PROCEEDINGS

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF WESTCHESTER
---------- x

ANNMARIE FLANNERY and DAVID FLANNERY
Plaintiffs

- against - INDEX NO.
11230/06

JOHN MARZANO, D.P.M. & WESTCHESTER PODIATRIC MEDICINE, P.C.
Defendants.

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TESTIMONY OF ROBYN JOSEPH
111 Dr. Martin Luther King, Jr. Blvd.
White Plains, New York 10601
July 16, 2010

B E F O R E:
HON. MARY H. SMITH,
Justice of the Supreme Court.

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

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BY: MARK McANDREW, ESQ.

CYNTHIA M. HILLS,
Senior Court Reporter.

MR. OGINSKI: Thank you, your Honor. At this time the Plaintiff calls Doctor Robyn Joseph.

THE COURT: Do you swear the statements you are about to give will be the truth, the whole truth, and nothing but the truth, so help you God?

THE WITNESS: Yes, I do.

ROBYN JOSEPH, having been first duly sworn, was examined and testified as follows:

THE COURT: Okay. Now, you are going to have to keep your voice up.

THE WITNESS: I'm fine. Thank you.

THE COURT: Be seated. Well, you think you are going to be fine.

THE WITNESS: I'm fine.

THE COURT: We are on the matrimonial floor. So we just project.

THE WITNESS: Yes. I just had a frog in my throat.

THE COURT: I'm trying to give you good advice. Be seated and give us your full name, please.

THE WITNESS: Dr. Robyn Joseph.

THE COURT: And, Doctor, give us your

professional address.

THE WITNESS: 1165 Northern Boulevard, that's Manhasset, New York, 11030.

THE COURT: Another request, Doctor. If you must use in your testimony any terms that are medical in nature, I do require at this point that the expert gives some kind of explanation or that counsel asks for an explanation, because, you know, we can't -- the jurors have to understand, all right.

THE WITNESS: Yes.

THE COURT: Thank you.

MR. OGINSKI: Your Honor, at this time I offer into evidence on stipulation Dr. Matthew Roberts' medical records as Plaintiff's 5 in evidence.

MR. MC ANDREW: So stipulated, Judge.

(Whereupon, Plaintiff's Exhibit No. 5 was marked In Evidence.)

MR. OGINSKI: And also --

THE COURT: This is Matthew Roberts?

MR. OGINSKI: Yes, Matthew Roberts, MD. And Plaintiff also offers into evidence the Hospital for Special Surgery records, Plaintiff's 6 --

MR. MC ANDREW: So stipulated.

THE COURT: -- in evidence. Five and six.

MR. MC ANDREW: Judge, we have agreed we are going to mark into evidence also as seven Dr. Caragine's records.

THE COURT: How do you spell that?

MR. MC ANDREW: C-A-R-A-G-I-N-E.

THE COURT: Dr. Caragine's medical chart?

MR. MC ANDREW: Yes.

THE COURT: So stipulated?

MR. OGINSKI: Yes.

THE COURT: That's seven.

MR. OGINSKI: Subject to whatever redaction may need to be done.

MR. MC ANDREW: Naturally.

(Whereupon, Plaintiff's Exhibit No. 6 was marked In Evidence.)

MR. OGINSKI: May I proceed?

THE COURT: Yes.

DIRECT EXAMINATION

CONDUCTED BY MR. OGINSKI:

Q Good morning, Dr. Joseph.

A Good morning.

Q Going back a number of years, did I ask you to review the records in this case?

A Yes, you did.

Q And at my request, did you look at the records, Dr. Marzano's records and his x-rays?

A Yes, I did.

Q And during the course of the year, since 2006 up until now, have you reviewed additional records relating to this case?

A Yes.

Q And, Doctor, as a result of your review, did you reach certain conclusions about the treatment that was rendered in this case by Dr. Marzano?

A Yes, I did.

Q Tell us what those conclusions are, Doctor.

A Well, I feel that not only was it just a poor result, it was, he was negligent in his care because he did not review the whole foot. He just looked at a bunion and corrected a bunion poorly by taking too much bone, and he did not look at her clinical signs and her x-rays to determine what else needed to be done. You can't just look at one part of the foot because what you do to one part affects the rest. And she had a callous under the second metatarsal, which is the ball of the foot next to the bunion area or the first metatarsal.

Q Well, let me stop you for a second, Doctor.

I'm going to go into detail in a little bit.

A Okay.

Q Those conclusions, is that conclusion based -- withdrawn.

The conclusion that you reached, that Dr. Marzano did not perform the surgery properly, are you more likely right than wrong that your conclusion --

MR. MC ANDREW: Objection, your Honor.

THE COURT: No, no.

MR. OGINSKI: I'll rephrase it.

Q Doctor, does your conclusion lie within a reasonable degree of medical probability?

A Yes.

Q Does that mean that that medical probability lies within reason?

A Yes.

Q And, Doctor, beyond that, are you 100 percent sure?

MR. MC ANDREW: Objection, your Honor.

THE COURT: Sustained.

Q Doctor, by the way, you're licensed to practice podiatry in the State of New York?

A Yes, I am.

Q And are you also board certified in the

field of podiatric surgery?

A Yes, I am.

Q And I will get into your credentials a little later, but what is that board that qualifies you in the board certification?

A I --

Q I'm sorry. Is that the American Board of Podiatric Surgery?

A Yes, it is the American Board of Podiatric Surgery.

THE COURT: Let me ask a question. So, with regard to your testimony elicited by counsel, are you saying that to a reasonable degree of scientific certainty that the Defendant here departed from the fair and accepted standards of medical practice in podiatry and in doing this surgery?

THE WITNESS: In doing it where he did not have control.

THE COURT: Yes or no?

THE WITNESS: Yes.

MR. MC ANDREW: Judge, if I may. I don't think this witness has been qualified as an expert just yet.

THE COURT: She will be.

Q Doctor, our concern in this case is evaluating whether or not the treatment done by Dr. Marzano was done properly. And when you -- before we even get into the details of that, tell us when and where you learned how to do foot surgery.

A I went to the Pennsylvania College of Podiatric Medicine, four years, a degree of Doctor of Podiatric Medicine. And then I did three years of post graduate training, two years in Denver, Colorado. It was called Doctor's Hospital.

THE COURT: Slow down.

A For two years of surgical residency, foot and angle. And then I took my boards. It takes several years to acquire 75 different types of cases to become board certified, and then you have to take a three-hour written exam and ten oral questions.

Q And did you pass that?

