17 various parts of your body. These are the vessels
18 going up to your head, down to your arm, and then
19 farther down to your lower extremities.
20 Q Thank you, doctor. If you can, just take your
21 seat for just a moment. Let's take these down.
22 Doctor, just some background questions as I
23 continue.
24 A Sure.
25 Q Are you Jim Gregware's treating physician?
26 A I am.

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2 Q All right. Did there come a time, doctor, that
3 you became involved in treating Jim Gregware?
4 A I did.
5 Q In treating Jim Gregware, did you actually review
6 the records of Dr. Feldman?
7 A I did.
8 Q Do you know Dr. Feldman?
9 A I do.
10 Q All right. For what purpose would you review
11 Dr. Feldman's records when treating Jim Gregware?
12 A Oh, in the course of treating a patient, if the
13 patient's had previous treatment, you would need to know
14 what that treatment was in order for your treatment to be
15 effective and appropriate.
16 Q Do you know Mr. Feldman?
17 A I do know Mr. Feldman.
18 Q Okay. For how long have you known him?
19 A Many years.
20 Q Okay. Doctor, did you learn that Jim Gregware had
21 been involved and injured in an accident on May 20th,
22 2006?
23 A I did.
24 Q Did you have an opportunity to review the MRI's
25 and the radiographic studies that were done at the
26 hospital where he was first admitted, St. Vincents

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1 Hershman Direct - Rubinowitz
2 Hospital?
3 A I did.
4 Q So, what I'm going to do right now, doctor, I'm
5 going to turn first to the St. Vincent's Medical Center
6 records, which is in evidence, and I told counsel what
7 I'm going to do is, I am going to focus on the records that
8 I have. They're all in evidence, but to make it quicker,
9 I organized it in a way that I can do this, so doctor, if
10 you would, please come back up now.
11 MR. BAXTER: Mr. Rubinowitz, can you identify
12 what the exhibit number that is in evidence?
13 MR. RUBINOWITZ: I'm going to St. Vincent's
14 Hospital chart right now. St. Vincent's Hospital
15 chart is Exhibit 13 in evidence.
16 MR. BAXTER: Thank you.
17 13?
18 MR. RUBINOWITZ: In evidence.
19 THE COURT: Just so the jury knows, you don't
20 need to know what the numbers and letters are of the
21 exhibits. If you want them during your
22 deliberations, just describe for us what you are
23 looking for, we'll figure out, and send it into you.
24 MR. BAXTER: I need to know.
25 Q Doctor, if you come back up, I'm just going to
26 put this up first.

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1 Hershman Direct - Rubinowitz
2 A I'm waiting for him to get set.
3 THE COURT: It's a small space. Watch the
4 wire.
5 THE WITNESS: Right, it's New York.
6 Q Doctor, I am going to be referring to the St.
7 Vincent's Medical Center report of the radiology
8 examination. The date for this one that I'm talking
9 about is May 20th, 2006, and it was taken at 8:37 in the
10 morning. It's a CT of the knee without contrast to the
11 left knee. I know this is an MRI. We'll get to those in
12 just a moment, but what I want to do, first of all,
13 doctor, is I want to talk about certain things that are
14 actually listed here on the CT report, and it says that
15 contiguous helical axial images were obtained for the
16 left knee.
17 What are those, first of all?
18 A A CT scan is an x-ray where we take films in a
19 cross-sectional fashion, so a plain x-ray is just like
20 sort of a frontal view, let's say, where a CT scan is a
21 cut. It's a cut.
22 Q I'm sorry, I should have done this. The number
23 is 26 I put up in evidence.
24 MR. BAXTER: 26.
25 Q Please, continue, doctor.
26 A CT scan is like a cut. Helical refers to the

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1 Hershman Direct - Rubinowitz
2 device you lay inside. It looks like a big donut. You
3 get inside, it takes slices. It gives you, actually,
4 more detail of the bone, the natural soft tissue, so to
5 see soft tissue, you need an MRI, and they compliment
6 each other.
7 Q For clarity, doctor, when you talk about soft
8 tissue, would that be, for example, the collateral
9 ligaments and the cruciate ligament?
10 A Yes. Soft tissues includes the muscle, tendons,
11 ligaments, meniscus, articular cartilage. Those are seen
12 in MRI, and bone are seen best if you are looking at the
13 fractures in a CT.
14 Q So, it continues, it says these contiguous
15 helical axial images were obtained of the left knee
16 joint, as well as multi plank planer formatted images.
17 One of the first things that it talks about
18 is there's an avulsion fracture of the lateral tibial
19 spine, which is displaced superiorly into the knee
20 joint.
21 What is that, doctor?
22 A So, we are talking a little bit about where the
23 cruciate ligaments are in the center of the knee, and
24 those are the ligaments that prevent front and back
25 motion. The spot where they actually attached has a
26 name, that is called a tibial spine. It's a little

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1 Hershman Direct - Rubinowitz
2 prong that's on the tibial bone itself, and you can see
3 here the ligament is not shown, but the ligament is over
4 here, and here's the avulsion fracture.
5 Avulsion means pulled off, so pulled off, you
6 avulse something. Anything you pull apart, you can
7 say you avulsed that, so if you wanted you can,
8 actually, say if the doorknob is loose, I pulled it
9 off, I avulsed the doorknob. I don't think I've said
10 that, but in medicine, that's how we do this.
11 So, if a ligament is pulled off, it comes off
12 with a bone, that's a bony avulsion. If there's a
13 ligament just pulls off by itself, that's a soft
14 tissue avulsion.
15 Q Now, one of the things that it continues with, it
16 says, additionally, there's an avulsed fracture of the
17 lateral tibia plateau. I'll just stop there.
18 When you talk avulsed fracture, doctor, first
19 of all, is that a traumatic injury?
20 A It is. And you can imagine, some thing is being
21 pulled off, being pulled off with a piece of bone, so we
22 call it avulsion. We say fracture because the piece that
23 came off as it pulled off has fractured away from the
24 other part of the bone, so you can imagine, if I put a
25 force on this knee this way, okay --
26 Q Indicating medial?

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1 Hershman Direct - Rubinowitz
2 A This is varus, so a force this way, the femur is
3 going to the inside here, see what's happening on the
4 outside here? Everything is get stretched, so something
5 has to give. Something has to give. It can either give
6 at the bone where a piece of, a chunk of bone pulls, or
7 at the ligament where the ligament just tears, okay, and
8 that's what happens in your injury. When you get
9 injured, the motion exceeds, the motion is farther than
10 the ligaments can withstand, and the ligament fails. It
11 just tears, or the bone brakes.
12 That's what happens when you break your leg.
13 Q In addition, it reads there's an avulsed fracture
14 of the lateral tibial plateau, which is displaced
15 superiorly and laterally with lateral distraction of the
16 knee joint.
17 A So, this is -- that's drawn schematically right
18 here, this piece right here.
19 Q By the way, doctor, with respect to these
20 exhibits, these anatomic exhibits before you, did you
21 actually work with us and an illustrator to create
22 exactly what the injuries were for Jim Gregware,
23 specifically?
24 A Yes, I worked -- we worked together to make
25 these accurate, and to be as illustrative. You got that?
26 I don't know if I said it right? But, to be a good

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1 Hershman Direct - Rubinowitz
2 illustration of what was actually represented in MRI's,
3 and CAT scans, and all the images, studies.
4 Q So, when they displaced superiorly and laterally
5 with distraction of the knee joint, what does the
6 distraction mean?
7 A Well, it's this. It's -- imagine this. This is
8 a distraction, right, on this side of the joint. The
9 joint is opening.
10 Q When you say this side of the joint --
11 A The lateral side. Thank you.
12 Q Would that be left?
13 A The lateral side of the joint is opening, so
14 here's what happens; the force is going this way. The
15 fractures occur here, and because there's no anchor there
16 any more, the joint stays distracted, it stays open
17 because the connections are missing, okay. The
18 connections are off, so here it is; this is connected
19 with tissue up to here, and as everything moved this way,
20 it all pulled off and this stayed wider.
21 Q In addition, doctor, it says there is a
22 comminuted fracture of the fibular head.
23 First of all, doctor, I want to focus on the
24 types of fractures that there are. When we talk
25 about something called a nondisplaced fracture, what
26 is that?

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1 Hershman Direct - Rubinowitz
2 A A nondisplaced fracture is a fracture that's in
3 place. It's like a crack in the bone. Another name
4 might be a hairline crack, so you see it on the x-ray,
5 you see it on MRI, or see it CAT scan, but nothing has
6 moved. It's usually aligned. It would be oblique, or
7 transverse, but it's a line.
8 Q When you talk about things, such as, for example,
9 a displaced fracture, mildly displaced, what is that?
10 A Displacement is a description we use for where
11 the bones have moved, so if the bones are in one
12 position, we call it nondisplaced.
13 If the bone is moved, we call it displaced,
14 okay.
15 We can also describe fractures by how much
16 damage there is to the bone, and what type of damage
17 there is to the bone, so nondisplaced, transverse
18 fracture is a super line across.
19 Then we start to talk about one part, two
20 parts, three parts, how many, actually, fracture
21 parts there are, and when there are so many parts, we
22 actually can't count them, we call it comminuted.
23 Comminuted means there's lots of pieces of bone, lots
24 of fragments. That's what comminuted means. We
25 can't describe it as one piece, 2 pieces, 3 pieces,
26 no way. We just call it comminuted. That includes

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1 Hershman Direct - Rubinowitz
2 as many pieces as you want, but that means lots of
3 pieces.
4 Q Is that a shattering of the bone?
5 A This is a shatter, and those are fractures that,
6 you know, from the circle point of view, you know, there
7 are parts, actually, can't get together because there's
8 lots of little pieces.
9 Q It continues that there's a small hemarthrosis,
10 which extends into the suprapatellar bursa.
11 A So, when this fracture happened, okay, this
12 fracture extended into the joint, so here's the tibia.
13 Remember, we were looking before at the anatomy. If I
14 can just use this for a second --
15 Q Yes. Can you refer to the exhibit? You are
16 talking about the knee exhibit?
17 A The knee exhibit.
18 MR. BAXTER: I'm sorry, doctor, can I ask you
19 just give the number under your arm there?
20 THE WITNESS: Of course, 22.
21 MR. BAXTER: Okay.
22 THE WITNESS: Okay, so the tibia over here,
23 you can see is in one solid piece, and here's the
24 joint, and in this illustration, the one 26, we can
25 see that the joint is shorter now. It's shorter,
26 okay, all the way across.

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1 Hershman Direct - Rubinowitz
2 Why? Because part of it is up here, part of
3 it is up here. It's pulled up. That's comminuted
4 avulsion fracture, a couple of little pieces here.
5 Q In addition, doctor, it says right on the report
6 that the fracture fragments have effacement intervening
7 back planes compatible with hematoma.
8 A So, we talked about the fact that bone has blood.
9 Bone is living tissue.
10 When you have a fracture, you get bleeding.
11 Because this is a fracture in the joint, it's an
12 intra-articular fracture. It's within the knee
13 joint. The blood goes into your knee, and we have to
14 go to give it a special name because we're doctors,
15 and we call that hemarthrosis. All that means is
16 blood in the joint.
17 Q It also says multiple minute ossific structures
18 project interiorly and posteriorly to the intraoptic
19 membranes, the possible fibula and tibial diaxis may
20 represent additional fracture fragments, and it
21 continues, which are displaced and continues arterial
22 vascular calcifications.
23 A Right. So, essentially, there were two fractures
24 over here. One was from the lateral tibia plateau. One
25 was from the fibula head. These were both attached to
26 the soft tissues, and that is, as they broke, lots of

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1 Hershman Direct - Rubinowitz
2 little pieces end up in the soft tissue, lots of bleeding
3 because of the two fractures.
4 Q Doctor, if I continue then with the MRI of the
5 May 22, 2006, a CT was done on May 20th. One of the
6 things that it speaks about is this; it says acromion
7 images demonstrate a large avulsion-type corner fracture
8 of the lateral tibia plateau.
9 Can you point out what that is?
10 A That's, again, describing this piece here.
11 Q And it says the tibia plateau with retraction,
12 and opening of the joint space.
13 A And because the soft tissue restraints here are
14 gone, the joint space here is wider.
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1 Hershman - by Plaintiffs - Direct/Rubinowitz
2 Q And then continues that there's marked widening of the
3 lateral compartment.
4 Would you just point out the lateral compartment?
5 A (Witness complies).
6 Q It says there's a focal chondral lesion of the lateral
7 femoral condyle.
8 A That's here on the femur itself. It is on the
9 articular cartilage. So chondral or cartilage, that white
10 stuff, has a little bits of a chondral lesion. It could be
11 little like a little dent or slit or a gap or defect or a little
12 crater, something like that. But a defect encompasses all of
13 that.
14 Q So, was there damage to both the femoral articular
15 surface as well as the tibial?
16 A There was.
17 Q Now, with respect to the MRI continues that there is a
18 partial tear of the ACL, complete tear cannot be entirely
19 excluded.
20 A So, the ACL, if we look over here, again, that is one
21 of those crossing ligaments in the center of the knee. The one
22 in the front, the anterior cruciate, so there was damage to
23 that. You see that on the MRI.
24 Q Okay. And, Doctor, with respect to those illustrations
25 that we have right here with the CT, just for clarity would the
26 CT show, at all, any damage to the collateral or cruciate

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1 Hershman - by Plaintiffs - Direct/Rubinowitz
2 ligaments?
3 A It would -- it would not. The CT would not. CT would
4 show the soft tissue.
5 If you have an avulsion, remember we talked about that
6 pulls a ligament off, that usually implies that's damage to that
7 ligament.
8 But, specifically, it doesn't show the soft tissue part
9 of the injury.
10 A .
11 Q Now, what I'd like to do is I'd like to focus on the
12 right knee, and I'm going to show you Exhibit 27 in evidence.
13 And, Doctor, with respect to this illustration and,
14 indeed, of all of the illustrations, did you compare the
15 illustration for the radiographic studies as well as the
16 operative reports in creating this illustrations?
17 A I did.
18 A So, here is the right knee.
19 MR. BAXTER: I'm sorry, is there a question.
20 Q Would you briefly explain what that is, and I'll go
21 into it in detail, Doctor.
22 A So, here is the right knee.
23 And, then, if it's the opposite. Remember, right knee,
24 left knee. So, knee goes on the inside. Lateral is on the
25 outside.
26 On this side, here is the lateral side. Here is the

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1 Hershman - by Plaintiffs - Direct/Rubinowitz
2 medial side.
3 And much the damage in the right knee was in the soft
4 tissue.
5 Q Doctor, if I focus first on the CAT scan of the right
6 knee taken May 20th, 2006, at 10:20 in the morning slightly
7 after the left knee was done. It reads that there is a
8 comminuted fracture deformity involving the fibular head. Would
9 you show us where that is?
10 A So, the fibula head, here.
11 Here is the comminution, lots of pieces.
12 Q And it says, multiple minute avulsion fracture
13 fragments displaced superior to the tibial spines?
14 A Again, we talked before on the other knee about the
15 tibial spine.
16 Here we see it again in the center of the knee where
17 the cruciate ligaments attach, implying that there is damage to
18 the cruciate ligaments.
19 Q And, then if we continue with the MRI of the right
20 knee, dated May 22, 2006, taken 7:57 in the evening, what they
21 did was axial and coronal images, and they said they demonstrate
22 complete disruption of the medial patellar retinaculum.
23 What is that?
24 A Okay, retinaculum, on the sides of the patellar, holds
25 it in place.
26 Here we see it in the front view.

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1 Hershman - by Plaintiffs - Direct/Rubinowitz
2 Remember, we talked about the muscle in the thigh.
3 The tendon down the center.
4 And the retinaculum on each side of the kneecap.
5 Here is the patellar. Here is the kneecap.
6 The retinaculum is through here.
7 Q And, it continues that there is complete disruption of
8 the medial patellar retinaculum, and complete grade 3 tear of
9 the contiguous medial collateral ligament?
10 A You could see that in this illustration. Here is the
11 retinaculum right here, and it continues.
12 This is the collateral ligament. So, the ligament on
13 the side, right here, okay.
14 So, all the structures on the inside on the medial side
15 of this knee were disrupted.
16 So the retinaculum, next to the patellar, the MCL next
17 to that.
18 So the mechanism of injury was this. This is what
19 happened.
20 And as the knee continues to go, additional structures
21 keep getting damaged.
22 And you could see how that happens on the inside over
23 here.
24 Q Now, Doctor, you focused on the mechanism of the
25 injury, so let me just stay with that before I continue reading
26 the MRI report.

