SUPERIOR COURT OF NEW JERSEY
LAW DIVISION: MORRIS COUNTY
DOCKET NO. MRS-L-213-05

JANE DOE, :
Plaintiff, : DEPOSITION OF:
: RICHARD BONESTEAD, M.D.
vs. :
:
ANTONIO P. LORIANO, M.D., :
and JOHN DOES (fictitious :
persons whose true identities :
are presently unknown), and :
XYZ COMPANIES (fictitious :
persons whose true identities :
are presently unknown), :
:
Defendants. :
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TRANSCRIPT of the stenographic notes of the proceedings in the above-entitled matter, as taken by and before SUSAN M. STYRON, a Certified Shorthand Reporter and Notary Public of the State of New Jersey, held at the office of BENDIT WEINSTOCK, P.A., 80 Main Street, West Orange, New Jersey, on Wednesday, December 27, 2006, commencing at 2:15 a.m.

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

BENDIT WEINSTOCK, PA.
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1 I N D E X

2 WITNESS DIRECT CROSS REDIRECT RECROSS

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7 E X H I B I T S

8 NUMBER DESCRIPTION PAGE

DOCUMENT REQUESTS

NONE OFFERED

NOTED OBJECTIONS

NONE OFFERED

R I C H A R D B O N E S T E A D, M.D., practicing at Garden State Orthopaedic Surgery, LLC, 100 Commerce Place, Clark, New Jersey, having been duly sworn by the Notary Public, testified as follows:

DIRECT EXAMINATION BY MR. BERGE:

Q Good afternoon, Dr. Bonestead.

A Hi.

Q I previously introduced myself informally, but I will do so again. My name is Peter Berge, I'm an attorney with the law firm of Bendit Weinstock, and I represent the plaintiff in this case, formerly Jane Doe, and now Jane Rogers, R-O-G-E-R-S.

A Okay.

Q Since she married recently.

A Okay.

Q Have you given testimony in a deposition before?

A Yes, I have.

Q About how many times?

A At least 100.

Q When was the last time?

A Last month, probably.

Q Obviously we can't, we won't take the time to go through every one, but in general

categories under what circumstances have you testified in depositions?

A Medical malpractice matters, plaintiff and defense. Issues in personal injuries, plaintiff and defense. Issues in worker's compensation.

Q And have you ever been a defendant in a malpractice suit?

A I have.

Q How many times?

A Something more than five, less than ten total.

Q In any of those suits has the plaintiff prevailed?

A No.

Q Have any of those suits settled before trial?

A Not to my knowledge. I was either

dropped from the suit, and then I lost track of what happened to it, or if the suit came to a conclusion, it was without prejudice and there was no settlement or judgment.

Q You're pretty sure then that you're familiar with the general guidelines, I'll just go through them briefly.

You've been sworn, so you're aware that your testimony here has the same effect as if you were testifying in court before a judge or a judge and a jury; correct?

A Correct.

Q All right. The court reporter is going to try to take down everything we're saying, so please be sure to make your answers in words as opposed to gestures or non-word sounds like "um-hum" or "uh-uh," and to keep your voice up, even though I may have a little trouble doing that this week. Also, please be sure to wait until I'm finished asking the question before you answer so that the record is kept clear. If you refer to a document in order to answer a question, please let us know what it is you're referring to.

If you don't understand a question,

please let me know. If you answer a question without asking for clarification, we'll be entitled to assume that you understood the question as asked. Okay?

A Yes, all good.

Q If Mr. Laverghetta objects to a question, he'll probably tell you in the same

sentence that you may answer. And if so, just go right ahead and answer. If you're not told you may answer, please wait until we put whatever discussion on the record that we need to. Okay?

A Okay.

Q Clearly we don't want you to guess at anything. If you don't know the answer to a question, please tell me that. If you can give a reasonable approximation or estimate, you're free to do that. But let us know that that's what you're doing.

A Okay.

Q Okay, very good. You're not trapped in here. If you need to take a break for whatever reason, just let us know. We just won't be able to break in the middle of a question, so we would want at least to have the question answered before taking a break. Okay?

A Okay.

Q And if you can't hear me since my voice is a little scratchy, just let me know.

A Okay.

Q You've been kind enough to provide us with a copy of your curriculum vitae. Has that been updated?

A Not from the listed date, what is September '05.

Q Is there anything that should be added?

A Well, I have, you know, attended more conferences and meetings, they'll go in on the next update. I am a fellow in the American Academy of Disability Evaluating Physicians as opposed to a member only, I'm not sure that made it into this.

Q And what's the difference?

A Well, to be a member, you know, you send in an application and you may or may not be accepted. To be a fellow there is a set of requirements, peer-reviewed requirements. You have to take training courses in disability evaluation. Your disability reports are peer reviewed, and you have to show an interest in the field of disability evaluation to become a

fellow. An interest meaning actually doing the work.

Q Okay. Any other updates or corrections to your CV?

A I think it's correct. I don't think there's any major changes.

Q You're still currently licensed to

practice medicine and surgery in New Jersey?

A I am.

Q And you're still currently practicing orthopedic surgery?

A I am.

Q What's the nature of your practice?

A I practice general orthopedics. It's easier for me to tell you what I don't do than what I do. I no longer do primary bone tumors, which I send to a colleague now. I don't do infant-style pediatric orthopedics, which I've done in the past. I don't do, for instance, limb replantations or surgery that requires microvascular repairs. In every single part of orthopedics, and there's many, there's probably something that I would refer to somebody who does that pretty much all the time.

But on the other hand, almost all the

patients that come to my office I treat on my own.

Q I see you have a few publications here.

A Yes.

Q Any publications since this was printed?

A No.

Q Would I be correct in saying from looking at the titles of these articles, that none of them pertains to the procedure that's at issue in this case?

A That's correct.

Q Have you ever published anything relevant to the procedure at issue in this case?

A No.

Q Have you ever given any presentations on that subject?

A I would say no.

MR. BERGE: We'll go ahead and mark the CV as Bonestead-1.