A Yes, I did. Twice.

Q And in the process of continuing your career, during the course of your career, have you had occasion to perform foot surgery?

A Yes, I have.

Q And tell us how often you perform foot surgery?

A Every week.

Q Doctor, can you tell us, how long have you been performing Lapidus bunionectomies?

A Twenty-two years.

Q How long have you been performing Austin bunionectomies?

A Twenty-two years.

Q Can you give us an idea of how many Austin bunionectomies you have performed in the course of your career?

A Hundreds.

Q Can you give us an idea of how many Lapidus bunionectomies you have performed in the course of your career?

A Fifty to a hundred.

Q Now, when you -- we have used the term Lapidus and Austin. Let me get even more basic. Tell us, please, what is a bunion?

A Okay. Can I...

Q Do you want to use the model?

A Please.

THE COURT: We have two models.

MR. OGINSKI: She brought her own, Judge.

MR. MC ANDREW: Do we want to mark this?

THE WITNESS: This is actually a right foot.

THE COURT: A righty, okay.

THE WITNESS: It makes it easier.

THE COURT: We can mark it for demonstrative purposes only, but I don't think we need to. This is -- let me see it.

Okay. Question: Why does it have these plastic wires?

THE WITNESS: To hold it together. It is all strung up.

THE COURT: Oh, I see.

MR. MC ANDREW: A different type of coil.

THE COURT: All right. Right foot. And this is the big toe. We call it the big toe.

THE WITNESS: Right. And the pinky toe is the other side. Sorry. Okay.

BY MR. OGINSKI:

Q Doctor, tell us, what is a bunion?

A Okay, a bunion is a description of a change in the foot, or deformity, between the first metatarsal and the great toe. The first metatarsal is the bone in the foot past the web connected to the great toe, so what happens is over time --

Q Doctor, I'm sorry. Would it be easier if you show the jury?

A Can I stand up?

THE COURT: Yes. And why don't you start again because I want everyone to understand.

THE WITNESS: My back is to you. Sorry, Judge.

This is the heel, this is the ankle, and then this is the arch, and this is the ball of the foot. This is the big toe. These are five metatarsals with your five toes that connect behind like your fingers into your hand. So, what happens is your five metatarsals, hopefully when you are born, are all aligned and parallel. So you have a narrow foot.

What happens is the first metatarsal starts to spread out away from the second toe, the second metatarsal, and then because the bones are connected by tendons, the big toe will start to bow, like a bow and arrow, pull in that direction (indicating).

So, what you see on a foot is this bump. It is really the end of this bone, the first metatarsal sticking out, and the great toe being pulled over this way (indicating) pushing even further on that first metatarsal head, and that's what hurts in a shoe. And then as this continues, this can become a painful joint as

well.

So, when we determine a bunion, to give a rough estimate as to mild, moderate, severe, we measure the angle between the first metatarsal and the second metatarsal, and/or the distance of how much it is spread out. And that's what a bunion is.

The object is to bring this back into place, at the same time keeping everything level so that you're not having increased pressure on the one area, under one area more than another, and keeping the toe level and straight because the joint, the bones need to be end to end, not here, not there.

Q What is, to clarify, what is a metatarsal?

A A metatarsal is the long bones in the mid part of the foot behind the toes.

Q Okay. And what is a bunionectomy?

A Is a correction of the metatarsal alignment to the big toe to try to put the metatarsal back in the foot, aligned or parallel to the second metatarsal. So you are taking it from here and putting it back level.

Q Now, Doctor, what is a callous? What does that mean?

A A callous is a thickening of the skin. And the reason you get a callous is from pressure. It is pounding on the same area. The skin has two choices. It can either buildup, which is the healthy choice, or it can breakup, which is the non-healthy choice, which would become an ulcer or a sore. So a callous is protective to some degree, but when it gets to be too thick it becomes extremely painful. That's when you walk on the ball of your foot.

Q Now, we have heard some talk during the past few days about a Lapidus bunionectomy. Tell us, please, and if you need the model, tell us what that Lapidus bunionectomy is. What does that mean?

A I have to throw one more bone at you. It is the cuneiform. You don't have to know the name.

THE COURT: We know that.

THE WITNESS: Okay, good.

So, there are three cuneiform, one going behind the first metatarsal, one behind the second, one behind the third. The fourth and fifth metatarsals get a different bone, cuboid.

So, okay. So the cuneiform, the first cuneiform is behind the first metatarsal.

THE COURT: What is the name of that one?

THE WITNESS: The first cuneiform.

THE COURT: We are talking about, I think, the medial.

THE WITNESS: Medial or first. It is first, second or third, medial, middle or lateral.

THE COURT: Okay.

THE WITNESS: So it may be easier to say first.

THE COURT: First or medial.

THE WITNESS: Right. Okay. Fine, I'm sorry.

So what happens is sometimes the metatarsal is far out. And the cuneiform deforms with it and changes and can keep the metatarsal out like this (indicating). So when have you a very, very severe bunion, a big spread between the first and second metatarsal, the only way to bring it back over is to realign this whole joint and take this bone and this bone, the first metatarsal, the medial cuneiform, and fuse them together in good alignment.

If the foot is also very flexible, or you may have heard the word hypermobile. I don't know if that has come up at all.

THE COURT: That's a new one.

THE WITNESS: Meaning too much movement. Hyper.

BY MR. OGINSKI:

Q We heard the word unstable.

A Unstable. Then you want to fuse it between the first metatarsal and the medial cuneiform just to hold it in place. Because you can correct a bunion and bring it back by making a cut in the metatarsal itself without fusion. And it can spread back out if you have an unstable foot.

So, the two different reasons -- and the Lapidus is a fusion between, or a bringing of two bones to become one bone, first metatarsal to the medial cuneiform.

THE COURT: All right. Now, I have a question.

You have to tell me, these models are very fragile. Can the jury pass them around?

THE WITNESS: This is real bone, your Honor.

THE COURT: Can't do it, all right.

THE WITNESS: No.

MR. OGINSKI: Judge, they can see. It is fine.

THE COURT: You can pass it around.

THE WITNESS: Of course, please.

THE COURT: All right. I don't want anything to happen.

THE WITNESS: No, nothing is going to happen to it.

THE COURT: Just so they can see. Now, the first juror has it. Do you see where the medial cuneiform is? I'm going to test you. Do you see where it is, Mr. Provensano? Where is the medial cuneiform? Point it out to the doctor.

A JUROR: Right here (indicating).