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1 Hershman - by Plaintiffs - Direct/Rubinowitz
2 With respect to the mechanism of the injury, do you, as
3 an orthopedist, an orthopedic surgeon, make determinations as to
4 the forces that were necessary to create such an injury?
5 A Yes.
6 Q Can you explain to us then how this injury occurred
7 with specific respect to the mechanism of the injury?
8 MR. BAXTER: Judge, I'm going to object.
9 THE COURT: Grounds.
10 MR. BAXTER: I think we should approach.
11 THE COURT: Come on up.
12 (Discussion held off the record out of the hearing
13 of the jury).
14 THE COURT: All right.
15 MR. BAXTER: I withdraw the objection.
16 THE COURT: Thank you. You could come back,
17 Doctor. Thank you.
18 MR. RUBINOWITZ: I believe the objection was
19 withdrawn.
20 MR. BAXTER: Yes.
21 THE COURT: Withdrawn, yes.
22 Q Doctor, let me focus your attention back on the
23 mechanism of the injury. And, you were starting to explain to
24 us, obviously, having looked at both the MRIs for the right
25 knee, the left knee, and CAT scans to the right knee and left
26 knee, why don't we take it right now and talk about the

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1 Hershman - by Plaintiffs - Direct/Rubinowitz
2 mechanism of injury. I'd ask you to continue.
3 A Sure. We talked about this actually a little bit
4 before when we talked about how ligaments get damaged and the
5 stresses that -- that go on joints.
6 And, if you stress a joint, the direction that the
7 bones go will predict where the injuries are. Okay.
8 So, if the joint goes this way.
9 Q Indicating?
10 A To the valgus side, okay. Where, where is the injury?
11 On the medial side. Right. Everything gets stretched this way.
12 If the joint goes laterally or varus, what gets
13 stretched? Everything on the lateral side.
14 We have two knees, two knees. Each have somewhat
15 opposite injuries. That you have opposite injuries. Okay.
16 The right knee has a medial side injury.
17 The left knee, the fibula head, the avulsion fracture
18 of the lateral tibial plateau, that was a lateral injury. This
19 type of injury. Okay.
20 So what is happening? The knees are going this way.
21 The knees are going this way. We call this windswept knees.
22 So, imagine, if the wind is blowing at you, and your
23 knees go into a direction, they go in actually different
24 directions, but parallel to each other.
25 So, if you are injured, and you are hit this way,
26 you'll get the inside of this knee, and the outside of that

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1 Hershman - by Plaintiffs - Direct/Rubinowitz
2 knee.
3 So, if I were --
4 Q When you said the inside of this knee just for clarity?
5 A I'm sorry. The inside of the right knee, and the
6 outside of the left knee.
7 So, if I'm looking at a right knee, and my right knee
8 is hurt on the medial side, and my left knee is hurt on the
9 lateral side, my thoughts on this would be that this injury came
10 in this direction, and that's how that happened. That would be
11 how I would envision this injury.
12 And, I need to know that because -- and I'm thinking
13 about how to rebuild the joints, you know, that goes to the
14 structures that I have to focus on.
15 And, as the injury keeps going, more and more parts
16 keep getting injured. So, eventually get to commonality which
17 is the central portion of the joint, the cruciate ligament.
18 Q Now, if we focus back on the MRI reports for the date
19 May 22, 2006, it says:
20 Open and medial joint including complete disruption of
21 the medial patellar retinaculum and medial collateral ligament
22 completion disruption of those.
23 Show what that is?
24 A Those on the right knee, that is these structures right
25 here, on the inner part of the right knee.
26 Q With respect to the -- it says also there's disruption

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1 Hershman - by Plaintiffs - Direct/Rubinowitz
2 of the musculotendinous vastus medialis?
3 A The vastus medialis is part of the quadriceps muscle
4 that you see up here on the top.
5 And, we just give the name, it's quadriceps. Quad
6 means four. So there's four parts to it, and each part has a
7 name. So one of the parts is vastus medialis. It's on the
8 medial side.
9 So, we're orthopedic surgeons. We try to keep it
10 simple. So, medial, everything on the medial side is medial.
11 Medial retinaculum. Medial collateral ligament. Vastus
12 medialis.
13 Q And, with respect to the injury to the muscle itself,
14 if I focus on that for a moment, where is that in relation to
15 the patellar itself, the kneecap?
16 A Right adjacent to. The vastus medialis attaches
17 actually to the patellar.
18 Q And, Doctor, even then it continues that there is a
19 complete tear of the anterior cruciate ligament.
20 A So, we see that here in the center of the joint, as the
21 torn ACL, anterior cruciate ligament.
22 Q It continues that avulsion fractures to the tibial
23 spines, where is that?
24 A Those are again adjacent to the ACL, anterior cruciate
25 ligament tear.
26 Q There is also a tear of the posterior cruciate ligament

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1 Hershman - by Plaintiffs - Direct/Rubinowitz
 2 at the origin. What is it first of all?
 3 A The posterior cruciate is the ligament in the back, and
 4 the origin is up on the femoral part.
 5 Q Okay. When they talk about again an avulsion there,
 6 what is that?
 7 A Some fibers have been pulled off.
 8 Q Does it also take bone with it when it's coming down?
 9 A It can, but sometimes it doesn't.
 10 Q It also says there's a fibular head fracture?
 11 A And that would be over here.
 12 Q There is an evidence of cortical compression fracture
 13 of the anterolateral aspect of the lateral tibial plateau?
 14 A So, that would be in this area right over here with
 15 compression on the tibial plateau area.
 16 Q With respect to the tibial plateau itself, Doctor,
 17 where is the articular surface in relation to the tibial
 18 plateau?
 19 A The articular surface is on top of the tibial plateau.
 20 Here is -- plateau is a sort of a prominence. And then
 21 articular surface is on top of it.
 22 Q It says that there is a small interarticular loose body
 23 lateral compartment as described above. What are they talking
 24 about? Still with the lateral, still with the tibial spine?
 25 A Yes, I think some loose bodies came off from where the
 26 spine was pulled off.

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1 Hershman - by Plaintiffs - Direct/Rubinowitz
 2 Q And, the tear of the vastus lateralis muscle?
 3 A That -- what happened was I -- I believe that as this
 4 continued, some of the muscle fiber tear, some of the muscle
 5 tear extended over to the lateral side.
 6 Q All right. Now, Doctor, with respect to all of the
 7 injuries that were just described in both the CT and the MR for
 8 both the right and left knees, first question that I have,
 9 Doctor, to go through quickly, instead of asking individually,
 10 do you have an opinion as to whether all of those injuries were
 11 caused by trauma?
 12 A Yes.
 13 Q And what is your opinion?
 14 A My opinion is this group of injuries would be caused by
 15 trauma.
 16 Q How would you know that, Doctor, as an orthopedic
 17 surgeon?
 18 A Well, trauma is what leads to disruption of anatomic
 19 structures. So, this constellation, this group of injuries
 20 would -- would -- would need to be caused by trauma.
 21 Q And, with respect to that, Doctor, do you have an
 22 opinion as to whether or not the accident of May 20th was the
 23 cause of these injuries?
 24 A My opinion is after reviewing the records and talking
 25 to the patient that those injuries occurred at that time.
 26 Q Okay. Doctor, with respect to each of those injuries

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1 Hershman - by Plaintiffs - Direct/Rubinowitz
 2 that we just did, and I don't want to break this down
 3 individually, to save sometime, do you have an opinion as to
 4 whether or not those injuries that you have described are
 5 competent producing causes of pain?
 6 A Yes. These injuries are extensive injuries to many
 7 structures -- muscle, tendon, ligament, bone, cartilage -- and
 8 all those individually and together can cause pain.
 9 Q Doctor, if I continued through with the May 20th, 2006,
 10 CT, CAT scan of the pelvis, it indicates that there is a
 11 comminuted fracture deformity involving the right superior pubic
 12 ramus.
 13 What I'd ask you to do, Doctor, is with the
 14 illustration of the pubic ramus that's it -- just identify the
 15 number on the back please.
 16 A Number 23.
 17 Q Would you just first of all tell us and show us where
 18 the right superior pubic ramus is?
 19 A So, by convention, we put illustrations and look at
 20 x-rays in what's called the anatomic position. It's as if you
 21 are looking at the patient here.
 22 So, the pelvis, in the anatomic position, this is the
 23 ride.
 24 So, a right superior ramus fracture would be over here.
 25 And, comminuted would mean it's in lots of fragments.
 26 Q Doctor, what I would just ask you to do is if you

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1 Hershman - by Plaintiffs - Direct/Rubinowitz
 2 would, with this pen, if you would just write "comminuted,"
 3 where the comminution took place, where the fracture happened?
 4 A This is the ramus. So the comminution would be
 5 somewhere here in the ramus.
 6 MR. RUBINOWITZ: Let the record reflect the Doctor
 7 put a circle in that area, actually an oval in that area
 8 where the fracture was.
 9 Q Doctor, with respect to the comminution fracture of the
 10 superior pubic ramus, do you have an opinion as to whether or
 11 not that bled?
 12 A Well, like all fractures, a ramus fracture would bleed.
 13 Q And, with respect to the fracture itself concerning the
 14 pelvis, do you have an opinion as to whether or not that was a
 15 competent producing cause of pain?
 16 A Well, certainly, at the time of injury, pelvis
 17 fractures are quite painful because there is a rich blood supply
 18 around the pelvis, and pelvic fractures could be quite
 19 uncomfortable.
 20 Q By the way, when I ask you these opinions, you have an
 21 opinion to a reasonable degree of medical certainty, you
 22 understand.
 23 Do you have an opinion as to whether or not that injury
 24 to the superior pubic ramus, the comminuted fracture, was caused
 25 by the accident of May 20th?
 26 A It would be my opinion that these type of fractures are

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1 Hershman - by Plaintiffs - Direct/Rubinowitz
 2 caused by trauma, and given the story that that would be
 3 consistent with the injuries sustained at that time.
 4 Q It also indicates, Doctor, on the same set of x-rays
 5 that were taken for that same date, May 20th, 2006, that there
 6 were fractures of the ninth and tenth ribs.
 7 Would you just point out to us where those are?
 8 Posterior ninth and tenth rib fracture?
 9 MR. BAXTER: Sorry, Doctor, could you identify that
 10 please.
 11 THE WITNESS: Sure. Certainly. Number 25.
 12 A Okay.
 13 Q Okay.
 14 A We could see the ribs here are marked and numbered.
 15 So, 9 and 10.
 16 And, the description is posteriorly. Posterior means
 17 back. So, it's low down on the rib cage in your back.
 18 Q Okay. And, Doctor, the same question with respect to
 19 the rib fractures. Do you have an opinion as to whether those
 20 are competent producing causes of pain?
 21 A Yes, I agree those are competent producing causes of
 22 pain.
 23 Q And, as far as the causation, Doctor, do you have an
 24 opinion as to whether those rib fractures were caused by the
 25 accident of May 20th, 2006?
 26 A Looking at the records and talking to the patient, it's

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1 Hershman - by Plaintiffs - Direct/Rubinowitz
 2 consistent with being caused by the accident.
 3 MR. RUBINOWITZ: And, Doctor, before I move onto the
 4 operative report, your Honor, perhaps, we could take a break
 5 at this time.
 6 THE COURT: That would be a good time.
 7 (Whereupon, the jury leaves the courtroom.)
 8 (Brief recess).
 9 MR. RUBINOWITZ: Any objection?
 10 THE COURT: In evidence.
 11 (So marked and received Plaintiffs' Exhibit 35 in
 12 Evidence).
 13 (Whereupon, the jury enters the courtroom).
 14 THE COURT: All right. Let's sit down please.
 15 ELLIOTT HERSHMAN, resumes.
 16 THE COURT: Please continue.
 17 MR. RUBINOWITZ: Thank you.
 18 BY MR. RUBINOWITZ:
 19 Q Doctor, before the break, I mentioned that we would be
 20 focussing on the operative reports.
 21 The first one I'd like to focus on though is is your
 22 operative report from August of '99. Did you perform surgery on
 23 Jim Gregware years before this accident took place?
 24 A I did.
 25 Q Would you please explain what was done in this surgery
 26 just so we know.

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1 Hershman - by Plaintiffs - Direct/Rubinowitz
 2 And I just ask you if you would, feel free to use
 3 Exhibit 35, the anatomic knee that we've been using.
 4 A JUROR: There's one right here. Straight over
 5 here.
 6 THE COURT: And, before you use something, there is
 7 a label on the back of it, tell us what is.
 8 MR. BAXTER: That one is on the front.
 9 THE COURT: Sorry, upper right.
 10 THE WITNESS: Flexibility.
 11 22.
 12 THE COURT: Thank you.
 13 A Excuse me. I'm sorry.
 14 A In 1999, I operated on Jim Gregware. That's when I
 15 first met him.
 16 And, at that time he had problems with his left knee.
 17 We found at that time that he had a torn lateral meniscus, and
 18 that he had a chondral injury on his femur with a loose piece.
 19 We did arthroscopic surgery. I did arthroscopic
 20 surgery, where we looked in the knee with an arthroscope. It's
 21 a little device. I trimmed the piece of the meniscus that was
 22 torn, and I removed the loose chip that was in the joint.
 23 Roughly, on average, 45-minute procedure.
 24 So, basically what happens is, for the lateral
 25 meniscus, which is the fibrocartilage structure right here
 26 between the bones, gets a tear.

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1 Hershman - by Plaintiffs - Direct/Rubinowitz
 2 If you look here, that's this structure right here.
 3 It's a little pad. We talked about it before. It's a
 4 structure that does not have a good blood supply. So, when they
 5 get little tears, they don't heal. They become symptomatic.
 6 Patients come in and say, My knee hurts. It swells. We get an
 7 MRI. There was a tear there. I trimmed the tear.
 8 We also found on the surface of the bone a little piece
 9 of cartilage was damaged with a little piece free, and I removed
 10 that. That was the surgery in 1999.
 11 Q Now, you mentioned arthroscopic surgery. Would you
 12 just compare and contrast that to, for example, what is open
 13 surgery?
 14 A Open surgery requires a large incision. So, anywhere
 15 from open surgery being done with an incision of this length or
 16 an incision of this length.
 17 Q Indicating about three inches to twelve inches?
 18 A Three inches to twelve inches.
 19 And, depending on what surgery you are going to
 20 perform, the size of the incision would reflect the amount of
 21 exposure, that is what we call it, the amount of tissue that we
 22 need to open to expose whatever we want to accomplish in the
 23 joint.
 24 Over the years, we've developed techniques to make
 25 those incisions smaller and smaller and smaller. And, virtually
 26 all parts of the body now can be reached by minimally invasive

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1 Hershman - by Plaintiffs - Direct/Rubinowitz
2 techniques. And joints, arthro means joint, so the surgery is
3 called arthro, and you use a scope, arthroscopic. Laparo,
4 laparoscopic is in the abdomen, things of that sort.
5 There are some things we could do currently that are
6 actually relatively significant surgery using arthroscopic
7 techniques. And, there are still some procedures that we have
8 to do open techniques because those parts of the knee, for
9 example, are not accessible by arthroscopic techniques.
10 Q Doctor, with respect to the surgery that you had done
11 in 1999, did you make note of the anterior cruciate ligament and
12 the posterior cruciate ligament?
13 A We did. As a routine in all arthroscopic procedures,
14 we look at all the structures in the joint to make sure they are
15 intact. And the ACL at that time was normal.
16 Q And with respect to the PCL?
17 A The PCL was normal.
18 Q Again anterior cruciate ligament?
19 A Both normal. ACL, PCL, both normal.
20 Q How about the MCL, medial collateral ligament, and the
21 lateral collateral ligament?
22 A They were also normal at that time although we don't
23 see those arthroscopically because they're outside the
24 extraarticular, we call that, they were on the surface of the
25 bone, but they both were normal.
26 Q And, was that with clinical evaluation?