(Exhibit Bonestead-1, Curriculum vitae, was marked for identification.)

Q There's a notation here, American Board of Orthopedic Surgery.

A Yes.

Q Did you take an exam for that?

A Yes, that's a two-day examination.

Q Did you pass that the first time?

A I did.

Q Is that a board for which recertification is required?

A When I came through, there was no

recertification. There is now, but I'm not subject to that.

Q So you haven't had to, you haven't been required to retake it?

A That's correct.

Q Is that something that one can do voluntarily?

A You can.

Q Have you chosen not to?

A That's correct.

Q Any other board certifications?

A No.

Q Have you ever practiced in the area of medicine or surgery apart from orthopedics?

A No.

Q What percentage of your time is devoted to teaching activities?

A Well, I never thought of it time-wise.

I attend the teaching conference at the orthopedic residency program at St. Joseph's. That's Tuesday mornings. I usually try to go at least twice a month.

I have fellows in sports medicine who come to my office for four to eight weeks at a time, one to two fellows a year, that's been

going on for years now.

In the operating room I'm often working with orthopedic residents, and I give them instructions in how to operate. So all in all, I don't know the time, but it's part of my practice.

Q The fellows who rotate or who come to your office, what institution are they affiliated with?

A They're from the sports medicine fellowship from the St. Barnabas System, Union Hospital, St. Barnabas.

Q What hospitals are you, or at which hospitals are you a credentialed orthopedist?

A Right now St. Barnabas, Livingston, Union Hospital in Union. Rahway Hospital in Rahway. And I also work at The Center for Ambulatory Surgery, which is in Mountainside, New

Jersey.

Q From your earlier answer regarding depositions, you said you've given testimony in at least 100 depositions.

A Right.

Q Over what period of time would that have been?

A Well, I guess my first deposition was sometime in the '80s, I don't recall for what issue. So I've been in practice for 25 years.

Q For what period of time have you been a consultant for medical/legal cases?

A That began towards the, sometime in the '80s. When I first came into practice I didn't do any of this, but later on in the '80s I started, and I've continued through the years.

Q How many, say in the last year, how many patients per week would you say you have seen for medical/legal purposes?

A For medical malpractice I rarely see any, it's rarely they come to my office, a few a year. But are you including what's called independent medical examinations?

Q Yes, examinations at the request of an attorney.

A Or if not an attorney, an insurance firm or something like that?

Q A carrier, yes.

A Most weeks I see two. Some weeks I'd see five. Because I have a, every second week I have an afternoon where I try to do three what's called IMEs, so that's the week that I would do

five. But most weeks I do two.

Q Of the two to five, how many of those are at the request of an attorney specifically?

A Well, generally they all are. They're all attorney requested, although if the attorney is on the defense side, there's usually an insurance company as well. Most of these IMEs, I would say the majority of the IMEs are what we'll call defense, although not exclusively, and I do what we'll call plaintiff's examinations. I have no -- it doesn't matter to me. The role of a disability evaluating physician, it shouldn't matter what side, and it doesn't to me. You have the same job to do, what happened.

Q Do you do disability examinations for petitioners at all for injured workers?

A Sure.

Q As opposed to for the insurance

carrier?

A Absolutely.

Q What's the percentage of your worker's compensation practice for petitioners versus for respondents?

A Actually, I do a very small number of summary examinations in worker's comp. Most of

my practice there is actually treatment of injured workers, or second opinions of treatment for injured workers. So the few that I do tend to be more on behalf of the respondent.

Q How many patients a week do you see unrelated to any legal issues?

A Sure. I have office hours three days a week, three half-days a week. And we try to see about 15 people per session. So that's roughly 45 people. And it can be more or it can be a little less, but that's a rough number.

Q Now, you said that medical malpractice cases are very rare. How about personal injury cases?

A Well, in terms of office exams.

Q Yes.

A Okay. See, I have to be clear what you're asking. Many orthopedic patients, I'm not

the medical expert, I'm just treating them, but they happen to have personal injury.

Q Right.

A So that's a lot of everybody's practice.

Q Right, of course. Let me clarify. I'm really referring to patients who you're seeing to

evaluate the extent of their injury or disability for legal purposes.

A That would be the two or five combination.

Q And remind me, what was, what determined whether it was two or five?

A The week of the month. Twice a month I see, I have an afternoon where I try to see three patients purely for disability evaluation, or impairment evaluation.

Q Aside from seeing patients and performing examinations, do you review cases for merit regarding medical malpractice?

A I do see cases that I don't get into. There's a number of cases sent to me on behalf of patients where I'll take a first look at the case, and then speak to the attorney and say one of two things: Either I believe there's a

negligent issue, or I don't.

And let me add another thing that I might say. It's just not the right kind of case for me, I don't do this kind of work, I don't consider myself the right witness for you. So I see cases along those lines, too, yes.

Q First of all, how many of those would

you say a week, a month or a year?

A Well, I remember one year, the most I ever did was one year I saw like a lot, like 40 or so. I didn't take them all. But now they seem to be a couple a month.

Q And of those, what percentage are for plaintiff's attorneys and what percentage are for defendant's attorneys?

A Right now as a first look, I see more plaintiff's work. And that's because it's just the nature of medical malpractice that there's more plaintiff's work for first look. But in terms of things that I actually do, it's about 50/50. I do as much medical review and testimony for defense as I do for plaintiffs. And depositions and trials, it's about 50/50.

Q Just to be clear. You said that of the first-look reviews there are more plaintiffs than

defense?

A Oh, yes.

Q And what proportion would you say?

A I think in terms of first look, you know, I don't want to guess, but it's substantially more, because many of them have no merit, in my opinion, or I'm not the right person

for them.

Q Okay. What do you charge for reviewing cases?

A $400 an hour.

Q What do you charge for giving testimony?

A Deposition is $450 an hour with a two-hour minimum.

Q And court?

A Court I think is half-day is $5,000, and a full day is $8,000.

Q Do you belong to any organizations or groups that have the purpose of providing medical/legal consultations?