THE COURT: Good. Okay. This is real bone?

THE WITNESS: Yes.

THE COURT: It is a very small foot, a child?

THE WITNESS: A woman.

(Whereupon, the above-mentioned exhibit was published to the jury.)

THE COURT: Is anyone having trouble finding the medial cuneiform? Because I think it is important we know which bone we are talking about. All right, thank you very much.

Any questions on this demonstration right now? Any unclarity? You understand?

All right. Super, let's go on.

BY MR. OGINSKI:

Q Doctor, what is a joint arthrodesis?

A Arthrodesis. Arthro means joint. Desis is fusion of. Again, trying to bring one bone and another bone, two bones to become one bone. Between two bones are cartilage. Everyone has seen a chicken bone and the end is white and glistening. That's what cartilage is. Cartilage on x-ray you can't see, so the space between joints is that dark space is the cartilage. So, you have to remove the cartilage on either side, and that's about maybe less than a millimeter thick on the cartilage on either end, and you rough up the bone edges and you bring them together.

Q And have you done that in your career?

A Yes.

Q Now, what is an Austin bunionectomy?

A That is a cut or osteotomy is the same thing as making a cut in the bone. So you are making a fracture really with a saw blade in this part of the bone, which is behind the head, or the round thick part where the ball of the foot is. In the neck

region we call that, where you cut the bone here and you move the bone, the first metatarsal head. You leave the back part of the bone where it is, and you move this part over. You can only move it to reattach it onto itself a third of the width of the bone. You're limited in how much you can reduce your ankle between your first and second metatarsal.

Q And you can sit down, Doctor. Have you seen and treated patients who have had severe bunions?

A Yes.

Q And is that an indication to perform a Lapidus procedure?

A Sometimes, yes.

Q Okay. Doctor, let me ask you this. In order to arrive at the conclusions that you did regarding the care and treatment rendered in this case, tell us what you looked at to reach those conclusions?

A You look at -- well, obviously, I did not have the patient to look at, so you look at the x-rays and you look at what the deformity is. You look at the entire alignment of the foot. You want to look at, to simplify it, just how far spread out the first metatarsal was from the second metatarsal. You want to look at the angle of how far over the big toe is

going towards the pinky toe. You want to look at the relative lengths of your metatarsals.

Q Tell me what that means.

A Meaning is the second metatarsal longer than the first. Is it getting more weight in that area because it is long? And I would like to just explain that your foot is an arch. So you have a heel like this and your arch goes like this.

Q Doctor, I'm sorry.

A It goes down. It angles down.

Q It might be easier to show it in front of the jury so they can see.

A You want me to stand back up? Sorry. I'll stand here.

So, what happens is the metatarsals are angled down because of an arch. Whether you're flatfooted or not, there is still some angle. So the bottoms of the metatarsals are rounded and thickened on purpose to withstand that force because that's just normal anatomy, and it is intended for that.

So, you want to look at, what I mean by relative lengths, you wanted to look at which joint, which bone is getting most of the weight. You want to look at the toe to the metatarsal. Is it sitting up? Is it out of alignment? And when I looked at her

x-rays, she had a bunion and her second metatarsal was longer than her first and the second toe to the second metatarsal was out of alignment. And what that means, to me, is that there is extra force under this area (indicating) already.

Q You're pointing to what?

A The second metatarsal head to the toe. Then I read the chart, and I see that she has a callous under here, which what I said before what a callous is is from pressure. So that means she already has pressure there. So now when you're going to correct a bunion you want to make sure that whatever you do helps alleviate this or she is going to continue to have problems there.

So when you bring the first metatarsal in, that helps because now more weight is going to be under the first metatarsal. But, if the second metatarsal is still too long, the forces, when you are walking on that longer bone, because the longest bone is going to hit the ground most and first, bam, bam, bam. Okay, you want to correct that.

Q Let me just stop you for a second.

Doctor, I have enlargements of the x-rays that are already in evidence and ask you whether that would help you explain to the jury what we are talking

about?

A Yes, I think so.

Q And these are simply blowups or enlargements of the various x-rays.

A That would help. Is there an easel?

THE COURT: There is an easel over there.

MR. MC ANDREW: Judge, may we establish with this witness that these are actual blowups of the x-rays that are here in evidence, that she has compared those?

THE COURT: Right. I think we have a light box so we can put the x-ray up and then the blowup.

MR. MC ANDREW: I don't think that's necessary if she can state that those are equivalent. That would be fine by me.

THE COURT: I have no idea. Do you want to put it up?

MR. MC ANDREW: I'll take your guidance, Judge.

THE COURT: Do you want to put a foundation?

THE WITNESS: There is a label.

Q Doctor, let me just ask you, you reviewed the x-rays regarding this patient, both preoperative

and postoperative x-rays, correct?

A Yes, I did.

Q You used those x-rays in coming to your conclusions?

A Yes, I did.

Q And these blowups, this enlargement that you have, do you see the patient's name is on here and it has the date?

A Yes, it does, down here.

Q And this particular blowup that you are looking at is dated March 10th, 2005, correct?

A Correct.

Q That's the same x-ray, just not in that form that you looked at in order to come to your conclusions?

A Just larger, yes.

Q And would the same be true of the other four exhibits that I have here as well?

A Yes.

THE COURT: So those are postoperative x-rays?

MR. OGINSKI: They are both, your Honor. Pre-op and post-op.

THE COURT: Well, can you have your witness identify which it is?

MR. OGINSKI: Yes.

MR. MC ANDREW: Judge, may I take a position?

THE COURT: Of course.

Q Doctor, we have already established that that one is March 10th. That's preoperative, correct?

A Yes.

Q Tell us what is on that x-ray, Doctor.

A This is left and right foot. We call that DP view or looking straight down on the foot when the foot is in a standing position. So, this is just a straight-on view. Okay.

Q And what do you see in this x-ray?

A You can see that there is definitely a big gap.

Q Can you turn it a little bit so everybody can see that?

A Okay.

Q Go ahead.

A There is a big gap or space between the first metatarsal and the second metatarsal. These are actually --

MR. MC ANDREW: Judge, there is glare. It is very hard to see.

THE COURT: Off the record.

(Off-the-record discussion.)

THE WITNESS: All right, this and this, these little bones are called sesamoids. They are like a kneecap within a tendon under the first metatarsal. They used to be directly underneath the first metatarsal. That gives us a guide also as to see how much the first metatarsal splayed away from the second metatarsal.

So that shows me how much of a bunion she has. Besides you can measure the angle between the second and first metatarsal.