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1 Hershman - by Plaintiffs - Direct/Rubinowitz
2 A Yes.
3 Q And, with respect to that surgery, how long was it
4 before Jim Gregware healed?
5 A Approximately, about six weeks.
6 Q After about six weeks how was he doing?
7 A Doing very well. Back to sports, back to activities of
8 daily living.
9 Q All right, Doctor, what I'd like to do now is I'd like
10 to focus your attention specifically on the first surgery that
11 was done at Saint Vincent's Hospital, and what I'll do is I'll
12 put up the exhibits, as we go, of the left knee. And we do have
13 two.
14 So, if you just take them and show us as you are going.
15 If you just use both please.
16 Okay. Doctor, what it reads, procedure performed?
17 MR. MILLER: Before we begin, can we mention the
18 exhibit numbers on both of those.
19 THE WITNESS: This is this is Exhibit 29.
20 MR. MILLER: Thank you.
21 A So, we spoke a little bit about the injuries, and what
22 happened, and you could see here that surgery was performed to
23 repair the damaged structures, on the outside of the knee, the
24 extraarticular part.
25 This did not repair all of the damaged structures. The
26 reason being, and we could talk about that, is that there was

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1 Hershman - by Plaintiffs - Direct/Rubinowitz
2 actually so much damage, doing all the surgery at once would be
3 too much surgery. And, that's just a basic principle of these
4 kind of injuries. Okay.
5 But, here, the avulsed fracture, the tibial plateau was
6 visualized.
7 How? By making an incision over it. Open the skin.
8 Open the fat underneath the skin. Spread the tissues, and you
9 find the piece of bone. The soft tissue was attached to it.
10 So, the surgeon Dr. Feldman brought the piece down,
11 replaced it in the bed where it came from, drilled two pins, had
12 a drill, with an pin, a pin driver we call it, drilled two
13 pins -- here you could see it -- into the fragment.
14 Held the fragment in place with the pins.
15 And, then actually put screws across the fragment to
16 hold them until the fracture heals.
17 Because bone is a living tissue, and fractures can heal
18 just like a cut in your skin. You know, fractures heal.
19 So, we put the screws in because we need to hold it in
20 the right place until the bone heels.
21 Q Doctor, one of the things that the operative report
22 actually reads, that examination under anesthesia showed
23 complete lateral collateral ligament instability; complete
24 anterior and posterior cruciate ligament dysfunction.
25 A So, one thing we do.
26 MR. BAXTER: I'm sorry, is that a question?

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1 Hershman - by Plaintiffs - Direct/Rubinowitz
2 THE COURT: Go ahead.
3 Q Doctor, with respect to that, first of all, tell us how
4 it is that you go about repairing that, or how it was that they
5 went about repairing that, or what they were doing with respect
6 to that?
7 A In terms of how they repaired that, they found when
8 they examined him there was lateral collateral ligament laxity,
9 and that was because the lateral collateral ligament was
10 attached to this avulsed piece and pulled off the bone. So,
11 there was no more continuity of that structure.
12 So, if, just like we do with this knee, we do with a
13 person's knee. No different.
14 So, I'll take a knee, and do this to it. And I'm
15 applying stress to the joint.
16 (Continued on following page).
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1 Hershman Direct - Rubinowitz
 2 A So, I'll take a knee and do this to it, and I'm
 3 showing, applying stress to the joint, and when I have a
 4 normal knee, the ligament is attached, there's very
 5 little motion. Sometimes people have physiologic motion,
 6 where's there's a little bit of play in the joint
 7 normally. It's hard to tell if there's, you know,
 8 ligament injury or not, and you have to get an MRI, or
 9 take a look to confirm it, but most of the time we can
 10 tell in injuries like this where there's complete
 11 disruption of all the structures on one side of the
 12 joint, the joint tends to open up, so we need to restore
 13 that, and in this situation, because the ligament came
 14 off with a piece of bone, if we put that piece of bone
 15 back where it came from and fix it, we should be able to
 16 restore stability to that structure, and that was the
 17 intent of this operation, so what Dr. Feldman did was put
 18 suture anchors. These are little anchors that we insert
 19 into the bone. They have suture material, little strings
 20 attached to them, so the anchor is just like an anchor
 21 going into the sand, and has a rope, or a chain tied to
 22 the rope, the same idea, tied to the boat; well, this is
 23 tied to the ligament, so we put the anchor into the bone.
 24 We bring the piece of bone down and we attach the piece
 25 of bone. It's, actually, down here. Here's the anchors.
 26 Here's the sutures, you can see them right there, and it

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1 Hershman Direct - Rubinowitz
 2 bring the piece of bone down here, so two different
 3 techniques were used here probably because of the size of
 4 the fragments. This is a large fragment, so screws.
 5 This is a smaller piece, suture anchors, and bringing
 6 both pieces of bone back, putting them where they came
 7 from, repairing the lateral side of the knee.
 8 Nothing was done at this procedure for the
 9 cruciate ligament injury. Nothing was done at this
 10 procedure for the cruciate ligament injury.
 11 Q Now, doctor, with respect to this surgery, the
 12 date is May 31st, 2006. The date of the accident was
 13 11 days earlier.
 14 With respect to the time lag, have you had an
 15 opportunity to review the records?
 16 A I have.
 17 Q Doctor, what's the significance of the time lag
 18 as it relates to vascularity?
 19 A This is a question that deals with timing of
 20 surgery, and major injuries, so these are major injuries.
 21 These are multi-ligament injuries we call them, so more
 22 than one ligament.
 23 When more than one ligament is damaged, we
 24 are concerned about the amount of displacement of the
 25 bones, of the knee, at the time of the injury, so if
 26 you are injured, and your knees move really quite far

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1 Hershman Direct - Rubinowitz
 2 because the ligaments are torn, and there's great
 3 force on your knee, there's a lot of displacement;
 4 number one, we see that as orthopedists because of
 5 the number of ligaments involved, and that -- the
 6 light bulb goes off that with that injury could be a
 7 vascular injury, so the main arteries to the leg can
 8 be damaged, okay, so we always, number one, check
 9 that because if we miss that, and there's a vascular
 10 injury, then that compromises the circulation to the
 11 whole leg. The person can potentially lose their
 12 leg, okay, and if we identify it, which we hope to do
 13 a hundred percent of the time, we get the vascular
 14 surgeons to repair it, so we always watch these legs.
 15 Do we get a Doppler test, or arteriogram, or MRI, a
 16 variety of different tests we can get to check the
 17 circulation. We wait for some of the swelling to go
 18 down, and then we reconstruct, we start the process
 19 to reconstruct the ligaments.
 20 Q Doctor, would you please continue with what was
 21 done with the surgery?
 22 A So, in this surgery, essentially, after the
 23 swelling went down, the vascular people cleared him.
 24 Then that was all in the record.
 25 The tibial plateau was repaired, and the
 26 fibular collateral ligament with the avulsed fracture

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1 Hershman Direct - Rubinowitz
 2 was repaired, and that was what was accomplished with
 3 the first surgery on the left knee.
 4 Q Doctor, with respect to the left knee, can you
 5 take a look at the other exhibit. Show us what that
 6 represents, and read the number on that, as well.
 7 A Sure. Thank you for reminding me. This is
 8 number 30.
 9 Q You know, before we get to that, doctor, I'll
 10 just -- all right, going to the right knee surgery --
 11 A So, this is Exhibit 28.
 12 So, on 5/31, so you know, some days after the
 13 original injury, he had this left knee surgery, and
 14 at the same sitting, same sitting, they did some
 15 right knee surgery, as well, and again, repairing the
 16 structures that can be repaired. Repairing the
 17 structures that can be repaired, so repair means in
 18 orthopedic terminology, sort of sewing things back
 19 together.
 20 To contrast that, we talk about
 21 reconstruction is when we replace things, so here Dr.
 22 Feldman repaired the soft tissues that were torn that
 23 he identified on the MRI, and identified on an exam
 24 under anesthesia before we started, so initially,
 25 this was the medial region, so we repaired the
 26 quadriceps tendon, the vastus medialis, the medial

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1 Hershman Direct - Rubinowitz
2 retinaculum.
3 Q If I can just stop you for one moment; when the
4 procedure was taking place, it reads in part examination
5 under anesthesia showed complete avulsion with open book
6 medial region, and anterior tear and posterior cruciate
7 ligament tearing.
8 First of all, what does that mean, a complete
9 avulsion with open book medial region?
10 A Open book is a term we use to describe how much
11 the joint opens, okay. I'm looking for a book, but I
12 don't see one. I'll pass on using the Holy Bible that's
13 up there.
14 Essentially, an open book is --
15 Q Here's a book.
16 A Thank you.
17 So, open book, if you look at a book, open
18 book implies how much the joint opens, so if we look
19 at two bones kind of like this, the amount of the
20 displacement means it opened all the way, okay.
21 That's how much it opened, and that's a description
22 of wide, wide opening, so if you want to tell your
23 colleague, another orthopedic surgeon, it was open
24 book, they know everything was torn just by listening
25 to that description.
26 Thank you.

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1 Hershman Direct - Rubinowitz
2 Q Please, continue, doctor, if you would with the
3 surgeries that took place on May 31, 2006, to the right
4 knee?
5 A So, the right knee, so the open book was because
6 of the torn retinaculum, torn medial collateral ligament,
7 damage to the tendon, so Dr. Feldman, essentially,
8 repaired all the structures, put everything back where it
9 belonged, and either sewed it back together, or used a
10 screw and a washer to put it back to the bone where it
11 came off, an avulsion-type injury, so you have the screw
12 up here on the medial femoral condyle where it got pulled
13 off of, and the avulsion up here, and this is how it
14 looked when they started, and this is mostly likely how
15 they looked when it was repaired after reading the
16 operative reports and the descriptions.
17 Q One of the things that this operative reports
18 reads, I'm quoting, that the quadriceps muscle was ripped
19 off the proximal patella, and it follows medial
20 collateral repaired to stump.
21 When it says ripped off the proximal patella,
22 where is that?
23 A The proximal patella is the top part of the
24 patella right here.
25 Q With respect to this surgery, doctor, was
26 anything done with respect to the soft tissues?

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1 Hershman Direct - Rubinowitz
2 A Well, these are all repairs of the soft tissues
3 in the subcutaneous area, and these are all -- this
4 surgery was done through an open technique, so the soft
5 tissues were opened. It was an incision made. This was
6 not an arthroscopic procedure, and all exposed through an
7 incision.
8 Q What about the repairs, for example, of the ACL,
9 and PCL, and the MCL?
10 A These were not done at this time. This is for
11 staging purposes, so initially, big swollen knee, you
12 repair the structures initially that you want to repair
13 that are on the superficial part of the knee. Then we
14 stage it, and do the cruciate part at a later time. That
15 helps with scar tissues problems, range of motion
16 problems, things like that.
17 Q And, doctor, if I can direct your attention to a
18 portion of the hospital record, the St. Vincent's
19 Hospital records for these admissions when these two
20 surgeries were done on the 31st, before they were ever
21 done, one of the things that happened May 20th, 2006 when
22 he first came into the trauma unit is that a Foley
23 catheter was inserted.
24 What is that?
25 A Foley catheter is a tube, rubber tube, that goes
26 into your bladder. One of the urology people would

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1 Hershman Direct - Rubinowitz
2 insert, or perhaps, one of the emergency room doctors.
3 It's, generally, part of the trauma protocol.
4 In emergency rooms they have
5 traumatologists. Traumatologists put together trauma
6 protocols. When you come in with major injuries,
7 major injuries includes chest injury, pelvis injury,
8 extremity injuries. These are motor vehicle
9 accidents, falls from a height, things like that, you
10 automatically get the trauma protocol. That many
11 times includes a Foley catheter. It's a catheter to
12 prevent -- it's to help you void urination.
13 There are other times we put Foley catheters
14 in after major surgery --
15 MR. BAXTER: Objection.
16 THE COURT: Sustained.
17 Ask another question.
18 Q Doctor, one of the things that I want to focus on
19 is in the chief complaints, or the history, it reads in
20 part that Jim Gregware was thrown an unknown distance,
21 complained of severe knee pain, and right shoulder pain,
22 and road rash.
23 Let me stop there. What is road rash?
24 A Road rash is abrasions. Another name for it is
25 like a strawberry. If you play baseball, you slide into
26 second base, you get a strawberry. It's from sliding on

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1 Hershman Direct - Rubinowitz
2 the ground, you get an abrasion, takes the skin off and
3 when people are thrown along a sidewalk, or road, and
4 move along it, you get an abrasion, and we call it road
5 rash.
6 Q It reads that the road rash was noted on all four
7 extremities; knees abraded, and the back was ecchymotic.
8 What is ecchymotic?
9 A Black and blue.
10 Q Doctor, here in the record on the 21st it reads
11 that the doctors were concerned about vascular injury.
12 Is that what you were talking about before?
13 A Yes.
14 Q The test, the doppler, for example, the others,
15 was that to evaluate vascular function?
16 A It was.
17 Q One of the things that is included from the time
18 that he's in the trauma unit right through the end of his
19 stay is that he was given medications, including Percocet
20 and morphine starting on the 20th of May.
21 What is Percocet?
22 A Percocet is a narcotic. It's a codeine
23 derivative. It's a pain medicine. Percocet is combined
24 with acetaminophen. It's an ingredient in Tylenol.
25 Q Right. Surface morphine, what is that?
26 A Morphine is another narcotic. It's injectable.

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1 Hershman Direct - Rubinowitz
2 Q On the 21st of May, they doubled the dosage from
3 two milligrams now to four milligrams given IV.
4 What is that significance of that?
5 A We give morphine IV. That is a little more
6 effective. It works a little quicker. People who are
7 having significant pain, morphine, it's a narcotic. It's
8 a medication of choice, and if you give it intravenously,
9 it's a little more effective.
10 Q One of the things they mentioned with respect to
11 those pain medications is that they were at times
12 alternating percocet and morphine, and at times giving
13 them together?
14 What's the significance of that?
15 A Just reflects the level of pain a person is
16 having. The more pain medicine people require, the more
17 pain they're having.
18 Q All right. One of the things that is said is
19 that venadynes were in use.
20 A Venadynes are just these devices to help prevent
21 blood clots because laying in bed, people get blood
22 clots. It's a device you put on peoples' calves that
23 compress them, so that it keeps the circulation going,
24 and prevents deep vein thrombosis. That's one of the
25 potential complications of bed rest, limb surgery,
26 trauma. That's one of the prophylactic measures we use.

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1 Hershman Direct - Rubinowitz
2 Q Doctor, with respect to the pain management
3 during the time that he's in the hospital, it is noted
4 that he had suffered from break through pain even when
5 given morphine.
6 What is the significance of that break
7 through pain?
8 A The pain management people use that term to
9 describe patients who are given a level of pain medicine
10 that they feel is adequate to manage someone's pain, and
11 the patients have more pain, so they call that break
12 through pain. They give additional medicines. Sometimes
13 they call that rescue medicine, rescue medicine.
14 Q For example, when following the surgery June 2nd,
15 it says the patient reports being this excruciating pain
16 not being able to sleep. One the things that they
17 checked was respiration, and then gave the narcotic
18 medication.
19 A They checked the respiration because one of the
20 side effects of high narcotic dosing is respiratory
21 arrest, so if you get enough morphine, you stop
22 breathing.
23 Q Doctor, one of the notes reads that the patient
24 was suffering excruciating pain from suprapubic pain.
25 What is that?
26 A Suprapubic is the area around the pelvis, so

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1 Hershman Direct - Rubinowitz
2 suprapubic pain can be from anything.
3 Q Knowing that he suffered a fracture, a comminuted
4 fracture of the superior pubic ramus, would that be the
5 area?
6 A That could be consistent with the etiology of
7 that pain.
8 Q And, doctor, before he was discharged on the 6th,
9 on of the things that they noted surface rehab is that he
10 was NWBBLE.
11 Would that be non-weight bearing bilateral
12 lower extremities?
13 A It would.
14 Q Doctor, what I would like to do now is, I'd like
15 to focus on the surgeries first. Then we will come back
16 to what you did, all right.
17 So, let's go now to the surgery right here of
18 January, 2007. If you can, just read the number
19 again.
20 A This is Exhibit 30.
21 Q Ones again, doctor, is this anatomically correct
22 illustration that you, illustrative creations you did for
23 the surgery?
24 A It is.
25 Q Would you please tell us what this represents,
26 doctor?