A I'm not sure that I would use the word belong to. But I do get cases from a firm in Manhattan called Medquest, Elliot Stone's firm. But I'm not a member in the sense of an owner

or -- from time to time they will call me and ask me would I like to review a case.

Q Is the referrals from Medquest, are they doing either plaintiff cases or defense cases predominantly?

A Oh, it's almost all plaintiff's cases.

Q Have you ever been denied staff

privileges at a hospital or accreditation?

A No.

Q Have you ever had your privileges or accreditation from a hospital withdrawn?

A No.

Q Have you ever been the subject of disciplinary procedures by a board of medical examiners?

A No.

Q All right. You've provided me with a copy of some papers relating to the plaintiff's visit to your office for your examination on November 20.

A That's right.

Q Do you have any other papers related to that visit?

A Not really. I mean, there's, some of my office staff regarding setting up the

appointment. And that's it.

Q Just to show you, is that this here?

A Yes, that's it.

Q Did you have any other, any notes or any other paperwork related to that visit?

A No.

MR. BERGE: I think we'll go ahead and

mark this.

(Exhibit Bonestead-2, Doctor's notes, was marked for identification.)

Q So these papers that I've marked as Bonestead-2, is it correct to say that they reflect all of your notes, papers or documents associated with that visit, with your examination of Jane Doe?

A Yes.

Q Aside, of course, from your report?

A Yes.

Q Where did you examine Miss Doe?

A It was at my office in, I believe it was in the Fairfield location.

Q How many offices do you have?

A Well, I'm not going to really call that my office. I have one principal office. And in Fairfield I lease or rent space two afternoons,

two half, well, no, two half a days or two afternoons a month, and that's in Fairfield. And that's exclusively to do my medical/legal work. I don't do any patient visits there.

Q From whom do you rent that space?

A There's two chiropractic physicians that own the office. I'm sorry, one chiropractic

physician and one internist. And I rent from them.

Q Okay. How many times did you examine Miss Doe?

A One time.

Q Was she cooperative?

A Oh, yes.

Q In your report you have some mention of her history. Who took her history?

A I did. I do the whole thing.

Q There's a sheet in, the second sheet in your packet of notes has her historical information, medications, allergies, surgeries, et cetera. Was that written by Miss Doe or by you?

A By her.

Q How much time were you, did you spend evaluating Miss Doe including taking the

history and performing your physical exam?

A I don't know. I reserve an hour in the office, but -- I reserve an hour, but I'm not exactly sure how much I spent exactly with her. Of course I knew a lot about her before she came in, since I had already reviewed all the records. So I tried to use that examination to update

where she stood at that point in time, and to do a physical examination. And in her case this was not a multi-system multiple area examination, it was limited to the wrist and hand region.

To answer the question, I don't know exactly how much time. Enough time to do all the testing I wanted to do.

Q What specific examinations did you perform?

A Well, if you take a look at my report, it's divided into sections beginning on Page 2. So I do a general assessment of the patient. I look at the skin, the vascular status, the neurological status, and then the musculoskeletal status.

Q Did you perform any specialized maneuvers or tests as part of your examination?

A Yes, I did.

Q Can you describe those, please?

A Well, I took a tape measure and actually measured her incision. In the neurological examination I carefully tested her ability to feel in the area of the nerve in question. In the musculoskeletal examination I used a device called a Jamar, J-A-M-A-R, to

actually measure her grip strength. So those are specialized exams.

Q Can you tell me about the Jamar, how does it work?

A A Jamar is a commercially-available device that has a grip and a gauge. And you give the patient a short training period, and then you ask them to squeeze. And the gauge measures the amount of force or strengths of their grip. And then we can compare that to known standards and have an idea of the patient's grip strength.

Q Now, I believe there was a mention on Page 3 of your report of three averaged trials of the Jamar?

A That's right.

Q What does that mean?

A Well, after they practice for a little bit and they know what to do, you ask them to

squeeze for grip strength three times, you come up with three numbers, and then you average them to get the number that's recorded here.

Q And I believe you referred to that as an objective test?

A That is objective, yes.

Q All right. How so?

A Well, you're coming up with a physical measurement as opposed to a report from the patient. So it becomes objective.

Q Is that a reliable test?

A Yes, it's considered reliable, yes.

Q Did you have any reason to doubt the findings that resulted from your applying that particular test, the Jamar?

A No. I believe she made a true effort and recorded the results. And I thought the test was satisfactory.

Q In your report you don't, I believe you don't mention what her dominant hand is. Are you aware of which hand is her dominant hand?

A You know, if I don't mention it, I should have, I'm sure it's someplace in my records. I don't see that right now.

Q I believe you mentioned in the earlier

report, which we'll refer to later, that you reviewed the records of Accelerated Hand and Rehabilitation.

A I did.

Q So let me get you a copy so we can all follow along.

A This is Dr. Miller's.

Q Yes, sorry. Here we go. And that report, on the first page, I believe after, "Dear Dr. Miller," the second sentence indicates that she's right hand dominant; does it not?

A Yes, it does.

Q Do you have any reason to disagree with that?

A No.

Q In the results of your examination with the Jamar -- let me go ahead and mark this report, the November 20th report, since that's the history and physical examination.

(Exhibit Bonestead-3, Report 11/20/06, was marked for identification.)

Q All right. So on Page 3 that we were discussing you have a note that the left side, the grip of the left side was 34 kilograms, and the right was 32 kilograms; correct?

A That's correct.

Q You also note on Page 4 that as you just mentioned -- withdraw that whole question and I'll start over.

You mentioned a couple minutes ago in your testimony that once you have the findings from your examination you compare those to, I

think you said standards or normals, or what is it you normally refer those two, compare those two?

A There's tables of ranges of grip strength, dominant hand, non-dominant hand, and by age group. I don't have that table with me today, but that's what I use.

Q Okay. And so comparing her findings to the normals for a female in her age group, you note that the normal grip for the dominant hand is 30.8, and for the non-dominant hand is 28.