You also look and you see that the big toe is turned towards the little toe, because, remember, I told you that pull of the tendon makes that happen.

Then if you look at the second metatarsal compared to the first, compared to the third, it is much longer. Then if you look at the second toe it is sitting off, not sitting end to end of where it should be. It is sitting off toward that pinky toe again. And this is mostly from the pressure of the metatarsal hitting the ground most.

When you have a metatarsal in a toe you

have ligaments which are stretchy material, let's say, almost, that holds the joint together and in alignment. When you have too much force on a joint it cannot withstand that. It is not meant to withstand too much force in one spot. The ligaments start to tear and the toe comes up and out, and that's what is happening. It is from too much pressure and force on that area.

So, that shows me that is an issue that needs to be addressed in surgery. You can't just bring this back and have a short, or first metatarsal, then a second metatarsal and not -- and think, excuse me, not not think. But think that you are going to have relief of pressure and pain and callous formation in that area. And it is going to continue and it is going to continue to get worse.

Q Explain what you mean -- what is the significance of having a long second and third metatarsal?

A More pressure in that area, because I said that the metatarsals are angled down from the arch. The top of the arch is in the middle of the foot and then the metatarsals come down. I'm exaggerating, but they come down. So when have you too much length in

one area it is going to be too much pounding on that spot. And in the surgery when it was corrected, you want to minimize how much you shorten the first metatarsal so that you get less increase in stress in this area.

So, you want to be careful. You have to have control in surgery. You have to plan out. A Lapidus is a procedure that causes more shortening than some other bunionectomies. So, if you know that and you now have a long second metatarsal to begin with, well, you shorten as minimum as possible to reduce the risks. And you can either put in extra bone, you take a bone graft, which is extra bone you could take from the person or from something, a cadaver, from a bone bank. Or you shorten this.

Q When you say "this?"

A The second metatarsal and realign the joint to give a better weightbearing surface on the ball of the foot.

Q Why is that good practice?

A You can't have blinders on when you treat a patient. You can't -- in other words, with foot surgery, you can't say, oh, she has a bunion. Well, I'll just correct that, and I'll do whatever it takes to correct that. Take an inch of bone, take a

centimeter of bone, and that's the end of it. You have to look at what you do to the foot to correct that bunion is what kind of effect it is going to have to the rest, or you are going to end up with all kinds of deformities.

Q And what happens if you don't take that information into account when you go ahead and do this surgical procedure?

A It is not good medical practice, number one. And, number two, you're going to have --

THE COURT: Is it a departure of good podiatric --

THE WITNESS: Yes, your Honor.

THE COURT: It is a departure?

THE WITNESS: Yes, your Honor.

I mean, looking at this foot, I can tell you that, that without any correction, she is going to have a problem here, under the second metatarsal, second metatarsal to the toe.

So when you are correcting this, you need to correct the second -- the bunion. When you are correcting the bunion, you need to correct the second metatarsal toe area at least.

Q Tell us, when you say you need to correct it, tell us what you mean by that.

A You need to level out the playing field. You need to make the lengths of the metatarsals a little closer so that there is less force and pressure and pain on weightbearing with every step you take under that second metatarsal or ball of the foot, where she already had a callous.

Q Should every podiatrist who treats patients know this?

A Yes.

Q Should every board certified podiatrist know this?

MR. MC ANDREW: Objection. Asked and answered.

THE WITNESS: I think so.

THE COURT: I'll allow it.

THE WITNESS: Yes.

Q Now, Doctor, in addition to the x-rays and the records that you looked at -- withdrawn.

Are there other x-rays, preoperative, that will also assist you in explaining to the jury what you see prior to surgery?

A No. These are -- these x-rays here are just a slightly angled view, and it gives us pretty much the same information.

Q Okay. Now, how do you know how much bone to

remove when you're going to do this procedure?

A When doing a Lapidus procedure?

Q Yes, thank you. A Lapidus procedure.

A You want to, in this case --

Q Yes.

A -- in this case, again, you want to take as minimal an amount of bone as possible because you are already -- you already have a first metatarsal, a second metatarsal relative length off. It is not equal. And there is more weight under the second metatarsal, and the second metatarsal is longer. So if you shorten the first metatarsal a great deal, there is going to be a big discrepancy between the metatarsals and significant weightbearing or the way that she is walking, pressure on that second metatarsal joint.

Q Okay. So, if you recognize that at the beginning, what do you tell the patient? What do you do at the beginning? You have to say, look, we are now going to address this issue?

A You say that you need to do a procedure to stabilize the foot, which is a Lapidus, because you're making two bones one so that the bunion does not come back. Fine. This is a procedure that shortens the bone more than any other bunion procedure. Therefore,

I need to address your long second metatarsal by shortening the second metatarsal at the head and bringing it at least to the level of the third metatarsal and straighten out the toe and put everything in place by usually putting a pin to hold it while it is healing.

Q Is that, in your opinion, Doctor, is that good podiatric practice?

A That's what I do all the time. Absolutely, yes.

Q And failure of Dr. Marzano to actually do that in this case, did you reach a conclusion that that was a departure from good and accepted podiatric care?

A Yes, I did. And, besides that, he shortened the metatarsal.

THE COURT: And the answer is yes, you did? What was your opinion?

THE WITNESS: Yes.

Q What was your opinion, Doctor?

A Was that he overshortened the first metatarsal and that it was not good practice. He shortened it a centimeter.

Q How do you know that he shortened it a centimeter?

A Looking at the postoperative x-rays and measuring.

Q And I'm going to ask you to do that in just a moment. When you are looking at this preoperatively and talking to the patient about what to do, we have had testimony in this case that Dr. Marzano said I am not going to address the second and third toes because I don't know that this problem will arise in the future. Do you agree or disagree with that statement?

A I disagree with that statement.

Q Tell us why.

A She already has a problem at the second metatarsal toe joint. She already has a callous there. She already has too much weightbearing in that area, and she already has a dislocated joint there, meaning the joint is not level. Toe and metatarsal are not lined up. It is off.

Q We have also had testimony by Dr. Marzano that he said, look, I am not going to touch bones that don't need to be addressed until the patient has a problem later on, and then if it happens later on we can address that. Do you agree or disagree with that statement?

MR. MC ANDREW: I object to that, your Honor.

THE COURT: Could you read it back.

(Requested testimony repeated.)

MR. OGINSKI: I'll rephrase it, your Honor.

THE COURT: All right, fine.