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1 Hershman Direct - Rubinowitz
2 A Oh, this represents a procedure that he had for
3 approximately seven months after the original surgery, so
4 the first surgery is the end of May.
5 This is a surgery in January, and represents
6 removal of one of the screws that according to the
7 record was backing out.
8 Q How is it that that can possibly happen?
9 A Oh, once the fracture heals, the screws are
10 actually not necessary any more because the bone is back
11 to being normal, so the hardware becomes superfluous.
12 Sometimes with motion, the screws can actually back out a
13 little bit, and if they do, they're right under the skin
14 and irritate the skin, so the surgeon would see this on
15 an x-ray, and then make a small incision, and literally
16 just unscrew it and remove the screw.
17 Q Doctor, one of the things it reads surface the
18 diagnosis is, complex poste lateral meniscus tear, grade
19 three, chondral lesion of the tibia plateau lateral
20 compartment, and protruding painful hardware.
21 A At the time of surgery, according to the
22 operative report, he also did an arthroscopic procedure,
23 patient's under anesthesia, and if the patient's having
24 any issues in the knee, you would do arthroscopy to check
25 out what's going on in the knee, and he did that, and
26 found some damage to the meniscus, which he cleaned up,

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1 Hershman Direct - Rubinowitz
2 and some damage to the tibial plateau, which he also
3 cleaned up a little bit with little device, and roughened
4 it up with a device called a shaver.
5 Q Doctor, what is the significance of a grade three
6 chondral lesion of the tibia plateau?
7 A Chondral lesions could cause pain, so articular
8 cartilage, loss of the continuity of the surface, and
9 they can be painful.
10 Q Do you have an opinion as to whether or not that
11 type of lesion is the type of lesion that can result in
12 osteoarthritis?
13 A Oh, chondral lesions can be the precursor to
14 arthritis, and many times we see people who had chondral
15 lesions, and depending on their size and location, and
16 can go on to develop osteoarthritis.
17 Q Doctor, with respect to this surgery that was
18 done January 22nd, 2007, was any attempt made to repair
19 those structures, including the vena collateral ligament,
20 posterior cruciate ligament, anterior cruciate ligament,
21 so on?
22 A No. There was no surgery done at that time to
23 repair the cruciate ligaments.
24 Q All right. And, doctor, was there a reason that
25 the surgery wouldn't take place at this point in time for
26 those ligaments?

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1 Hershman Direct - Rubinowitz
2 A If a patient was still working on the range of
3 motion, getting their strength back, the screws was
4 bothering them, limiting some of their range of motion,
5 that might still be a way to defer that surgery.
6 Q Now, doctor, you had actually met with Jim
7 Gregware in fall of 2006, correct?
8 A I have.
9 Q What was your impression at that point in time
10 when you had met with Jim Gregware following this
11 accident of May 20th, 2006?
12 A Well, my thought was that at some point he would
13 need some reconstructive surgery to address the cruciate
14 ligament issues in the knee when I thought it would be
15 the appropriate time.
16 Q And, doctor, were there certain things that you
17 wanted to see a benchmarks before you would that type of
18 surgery?
19 A We look to see that the patient regains the range
20 of motion, the swelling is resolved, the patient has good
21 strength. We might want to check his amount of laxity he
22 has, and see what types of symptoms the patient is
23 having.
24 Q At this point in time was Jim Gregware required
25 at some point to use braces on the knees?
26 A Well, typically, patients who have some cruciate

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1 Hershman Direct - Rubinowitz
2 laxity, surgeries, and injuries like this would at times
3 use a brace.
4 Q What is a Bledsoe brace?
5 A A Bledsoe brace is post-operative. Bledsoe is
6 just a company. It's just a company. There are lots of
7 braces that the company Bledsoe makes, so
8 postoperatively, they put people in Bledsoe braces that
9 are long braces.
10 Bledsoe also makes ACL braces.
11 Q Was it your understanding that Jim Gregware
12 indeed had Bledsoe braces on both legs?
13 A He was using at the time long braces to help
14 protect his knees.
15 Q Now, doctor, did there come a time that you
16 actually did surgery on Jim Gregware?
17 A I did.
18 Q What I'll do now is focus on the fourth surgery,
19 the date 2/5/09, February 5, 2009, and I'll show you the
20 exhibit that we used, these two exhibits and we're
21 referring to, Exhibit 31 and 32.
22 MR. BAXTER: Which one are you going to use
23 first?
24 THE WITNESS: We're going to use 32 first.
25 Q All right. Doctor, one of the things that I
26 would like you to do before you describe the surgery is

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1 Hershman Direct - Rubinowitz
2 tell us what is the difference between an autograft and
3 allograft?
4 A Oh, sure. I'm just -- can I hold that? I
5 just want to switch the exhibits.
6 I would like to do this one first.
7 THE COURT: All right, so we're going to be
8 starting --
9 THE WITNESS: With 31 first.
10 THE COURT: Thank you.
11 THE WITNESS: Question was, what was the
12 difference between autograft and allograft?
13 Q Yes.
14 A When when reconstruct, when we use things to
15 rebuild, not repair, we take structures to recreate the
16 stability of joints, you can either use structures from
17 yourself that, perhaps, you might not need quite as much,
18 that would be an autograft, so auto-self, grafting it to
19 a different place, and an easy example of that is a skin
20 graft. Let's say you have a burn, and it's quite a thick
21 burn, and you need to get some skin over it, so you can
22 take an autograft, and take some skin from an area that's
23 not so exposed, take a partial thickness, skin graft it
24 on there, and that's an autograft.
25 Sometimes there are structures that you want
26 to not take a piece of native tissue to reconstruct,

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1 Hershman Direct - Rubinowitz
2 and you can use an allograft. An allograft is donor
3 tissue, so it's donor issue. It's part of what's
4 harvested when a donor elects to donate their body
5 parts, so people commonly here about, you know,
6 someone got a kidney from a donor, on a liver
7 transplant, or a heart transplant from someone like
8 that, but actually, when they harvest tissue parts,
9 they actually also harvest tendons and bone, and one
10 thing you use commonly in orthopedics is bone graft,
11 which comes from donors, and we use tendons that come
12 from donors, so we can use an Achilles graft, we can
13 use a patella tendon graft, we can use a hamstring
14 tendon graft, so it's really quite versatile.
15 What's good about donor tissue in the
16 musculoskeletal situation, you don't require
17 immunosuppressant drugs, so people that have a kidney
18 transplant, they have to go on kidney treatment their
19 whole life. For us, we don't have to do that, so
20 it's a very versatile, helpful technique in
21 reconstructing joints.
22 Q Thank you. Doctor, with respect to an
23 allograft, is it from a dead body?
24 A It is, it's from a dead body.
25 Q How is it that if you were to take an allograft
26 from a dead body, the body part doesn't die?

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1 Hershman Direct - Rubinowitz
2 A Oh, allografts work because they can be
3 revascularized, so your body recognizes that it actually
4 is tissue from someone else, and uses the collagen that's
5 in that donor tissue as a scaffold, and elements actually
6 from the bone and the soft tissues migrate to that
7 tissue, put down cells that make collagen, and put down
8 cells that make blood vessels, so over time we have a
9 process where allografts can revascularize.
10 Does that happen a hundred percent of the
11 time? No. But, fortunately, it happens most of the
12 time, so most people can revascularize allograft
13 tissue.
14 Q Doctor, was this one things that you were in the
15 forefront of when you were in places, such as Cleveland
16 Clinic and the others when you were talking about
17 transplants?
18 A Yes, and no.
19 At Cleveland Clinic, I was taught and learned
20 how to do autograft patella tendon ACL
21 reconstruction. That was particularly what I
22 learned, and that's a technique, actually, that I
23 used here on Jim Gregware where we take a piece of
24 patella tendon to replace the anterior cruciate
25 ligament.
26 In his instance, I used a donor tendon

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1 Hershman Direct - Rubinowitz
2 because we had to actually in this knee reconstruct
3 two ligaments.
4 Q When you say this knee, you are talking about the
5 right?
6 A The right knee.
7 Q All right. So, please, doctor, tell us what it
8 is that did you with respect to Jim Gregware's right knee
9 when you performed surgery on February 5, 2009?
10 A I reconstructed two ligaments, the anterior
11 cruciate ligament, and the medial collateral ligament.
12 Q You said medial collateral?
13 A Yes.
14 It turned out that the repair on the medial
15 collateral ligament didn't hold up very well. His
16 knee was still loose in that area. We determined
17 that when we were examining him.
18 What I did was, I took allograft tissue,
19 donor tissue, and reconstructed the two ligaments.
20 How do we do that? We -- first off, we do
21 arthroscopically, so looking on a TV screen using
22 small instruments, I literally drilled holes with a
23 drill through the bone, through the tibia bone on
24 bottom, through the femur bone on the top, placing
25 those created tunnels in the joint where the ACL
26 resides, where the ACL attaches, and then I passed

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1 Hershman Direct - Rubinowitz
2 the allograft, the donor tissue, into the joint and
3 held it with screws, so we actually did that part
4 arthroscopically, so here's the torn ligament, here's
5 the drill coming through into the femur, and then we
6 passed the tendon in.
7 Q Why don't you take the other illustration down,
8 so we can all see clearly.
9 A Then we passed this tendon, this donor tendon up
10 into the knee, and hold it with a screw at each end.
11 Sometimes we use some additional fixation, in this case a
12 staple. Well, no -- I'm sorry, in the patella tendon
13 we used two screws. Then we opened up the medial side
14 to reconstruct the medial collateral ligament, and I
15 literally removed the screw that was up here before from
16 Dr. Feldman, so I took that screw out. I drilled a hole
17 into the femur where the medial collateral ligament
18 attaches.
19 I took another graft that had some bone on it
20 with tendon, put it into that tunnel, passed this
21 down alongside of the knee, and then attached it to.
22 Q When you say this, what is it you are referring
23 to?
24 A The donor tissue.
25 I passed it down the side of the knee, and
26 then attached it on the tibia, the medial collateral

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1 Hershman Direct - Rubinowitz
2 ligament, where the medial collateral ligament
3 attaches with a screw, and a washer, and a staple, so
4 you can actually see that on this x-ray where here's
5 the piece bone that we put in. You can't see the
6 ligament, but then you can see the staple and the
7 washer down here.
8 Q That is because the soft tissues don't show up on
9 the plain film?
10 A Yes, that is correct.
11 So, we reconstructed on this surgery of this
12 right knee his ACL and his MCL.
13 Q Doctor, why is that you use the Achilles tendon
14 and patella tendon?
15 A Oh, so for the patella tendon, you need bone on
16 each end, so your patella tendon, okay, is this here, is
17 this part in front. When they harvest from the donors,
18 they can actually take it with a piece of bone from the
19 top, a piece of bone from the bottom, so I get what's
20 called bone, tendon, bone, and that's the standard, gold
21 standard for graft in the United States, actually,
22 worldwide for ACL's, BTB, bone, tendon, bone.
23 The MCL is a much longer tendon, much longer
24 than the patella tendon, so a patella tendon would be
25 too short to reconstruct than an MCL, so you need a
26 longer tendon. The Achilles is much longer. It

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1 Hershman Direct - Rubinowitz
2 comes with a piece of bone on the end, the piece of
3 bone with the heel, but the other side is soft
4 tissue, so we make do with that, so we put in the
5 bone in the femur. Then you can imagine, what we do
6 is we take the soft tissue of the tendon, and put a
7 staple over it. That's how we meld it to the bone,
8 instead of putting a screw.
9 Q Doctor, when you take, for example, the Achilles
10 tendon, you mentioned the heel. Is that tendon actually
11 attached to the gastrocnemial muscle?
12 A Yes, that's where the Achilles is.
13 Q Doctor, with respect to this surgery, why is it
14 that you did the right knee first with Jim Gregware?
15 A I believe this was the knee that was more
16 symptomatic and more loose.
17 Q And was there a certain laxity that you found
18 when you were doing the examination of Jim Gregware?
19 A This knee had both anterior laxity in the front,
20 in the ACL part, and medial laxity, analogous laxity from
21 the MCL part.
22 Q Doctor, that is the fourth surgery?
23 I'd like to go now to the fifth surgery, the
24 date 5/23/11, and I'm going to do the same thing; I'm
25 going to ask you to tell us the exhibits numbers on
26 the illustrations that you prepared.

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1 Hershman Direct - Rubinowitz
2 A So, first we're going to use Exhibit 33, and the
3 subsequent exhibit will be 34.
4 So, on this knee, which we did two years
5 later, okay, the ACL became symptomatic, and we did a
6 reconstruction of the ACL very similar to what we did
7 on the other knee; arthroscopic, we drilled a tunnel
8 through the tibia, drilled a tunnel through the
9 femur, and again, passed a patella tendon, bone,
10 tendon, bone, allograft into the joint, and held it
11 with screws at each end.
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1 Hershman - by Plaintiffs - Direct/Rubinowitz
2 A (Continuing)) We also, when we looked in, as we always
3 do and look around the entire knee, saw some more damage to the
4 lateral meniscus, and we trimmed that some more.
5 Q Doctor, with regard to that lateral meniscus, how does
6 that compare at this point in time to the original surgery you
7 did in 1999?
8 A Well, he's had two procedures additional now on the
9 lateral meniscus. So, the size of the meniscus is getting
10 smaller and smaller, and that's significant because that's the
11 pad of the knee.
12 Q Doctor, when there is bone on bone, what happens with
13 respect to the knee joint itself?
14 A Bone on bone implies there is no cushion that is
15 functional. There is no articular cartilage, and literally the
16 bone is rubbing on the bone, and that's the most advanced stage
17 of osteoarthritis.
18 Q And, Doctor, with respect to the fact that the
19 meniscus itself is getting smaller as a result of having partial
20 menisectomies, what is the significance with respect to Jim
21 Gregware?
22 A Injuries like these, including the ligament portion and
23 the meniscus portion, are associated with osteoarthritis.
24 Q Doctor, what is the cure for osteoarthritis?
25 A There actually is no cure for osteoarthritis, like you
26 could take a pill and cure it.

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1 Hershman - by Plaintiffs - Direct/Rubinowitz
2 We have -- we manage symptoms of osteoarthritis in
3 people. We give people anti-inflammatory medicine. We have
4 them in physical therapy, weight loss. But, in the end, when
5 symptoms interfere with activities of daily living can't
6 participate in sports, the treatment is knee replacement.
7 Q Before we get to that, Doctor, I want to ask you a few
8 questions about each of the surgeries. With respect to those
9 surgeries, and I'm just going to do this as lumping them
10 together so I don't have to do each one.
11 Do you have an opinion as to whether or not the
12 patient, Jim Gregware, suffered pain following these surgeries?
13 A I do, and I believe that these surgeries certainly lead
14 to pain.
15 Q And, in fact, Doctor, was he given the same type of
16 narcotic medications following each of these surgeries?
17 A My custom is to give patients narcotics after these
18 surgeries, the oral narcotics.
19 Q And, Doctor, with respect to these surgeries, is --
20 withdrawn.
21 Was there a certain period of time you wanted to Jim
22 Gregware to go under physical therapy?
23 A Always following surgery we have patients undergo
24 physical therapy.
25 And, even with these injuries alone, people would do
26 physical therapy.

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1 Hershman - by Plaintiffs - Direct/Rubinowitz
2 Q And, in fact, Doctor, before he even had the surgeries
3 with you, did you want Jim Gregware to have physical therapy
4 because of atrophy of the muscle?
5 A I did.
6 Q First of all, what is atrophy?
7 A Atrophy is loss of size and strength in a muscle. So
8 muscle gets smaller, that's atrophy.
9 Q For what purpose did you want him to have physical
10 therapy, strength in the muscles?
11 A Well, there's a few reasons. Number one is just for
12 activities of daily living and functioning it's always better to
13 have stronger muscle.
14 Number two, he had all these injuries. And at times,
15 at times, people can develop enough strength to stabilize their
16 knee somewhat during activities of daily living by muscle
17 strength alone.
18 And, third, muscle strength is important for
19 postoperative recovery.
20 Q So, now, let me focus then on what we just left off
21 with. Given the fact that you've treated Jim Gregware over the
22 years, do you have an opinion to a reasonable degree of medical
23 certainty as to whether he is going to need additional surgeries
24 in the future?
25 A Well, right now, his knees are relatively stable. And,
26 at least, on the macro stability point of view, he is -- he is

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1 Hershman - by Plaintiffs - Direct/Rubinowitz
2 there. We're accepting where his knees are.
3 But, knees with multiple ligament injuries, the -- when
4 we see these patients over time, five, ten, fifteen years, there
5 is an amount of play, micro motion play, because we can't make
6 the knee exactly normal. We're taking donor tissue, and we're
7 putting it where we believe the ACL goes, but it's not exactly
8 like an ACL. So, people get microscopic motion.
9 From that microscopic motion, people can develop
10 osteoarthritis.
11 Q And, Doctor, what I'm going to do right now, as we
12 continue along this line of questioning, I'm just going to ask
13 you just to move those. If you would put them down here for a
14 time being.
15 Doctor, I want to direct your attention to your own
16 office records. X-rays that you took, for example, on
17 October 11, 2012, where I'm pointing right now.
18 MR. BAXTER: I'm sorry, counsel, is that something
19 that is in Exhibit 21.
20 MR. RUBINOWITZ: We agreed to mark these.
21 MR. BAXTER: We will mark it after.
22 MR. RUBINOWITZ: That's what we agreed to in the
23 beginning. I want to move along.
24 THE COURT: You know what, let's give the jury a
25 break. Take five minutes.
26 And, we will take care of marking it.