A Correct.

Q Now, that reflects a 2.8-kilogram difference typically between the dominant and the non-dominant; correct?

A It does, yes.

Q And it reflects that the, or it shows that the dominant hand is typically stronger than

the non-dominant hand?

A That's correct.

Q Those were not the findings in her case; correct?

A No. Her findings were as I recorded, or as the, you have another set of findings from another observer.

Q I'll get to those.

A Yeah, okay.

Q So, in fact, in her case she, her dominant hand was essentially 2 kilograms weaker than the non-dominant hand; correct?

A That's right.

Q So, in fact, if you were to compare that side by side with the expected normals, she would have what, about a 4.8 kilograms or so less than expected?

A Right, in that analysis. But that's not how we do it. But what you did is correct. But it's not the issue with grip strength, though.

Q What do you mean by that?

A Well, the most important thing with grip strength is the individual patient. So she happens to have a stronger grip strength than the

norm. And what you look for is relatively close measurements between the hands. It's not always true that the dominant hand must be stronger than the non-dominant hand, but in normagrams it's usually listed, it is listed as stronger.

So looking at her the only way you're supposed to, which is as an individual patient,

she has a very good match between her two hands, they're separated by less than 2 kilograms. And she's actually stronger than the norms. So you would come to the conclusion that objectively her grip strengths are symmetrical and normal for that one measurement.

Q But, again, comparing them to the normals as you did, she's actually reversed in terms of which is stronger at the time of your examination?

A That's right. She's reversed, but stronger.

Q Stronger than the average person?

A Than the norms, right.

Q Now, I will refer now to the Accelerated Hand Therapy and Rehabilitation. I believe, was that what you were about to refer to there, the measurements that they took?

A That's right. Here the grip strength, the right side was stronger than the left, and this is measured in pounds instead of kilograms, so you would have to make that conversion. So, once again, what's important that she has her grip strengths are relatively symmetrical, and interestingly, this was done on March 26, '03,

and her nerve repair surgery was early February '03. So she was in the early recovery stage, and yet she had a grip strength that was symmetrical. So this piece of information kind of finishes my thought that grip strength is not an issue with this girl. She has good grip strength right after surgery, and she had good grip strength when I see her several years later, so there's no objective evidence of trouble with grip strength.

Q Well, during that very early examination shortly after the nerve repair, indeed, it looks like, let's see, it looks like we're talking about, the repair was on February 5, 2003, and this was March 26th.

A Maybe six weeks.

Q About six weeks?

A Right.

Q She did have the normally expected ratio or proportion, if you will, with the dominant hand stronger than the non-dominant hand; correct?

A That's right.

Q And over the time between that examination and your examination, her dominant

hand is now not as strong as her non-dominant hand; correct?

A That's right, at the time of my one examination, yes.

Q Aside from the grip strength not matching the normal tables to which you referred, were there any other findings that were abnormal?

A Abnormal. Well, you're calling that abnormal, I'm not.

Q Well, okay. Aside from the fact that the measurements you took were not consistent with the proportion that you referred to in the normal tables, were there any abnormal findings?

A Well, yes. She had scarification from her surgery. She also had diminished perception of light touch in the superficial nerve distribution on the right side in comparison to the left.

She also had what we would call a Tinel's sign tapping the incisional area. There was also some post-surgical, firm post-surgical type swelling in the region of her operative incision. So those are abnormal findings of someone who's had surgery, yes.

Q You also, as I understand, reviewed the

notes and records of Dr. Jeffrey Miller, the surgeon who performed the nerve repair; correct?

A I did, yes.

MR. BERGE: I'm just going to mark my packet here with the records of Dr. Miller.

(Exhibit Bonestead-4, Dr. Miller's record, was marked for identification.)

MR. BERGE: And, actually, what I'm going to do is mark as 4A the operative report of Dr. Miller from 2/5/03.

(Exhibit Bonestead-4A, Operative report 2/5/03, was marked for identification.)

Q Now, on the first page of the operative report, the last paragraph on the first page, I'm going to read some of this into the record and just follow along with me and let me know if my reading is accurate. "The prior incision was opened. Readily apparent was the distal end of

the entire superficial radial nerve. Proximally, the proximal stump was somewhat irregular. It was necessary to extend the incision for an additional 1 inch proximally to allow for good exposure for the repair. Both ends of the nerve were mobilized. The first compartment tendon sheath was checked for a complete release. The

release was indeed full. The EPB tendon was free and solitary. A microscope was brought in, and under very high-powered magnification," and it goes on.

A Yes, sir.

Q Would you agree with the conclusion that the statement that the distal end of the superficial radial nerve was readily apparent referred to a time before the microscope was being used?

A It appears that way, yes.

Q In your experience, does that make sense from a surgical perspective?

A Well, I think in this case it would. Because at that point the nerve had already been tagged by Dr. Loriano. So it would be apparent, yes.

Q When you say tagged, what do you mean?

A In the index surgery by Dr. Loriano, after recognizing the transection of the nerve, he repaired it with a single suture. So, therefore, it would be very apparent when you opened, you would see that immediately. And also, you're looking for it, because you're being told there's an issue, so your awareness is there

that that's what you're going for.

Q And would it also be accurate to conclude from this documentation when Dr. Miller says both ends of the nerve were mobilized, that that procedure was also done without the assistance of a microscope?

A It looks like he did it that way if you follow his -- he mobilizes the nerve ends and then brings in the scope for the repair.

Q Is microscopic surgery part of your practice?

A No. I use loups, we call them, eye magnification. But not a high-power microscope.

Q Now, within the same packet we have a letter from Dr. Miller to Dr. Loriano describing the consultation that's dated January 31. We'll go ahead and mark that 4B.

(Exhibit Bonestead-4B, Consult letter,

was marked for identification.)

Q In the third paragraph, it begins with, On examination today, Dr. Miller refers to an exquisitely positive Tinel's sign?

A Yes.

Q Would you say that that is consistent with your finding, at least in terms of the

presence of a Tinel's sign?

A Yes.