Q Doctor, we have had testimony that Dr. Marzano has said in sum and substance that he is not going to address a problem with the second and third metatarsals if there is a shift in the weight forces until the patient actually develops that problem?

MR. MC ANDREW: Same objection.

I'm sorry if you were not done, counsel. Objection.

THE COURT: Well, let's put it this way: Assuming that that was said, and it is the jury's recollection whether it was said or not, all right, assuming that was said, what is the rest of your question?

MR. OGINSKI: Okay.

Q Assume that Dr. Marzano has told us that he was not going to address the second and third metatarsal, unless Annmarie Flannery had the problem later on down the road, do you agree with that assessment not to touch the second and third

metatarsals in her case until she developed a problem?

A No. But then also intraoperatively when you see that you have now taken so much bone and shortened it more than what is typical, by a long shot, on a Lapidus bunionectomy, you're obligated to do something. You can't leave somebody --

Q Why?

A -- you can't leave somebody with something that is absolutely going to be a problem. You can't have a metatarsal be a whole centimeter longer than another metatarsal. It is like, you know, just taking a nail and driving it through the bottom of her foot.

Q What do you do?

MR. MC ANDREW: Objection, your Honor, to that last characterization as to driving a nail through her foot.

THE COURT: Overruled.

THE WITNESS: Sorry.

THE COURT: Overruled. That's how she phrased it.

Q Doctor, let's take a look at the postoperative x-ray. And I would like you to show us, please, if you can, first off. This is an x-ray taken June 1, 2005. What do we see in this x-ray?

A Okay. A couple of things. First, the first

thing we see, those two screws that you see right here are to hold the first metatarsal to the medial cuneiform to make it one. The metatarsal is a little overcorrected, meaning the angle between the first and the second metatarsal is a little negative. That's Number 1.

It should be.

THE COURT: What does that mean, negative?

THE WITNESS: Negative meaning a positive angle. A zero would be parallel. It is now facing the second metatarsal a little bit. It is a little bit overcorrected.

Two, now those bones, those sesamoids that we talked about, are up into the joint, which they are not supposed to be. They are supposed to be behind the first metatarsal head. Down in this region here (indicating). I'm pointing to it.

That shows me two things. A short metatarsal will cause that. And the big toe, big up in the air, pulls the sesamoids up as well, because it attaches the tendons on the bottom.

The first metatarsal length to the second metatarsal is hugely out of proportion. It is a

full --

Q Explain that.

A -- it is a full centimeter shorter. No, it is more than a full centimeter because it was already longer. So it is a centimeter shorter than it was preoperatively. I actually don't know the length. I think it was like 1.46.

Q What is the significance of that difference?

A If you take this and turn it so that now you're looking at the metatarsals down like this, her metatarsal is almost like a thumb compared to her second metatarsal. How can you expect somebody to walk on that without having pain and causing that second toe to completely come out of alignment? It is impossible.

So, whether or not it was not done and discussed preoperatively, now you're in the operating room and you are taking x-rays to make sure your screws are in correct alignment, to make sure that it is -- that it is how you want it. How do you leave that like that?

Q There has been testimony in this case that there was no intraoperative x-rays. In your opinion, Doctor, within a reasonable degree of podiatric probability, is that acceptable medical care?

A That's not acceptable medical care. That's not how I do it. You need to know that you have a good purchase of your screws, that they are where you want them to be, that they are not into the next joint. You need to assess your alignment. You can only see so much. Clinically looking at the foot, you need to look at your x-rays and compare one bone next to the other to make sure your alignment is right.

Q And you mentioned that this is not acceptable. Withdrawn. That during the course of surgery, in order to determine where the screws are and positioning, it is good podiatric practice to take x-rays during the surgery, correct?

A Yes.

Q And --

THE COURT: Is it good and accepted?

THE WITNESS: Good and accepted.

Q And the failure to take x-rays intraoperatively, Doctor, in your opinion, is a departure from good care?

A It is. And then besides that, if for some reason you think that you're perfect and you're going to have a great result and not do it exactly intraop, you do it at the end of the case before the patient leaves the table so that if there is a problem you can

correct it before they leave the operating room. Most hospitals don't let you have the patient leave the operating room until you see those x-rays.

MR. MC ANDREW: Objection, your Honor. Most hospitals, what most hospitals do.

THE WITNESS: Mine does. Sorry.

THE COURT: Well, is it your experience that most hospitals won't let the patient leave?

THE WITNESS: Yes.

MR. MC ANDREW: Judge, I don't think she is at most hospitals, frankly.

THE COURT: That has been your experience that the hospitals you have worked in would not let you leave until you have taken x-rays and examined the result?

THE WITNESS: Yes.

Q Doctor, I am showing you the enlargement of the postoperative x-ray taken on March 25th, 2005. We see that the doctor has told us that the bandages were already on there. Tell us what you see in this x-ray.

A This is a sideview, but it is not a weightbearing sideview, so it is a little skewed. But you can get an idea. I am aware that Dr. Marzano had said that he tried to address the shortened first metatarsal by making it lower. He made it so low that

he brought the metatarsal down past the surface of the second and third metatarsal. So he brought it down like this (indicating), and that's going to cause the great toe to come up, because if your metatarsal in your toe is supposed to be aligned -- and that's part of the purpose of doing a bunion -- if you have a metatarsal that's even with your plain, or even with the rest of the metatarsals, the toe is going to sit straight. When you have a metatarsal that is now low like this, where the toe is going to go into the ground, you're going to make a hole in the ground every step she takes, no.

So the big toe starts to come up, up, up. Starts to sit up like this, and you can't get the joint to come down, so the toe sits up in the air. And that was then addressed later.

Q The positioning of the metatarsal that's visible in this x-ray, is it your conclusion that the positioning of that metatarsal was improperly set?

A And he would have seen -- yes, I do. And I feel that he would have seen that if he had taken intraoperative x-rays. You look at where the big toe is. It is sitting up on top of the metatarsal. That's not correct. That's going to end up with arthritis in there if that's not corrected.

Q Is it a departure from good and accepted care to position this metatarsal in the way that it is done here?

A It is not good care to position it in the position that -- the way that it sits here.

Q Let me rephrase it.

A Sorry.

Q Do you have an opinion, within a reasonable degree of medical probability, that the position of the metatarsal, as shown here on this x-ray dated March 25, 2005, is not in correct position?

A Yes, it is not correct position.

Q And that it was a departure from good practice to place it in this position, correct?

A Yes.

Q And as a result of the improper position, what effect, what does this mean for Annmarie Flannery?