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1 Hershman - by Plaintiffs - Direct/Rubinowitz
2 MR. RUBINOWITZ: By date.
3 COURT OFFICER: All rise.
4
5 THE COURT: Watch yourself as you go.
6 (Whereupon, the jury leaves the courtroom.)
7 MR. RUBINOWITZ: I'm going to identify them by date
8 and time.
9 THE COURT: I think we're up to 36.
10 MR. RUBINOWITZ: 36, 37 and 38, 39.
11 MR. BAXTER: When were these taken?
12 MR. RUBINOWITZ: 10/11/12.
13 MR. BAXTER: October of 2012?
14 MR. RUBINOWITZ: Right.
15 MR. BAXTER: Did you provide us an authorization.
16 MR. RUBINOWITZ: I sure did.
17 MR. BAXTER: Can you show it to me? I don't know
18 that I have it.
19 THE COURT: Mr. Miller can you show it to him.
20 MR. BAXTER: That's a good question. Do you have
21 it?
22 Let me see what I have.
23 MR. MILLER: I'm coming up short on than one.
24 I only got the case a month ago.
25 THE COURT: These are part of the treating
26 physician file.

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1 Hershman - by Plaintiffs - Direct/Rubinowitz
2 MR. BAXTER: Subsequently to the filing of the note
3 of issue.
4 THE COURT: But it's a continuing authorization,
5 isn't it?
6 MR. RUBINOWITZ: Hold on a second.
7 MR. RUBINOWITZ: There's no objection.
8 THE COURT: In evidence.
9 (Plaintiffs' Exhibits 36, 37, 38 and 39 marked and
10 received in Evidence).
11 COURT OFFICER: Jury entering.
12 (Whereupon, the jury enters the courtroom.)
13 THE COURT: All right, thanks, folks. Please sit
14 down. Stay with us.
15 All right, let's continue.
16 MR. RUBINOWITZ: Thank you.
17 BY MR. RUBINOWITZ:
18 Q Dr. Hershman, what I'd like you to do, I'm going to
19 show you what has been marked 36 in evidence, which is an X-ray
20 from the date October 11, 2012, taken at Lenox Hill Hospital.
21 Is that where your office is located?
22 A It is.
23 Q Is this one of the x-rays you had taken of Jim
24 Gregware?
25 A It is.
26 Q Focussing on the left knee itself, Doctor, would you

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1 Hershman - by Plaintiffs - Direct/Rubinowitz
2 tell us what this X-ray represents?
3 A This is a standing view of both knees with the knees
4 slightly flexed. That is what that is.
5 This is a view, it's called a Rosenberg view, and what
6 it does it brings out joint space narrowing. That's what we
7 look for.
8 So, loss of height between the bones. The bones are
9 getting closer, and that's because of wear and tear or
10 osteoarthritis in the joint. And that's what the Rosenberg
11 view, does.
12 And we compare apples to apples. So, we compare the
13 medial side to the medial side, and we compare the lateral side
14 to the lateral side.
15 And, in this particular view, what we see is that in
16 the left knee -- we know this is left because the X-ray is
17 marked left here -- this is more narrow than the right knee
18 image.
19 Q What is the significance of that?
20 A Physiologically this is loss of articular cartilage
21 height and osteoarthritis.
22 Q And, what is the significance of that for Jim Gregware
23 as far as future treatment goes?
24 A If he has symptoms, if his knees are stiff or achy,
25 painful, we could often attribute those symptoms to
26 osteoarthritis, and this X-ray gives us evidence of that.

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1 Hershman - by Plaintiffs - Direct/Rubinowitz
2 Q And, Doctor, with respect to the left knee again, the
3 different view taken on the date October 11, 2012, Exhibit 37?
4 A This is a side view of the left knee, and we take this
5 routinely.
6 You could see his anchors in his fibula head are still
7 there.
8 One of the screws, they left one screw in.
9 Dr. Feldman. That's still there.
10 This is the screw I put in for his ACL reconstruction
11 here, and you could see those.
12 And this just shows everything on the lateral view that
13 we look for is stable.
14 Q Doctor, with respect to the right knee, if I could come
15 to the date October 11, 2012, I'd like you to to focus on that.
16 A Now, this is a standing view with a knee straight. We
17 talked about the Rosenberg view where the knees are slightly
18 bent.
19 MR. BAXTER: What exhibit is that?
20 MR. RUBINOWITZ: This is Exhibit 39.
21 MR. BAXTER: Thank you.
22 A And this is now with the knees straight. It actually
23 shows a little bit different area of the knee in terms of
24 standing and joint space loss.
25 Again, in the left knee you see narrowing. In that
26 area, we could see that the hardware is stable. And, we get a

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1 Hershman - by Plaintiffs - Direct/Rubinowitz
2 sense on this image that, perhaps, there is some early narrowing
3 on the medial side of the right knee.
4 And if we look at the height here and compare the
5 height there, the space, the two spaces, you could get a sense
6 that, perhaps, there is a little bit of wear developing in that
7 portion of that knee.
8 And, again, on the right knee, everything looks -- the
9 hardware is where it should be. Nothing is backed out.
10 Remember, early on one of the screws backed out. From
11 these x-rays, everything is staying where it should be.
12 Q And, Doctor, again I show you Exhibit 38 of the right
13 knee. Ask you to explain what that is?
14 A Again, it's just another image that we take. This is a
15 lateral view. And on this we again are looking for making sure
16 all of these hardware elements are where they should be.
17 Nothing has changed in position. I see no loose
18 fragments.
19 This is just complements the other x-rays and gives us
20 some additional information.
21 Q And, Doctor, have you been taking sequential x-rays
22 over the years in addition to Exhibits 36 through 39?
23 A We have taken some x-rays over the years.
24 Q And, Doctor, with respect to that, have you taken the
25 x-rays, having examined Jim Gregware for as long as you have,
26 and performing surgery on him, do you have an opinion as to

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1 Hershman - by Plaintiffs - Direct/Rubinowitz
2 whether or not Jim Gregware will require total knee replacements
3 in the future?
4 A My opinion is that given the injuries that he has, the
5 findings that we see, what we found at the time of the both knee
6 surgeries it is likely probable that he would require knee
7 replacements in the future.
8 Q And when would that be, Doctor?
9 A Generally, patients like this can go onto develop
10 progressive arthritis in the early on.
11 MR. BAXTER: Objection to "patients like this."
12 THE COURT: All right, let's speak to this patient.
13 THE WITNESS: Okay.
14 Q Please with respect to Jim Gregware?
15 A So, Jim Gregware, with these injuries could develop
16 osteoarthritis within the next five to ten years.
17 Q And, would he require knee replacement in the next five
18 to ten years?
19 A Yes, that would be the treatment for osteoarthritis.
20 Q And, Doctor, before I ask you about what the knee
21 replacements are, how long is the life expectancy of a knee
22 replacements?
23 A About ten to fifteen years.
24 Q Given the fact that Jim Gregware is the age that he is
25 right now, do you have an opinion as to whether he will require
26 multiple total knee replacements for each leg?

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1 Hershman - by Plaintiffs - Direct/Rubinowitz
2 A If his knee replacement last fifteen years, then at the
3 age he is now, which I believe is 49, and he goes let's say five
4 years before having knee replacement, that would make him 54.
5 Then we add fifteen years to that is 64, 70 let's say. That's
6 still relatively young by the life insurance tables, at that
7 point he would require a second set of knee replacements on one
8 or the other because of wear of the joint replacements and
9 damage to the bones around the joint replacements.
10 Q Now, what I'd like to do, Doctor, is I'd like to focus,
11 if you would, on the anatomic exhibit in front of you, the model
12 in evidence, 35.
13 What I'd ask you to do is tell us what is included in a
14 total knee replacement.
15 A In a total knee replacement, we replace the surfaces of
16 the bone.
17 So, how do we do that? It's an open operation. So we
18 have an incision in the front of the knee. There are no
19 arthroscopic techniques for knee replacements.
20 Often we move the patella to the side, and with a saw,
21 a sagittal saw, we actually cut the bone surfaces. So, we take,
22 one, two, three cuts on the femur, one cut on the tibia, and
23 those portions of the knee are actually removed.
24 Q Doctor, what portions of the knee are removed as it
25 relates to the femoral condyle and the tibial plateau?
26 A So the -- on the femoral condyle both -- all the

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1 Hershman - by Plaintiffs - Direct/Rubinowitz
2 articulating surfaces are removed from the femoral condyle, and
3 the articulating surfaces on the tibia are removed. The
4 meniscus is removed, and many times the ligaments are removed.
5 And that's because the knee replacements often have
6 elements that make the knee stable built into the components.
7 What are the components? There are three components
8 generally to a knee replacement.
9 One is a metal component that goes on the end of the
10 femur. So, to make three cuts, and the metal femoral components
11 is slid over the cuts to fit over that.
12 And, then on the tibial side, the surface is cut off,
13 the top of the tibia is actually removed, and we insert a metal
14 and a plastic piece this way, which then has a plastic pad.
15 Q You say "this way," you talking about coming on
16 replacing the tibial plateau?
17 A Vertically down with a plastic pad here.
18 And then we relocate the metal piece on top so it can
19 glide.
20 Many times also with knee replacement people also
21 resurface the patella. They make a cut along the surface here,
22 and put a little plastic button. These people are --
23 Q Pointing to the underside of the patella.
24 A Patella. These pieces are all held in place by cement.
25 Q What does that mean, cement?
26 A Cement is a poly methyl methacrylate. It's a polymer

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1 Hershman - by Plaintiffs - Direct/Rubinowitz
2 that you mix, and it adheres to the bone, and it adheres to the
3 components, so the components stay in place.
4 Q Doctor, do you have an opinion to whether or not a knee
5 replacement surgery is a competent producing cause of pain?
6 A Knee replacements are -- well, knee replacements of the
7 surgery itself causes significant pain.
8 Patients who have knee replacements need to be managed
9 for pain control perioperatively.
10 Q And when you say perioperatively, what is that?
11 A After surgery.
12 Q And, does it require additional treatment after that,
13 Doctor?
14 A People who have knee replacements are often in the
15 hospital for a few days. Many times they go to rehabilitation
16 facility for sometime afterwards.
17 They require narcotic pain control for quite a few
18 weeks after surgery while they do physical therapy.
19 It's a big surgery, lots of soft tissue, and physical
20 therapy is extensive. It takes almost for many patients a year.
21 MR. BAXTER: Objection "for many patients." Move
22 to strike.
23 Q Doctor, do you ever have an opinion as to how long it
24 would take for someone like Jim Gregware to recover?
25 A Most likely it would take Jim Gregware a year to
26 recover from knee replacements.

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1 Hershman - by Plaintiffs - Direct/Rubinowitz
2 Q Doctor, are you familiar with the term osteoporosis?
3 A Yes.
4 Q What is that?
5 A Osteoporosis is loss of bone. From many reasons, but
6 just loss of bone.
7 Q And, Doctor, as a patient becomes elderly, can coming
8 into their sixties, do you have an opinion as to whether or not
9 there are osteoporotic changes that take place?
10 A A hundred percent people as they age lose bone, and get
11 osteoporosis all to different degrees.
12 Q And, there is such a thing as a disuse osteopenia?
13 A Disuse osteopenia is a condition where people who are
14 not using a limb get loss of bone from inactivity.
15 Q Doctor, with respect to a patient who -- do you have an
16 opinion as to whether or not by the time Jim Gregware is in his
17 mid-sixties whether or not he'll be suffering from osteoporosis?
18 A Well, osteoporosis is just a term of loss of bone. So,
19 when he's 60 years old, we know that people lose bone starting
20 around age 40 or so, maybe earlier. So, he would be losing some
21 bone at age 60.
22 Q What, in your opinion, is the significance of that as
23 it relates to a secondary open knee replacement surgery?
24 A It makes a second knee replacements more difficult.
25 Q Why is that?
26 A Because of the fixation of the cement to the bone.

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1 Hershman - by Plaintiffs - Direct/Rubinowitz
2 When there is less bone, it's harder to get the components into
3 the exact right location.
4 Q And, Doctor, I'd ask you to just -- you could resume
5 your seat.
6 I want to direct your attention to Exhibit 16 in
7 evidence. Are you familiar with a doctor by the name of Steven
8 Yang?
9 A Yes.
10 Q Who is what Dr. Yang?
11 A Dr. Yang is my associate in my group practice, and is
12 an upper extremity orthopedic surgeon.
13 Q And, indeed, was he the orthopedic who took care of Jim
14 Gregware's shoulder?
15 A He did.
16 Q With respect to the shoulder itself, Doctor, did it
17 indicate that the assessment was that Mr. Gregware has
18 chronic --
19 MR. BAXTER: Objection.
20 THE COURT: It's in evidence.
21 MR. BAXTER: I understand the document is in
22 evidence. This is his knee surgeon.
23 THE COURT: It's already in. I'm going to allow
24 it.
25 MR. BAXTER: Objection.
26 THE COURT: Overruled.

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1 Hershman - by Plaintiffs - Direct/Rubinowitz
2 Q Doctor, as far as the assessment, it indicates
3 Mr. Gregware has chronic right shoulder problems due to
4 traumatic injury three years ago. This is dated November 6,
5 2009.
6 Doctor, was it your understanding that Jim Gregware
7 suffered, among other things, a labral tear in this accident?
8 A I believe that Mr. Gregware -- I know that Mr. Gregware
9 had an MRI of his shoulder performed by Dr. Yang.
10 The records reflect that the MRI was performed on
11 11/18/2009, MRI right shoulder, and the results interpreted by
12 the radiologist include rotator cuff tendinopathy.
13 Q What is that?
14 A The rotator cuff is the tendinous portion that holds
15 the shoulder in place. So, that is some degeneration of the
16 tendon.
17 Biceps tendinopathy, that is another tendon there.
18 Tendinopathy means some degeneration of the tendon.
19 Tear of the posterior labrum. So, the labrum is soft
20 tissue portion of the socket that holds it in place, and there
21 is -- the radiologist saw a tear of that on the MRI.
22 They also showed -- some MRI results are described as
23 having acromioclavicular osteoarthopathy, which is degenerative
24 joint disease, some osteoarthritis of the upper part of the
25 shoulders, the acromioclavicular joint.
26 Q Doctor, if I go back to the knees for just a moment, do

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1 Hershman - by Plaintiffs - Direct/Rubinowitz
 2 you have an opinion to a reasonable degree of medical certainty
 3 as to whether Jim Gregware will have pain in the future from his
 4 knees due to the accident of May 20th, 2006?
 5 A It's my opinion that Jim Gregware will have pain in his
 6 knees in the future related to this accident.
 7 Q And, will he have that pain for the rest of his life?
 8 A I believe he will.
 9 Q Why is that, Doctor?
 10 A I think because of the extent of the injuries, the
 11 extent of the surgery, the amount of damage to the structures of
 12 the knee, he will have pain.
 13 In my experience patients like this have pain.
 14 Q And, Doctor, with respect to the shoulder injury, based
 15 on what you know from your associate's records, do you have an
 16 opinion as to whether or not that is a permanent injury?
 17 A Looking at these records, the records reflect that he's
 18 having pain in his shoulder. He does have some damage that is
 19 reflected in the MRI, and patients with these types of issues do
 20 have shoulder pain.
 21 MR. BAXTER: Objection "patients with these type of
 22 issues."
 23 THE COURT: Overruled. You could cross examine.
 24 Go ahead.
 25 Q And, do you ever have an opinion as to whether Jim
 26 Gregware himself will have pain well into the future for the

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1 Hershman - by Plaintiffs - Direct/Rubinowitz
 2 rest of his life?
 3 A It would be, in my opinion, looking at this MRI, he
 4 would have pain as a result of what I see on the MRI for the
 5 rest of his life.
 6 Q Doctor, with respect to the knee injuries that Jim
 7 Gregware suffered, is there any cure for them?
 8 A There is none.
 9 Q With respect to medications, what is Mobic?
 10 A Mobic is a non-steroidal anti-inflammatory medicine.
 11 Q And what is Percocet?
 12 A It's a narcotic analgesic pain medicine.
 13 Q Doctor, are you being compensated for your time in
 14 court today?
 15 A I am.
 16 Q And tell us what rate you are being compensated?
 17 A I'm being compensated at a rate of \$500 an hour.
 18 Q Does that also include time to speak with us and to
 19 review?
 20 A Compensation included preparation for today, review of
 21 the records, looking at all the films, making sure that the
 22 pictures were anatomically correct and appearing today.
 23 MR. RUBINOWITZ: Just give me one moment, your
 24 Honor.
 25 (Pause).
 26 MR. RUBINOWITZ: Thank you, your Honor.