Q How would you characterize the Tinel's sign that you elicited in regard to what you can observe from Dr. Miller's description?

A Compared to mine?

Q Yes. Or compared to your recollection. Or I didn't ask you, do you have an independent recollection of the examination?

A Yes, I do remember the exam. Not as if it happened yesterday, but I remember the patient, yes.

Q All right.

A Let's see. It was in the same area. I found that when I tapped the incisional area, it caused the shocks traveling towards the wrist but not the fingers. So there was a Tinel's that went from the operative incision to the wrist.

And Dr. Miller only says, he says that his sign is present proximal and volar to the incision, so that's the incisional area also, but he doesn't say how far down the hand that she feels the shocks. So it's a little different discussion of the sign.

Q So when you state in your report that,

"Patient states that tapping the incisional area causes shocks traveling toward the wrist but not to the fingers," that's in a general sense consistent with her examination back in January of 2003; correct?

A In the general sense, yes, there was a Tinel's sign, yes.

Q And would you expect that any such tapping or bumping into objects would produce those same symptoms?

A If you bumped or struck the area of the nerve you would, since she was showing that in '06, several years later, I would think it would still be there, yes.

Q And is that consistent with the surgical history?

A Yes.

Q You mention decreased sensation to

light touch. How do you perform your examination for light touch?

A Well, I have devices for two-point discrimination, they're manufactured devices that measure two-point discrimination. Well, but actually, you asked me about light touch.

Q Yes.

A I usually brush with a soft object such as a Kleenex tissue. And it's a subjective response. A light, there are commercially available brushes and so forth, but a soft tissue serves the same discrimination.

Q Are the patient's eyes opened or closed when you're performing that?

A They should not be directly looking where you're brushing. On the other hand, though, it doesn't negate the test. These kind of subjective tests depend on the patient being fair and true about what they feel whether they're looking at it or not.

Q Was Miss Doe looking when you performed the light touch examination?

A I don't specifically say, Don't look, but I kind of position myself, and in the way I do things so that they're not quite able to see

what I'm doing. So I would have to say she didn't have her eyes closed, but she wasn't focused on the area that I was examining.

Q And does that apply to your examination for two-point discrimination as well?

A Yes, same idea. But, again, it doesn't depend on the patient not looking. It's more

dependent on the patient being forthright about what they feel.

Q You report, when you say, "Patient reports decreased sensation to light touch in two-point discrimination testing in the description of the superficial radial nerve on the right side," does that indicate that her responses were consistent with the anatomy of the nerve involved?

A Yes.

Q What's the minimum distance in that two-point discrimination?

A I didn't record it because I was only interested in the comparison. What I was trying to find out, I had a purpose to this part of the exam. I wanted to see if she had any sensation in that distribution, and did it offer her protection, which I came to in my conclusion. I

wasn't really interested in the number. What I wanted to know was does she have protective sensation, does she have some element of sensation in that distribution as opposed to a number. And I answered that question, which is part of my report.

Q The instrument that you used, the

commercially available instrument for measuring two-point discrimination, what's the nature of the part or parts of the instrument that come in contact with the patient's body?

A Well, it's a wheel. And from the wheel are prongs, they're blunt prongs. And they're spaced at different distances, 2 millimeters, 3 millimeters, 4 millimeters, 5 millimeters, all the way up to 10 millimeters. So that you're able to touch the patient with two prongs at a time and you say are you feeling one touch or two, that's two-point discrimination. So it's a better way of doing it because you get a number readout.

But, again, in her particular case, I know she had decreased sensation. But my whole point was to discover if she had protective sensation, did she have any sensation.

Q So it's not the type of exam for two-point discrimination that you might use a sharp object such as an EKG caliper or something along those lines?

A Well, you really shouldn't 2 PD with sharp objects because then you're getting a pain response. Two PD is really a touch or pressure

response, it's not a pain response.

Q Did you measure pain response in any way?

A She had no pain response. It's implicit in the exam. When I touched her arm she did not have any pain response to that, except for the tapping at the wrist, which gave her the shocks.

Q Well, really what I'm asking is did you, for instance, did you examine her to see if she could distinguish between a sharp touch and a dull touch?

A No, I didn't.

Q Or if you could elicit pain with a sharp object?

A No, I specifically didn't do that part of it. Again, I was focused on the question of protective sensation, which is really the issue

in this particular part of your hand. It's because it's the top of the hand and not the fingertips. So, the top of her hand is not an area where we make discriminatory touch, it's, we do that with our fingertips. Here the top of the hand is temperature sensitive, and she had no evidence of any trophic changes or loss of

protective sensation, and that's what I was interested in.

Q What's protective sensation?

A It means that you have enough feeling so that you don't harm yourself unintentionally. So if you inadvertently have your hand against a hot object, and you have no sensation, you'll burn yourself and not know it. Protective sensation allows you to withdraw the hand.

Q A person can have sensation that's intact to pressure but not, say, to temperature; correct?

A That would involve a more complex neurological problem that usually from a spinal cord type injury. But the nerve in question here is a sensory nerve, you know, and it's concerned predominantly with touch.

Q Aren't pressure receptors deeper than

pain receptors?

A I don't know what you mean by deeper.

Q Farther down under the skin.

A I don't know the answer to that.

Q And you said you didn't measure to see whether or not she could perceive heat?

A Not particularly, no.

Q So, in fact, you weren't able to evaluate, or at least you didn't evaluate whether or not she had protective sensation in terms of a sharp object touching her or in terms of a hot object touching her; correct?

A Well, no, that's not exactly true. If you have the sensation of light touch and you have feeling, it means that you can feel hot and cold as well. Because we're not dealing with a brain or a spinal cord problem here. If someone in the hand has sensory function, they can feel hot, cold, light and dull. Although I'm agreeing that her function is diminished.

Q Do you have any reference for your assertion that essentially that if her light touch is intact that the other sensations would be intact?

A Well, I could probably get that. I

don't have it on the top of my head here. But we're talking about one specific nerve now, again, and we're not talking about a spinal cord injury. We're talking about the radial sensory nerve.