A It means that her big toe is going to be sitting up in the air. And the one thing that you want to be careful with when you are doing bunion surgery is to get what we call good purchase of the big toe. Meaning that it sits on the ground. Because the thing about the big toe is, it is one of the most important things on our foot for balance. When people

have an injury and they lose their big toe, they are very unstable. They can fall over.

So now you have a big toe that is not sitting on the ground. And it is -- she is unstable in that regard. And then where is all the weight going, the second toe and the second metatarsal. Back to where we were in the first place. That should have been fixed originally.

Q If the podiatrist who performed this procedure recognizes right after doing the surgery that this is the result and it is incorrect, what does good practice dictate that you do?

A Go back in and fix it right then and there.

Q Did Dr. Marzano do that in this case?

A No.

Q Was it a departure from good practice not to go back in and fix it then and there?

A Yes.

Q And, Doctor, is that your opinion, with a reasonable degree of podiatric probability?

A Yes.

Q Now, we know in this case that Annmarie Flannery developed problems in her second and third metatarsal following this procedure.

A Continued to develop them, yes.

Q And when -- well, let me ask you and go back for a second to the x-rays taken after the surgery.

The positioning of this metatarsal that we talked about, that positioning, is that something that any experienced podiatrist should be able to recognize?

A That it is not correct?

Q Yes.

A Yes.

Q In other words, this is not something that only a -- withdrawn.

Let me ask you, Doctor, when you performed these Lapidus procedures, and you do the x-rays intraoperatively, and you see that there is incorrect alignment, what do you do at that point?

A Pull out the screws and realign and put them back. And if you can't put new screws in you put a plate, whatever it takes to fix it.

Q Now, you had mentioned that Dr. Marzano had taken out I think you said a centimeter of bone?

A Yes.

Q How did you determine that he took out a centimeter of bone?

A I measured the preoperative length of the first metatarsal to the postoperative length of the

first metatarsal and then also the comparative between the first and the second originally preoperatively and postoperatively.

Q And that amount of bone, what does that indicator signify to you?

A There was too much bone. He did not have enough -- he either did not have enough control in surgery and took too much bone or did not plan appropriately.

Q And is it important for a podiatrist in preparation for doing this type of surgery to plan everything that is necessary to achieve what hopefully is a good outcome?

A Yes.

Q Now, we have had testimony in this case that there are certain risks associated with this procedure. Correct?

A Correct.

Q And one of the risks that Dr. Marzano claims to have told Annmarie Flannery about was that there was a risk of her developing or needing a second surgery.

A Okay.

Q Okay. Now, is that a risk of this procedure?

A It is a risk of any surgery.

Q He also -- there has also been testimony that there was a risk of her developing a callous under the second metatarsal.

A But she already had that.

Q Okay. What can be done in order to prevent or minimize or limit that risk from recurring after this procedure?

A Several things. One is taking as minimum amount of bone as possible. And when you -- I do Lapidus procedures. You're taking the cartilage out only. And if you have an issue where you cannot put the metatarsal back into place, you are taking your blade and you are feathering like you do in carpentry work, a little bit of bone at a time just to bring it around. You're not cutting a wedge of bone. It may be easier to do that and put it back in place, but you're going to have to see what the consequences are. You are going to have a very short bone. You can't do that with a Lapidus because you're taking about a millimeter on one side and a millimeter on the other, cartilage. Because if there is cartilage it won't fuse. You have to have bone on bone.

THE COURT: You have to slow down.

THE WITNESS: You cannot have cartilage.

You have to have bone on bone, and you have to minimize the amount of bone loss to bring it around. So you are just taking cartilage and then you put some holes in the bone so it bleeds and that makes for healing of the bone, and you then put it in position. If you can't put it in position, something is blocking it. You take away just the portion of bone that's blocking it. And this is just because maybe there is a spur or an angle that you take away. You don't take the whole bone. You take an angle away and bring it around and put it together. You don't take a chunk of bone.

Q There has been testimony given yesterday by Dr. Marzano that when he made the cuts with the saw that he was taking, and he described the cuts that he made, and he did not indicate that it was done by this method that you described by feathering. Do you have an opinion, with a reasonable degree of podiatric probability, as to whether it is appropriate to take out this bone in one piece at one time?

MR. MC ANDREW: I object to the question, your Honor.

THE COURT: Overruled.

THE WITNESS: It is, especially when you

are dealing with --

Q First, Doctor, do you have an opinion?

A Yes, I have an opinion that it is.

Q What is that opinion?

A You don't take that much bone. Just don't do that.

Q Is that a departure from good and accepted care to do it in that fashion?

A Yes.

Q Why?

A Because you're going to completely offload the first metatarsal, meaning that it is going to get less weight, and you're going to put more weight on the second metatarsal.

You need to take as minimal amount of bone to stabilize and correct the bunion as well as not cause other problems. If you know for some reason that this is very difficult, the angle is so off, that you have to take a chunk of bone, you need to replace that bone and have a plan to put bone back. Again, like I said, whether it is through the person's own bone, you can take some bone from a hip, take some bone from the part -- another part of the foot, or take bone from a bone bank and put it in there. They come in these little pieces of square and you put it

in and you make that, incorporate in to keep your length.

Q Was that done in this case?

A No.

Q Was that a, the failure to do that, a departure from good and accepted care?

A Failure to keep the length?

Q Yes.

A Either way, yes.

Q Okay. Now, Doctor, we talked a bit, you have told us about the departures from good care. Now, I have to ask you whether you have an opinion as to whether those departures from good and accepted podiatric care was a substantial factor in causing Annmarie Flannery's injury.

A Yes.

Q And were those departures from good and accepted podiatric care a substantial factor in causing her discomfort in the bottom of her foot in the second and third metatarsals?

A Yes.

Q And the same question, slightly modified, were those departures from good care, good podiatric care, a substantial factor in causing Annmarie Flannery's pain that she had under the second

and third metatarsals?

A Yes.

Q Now, there has been testimony by the Defense that this condition that Annmarie wound up with, this second and third metatarsal problem, is a known risk of this procedure. In light of her initial findings on x-ray and the records that you reviewed, tell us why it is not okay that she wound up with this particular complication.

A It is not okay because she already had the situation set up. And, again, like I said, you need to know that this is a problem. You are looking at the whole foot, and you know that there is weight under the second metatarsal that is excessive, and you need to then address that by keeping the length of the first metatarsal while you are correcting it. You can't say to, you know, a surgeon who is doing a knee replacement, can't say to you, well, there is a risk that you are going to have some shortening of that leg. Yes, a certain degree.