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1 Proceedings
 2 Thank you, Doctor.
 3 THE COURT: Do you want to begin, or do you want to
 4 take a lunch break?
 5 MR. WANG: I'd like to take a lunch break.
 6 THE COURT: See you back here promptly at 2:00.
 7 Don't talk about the case among yourselves or anyone else.
 8 COURT OFFICER: All rise.
 9 (Whereupon, the jury leaves the courtroom).
 10 THE COURT: Everything you need?
 11 MR. BAXTER: No.
 12 THE COURT: What do you need?
 13 MR. BAXTER: So, we don't waste time before I
 14 cross-examine him.
 15 THE COURT: That's why I asked now.
 16 MR. BAXTER: I'm going to want to see his entire
 17 folder. Could I have it now?
 18 THE WITNESS: You mean the record? Here, sure.
 19 THE COURT: That's fine.
 20 MR. BAXTER: Thank you.
 21 THE COURT: Anything else?
 22 MR. BAXTER: No.
 23 THE COURT: Very good. See you all at 2:00.
 24 MR. BAXTER: Could I stay here for a few.
 25 THE COURT: You could stay here for a few, until
 26 1:00.

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1 Proceedings
 2 (Lunch recess).
 3 (Continued on following page).
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1 Hershman Cross - Wang
2 *AFTERNOON SESSION*
3 COURT OFFICER: Officer jury entering.
4 (Whereupon, jury entered the courtroom.)
5 THE COURT: All right, welcome back. Come
6 on in. Watch your step. Please, sit down.
7 Mr. Wang, cross-examination, please.
8 MR. WANG: Thank you, your Honor.
9 CROSS-EXAMINATION
10 BY MR. WANG:
11 Q Good afternoon.
12 I want to focus your attention on your
13 opinion on causation.
14 If I understood correctly, it's your
15 testimony, it's your opinion, that the Plaintiff's
16 injuries were caused by trauma, correct?
17 A Correct.
18 Q And, in particular, I believe what you testified
19 is that the plaintiff's injuries were caused by a trauma,
20 an impact to the right side of his body.
21 Did I get that right?
22 A I did testify to that.
23 Q And, in particular, I believe you testified you
24 might have used slightly different wording, you testified
25 that the plaintiff's injuries were consistent with an
26 impact on the right side by a moving car, is that

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1 Hershman Cross - Wang
2 correct?
3 A Correct.
4 Well, I testified that the injuries were on
5 -- I thought were from the right side.
6 Q You thought the injuries were from the right
7 side. It's your opinion, it's your medical opinion that
8 the plaintiff's injuries are consistent with an impact by
9 a moving car from the right side?
10 A Sure.
11 Q Is that your opinion?
12 A Yes. Well, you know, my opinion is yes, that
13 something struck him on right side to cause these
14 injuries.
15 Q Is there anything that you can identify that
16 would be consistent with the plaintiff's injuries based
17 on the facts as you know it, other than impact by a
18 moving car from the right side?
19 MR. BAXTER: Objection, your Honor. He
20 testified impact from something, not from a car.
21 THE COURT: Yeah, and we're not here to
22 speculate so --
23 Q Your testimony is that the plaintiff's injuries
24 are consistent with impact by a car, right?
25 MR. RUBINOWITZ: Objection, Judge. Impact
26 from the right is what he said.

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1 Hershman Cross - Wang
2 THE COURT: Yeah. Do you have a question?
3 I mean, his testimony is his testimony.
4 MR. WANG: Okay.
5 Q Is it your opinion, is it your medical opinion
6 that the plaintiff's injuries were consistent with impact
7 by a moving car on the right side, is that your opinion?
8 A My opinion is that he was struck on the right
9 side by an object that caused his injuries.
10 Q Would that object have to be moving to cause
11 injury?
12 Let me withdraw that question.
13 Was he struck by a moving object on the right
14 side? Do you have an opinion on that one way or
15 another?
16 A Well, I mean, in my opinion, the injuries are
17 consistent with being struck by a moving, a large moving
18 object on the right side.
19 Q Do you have any opinion on the degree of force
20 with which the Plaintiff would have to have been struck
21 to suffer the injuries that he suffered as you
22 articulated this morning?
23 A Well, I would speculate --
24 MR. RUBINOWITZ: Judge, I'm going to object.
25 THE COURT: Sustained.
26 Q My question is do you have any opinion on the

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1 Hershman Cross - Wang
2 degree of force that is required to cause the injuries
3 that you have explained at this point?
4 THE COURT: An opinion with a reasonable
5 degree of medical certainty?
6 Q Right, exactly.
7 THE COURT: So, that he is not speculating.
8 THE WITNESS: So, these injuries are
9 consistent with large forces across the joint with
10 medical certainty.
11 Q And, again, large forces impacting on the right
12 side of the body?
13 A I believe that, yes.
14 Q Do you have any opinion one way or another of the
15 height at which the impact occurred? So, for example,
16 could the impact have occurred up near the shoulder, or
17 hip, or knee, or do you not have an opinion on that?
18 A I would say, I do not have an opinion.
19 Q Am I correct that you are not opining that the
20 Plaintiff's injuries were caused by anything that the
21 City did, or didn't do?
22 MR. RUBINOWITZ: Objection.
23 MR. MILLER: Objection.
24 MR. BAXTER: Objection.
25 THE COURT: Sustained.
26 Q You are not opining that the plaintiff would have

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1 Hershman Cross - Baxter
2 suffered the same injury had he stayed in the car with
3 the seatbelt on? That's not your opinion?
4 MR. RUBINOWITZ: Objection.
5 MR. BAXTER: Objection.
6 THE COURT: Sustained.
7 MR. WANG: I have nothing further.
8 THE COURT: Mr. Baxter --
9 CROSS-EXAMINATION
10 BY MR. BAXTER:
11 Q Good afternoon, doctor.
12 You and I have never met before today, have
13 we?
14 A We have not.
15 Q Okay. And we have never got together to discuss
16 this case, right?
17 A We have not.
18 Q Okay. You told us earlier that you did have an
19 opportunity to get together with Mr. Rubinowitz, or
20 someone from his firm to get ready to come and testify,
21 right?
22 A That's correct.
23 Q And you told us that you were getting \$500 an
24 hour to do that, right?
25 A Correct.
26 Q How many hours have you spent up until today?

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1 Hershman Cross - Baxter
2 A About ten hours.
3 Q Ten hours. And ten hours, part of that was
4 reviewing records?
5 A I'm sorry, about five hours.
6 Q Five hours before today?
7 A Correct.
8 Q Part of that was reviewing all the records,
9 right?
10 A Yes.
11 Q Part of that was making these exhibits with Mr.
12 Rubinowitz's firm, right?
13 A Yes.
14 Q Okay. And part of that was going over what
15 testimony you were going to have, right?
16 A Yes.
17 Q In fact, when you used the term dead body, that
18 was something you agreed upon with Mr. Rubinowitz that
19 you were going to say, you took a tendon from a dead
20 body, right? That is what you agreed on, right?
21 A No.
22 Q You don't call them dead bodies in your business,
23 you call them cadavers, don't you?
24 A No.
25 Q You call them dead bodies?
26 A I call them donors.

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1 Hershman Cross - Baxter
2 Q Donors? Here you called them dead bodies, what,
3 for the jury?
4 MR. RUBINOWITZ: Objection, Judge.
5 THE COURT: Overruled .
6 THE WITNESS: It's a donor, and it is a dead
7 body.
8 Q But, you did not say donor, you said dead body,
9 right?
10 A I think I said donor, also, donor tissue.
11 Q After you said dead body?
12 MR. RUBINOWITZ: Objection, Judge.
13 Q Right?
14 THE COURT: Overruled.
15 THE WITNESS: It's my choice of words.
16 Q Okay. Now, with regard to Mr. Gregware, you saw
17 Mr. Gregware --
18 Let me ask you this, the first time you saw
19 him was back in 1999, right?
20 A Yes.
21 Q You have those records with you, don't you?
22 A I do.
23 Q And was he referred to you by someone?
24 A I have no recollection.
25 Q How about Dr. Bell, do you know who Dr. Bell is?
26 A I do.

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1 Hershman Cross - Baxter
2 Q Who is Dr. Bell?
3 A Dr. Bell is one of the internists on the staff of
4 the hospital.
5 Q And, doctor, does it refresh your recollection
6 that Dr. Bell recommended Mr. Gregware to you?
7 A Well, I know from the record that I sent a letter
8 to Dr. Bell about Mr. Gregware.
9 Q By the way, you have done a pretty good job of
10 testifying here today without looking at your records,
11 haven't you?
12 A So far.
13 Q Okay. And as you did that just now, you
14 remember that your file contained a letter to Dr. Bell
15 from 1999, isn't that right?
16 A I do.
17 Q Did you study those records before you came into
18 testify?
19 A I looked at that letter last night.
20 Q That's not the only thing you looked at last
21 night, right?
22 A Well, I looked at the record last night, yes.
23 Q Okay. And so, the first time you saw him, you
24 took a history, right?
25 A I did.
26 Q How was he injured?

1 Hershman Cross - Baxter
2 A I'll look, but my recollection is that it was
3 skiing.
4 Q Okay. Any time you want to look at your records
5 to refresh your recollection if you have not memorized
6 that part, please do so.
7 A Thank you.
8 But, going back to 1999, my record shows that
9 he injured his left knee skiing.
10 Q Okay. How often did he ski back then, do you
11 know?
12 A I do not know.
13 Q Okay. And you performed surgery on his left
14 knee, isn't that correct?
15 A It is correct.
16 Q And his left knee, that's the knee --
17 A It's upside down.
18 Q Is that what it is? I don't know if that's
19 going to make a difference. That's how it looks. The
20 left knee, that's the one, that's the most recent x-ray
21 you took?
22 A It is.
23 Q By the way, do you have the radiologist report
24 with regard to that x-ray?
25 A Oh, I don't think so, but let me look.
26 Q Please.

1 Hershman Cross - Baxter
2 beginning of arthritic changes, isn't that right?
3 A On the exhibit.
4 Q In that x-ray that's what it showed, right?
5 A Yes.
6 Q Slight beginning of arthritic changes, right?
7 A Well, I said slight, particularly with respect to
8 the right knee.
9 Q You were comparing right to left, right?
10 A No. The medial compartment of the right knee, I
11 said there's slight arthritis.
12 Q On the right was slight?
13 A Correct.
14 Q What about the left?
15 A I think there's more than slight on the left
16 knee.
17 Q You did not testify to that, right?
18 A We can read it back.
19 Q Do you recall testifying to that this morning?
20 A I recall testifying there was arthritis in the
21 lateral compartment of the left knee.
22 Q Of the left knee?
23 A Correct.
24 Q What caused that?
25 A I believe it's a result of trauma.
26 Q The trauma from the skiing accident, right?

1 Hershman Cross - Baxter
2 A No, I do not have the report for that radiograph.
3 That's the ones from 2012. I do not.
4 Q You don't have them?
5 A Correct.
6 Q So, we can't show the jury what the radiologist's
7 opinion of these x-rays are with regard to what you told
8 them was the start of some arthritis, right? We don't
9 have that record to show them?
10 A We do not.
11 Q Okay. Why isn't it in your file?
12 A It didn't make it there yet.
13 Q From October of 2012 until today, it didn't make
14 it there yet?
15 A Could be.
16 Q But, you knew that you were coming to here
17 testify, and you knew one of the things that you were
18 going to talk about was this beginning of arthritis in
19 Mr. Gregware's knee, his left knee, isn't that right?
20 A Correct.
21 Q And you didn't think it would be important to
22 show the jury what the radiologists said, did you?
23 A It's important. It's just not here.
24 Q Okay. And, by the way, you said when you were
25 standing here, correct me if I'm wrong, when you were
26 looking at Exhibit 36, you said that there was a slight

1 Hershman Cross - Baxter
2 A No. I believe it's a result of trauma from the
3 subsequent injuries.
4 Q Why don't you take a look at that letter that you
5 say you looked at just the other day that you wrote to
6 Dr. Bell.
7 A Right, and I do believe --
8 Q Sir, please, do what I ask. Can you please look
9 at the letter?
10 A Of course.
11 (Brief pause.)
12 Q It's way towards the back.
13 A I'm close.
14 Here it is.
15 Q Do you have it?
16 A I'm ready.
17 Q What's the date of that letter?
18 A February 12, 1999.
19 Q And you would agree with me, doctor, in that
20 letter that you wrote to Dr. Bell --
21 A Yes.
22 Q Okay. And you would agree with me that at the
23 time October, 1999 you wrote I think over time he will
24 develop acute changes, arthritic changes based upon the
25 articular cartilage damage in the lateral compartment, is
26 that what it says?

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1 Hershman Cross - Baxter
2 A Oh, you might be referring to a different letter.
3 Q May I approach?
4 A You are referring to the August 2nd letter.
5 THE COURT: Yes.
6 Q Okay, August.
7 A Yes, so that was the letter written after his
8 knee surgery.
9 Q After his knee surgery?
10 A Yes.
11 Q And tell us, read for the jury what you wrote
12 about what you thought he would develop in time?
13 A I will. I think that over time he will develop
14 arthritic changes based on the articular cartilage damage
15 in the lateral compartment.
16 Q Okay. And that was in 1999, and in 2012 he had
17 some arthritis in that knee, right?
18 A Correct.
19 Q Okay. And how soon after the surgery were you
20 expecting to start showing signs of arthritis?
21 A 20 to 30 years.
22 Q 20 to 30 years. And now his last surgery to
23 that knee was when?
24 A The left knee surgery was in -- the last one,
25 let's see, I will get you the exact date.
26 5/23/2011.

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1 Hershman Cross - Baxter
2 Q 5/23/2011. And you told the jury, I could have
3 sworn you said well, may be he'll need a knee replacement
4 because of arthritis in 5 to 10 years after that surgery,
5 right? Isn't that what you told this jury?
6 A I did.
7 Q Then when you calculated out for this jury the
8 two surgeries that he was going to have, you didn't use
9 the ten-year starting period, you used the five-year
10 starting period, right?
11 A Okay.
12 Q Is that correct?
13 A I think so.
14 Q I'm sure you did. You want to me to get it read
15 back?
16 A Sure.
17 Q Let me see if we can have it read back.
18 I'm sorry, Judge, you know what, I'll
19 withdraw that. I'll withdraw that. The jury will
20 remember.
21 Now, you would agree with me that this x-ray
22 taken in 2012 and -- when was your last exam of him?
23 A I'll get you exact date.
24 Q Please.
25 A January 24th, 2013.
26 Q You would agree with me that when you took this

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1 Hershman Cross - Baxter
2 x-ray, and based upon what you know about Mr. Gregware's
3 injuries, he is not presently a candidate for knee
4 replacement, is he?
5 A He could be.
6 Q Is he a candidate for knee replacement right now?
7 A I would say that right now, today, he is not.
8 Q Okay. How about his left knee?
9 A His left knee, that is what we we're talking
10 about.
11 Q How about his right knee?
12 A He is not.
13 Q Now, when he comes to see you this second time,
14 this is after the accident, right?
15 He came to see you first. You did surgery in
16 '99, right, and then you stopped treating him for a
17 period of time, right?
18 A Right.
19 Q After he recovered, would you agree with that?
20 A Well, I would consider him to be my patient the
21 whole time.
22 Q So, what was the time span between the next time
23 you saw him from the last time you saw him in either '99
24 or 2000?
25 A Can you be a little more specific?
26 Q When was the first time you saw him after May of

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1 Hershman Cross - Baxter
2 2006?
3 A Okay, so --
4 Q The first time you saw him after the accident?
5 A Okay, I saw him in September, 2006.
6 Q That would be the first time after the accident,
7 right?
8 A Right.
9 Q And how many surgeries had he had at that time?
10 A Three.
11 Q And the first two were open, right?
12 A Yes.
13 Q Third was open, or not?
14 A Open and arthroscopic.
15 Q Open was the small opening to remove the screw?
16 A Correct.
17 Q Now, when you saw him that first time, you took a
18 history from him again as to what happened to him, right?
19 A I did.
20 Q And I think you told us that you got all the
21 records that he had for the treatment that he had from
22 the day of the accident up until the time you saw him,
23 right?
24 A I got the records of the big surgeries.
25 Q Well, maybe I'm wrong, but didn't you tell this
26 jury that you got Dr. Feldman's records, you wanted to

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1 Hershman Cross - Baxter
2 see what Dr. Feldman's said?
3 A I did.
4 Q Where are they?
5 A They're here.
6 Q Let's see them.
7 A I also --
8 Q Let's start with this.
9 A Sure. I have these records.
10 Q May I see it? So, you got an operative report,
11 is that right?
12 A Correct.
13 Q So, you didn't get his records?
14 A Well, that to me is the pertinent records.
15 Q But, you didn't say pertinent records before.
16 You said you looked at all of his records, right?
17 MR. RUBINOWITZ: Objection.
18 THE COURT: Sustained.
19 Q Did you look at all of his records, or just that
20 operative report?
21 A I looked at the operative error.
22 Q So, you looked at the operative report. You
23 never looked at other records until when, when Mr.
24 Rubinowitz showed them to you?
25 A I saw the records from St. Vincent's.
26 Q Do you have them with you, too?