Q But, in any case, you didn't demonstrate sensation to sharp or sensation to

heat?

A It's not specifically held out there. But, again, it's implicit in the fact that her skin is intact, there's no evidence of burns, there's no healing abrasions indicating inadvertent injury. There's much more to it than the physical testing alone. The fact is her hand had normal form and appearance, her skin is not burned, it's not scratched, it's not ulcerated. She doesn't have loss of hair, she doesn't have trophic changes, meaning nutritional changes, she doesn't withdraw with hypersensitivity. None of that is present. So what she's got is diminished sensation, that's what this girl has.

Q And as to how diminished, you were not able to quantify that; correct?

A Correct. I was seeking one issue, does she have protective sensation, and she does. She

feels there.

Q The Jamar test involved three attempts; correct?

A That's right.

Q Did you do any testing that would evaluate the effect of motions of a more repetitive nature?

A No.

Q And did anything that you did allow you to evaluate the effect of fatigue on her hand function?

A No, that would require a functional capacity exam.

Q So as a logical corollary, is it accurate to say that you did not evaluate the effect of, say, prolonged use of a computer keyboard and what that would, how that would affect her?

MR. LAVERGHETTA: Object to the form of the question.

A I did not do that kind of testing.

Q I'm going to refer now to your other report, report of June 23, 2006, which we'll go ahead and mark.

(Exhibit Bonestead-5, Report 6/23/06, was

marked for identification.)

(A break is taken.)

CONTINUED DIRECT EXAMINATION BY MR. BERGE:

Q All right. So we have the June 23 report, which was the report that you wrote clearly prior to examining Miss Doe; is that correct?

A That's correct.

Q And then we have the November 20, 2006 report, which refers to your evaluation of Miss Doe; correct?

A That's correct.

Q All right. Have you written any other reports other than these two pertaining to this case?

A No.

Q Have you prepared any addenda or anything, any other change or addition?

A The only other thing I did was I prepared a timeline of the case, which actually I did today in preparation. That's all I have.

Q Okay. If I would be able to get a copy of that?

A Sure.

Q Would I be correct in saying that your

timeline doesn't include any opinions relating to the case?

A You're correct.

Q Do these two reports, the report of June 23, 2006, which is Bonestead-5, and the report of November 20, 2006, which is marked as Bonestead-3, do those two contain all of your

opinions regarding this case?

A They do.

Q Are there any opinions regarding this case that would pertain to Miss Doe's condition deviations from the standard of care or their absence, proximate causation, damages or permanency appear anywhere other than these two reports?

A No.

Q In the June 23rd report, which is Bonestead-5, you have a list of records that you have reviewed, it goes 1 through 13. Is that list accurate?

A Yes, certainly it's accurate. I believe all the deps are in there.

Q Do you have any corrections to make to that?

A Not to my knowledge.

Q Have you reviewed any reports or documents or records subsequent to that?

A No.

Q Now, there are two consent forms that have been previously marked. Those were consent forms that Miss Doe signed prior to her surgery by Dr. Loriano.

A Yes.

Q They were marked as D-1 and D-2.

A From Morristown Memorial?

Q Correct. D-1 is from Morristown Memorial -- actually, they both are. D-1 is dated 1/30/03. And D-2 is dated, I believe it says 1/27/03. And written in in the risks/benefit section of both of those after some pre-printed information is nerve damage; correct?

A That's right. Well, I just see one here; I'm missing something here. I have the Morristown consent, which is one page, that I have, yes.

Q And D-2 is, it's also marked as Morristown, but it has a different date.

A Yes.

Q My understanding, well...

A Was one done at the office perhaps and

one at the site?

Q That's my impression. Because the 1/27, D-2 is maybe in Dr. Loriano's record.

A Okay, let me find it. Well, I still have just one. I have the one from the hospital.

Q All right. Well, you're certainly welcome to refer to my copy. We're not going to

get into anything complex here.

A Okay.

Q All right. To my eye, the printed list of complications seems to be the same in both. Do you agree? Do you want to look those over?

A May I?

Q Sure.

A Yes, this is the same printed form, so all the printing would be the same. There's some differences in the handwriting.

Q And nerve damage is the only complication written in there; correct?

A That's correct.

Q Now, of the complications that are printed there, they include, it says, "These risks include allergic reactions, bleeding, blood clots, infections, adverse effects of drugs, and even loss of bodily function or life."

Picking one in particular, infections. Would you agree that infections are sometimes a known and unavoidable consequence of certain procedures?

A Yes.

Q Even though that's true, would you agree that surgeons have a duty to take

reasonable precautions to attempt to prevent infections?

A Yes.

Q And so, for instance, if a surgeon didn't adhere to aseptic technique, didn't use gloves, touched unsterile areas, or other breaks in aseptic procedure, then that would be negligent, correct?

MR. LAVERGHETTA: Objection to the form of the question.

A Well, that's too general, because I would have to know the circumstance he is in which those things happened. So I can't answer that, it's too general. I mean, there could be a circumstance where a surgeon could do something without aseptic technique, perhaps to save a life, and the result might be an infection.

Q All right. Well, perhaps in the more

general sense you would agree that a surgeon has a duty to take reasonable steps to attempt to prevent infection?

A I agree with that, yes.

Q All right. And that, therefore, some infections, and certainly the rate of infections may be preventable, depending on whether or not

those reasonable steps are taken?

MR. LAVERGHETTA: Objection to the form.

A Some infections or the rate of infections, the frequency or something like that?

Q Yes.

A Well, as a general statement, that is probably good. It can't be used broadly, but as a general statement that's okay.

Q And we mentioned that only one, or I mentioned that only one complication was written in. If a surgeon had written in, say, laceration of the radial artery, in your opinion, would that relieve the surgeon from the obligation to take reasonable steps to prevent that complication?

MR. LAVERGHETTA: Objection to the form.

A We always try to avoid complications as

best we can. So, the answer would be you should always take reasonable steps to avoid complications.