But, you know, if you say that the metatarsal is 6 centimeters in total and you are taking away 1 centimeter, that's one-sixth of the bone. If your leg is 2 feet and you are taking -- what are you going to do, take away 4 inches? That's

the equivalent. So you're going to end up with a limp and a scoliosis and pain in the hip. It is not -- it is beyond regular complication. It is now making a new deformity.

THE COURT: Well, what is scoliosis?

THE WITNESS: Curvature of the spine.

Q Now, I would like you to take a look and let me show you what is marked in evidence Dr. Matthew Roberts' records marked as Plaintiff's 5 in evidence, please.

THE COURT: Before she takes a look. You have not put on the record what she looked at in order to form her opinion.

MR. OGINSKI: I was getting to that, Judge.

THE COURT: Before you introduce any other records you have to do that.

Q Doctor, can you tell us, please, what records exactly you looked at in order to come to your conclusions that you are telling us about here today?

A The x-rays, pre- and post-op from Dr. Marzano, the, his chart records and then the next or subsequent treating Doctor, Dr. Roberts' x-rays and medical record.

Q Did you also review the deposition testimony

in this case?

A Yes, I did.

Q Okay.

MR. OGINSKI: May I now introduce, have the doctor look at Dr. Roberts' records, Judge?

THE COURT: Yes. And what exhibit is that?

MR. OGINSKI: This is Exhibit 5.

THE COURT: To make this clear, these are the records of an orthopedist who later treated your client?

MR. OGINSKI: Yes, that's correct.

THE COURT: After the surgery?

MR. OGINSKI: Correct.

Q Dr. Joseph, is it your understanding that Dr. Matthew Roberts is a board certified orthopedic surgeon?

A Yes.

Q And that he practices at the Hospital for Special Surgery?

A Yes.

Q I would like you to take a look, please, at his first office exam of Annmarie Flannery. The date is January 23, 2006. I would like you to tell us what complaints, I'm sorry, what Dr. Roberts noted in his

note as far as what happened to her in the past. Don't read it to us, if you can. Just summarize it briefly.

A He is reiterating what she says, and it is that she had the Lapidus procedure and that she has pain on the right foot, in the ball of the foot with a corn, painful corn, cramping and aching. And activity makes it worse. She has tried conservative care, which is orthotics, and that has not helped her, and she feels like her right foot is contracted.

Q Do you know what -- let me stop you for one second and ask you to take a look at Dr. Marzano's office, Dr. Marzano's office record for December 15th, the last visit that he had with the patient.

A Which date? I'm sorry.

Q December 15th. The page that I opened up to.

A Yes.

Q He writes that on weightbearing the hallux fails to purchase the ground. What does that mean, Doctor?

A I actually said that earlier where the big toe is up and it is not touching the ground so she is not using the big toe for balance, because she can't get it down on the ground because the first metatarsal

is so low we call that plantar flexed. It is so low that the big toe is sitting up on top of the metatarsal. So, if it is not -- if it is up in the air, it is not touching the ground, so that's what purchase means, meaning not gripping. Purchase is gripping the ground. So it is not stabilizing her.

Q And that's something that you told us that he should have recognized right after the surgery in that postoperative x-ray, correct?

A During the surgery.

Q During surgery. Okay.

Now, it also says on here, under his Impression and Assessment, Resultant shortening of the first ray has lead to failure of hallux purchase during ambulation.

Is that what you're just saying?

A Yes.

Q It is confirmation of what you just told us, right?

A Yes.

Q Now, he writes, Shortening of the first ray has lead to an increase in right second and third metatarsal head. Plantar pressures and resultant plantar hyperkeratosis.

Tell us what that means.

A It means that she has -- hyperkeratosis is that thickening. Keratin is the skin. So thickening of the skin, which is a callous formation. And increased pressure on the bottom of -- the plantar means the bottom of the foot. Ball of the foot.

So, like I said, looking at her pre-op x-rays or before surgery, that this was going to happen because it was already set up, and she was already getting callous or hyperkeratosis under the second metatarsal.

Shortening that metatarsal, putting more weight under that second and third metatarsal is, because it is now longer and protruding through the bottom of the foot, is going to lead to increased pressure and callous formation under that second and third metatarsal.

Q Now, if Dr. Marzano had done what you told us about, that he should have addressed the second and third metatarsal in the very first surgery, would Annmarie have developed this problem that we are now reading about nine months after surgery?

MR. MC ANDREW: Judge, I'm going to object. This is cumulative. We have already gone over this.

MR. OGINSKI: I did not ask this.

MR. MC ANDREW: Not in this phraseology.

THE COURT: I'll allow it. Can you say within a reasonable degree of podiatric certainty whether or not a problem would have developed with her second metatarsal and third?

THE WITNESS: If he had addressed the second and third metatarsals by shortening them and by taking the minimal amount of bone, not a significant amount of bone that he did on the first metatarsal, she would have had a much more level playing field and would not have developed increased pressure under that second and third metatarsal. So, yes.

Q You can close that, Doctor. Let's take a look and go to Dr. Roberts' notes, which are now in January of 2006. And he writes, "She has tried some orthotics which do not seem to be helping."

Would orthotics help this particular problem?

A They would not correct the deformity, no.

Q Now, let's go down a little further as to his physical examination.

THE COURT: This is whose physical examination?

MR. OGINSKI: I'm sorry, thank you.

Dr. Matthew Roberts, the orthopedic surgeon.

Q Tell us, Doctor, what he finds with regard to the first ray and the joint?

A The radiographs?

Q No, under Physical Examination.

A Because that's under Physical Examination. Okay. She -- that the first metatarsal is plantar flexed, which means it is down, with dorsal scarring, which means that the big toe has come up. And so now because once the toe is up in that position, the tendon that's attached to the top starts to pull back and tighten and scar in that position.

So she has a dorsal scar, which is the top of the foot. She has stiffness at the big toe to the first metatarsal joint with an elevation of that big toe, and she has a callous under the second and third metatarsal.

Q And then a little further down he talks about the x-rays that he took. Correct?

A Right.

Q Tell us what he writes, what he says here about the x-rays.

A That the first ray or the first metatarsal basically is down or plantar flexed, too much, because otherwise he would not comment on it.

MR. MC ANDREW: Objection, your Honor.

THE WITNESS: It is true.

THE COURT: Sustained. Strike otherwise would he not have commented on it.