Page 716

1 Hershman Cross - Baxter
2 A No.
3 Q So, the only time you saw the only records Mr.
4 Rubinowitz showed you were the St. Vincent's?
5 A Yes.
6 Q So, you never saw Dr. Feldman's office notes?
7 A I have not.
8 Q So, you did not see whether or not there was
9 anything about whether Mr. Gregware had complete range of
10 motion in his knees, did you ever see that?
11 A Oh, I don't recall seeing those notes.
12 Q How about any notes that his knee was stable, did
13 you see those notes from Dr. Feldman?
14 A No.
15 Q So, up until the first time you saw him, who
16 would have been in a better position to testify about
17 what the residuals after the surgery performed by Dr.
18 Feldman, Dr. Feldman or you?
19 A Oh, I feel like, you know, I examined him, and I
20 can certainly examine him and testify about the findings.
21 Q Well, you did not just testify about the
22 findings. You testified about everything Dr. Feldman
23 did, is that right?
24 MR. RUBINOWITZ: Objection. He did not.
25 THE COURT: Sustained.
26 Q Didn't you testify as to all the treatment

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1 Hershman Cross - Baxter
2 rendered by Dr. Feldman here today to this jury?
3 MR. RUBINOWITZ: Objection.
4 THE COURT: Overruled.
5 Did you?
6 THE WITNESS: I did.
7 THE COURT: Is that all the treatment?
8 THE WITNESS: I did. I testified about the
9 surgical treatment.
10 Q You did. You know what medication he was
11 provided, prescribed by Dr. Feldman?
12 A I do not.
13 Q Do you know what activities he was doing when was
14 seeing Dr. Feldman?
15 A He was doing physical therapy.
16 Q Was he doing any kind of sports?
17 A I do not know.
18 Q Did you ask?
19 A Oh, I don't recall asking that specific question
20 in 2006 when I saw him.
21 Q Did you ever see any of his records from
22 Performance Physical Therapy?
23 A I did not.
24 Q So, are you aware of any other accident that Mr.
25 Gregware sustained since the May, 2006 car accident?
26 A I am not.

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1 Hershman Cross - Baxter
2 Q So, are you aware as to whether or not in
3 February of 2007 he had a slip and fall?
4 A I do not have that history.
5 Q What about what Mr. Gregware was doing after the
6 surgery; was he working? Do you have any information
7 about that?
8 A I do not.
9 Q Do you know what Mr. Gregware does, right?
10 A I know he does videography.
11 Q And you know that since that accident, he's had
12 some time where he spent 12 to 14 hours up on his feet;
13 you're aware of that, right?
14 A I haven't talked, specifically, about the amount
15 of work he's doing with him.
16 Q No?
17 A I have not.
18 Q Okay. And when was the first surgery you
19 performed on him?
20 A February 9, 2009.
21 Q And how did he recover from that surgery?
22 A He recovered very well from the surgical
23 procedure.
24 Q February, 2009.
25 You were still treating him as of April,
26 2009, right?

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1 Hershman Cross - Baxter
2 A I was.
3 Q You were still treating him as of April of 2009,
4 right?
5 A Yes.
6 Q He told you that in April of 2009, he did a TV
7 show in Central Park where he was on his feet for 14 to
8 16 hours, right?
9 A That's consistent with his findings.
10 Q That's consistent because you repaired his knees,
11 and he had a great recovery, right?
12 A On April 14th when I saw him, he was doing well
13 as far as recovering from the knee surgery.
14 Q Right. By the way, you also testified about his
15 rib fractures, right?
16 A Yes.
17 Q This morning, right?
18 A I did.
19 Q And you testified about his pelvic fracture,
20 right?
21 A I did.
22 Q And you testified that they were a result of
23 trauma, right?
24 A I did.
25 Q And you took a history as to how the accident
26 happened, right?

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1 Hershman Cross - Baxter
2 A I testified -- can I have that question again?
3 Q You took a history how the accident happened?
4 A I did.
5 Q Because I think you told the jury that all these
6 injuries were caused by the accident based upon the
7 records and what Mr. Gregware told about the accident,
8 correct?
9 A Right.
10 Q Okay. Well, did you see in records that the
11 first accident involved Mr. Gregware striking a car, and
12 his air bag going off? Did you see those records?
13 A I looked at St. Vincent's Hospital record.
14 Q And saw that he struck the rear of another car,
15 his air bag went off, right?
16 MR. RUBINOWITZ: Objection, Judge. I object.
17 That's not what the record says.
18 THE COURT: Thank you. Thank you.
19 It's your recollection of the testimony
20 that's going to control. As to what is said in the
21 testimony, you can have that testimony read back to
22 you. We are taking this somewhat out of order, so
23 you don't have a lot of testimony about these parts
24 of it, but you will.
25 Please, continue.
26 A Repeat the question, please.

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1 Hershman Cross - Baxter
2 Q Can I have it read back please?
3 THE COURT: Read that back, please.
4 (Record was read.)
5 Q Did you see that?
6 A Oh, it might have -- I don't remember that
7 specific point from reviewing those records.
8 Q Okay. Would you agree with me, doctor, that he
9 could have gotten fractured ribs when he struck the car
10 in front of him?
11 A I would agree with that.
12 Q Yeah. Now, with regard to your treatment of him
13 -- Oh, by the way, the doctor that treated him, or his
14 shoulder was in your group. That was Dr. Yang?
15 A Yes.
16 Q Did you look at Dr. Yang's records?
17 A I did.
18 Q When was that?
19 A Yesterday.
20 Q That was when you met with Mr. Rubinowitz, so you
21 can testify as to what Dr. Yang did?
22 A Yes.
23 Q Okay. Well, what sports was Mr. Gregware
24 playing that was causing him pain to his shoulder?
25 A I believe the note reflected having catch with
26 his son.

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1 Hershman Cross - Baxter
2 Q Didn't it say playing baseball?
3 A That's having a catch.
4 Q Is that what it means, you took that word that
5 said playing baseball, and you turned that into having a
6 catch with his son?
7 A I did.
8 Q Is that something Mr. Rubinowitz told you it was,
9 or is that what you got from the record?
10 A That's what I got from the record.
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Page 723

1 Hershman - by Plaintiffs - Cross/Baxter
2 Q And did you ask Dr. Yang if that's what the record
3 meant?
4 A I did not.
5 Q Now, from the time you began treating him for the
6 second accident, the second surgery that you performed, you saw
7 him a number of times, right?
8 A Yes.
9 Q And -- by the way, are you aware that Mr. Gregware has
10 also had back surgery in the past?
11 A It's in the history.
12 Q What was the surgery about?
13 A My recollection is that it was a disk excision in the
14 lumbar spine.
15 Q And when did he have that surgery?
16 A I don't recall the exact date.
17 Q Now, part of the records that you recently received
18 were his treating doctor's records, right? His personal
19 physician's doctor's records.
20 A I do not have those records.
21 MR. BAXTER: May I approach?
22 THE COURT: Yes.
23 Q Take a look at those records?
24 A Thank you.
25 Q Are those his general practitioner's records?
26 A Yes.

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1 Hershman - by Plaintiffs - Cross/Baxter
2 Q What was the reason for getting them?
3 A This was a clearance for surgery.
4 Q Clearance for surgery, right?
5 A Correct.
6 Q And when did you get it?
7 A This was --
8 Q You see the fax date on the top?
9 A 4/14/11.
10 Q Okay. And, you'd agree that you had an opportunity to
11 review these records, right?
12 A I did.
13 Q And, you'd agree with me that when you reviewed those
14 records you saw that his general doctor said he was in overall
15 good health, right, over the period of time of the records you
16 have?
17 A Let's look.
18 The conclusion of the doctor from Northridge Medical
19 Associates is overall Mr. Gregware appears to be doing well and
20 he is cleared for surgery.
21 Q But, you have more than just one record; you have some
22 of his past records too?
23 A This is the clearance record.
24 Q Just that one record is for the clearance?
25 A That's it's.
26 Q It says he's not on any medication?

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1 Hershman - by Plaintiffs - Cross/Baxter
2 A His current medication include Mobic Percocet,
3 Prilosec.
4 Q Does it say who is prescribing that to him?
5 A Dr. Engelhardt.
6 Q So, Dr. Engelhardt is the one prescribing all these
7 medications to him, but you are the one who is going to do the
8 surgery for the pain, Doctor, is that right?
9 A Yes.
10 Q You see any records there that say that Mr. Gregware is
11 in any kind of pain or acute distress?
12 A The record says with respect to his medical condition
13 he's in no acute distress.
14 Q All right. Now, at some point, while you are treating
15 Mr. Gregware, the surgery, the last surgery he had was put off
16 for a while, right?
17 A I don't recall.
18 Q Well --
19 A You mean for his reasons or my reasons?
20 Q For his reasons.
21 A That I don't recall.
22 Q Well, you'd agree with me that you saw him on
23 November 3rd of 2009, right?
24 A Okay.
25 Q And, on November 3rd, you have a note that says he had
26 full range of motion, no instability, swelling, locking

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1 Hershman - by Plaintiffs - Cross/Baxter
2 buckling, numbness, or weakness? That's what you said, right?
3 A Yes.
4 Q And, then you said that you had a discussion with him
5 about a future surgery, and he wanted to wait until after he
6 finished the ski season, correct?
7 A Yes. He said that he might consider -- he said he's
8 planning on skiing this season, and a prescription for a brace
9 was given.
10 Q And, he said he'd have the surgery after he finishes
11 the season, right?
12 A That's what the note reflects.
13 Q And then later on you have notes that say he again was
14 going to go skiing, but he decided against it, right?
15 A Correct.
16 Q Now, as of 10/10/2011, you were going to do this
17 surgery, and I think you told us this before you do these
18 surgeries, because you do sports medicine, when people can't do
19 their sports any more, right?
20 A Well, you also do these surgeries so people can be
21 functional for activities of daily living.
22 Q But on 10/10/2011, you wrote that he was unable to
23 participate in sports, right?
24 A 10/10. Ah, September. That's October.
25 Let me catch up with you.
26 So on 10/10/2011.

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1 Hershman - by Plaintiffs - Cross/Baxter
2 Q You have a note for 10/10?
3 A No.
4 Q Let me look if you don't mind. Maybe I wrote it down
5 wrong?
6 A Okay. No problem.
7 Q This is 12. This is 11. Let's see.
8 I'm sorry. 3/10/2011. He's unable to participate in
9 sports and his knee is giving way, right?
10 A Yes.
11 Q So, what sports was it that he was playing?
12 A My notes don't reflect what sport he was playing, and I
13 do not recall.
14 Q Did you ask him?
15 A Probably.
16 Q You didn't put it down?
17 A Probably.
18 Q This is when you are not assuming it was a catch with
19 his son, is it?
20 A I don't remember.
21 Q Now, on 10/13, let's hope I got this right?
22 A You do.
23 Q 2011?
24 A Okay.
25 Q You saw him three months post-surgery, right?
26 A Post his left knee surgery, yes.

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1 Hershman - by Plaintiffs - Cross/Baxter
2 Q That's the last one you did, right?
3 A Correct.
4 Q And you'd agree with me that the note reads, he denies
5 any pain, right?
6 A It says that.
7 Q Swelling?
8 A It does.
9 Q Locking?
10 A Yes.
11 Q Buckling?
12 A Yes.
13 Q Numbness?
14 A Yes.
15 Q And weakness?
16 A Correct.
17 Q And, you put down impression of excellent postoperative
18 course, right?
19 A I did.
20 Q Now, you have a report from 10/13/11 as to the x-rays
21 performed on Mr. Gregware, right?
22 A We do.
23 Q And, the only X-ray, the finding on the X-ray was small
24 left knee effusion, right?
25 A No.
26 Q What else was found other than -- I'm talking about --

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1 Hershman - by Plaintiffs - Cross/Baxter
2 you are going to tell me there are screws there and all that
3 other stuff?
4 A I'm going to read the whole report.
5 Q Well?
6 MR. RUBINOWITZ: Could I have the date again
7 please?
8 MR. BAXTER: Hold on. Let me see.
9 MR. RUBINOWITZ: Just the date please.
10 THE WITNESS: 10/13/11.
11 Q What is the impression?
12 A Sure.
13 Small left knee effusion. Left anterior cruciate
14 ligament reconstruction new since 3/10/11.
15 Q So, it showed the surgery you performed, right?
16 A Among other things.
17 Q And, it showed slight swelling, right?
18 A Among other things.
19 Q That's the impression by the radiologist?
20 A That's the conclusion.
21 Q Now, about Mr. Gregware's course of physical therapy,
22 did you look at his physical therapy records?
23 A I have not.
24 Q You know what type of physical therapy he was getting?
25 A I know that the physical therapy he was getting was
26 making his knee improve.

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1 Hershman - by Plaintiffs - Cross/Baxter
2 Q You know they had him walking up and down the stairs?
3 A Close chain exercise.
4 Q Did you know he was riding a bike?
5 A Non-impact range of motion exercise.
6 Q Did you know he was riding a bike?
7 A I assumed he was riding a bike.
8 Q Were the sports that he could no longer do, were those
9 impact exercises?
10 A Most sports are impact, but not all.
11 Q Okay. And by the way, you know he also returned to the
12 gym, right?
13 A I assumed he did.
14 Q By the way, you told us about those first surgeries
15 with the screws that were put in, right?
16 A Yes.
17 Q The x-rays now show healed fractures in Mr. Gregware's
18 knees, do they not?
19 A They do, yes.
20 Q And, in fact, I think you told us that one of the
21 screws was able to be taken out, correct?
22 A I did say that.
23 Q And, you could see -- you'd agree that Dr. Feldman did
24 a good job in fixing the fractures, correct?
25 A I would agree.
26 Q Now, Doctor, just so I know, when was the last time you

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1 Hershman - by Plaintiffs - Cross/Baxter
2 did a knee replacement surgery?
3 A Probably about eight or nine years.
4 Q You don't do them any more?
5 A I do not.
6 Q Doctor, would you agree, with a reasonable degree of
7 medical certainty, based upon the injury sustained by
8 Mr. Gregware, he has a very good recovery up to today, right?
9 A It's my opinion that his recovery from the surgeries
10 that he's had has been excellent.
11 Q And the surgeries were to repair the injuries he
12 sustained in this accident, right?
13 A Correct. Yes.
14 Q When was the last time you saw him before today, you
15 told me 13, January?
16 A I did.
17 I didn't mean to nod my head. I'm sorry.
18 Q Did you currently have any appointments to see him in
19 the future?
20 A I do not. Not that I know of.
21 Q Okay.
22 A He may have an appointment. I do not know.
23 Q In April of 2009, did Mr. Gregware tell you that he had
24 spent the day at two birthday parties squatting all day?
25 A No. Not to my recollection.
26 Q By the way, in that time frame, did he tell he was

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1 Hershman - by Plaintiffs - Cross/Baxter
2 walked a lot and was out doing a lot?
3 A I hope so.
4 Q Did he tell you that?
5 A He might have. I do not recall.
6 MR. BAXTER: Just give me one second.
7 Q By the way, you also -- you told us that the reason
8 they delayed the surgery -- the first surgeries, the first two
9 surgeries were done at the same time, correct?
10 A Correct.
11 Q Okay. And you told us the reason they delayed, they
12 were looking for vascular injuries to his leg before they
13 operate, right?
14 A That's reflected in the Saint Vincent's record, yes.
15 Q They didn't find any vascular injury, right?
16 A They did not.
17 Q What did the hospital records say about the treatment
18 he received for the road rash?
19 A I don't recall exactly what it said.
20 Q You didn't see anything in there about the road rash
21 having to be flushed because there was gasoline in his road
22 rash?
23 A I don't remember that part of the record.
24 Q You also told us when we were looking at Exhibit 31 --
25 let me. You don't know them by number, right.
26 When we were looking at Exhibit 31, right, there was

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1 Hershman - by Plaintiffs - Cross/Baxter
2 some discussion about using the cadaver tendon, and you said
3 most people -- those tendons I think you said revascularize?
4 Did I say it correctly?
5 A Yes, revascularize.
6 Q This tendon did?
7 A It did as far as I know.
8 The only way to really know is to do a biopsy of it.
9 Q You also told us about this what you called bone on
10 bone, right?
11 A Bone on bone, I mentioned that in his testimony.
12 Q Mr. Gregware doesn't have any bone on bone, right?
13 A He does not.
14 Q And, by the way, you'd agree with me, Doctor, that
15 currently I think you told us about these knee replacements
16 lasting ten to fifteen years.
17 Back in the beginning when they started doing them,
18 they weren't lasting that long, right?
19 A Yes.
20 Q So, as technology gets better, they last longer, don't
21 they?
22 A Actually, actually, I don't think the literature has
23 actually borne that out.
24 Q Not yet?
25 A Not yet because the ones we're putting in now we have
26 to wait fifteen, twenty years to know.