Q And would you agree that a surgeon has a duty to take reasonable steps to avoid, at least known complications?

A Yes.

Q Would you agree that failure to take reasonable steps to avoid complications would be negligent?

MR. LAVERGHETTA: Objection to the form.

A Well, I could understand cases where I would agree with you, yes. In optimum settings where there's no particular reason why you shouldn't take reasonable steps, then you should.

Q Well, would you agree that the way we're using reasonable in this situation would take into account extenuating circumstances? In other words, if you had seconds to spare to save someone's life, you might not stop to wash your hands, that might not be reasonable under those circumstances.

A That's correct, that's my point, you have to go case by case.

Q And you agree that writing a complication on a consent form doesn't relieve the surgeon of the obligation to make a reasonable attempt to avoid that complication?

A Generally not.

Q Under what circumstances would it?

A Well, you're always trying to avoid

complications. But, you know, some are more avoidable than others. There might be a complication that's part and parcel of the procedure. For instance, in tumor surgery, in the process of removing a tumor, you might have to sacrifice a nerve that's transversing the tumor. So you have to give up that nerve to be rid of the tumor.

Q And, in fact, in a situation like that, there would be no reasonable step to prevent it if you're going to accomplish the procedure; correct?

A That's right.

Q Have you performed the procedure that Dr. Loriano was performing, a release of the first dorsal compartment?

A I have, yes.

Q Have you ever cut the radial nerve?

A To my knowledge, no.

Q You've reviewed Dr. Loriano's operative report; correct?

A I did.

Q And his deposition testimony?

A I did.

Q Would you agree that Dr. Loriano, when

he noticed that the superficial radial nerve was cut, saw that just using the operating loup that he was employing?

A Saw that what, sir?

Q Just with the use of the operating loup that he was using.

A Yes, that's correct.

Q And would you also agree from your earlier review of Dr. Miller's operative note that Dr. Miller was able to not only identify the radial nerve which you mentioned had been tagged, but was also able to manipulate it and mobilize it without the use of a microscope?

A That's true, yes.

Q Have you ever attempted to identify -- and we'll start with just identify the radial nerve during a surgical procedure?

A The superficial radial nerve?

Q Yes.

A Well, attempt to identify it, or better answer for me would be to attempt to know where it is or where it isn't.

Q Okay. Have you done that?

A Yes.

Q And how do you do that?

A Well, of course we have a knowledge of anatomy before we start, so we generally know what the course of the nerve is. And as we make our dissection, once you pass the skin, that nerve is rather superficial. So in order to complete this operation, you have one or two ways to do it. You either have to know where the nerve is and retract it away from the field if it's in the field, or, conversely, just simply know that it's not where you are as opposed to searching it out. That works, too.

Q All right. Let's start with the first example. How would you find it and retract it?

A Well, after you open the skin and go through the rather thin fat layer, you start to come up to the level where the nerve is, and you see it. If you see it, then you have to make a decision, is it in your operative field or is it

not. If it's in your operative field, then you have to mobilize it and move it out of the way.

If it's not in your operative field but you still see it, then you can just complete the operation knowing where it is and knowing that you're not there. That's one way.

Q And you mentioned going through the, I

guess you said the thin or relatively thin layer of fat under the skin, is that the subcutaneous fat?

A That's right.

Q Backing up a little bit, how do you get through the skin?

A The skin is opened with a knife.

Q All right. Is that what the layperson would refer to as a scalpel?

A That's right.

Q And in that process of finding the nerve, how do you go through the fat?

A Well, the nerve is not in the fat, it's below that. So you spread the fat apart. The fat doesn't require much in the way of cutting, we use a small instrument to spread it.

Q Well, what kind of instrument is that?

A Usually a hemostat.

Q And that's not a sharp instrument, is it?

A It's not.

Q And why would you use an instrument that wasn't sharp or was blunt?

A Well, because blunt instruments separate tissues one from the other as opposed to

cutting tissues. And a general principle of surgery, if we can separate something rather than cutting it, it's the way we prefer to work. It creates less bleeding and later less scar.

Q Would it be correct to say that in this particular example it also decreases the risk of cutting the nerve or any other structure that you're approaching?

A Sure, that's true.

Q Again, staying on this particular example. How long does that take from, on the average, from the point at which you've cut through the skin typically until the point at which through blunt dissection you've found the radial nerve on the average?

A Well, if it's in the field, just a few minutes. Cutting through the skin you also have, you may have some small bleeding points that

you'll stop for, coagulate. And then if the nerve is going to be there, you'll start to, you'll see it.

Q So three, four, five minutes?

A That's right. For a small incision like this.

Q It might take a little longer, I

assume, if the nerve isn't in the field, because you're trying to assure yourself that it's really not there.

A Well, that's the second way to do it. You've opened and the nerve is not there, it doesn't mean that you abandon the surgery, nor does it mean that you must search until you find the nerve. You have, you can take the other road then, which is proceeding with the operation knowing that the nerve is not where you are. That's a satisfactory way to do it.

Q And is the technique for determining that the nerve is not in your operative field the same technique as what you described for isolating it?

A Well, once you've cleared the operative field of the subcutaneous tissues, you know, if the nerve is not there, it's not there. And the

next step is to open the vasial (phonetic) tissues and the retinacular, and you're done.

Q Oh, that's also, clearing the fat is also done using a blunt instrument such as a hemostat?

A Yes.

Q And either way you're talking about a

procedure that only takes a few minutes?

A That's right. The complete release, if there's no side issues like a ganglion or something unusual, the actual release takes a few minutes.

Q But I mean even, what I'm specifically talking about is the process of either finding the nerve or determining that it's not in your operative field.

A That's right, that's not a long, time-consuming issue.

Q Okay. Is that a technically challenging issue for, or technically challenging procedure for a board-certified orthopedist?

MR. LAVERGHETTA: Objection to the form.

A Well, no, because we do it all the time. But it doesn't mean that it's always

successful. But it's done essentially in every operation, that you proceed when you either know where structures are, or you know they're not where you want to be. We do that all the time.