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1 Hershman - by Plaintiffs - Cross/Baxter
2 Q Fifteen to twenty years.
3 And we also know there are other things on the horizon
4 with regard to cartilage repair, right?
5 A There is cartilage repair currently for small defects,
6 not for osteoarthritis.
7 Q And, Doctor, you would agree with me also that there
8 are other things on the market to then simulate cartilage such
9 as soup parts, right, yes or no?
10 A No.
11 Q There are no injections that can be used presently --
12 let me finish the question.
13 A Go ahead you finish the question.
14 Q -- that can be injected into an area where cartilage is
15 damaged to help lubricate the area?
16 A There are injections to help lubricate the area.
17 Q And, Doctor, would you agree with me, with your
18 patients, people you treat, you tell them to do as much as they
19 can before they have any kind of knee replacement, don't you?
20 A I do.
21 Q In fact, you would tell that to Mr. Gregware that he
22 should wait as long as possible so that he doesn't need more
23 than one, right?
24 A I would tell people to wait as long as they can before
25 they need a knee replacement.
26 Q It's not your practice to put two sets of knee

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1 Hershman - by Plaintiffs - Cross/Baxter
 2 replacements in people is it?
 3 A I don't understand the question.
 4 MR. BAXTER: I'll withdraw it.
 5 Q Based upon the most recent x-rays you've taken, you'd
 6 agree that everything seems to be in place right now with regard
 7 to all the screws that are in Mr. Gregware, right?
 8 A Yes.
 9 Q They seem to be satisfactory in alignment his bones?
 10 A Based on the x-rays, all the screws are in place and
 11 are satisfactory.
 12 MR. BAXTER: Thank you, Doctor. I have nothing
 13 further.
 14 THE COURT: Mr. Miller.
 15 MR. MILLER: No questions, your Honor.
 16 MR. RUBINOWITZ: Thank you, your Honor.
 17 REDIRECT EXAMINATION
 18 BY MR. RUBINOWITZ:
 19 Q Doctor, one of the things that Mr. Baxter asked you was
 20 whether or not you had a radiologist report when, indeed, he was
 21 showing you certain films including Exhibit 36, which is in
 22 evidence.
 23 Do you, as an orthopedic surgeon, know how to read the
 24 radiology studies?
 25 A I do.
 26 Q Do you have to know how to do that before doing

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1 Hershman - by Plaintiffs - Redirect/Rubinowitz
 2 surgery?
 3 A I do.
 4 Q You teach your residents and fellows, you better know
 5 how to do it before doing surgery?
 6 A You spend a lot of time on it.
 7 Q Doctor, with respect to this exhibit, you had mentioned
 8 that there were arthritic changes. Is that to a reasonable
 9 degree of medical certain in your opinion as an orthopedic
 10 surgeon?
 11 A It is.
 12 Q And, Doctor, is it true that Jim Gregware suffers from
 13 osteoarthritis of the knees bilaterally?
 14 A He does.
 15 Q One of the things that counsel asked you about was the
 16 history as he referred to in the hospital record without showing
 17 it to you.
 18 So, I want to show it to you because this way there
 19 will be no doubt about what the history was when he says --
 20 THE COURT: All right. Ask a question please.
 21 Q Here is -- let's zoom in. And, I'm going to read over
 22 here, Chief Complaint, and this is for the date 5/20. It reads:
 23 MVA, motor vehicle accident. Patient partial out of
 24 car when his car was hit and he was thrown unknown distance.
 25 Patient -- make sure I could see this.
 26 Patient complained of severe right knee and leg pain,

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1 Hershman - by Plaintiffs - Redirect/Rubinowitz
 2 also right shoulder pain. Road rash noted on all four
 3 extremities. Right knee swollen and abraded, right back
 4 ecchymotic and abraded, and it says left hand fifth digit
 5 abraded.
 6 This is the history we went through before, right,
 7 Doctor?
 8 A Yes.
 9 Q Except at that time I didn't point out was partially
 10 out of the car, correct?
 11 A Yes.
 12 Q Then when we come to the date, the admitting note, so
 13 that there is no mistake about it, counsel asked you a question
 14 if you recall about the air bag going off?
 15 A Yes.
 16 Q Is there any place in the record that says he was
 17 inside the car when the air bag went off?
 18 A Not that I know.
 19 Q So, let's take a look at what it reads.
 20 And this is from the surgery, history and physical
 21 admitting note:
 22 41 year old male, trauma, restrained.
 23 And then it says:
 24 Involved in an motor vehicle, came out of car, was
 25 walking, hit by another car, complains of pain BL?
 26 MR. MILLER: Objection, your Honor.

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1 Hershman - by Plaintiffs - Redirect/Rubinowitz
 2 THE COURT: No, he's reading a record for the
 3 purpose of of laying a foundation for a question. The
 4 record is in evidence, so he's allowed to do it.
 5 Q It says, Complains of pain BL. Is that bilaterally?
 6 A That is bilaterally.
 7 Q To the lower extremities.
 8 Then it continues, Abrasions to the elbow.
 9 With respect to this, does it say anywhere he was in
 10 the car at the time he was hit?
 11 A It does not.
 12 THE COURT: But try not to lead.
 13 Q With respect to the medications that counsel asked you
 14 about the Mobic and the Percocet, what is Mobic?
 15 A A non-steriodal anti-inflammatory medication.
 16 Q What is Percocet?
 17 A A narcotic.
 18 Q With respect to the questions that counsel asked about
 19 whether the recoveries from the surgeries were excellent, do you
 20 have an opinion as to why he would need the further surgeries
 21 if, in fact, the further surgeries were excellent -- the
 22 surgeries that he had were excellent?
 23 A Yes.
 24 Q Please explain it.
 25 A I have an opinion.
 26 So, the surgeries restored function to his knees, but

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1 Hershman - by Plaintiffs - Redirect/Rubinowitz
2 his knees are not normal.
3 Overtime, his knees will deteriorate because he does
4 not have normal knees.
5 He had serious injuries to his knees. We've done the
6 best we can to get his knees in a situation that they function
7 for him, in activities of daily living, and even in some sports
8 so he could enjoy life. That's what it's all about. Okay.
9 But are they normal? No.
10 Will they deteriorate overtime? Yes.
11 Why? Because knees like this do. They just do.
12 Q Doctor, with respect to the slip and fall of
13 February '07 that Mr. Baxter asked you about, in February of
14 '07, was it your understand he had ligamentous laxity at that
15 time?
16 A He did.
17 Q Doctor, at that point in time in February of '07, had
18 he even had any of the ligaments repaired yet?
19 A No.
20 Q What is the significance of ligamentous laxity when
21 there is no repair being done yet?
22 A On ligamentous laxity predisposes you to fall. That is
23 one of the reasons we do the surgery, to prevent people from
24 falling.
25 Q Counsel asked you about skiing. Do you recall that you
26 pointed out in your notes --

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1 Hershman - by Plaintiffs - Redirect/Rubinowitz
2 A I do.
3 Q Did you have a further discussion with Mr. Gregware
4 about skiing?
5 A I did.
6 Q What was that all about?
7 A Well, he wanted to go skiing. And, in my desire to
8 have people mentally improving from their conditions, I try to
9 get people to do things that they might be able to enjoy.
10 However, considering his injuries, I also thought that
11 it probably was not in his best interest to go skiing. And so,
12 with further discussion, he agreed and said, perhaps, he should
13 not go skiing.
14 Q And, to your knowledge, has ever gone skiing since the
15 accident of May 20, 2006?
16 A To my knowledge, he has never gone skiing.
17 Q With respect to the question that he was -- Mr. Baxter
18 asked about sports and playing ball with his sons. Do you know
19 how old his sons were at the time of the accident?
20 A I do not.
21 Q You have any idea what he was even doing as far as the
22 sports activities he was talking about?
23 A I do not.
24 Q Or what he was capable of doing at that point in time?
25 A He was capable of standing and throwing a ball.
26 Q One of the things you did was you had read a note of

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1 Hershman - by Plaintiffs - Redirect/Rubinowitz
2 10/13/11, and you were focussed on the the small left knee
3 effusion. Okay.
4 A May I just search for that?K
5 Q Yes.
6 A Okay.
7 Q With respect to the small left knee effusion. First of
8 all, Doctor, what is synovial fluid?
9 A All joints have fluid in them that are a lubrication,
10 and we call that synovial fluid. It helps the surface glide
11 against each other. There is a little bit of liquid in there
12 almost like oil. If you feel, it it's viscous.
13 Q Did you say viscous like oil?
14 A Viscous like oil.
15 Q And, Doctor, when there is trauma to the knee, what
16 happens with respect to the synovial fluid with knee instability
17 and internal derangement of the knee?
18 A There are a couple of conditions where you could have
19 more fluid in the knee. One is if your knee is lose and
20 unstable and the bones move, that can lead to fluid in the knee.
21 Osteoarthritis can also lead to fluid in the knee.
22 Q And, do you have an opinion as to whether or not that
23 fluid in the knee was consistent at that point in time, that is,
24 October 13th of 2011, with osteoarthritic changes?
25 A Well, he had his surgery on his left knee in May of
26 2011. So May, June, July, August, September, October, so that's

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1 Hershman - by Plaintiffs - Redirect/Rubinowitz
2 five months. So, a typical ACL reconstruction with a perfect
3 knee at five months should not have effusion.
4 Q And, indeed, why did he have effusion?
5 A Probably because he's getting osteo --
6 MR. BAXTER: Objection to probably.
7 THE COURT: Sustained.
8 Q Doctor, do you have an opinion to a reasonable degree
9 of medical certainty why he had effusion?
10 A I do, and it's reflected in the x-ray report of
11 10/13/11 in the body of the report.
12 Q Please explain that.
13 A So, the radiologist, when he reads the films, reads the
14 whole film, and I'll read that to you:
15 AP, meaning the front view, lateral, tunnel, Merchant
16 views, and these are views we showed before, of the right and
17 left knee are submitted. These views are compared to some
18 radiographs that were taken 3/10/11. New interference screws
19 are seen in the distal left femoral condyle and proximate left
20 tibia consistent with new left anterior cruciate ligament
21 repair.
22 (Continued on following page).
23
24
25
26

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1 Hershman Redirect - Rubinowitz
2 A Other orthopedic hardware is noted without
3 change.
4 A small left knee effusion is noted.
5 Mild bilateral degenerative changes are
6 noted.
7 Q What is the significance to a reasonable of
8 medical certainty as to bilateral degenerative changes at
9 this time?
10 A The radiographs taken on 10/13/2011 and read by
11 the radiologist reflected that he has osteoarthritis in
12 both his knees.
13 Q And, doctor, is that one of the findings that you
14 base your opinion that he will need total knee
15 replacements for both knees?
16 A I based my opinion on his radiographs that I see,
17 and I look at, his injuries, the natural histories of
18 osteoarthritis, as I know it, and include the
19 radiologist's diagnosis as part of that.
20 Q Is that why he would need a total knee
21 replacement?
22 A That is what I believe.
23 Q Doctor, with respect to the total knee
24 replacements, counsel asked you about state of the art.
25 I want to focus on that specifically.
26 With respect to state of the art right now as

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1 Hershman Redirect - Rubinowitz
2 it exists, what is your opinion as to the life
3 expectancy of total knee replacements when they are
4 performed?
5 A I still believe that total knee replacements last
6 10 to 15 years.
7 Q Counsel asked you about new developments.
8 Are you aware of any new development that
9 works, for example, that can actually regenerate
10 miniscal injuries?
11 A No. There actually is -- there's a lot of
12 research going on, but there's no, right now, FDA
13 products that are approved that permit that.
14 There's nothing on the market that's
15 available to patients to reconstruct meniscus, and
16 there is -- there are techniques to improve cartilage
17 function in small areas, but not for people who have
18 diffuse osteoarthritis.
19 Q And would someone, for example, like Jim Gregware
20 who had those extensive injuries as you said, would that
21 work?
22 A No.
23 Q Now, counsel also asked you, specifically, about
24 other things that can be done.
25 Are you familiar with something known as
26 hyaluronic acid?

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1 Hershman Redirect - Rubinowitz
2 A Yes.
3 Q Is that what you were referring to he when
4 counsel asked those questions?
5 A Yes.
6 Q What is that?
7 A Okay, so we talked about synovial fluid, and it's
8 a fluid that's in your joint, and when you have
9 osteoarthritis, there's a substance in the joint fluid
10 called hyaluronic acid.
11 We found that if we replace the amount of
12 hyaluronic acid that is lost when you get
13 osteoarthritis because osteoarthritic joints have
14 lower amounts of hyaluronic acid, if we replace it,
15 people feel better, so it's a symptomatic treatment
16 for osteoarthritis.
17 I do it all the time, all the time, okay.
18 There are five products on the market;
19 Orthovisc, Supartz, Hyalgan, Symvisc, and Euflexxa.
20 They all are an injection to varying degrees. Some
21 are one. Some are three. Some are five. They are
22 measures that we do for people who need knee
23 replacement who have osteoarthritis and are trying to
24 get by.
25 That's what we do it for. It does not and
26 has not been shown to prolong the time until the knee

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1 Hershman Redirect - Rubinowitz
2 for a knee replacement. It's a symptomatic
3 treatment.
4 Q And, doctor, if I may, just please --
5 A No.
6 Q Doctor, with respect to the tendon
7 revascularization that Mr. Baxter asked you about, how
8 long does it take to revascularize the cadaver body part?
9 A We actually don't really know because we don't
10 have any human specimens to analyze.
11 We put them in, and if they're working, we
12 leave them alone, and if there's not working, you can
13 have a reinjury, so to answer your question
14 scientifically, I would have to do a study where I
15 bring people in at 6, 8, 12 months and biopsy their
16 ligaments.
17 We can look at their ligaments on MRI, but it
18 doesn't completely tell us about the
19 revascularization.
20 In animal models, which don't totally, you
21 know, equate with humans, probably about a year.
22 Q Are you aware that Jim Gregware was evaluated by
23 an orthopedist at the request of the defendants named
24 Helman Straus?
25 MR. BAXTER: Objection; scope.
26 THE COURT: Sustained.

1 Proceedings
2 Q If I can just have one moment.
3 Counsel asked you whether Mr. Gregware was a
4 candidate for total knee replacement today. You said
5 no.
6 Is that why you told us about, that he can be
7 in, approximately, five years?
8 A Yes.
9 Q Is that because, doctor, what you were talking
10 about deals, specifically, with progression of the
11 osteoarthritic changes?
12 A Yes.
13 MR. RUBINOWITZ: Thank you, doctor.
14 MR. WANG: Nothing, your Honor.
15 THE COURT: Mr. Baxter?
16 MR. BAXTER: No, your Honor.
17 THE COURT: Mr. Miller?
18 MR. MILLER: Nothing, your Honor.
19 THE COURT: Thank you, doctor. You can step
20 down.
21 THE WITNESS: Thank you, Judge.
22 THE COURT: We'll make sure you get, if
23 nothing else, a complete copy.
24 MR. RUBINOWITZ: I will make sure.
25 THE WITNESS: Thank you.
26 THE COURT: All right, it's hot.

1 Proceedings
2 MR. RUBINOWITZ: It is.
3 MR. BAXTER: Yes, it's boiling.
4 THE COURT: All right, we're going to call
5 it a day.
6 I'm going to ask you to be back here at
7 Monday morning 9:30 in the morning. We will expect
8 to hear from our next witness then.
9 Don't talk about the case amongst
10 yourselves, or with anybody else. Don't do any
11 independent research, or investigation.
12 Watch your step as you go, please.
13 (Jury left the courtroom.).
14 THE COURT: Gentlemen, anything for the
15 record?
16 MR. RUBINOWITZ: No, thank you, Judge.
17 THE COURT: Very good.
18 (Whereupon, jury trial adjourned to March 18,
19 2013.)
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