Q Okay. Now, staying with the first possibility, which is that the nerve is in the surgical field. If you've proceeded as you've

just described, i.e., cutting through the skin using a blunt instrument to separate the subcutaneous fat, and then found the nerve somewhere in your surgical field, I think you mentioned after that that you would retract it?

A Well, there's a little minor step in there. Assuming that it's actually where you need to work, then you mobilize the nerve, which means free it up, and retract it out of the way.

Q And what does retracting do for someone, what does it mean to retract it?

A It means that you take the structure, and we use a blunt instrument to hook it and essentially pull it out of the field.

Q Once you've, assuming that you've found the nerve, mobilized it and retracted it, you're not going to cut that accidentally, could you?

A Well, you could. You could have a slip

of the knife and cut it. It could be torn by the retractor. So it still could be cut.

Q Is it likely at that point in competent hands?

MR. LAVERGHETTA: Objection to the form.

A Well, it's not likely, because if it

was likely, we would have a lot of this kind of thing. But that doesn't mean it can't happen.

Q Well, would you agree that having identified the nerve, mobilized it and retracted it is the most effective way to avoid cutting it, assuming that it's in the field?

A Yes, with the assumption that it's in the field, yes. There's no need to do that if it's not in the field.

Q Granted. Because if you've explored the area and it's not there, it's not in your way essentially; correct?

A Correct.

Q Okay. Aside from what you just described, which was the possibility of, say, tearing or stretching the nerve with the retractor or despite -- well, really, aside from that, are there any risks to the procedure of

identifying the nerve, mobilizing it and retracting it?

A Well, yes. Nerves are sensitive, and simply mobilizing it and moving it can actually damage the nerve. In the process of retracting it, you can put a stretch injury on the nerve. And rarely but not impossible the nerve can be

torn. And then, of course, you know, rarely but not impossible, the nerve could be severed.

Q But you mentioned that that's done all the time. Would it be accurate to say that the risks of identifying, mobilizing and retracting the nerve if it's in your field, that the benefits of doing that are significantly greater than the risks to the nerve?

A Sure.

MR. LAVERGHETTA: Objection to the form.

Q Given that cutting the superficial branch of the radial nerve is a known risk in the first compartment -- is it first compartment release that we're talking about?

A Yes, it is.

Q Procedure, and given that the benefits are, exceed the risks, isn't that a reasonable

step to take in order to prevent laceration of the superficial branch of the radial nerve?

MR. LAVERGHETTA: Objection to the form. You can answer.

A In the case of the nerve being in your field, it's a reasonable thing to do.

Q In the case where you don't know

whether it's in the field or not, is it a reasonable step to search for the nerve and determine whether or not it's in the field?

A Well, the way you asked the question, if you don't know if it's in the field or not, then, yes, you have to make a decision. It's either in the field or it isn't. It can't be both.

Q Is there any surgical contraindication to looking for the nerve to determine whether or not it's in the field and, therefore, at risk of being cut?

A Only if you don't know where it is, or you're not satisfied that, you're not satisfied that you can't say it's not in my field. In other words, if you're satisfied that it's not in your field, then there's no need to look for it.

Q Granted.

A But if you're not satisfied, then you've got to either look for it or get yourself satisfied that it's not in your field.

Q All right. Given Dr. Loriano's testimony that he was able to see the nerve once it was cut, and that he was able to attempt a repair with a 4-0 suture, which I understand is

not a particularly fine suture, and given Dr. Miller's record, is there anything in the documents that you've reviewed, the records that you've reviewed, to suggest that this, that the radial nerve branch in this case that was cut was particularly difficult to see?

MR. LAVERGHETTA: Objection to the form.

A Well, particularly difficult to see. You know, seeing at the end of the case after all the tissues have been opened and retracted is different from seeing it as you proceed with the dissection. It's easier to see later after you've opened everything up, retracted everything back, there's more exposure. But there's nothing to indicate that this particular nerve was, shall we say, unusual or aberrant. No, I don't find that.

Q Nothing to suggest that it was more fine or narrow than the usual nerve in that area?

A No, I've seen no testimony from anyone that said that that was the case.

Q Okay. Have you seen anything in testimony or in the records that would document that Dr. Loriano attempted to identify and

isolate the radial nerve branch in this case?

A I have, yes.

Q All right. What was that?

A Well, in his operative report he's clearly aware that the superficial branch is a structure that's at risk in this particular procedure, because he says, he outlines the course of the superficial radial nerve prior to the procedure. So to do that prior to the procedure indicates with certainty that he understands that this nerve is at risk, and it has to be avoided or identified, whatever the situation might be.

He then makes a straight incision, which is what we call in the axis of the nerve. And that lessens the chance of lacerating the nerve, because you're cutting across its length as opposed to across it. So that indicates to me

that he has awareness of this nerve, and that he's doing things to avoid injury.

Q From you're reading of the record, was this nerve in the operative field?

A I believe that eventually it was in the region of the operative field, yes.

Q Is there any evidence that the nerve

was identified being mobilized and retracted?

A I don't see that, no.

MR. BERGE: I have no further questions. Any questions?

MR. LAVERGHETTA: No.

(Whereupon the deposition concluded at 4:02 p.m.)

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CERTIFICATE

I, SUSAN M. STYRON, Notary Public and C.S.R. of the State of New Jersey, License No. XIO1704, do hereby certify that prior to the commencement of the examination Richard Bonestead, M.D. was duly sworn by me to testify the truth, the whole truth and nothing but the truth.

I DO FURTHER CERTIFY that the foregoing is a true and accurate transcript of the testimony as taken stenographically by and before me at the time, place and on the date herein before set forth.

I DO FURTHER CERTIFY that I am neither a relative nor employee nor attorney nor counsel of any of the parties to this action, and that I am neither a relative nor employee of such attorney or counsel, and that I am not

financially interested in the action.

_____

Notary Public of the State of New Jersey
My Certificate expires January 25, 2009
Dated: January 5, 2007