Q Go ahead, Doctor.

A Sorry.

The sesamoids, which were those little bones that I talked about are, have migrated distally, because that means, distally means toward the toes. So up into that joint because the big toe is up. And she has a long second and third metatarsal now relative to the first. And there is also some arthritis with those sesamoids. That's what he comments.

Q What is arthritis?

A Wear and tear of a joint when it is not in the right position.

Q Okay. And according to Dr. Roberts' assessment and plan, tell us -- well, let me ask you this. Dr. Roberts writes, Annmarie Flannery has a plantar flexed first ray and difficult drifting of the great toe which has caused pain along the big toe area. What does that mean?

A That means that her alignment of her joint is not correct and that because she is suffering from

pain, because of the poor position, the big toe is up, because the first metatarsal is down. You can't get that big toe to come down if this is too low. There is no place for it to go.

Q He also writes, She also has pain in the second and third metatarsal region which is related to that being too long and the first ray is relatively shortened at this point through the tarsometatarsal joint. Tell us what that means.

A Whether you take bone from the metatarsal or from the medial cuneiform, the whole column, let's say, the whole first metatarsal to the cuneiform joint is so shortened that the, that he -- that is what he is talking about. Again, when you have a discrepancy that is great between metatarsal lengths, it is going to add to being pain in the ball of the foot because that's where you walk on.

Q And at the bottom he says, he recommends a second and third metatarsal shortening osteotomy. What is that?

A Osteotomy again means cutting or fracturing the bone to correct. And shortening would be to try to get the second and third metatarsals shorter, to have less weight on them, closer to the first metatarsal. Trying to even out, again, that playing

field.

Q And we know from looking at Dr. Marzano's note from December of 2005, Dr. Marzano also recommended a similar procedure to correct her problem, correct?

A Can I look at that?

Q Yes, absolutely. At the last paragraph. It says, Patient was informed that surgical shortening of the second and third metatarsal would reduce plantar pressures at these sites and would reduce pain. Do you see that? The last visit. The second page of the notes?

A Yes, I do. Yes. So I agree.

Q So, let's go back again, I'm sorry, to Dr. Roberts notes.

THE COURT: All right, counsel, I don't want to interrupt, but I think we are going to take a break.

MR. OGINSKI: Very good.

THE COURT: All right, 15 minutes, please.

(Recess taken.)

COURT OFFICER: Jury entering.

(Jury entering courtroom.)

THE COURT: Be seated, everyone. Welcome back. I believe that we are still on the direct

examination.

MR. OGINSKI: Yes, your Honor.

Q Doctor, we left off, we are now going to the second visit that Annmarie Flannery had with Dr. Matthew Roberts. The date is March 8th, 2006. And what does Dr. Roberts record in the second line of the history of present illness?

A That she has a plantar flexed first ray, and pain with decreased motion at the first metatarsal toe joint, as well as pain in the second and third metatarsals.

Q Is this the same thing that we have seen in the prior visit, in the January visit?

A Yes. Maybe added in a little bit more that he is saying that she has decreased motion at the joint.

Q And, again, does he recommend that the patient undergo this type of corrective surgery in order to address this problem?

A Yes.

Q Okay. And based upon your review of Dr. Roberts' records, did you see that he actually went ahead and performed surgery on Annmarie Flannery?

A Yes.

Q And what was the purpose of him trying to do

this surgery?

A He was trying to, if you understand what I'm saying by leveling the playing field, that he was trying to bring the metatarsals a little bit better or closer to the same length so that there would be less pressure in one spot versus another spot. So he attempted to shorten the second and third metatarsals, as well as to bring the first metatarsal out of that plantarflexed position and bring it back up so that it was more level in this -- from like a bottom to top view.

So that instead of being down, to bring it a little bit up so to keep that big toe from sitting on top of the metatarsal, to sitting a little bit more level.

Q And when you mentioned that he was going to try to bring that metatarsal up from plantarflexion, what does that mean?

A It means that he is going to try to recut the bone, take it and position it more even with the second and third metatarsals across the side of the foot. Let's put it that way.

Q What was the outcome?

A The outcome left her still with some deformity and length to the second and third

metatarsals and shortening to the first metatarsal.

Q And based upon your review of Dr. Roberts' records, did Annmarie still have complaints of pain and discomfort underneath the second and third metatarsals?

A Yes.

Q Doctor, based upon your observations of Dr. Roberts, your review of Dr. Roberts' records, do you have an opinion, within a reasonable degree of podiatric probability, as to whether Annmarie will require additional surgery to correct the problem that exists, based upon the records that you have reviewed?

A Yes, she is going to need a third surgery, and I feel bad.

MR. MC ANDREW: Objection.

THE COURT: I did not --

THE WITNESS: She is going to need a third surgery, and I feel bad for her.

MR. MC ANDREW: Objection, Judge, to the feelings of the witness.

THE COURT: Sustained. Strike it, I feel bad.

Q Doctor, she is going to need a third surgery?

A Yes.

Q What type of surgery will she need to try to correct this problem?

A I have not seen a most recent x-ray of her, so I can just tell you you need to try to get the metatarsals into better alignment.

Q With a wait. I'm sorry to interrupt you, Doctor. Let me just clarify. You have never seen or examined Annmarie Flannery, correct?

A Correct.

Q You're basing your opinions and your reviews based upon the records that you have told us about, correct?

A Correct.

Q Based upon your review of the records and what you see from Dr. Roberts' records and observations, tell us, please, what is your opinion as to what type of surgery Annmarie will require in the future to correct this problem?

A She needs to have procedures that will help to make the metatarsals a little bit more even in length by either reshortening the second and third metatarsals, or, doing joint destructive procedures. What I mean by that is taking out some joint. You know, by taking out -- remember, I told you that the end of the bone is called the head. The head of the

second and the third metatarsals.

Q Would you like to show the jury?

A May I?

THE COURT: Sure.

THE WITNESS: Thank you. Because there is such a discrepancy in the length of the first to the second metatarsal, instead of trying to recut the bone, because it has already been cut, to take out this whole area of bone, which is the head of the second metatarsal and third metatarsal so that the toes can go from here, out, leaning towards the pinky toe and up, to sitting down and flat where they should be. It is like having too many sardines in a can. You open up the can, you take out some sardines, and they all go ahhh. They all fit. We are trying to make everything fit back in place. So that's basically it. So you end up having to destroy the joints in order to do that.

Q Doctor, you told us that you went to podiatry school at the Pennsylvania College of Podiatric Medicine.

A Yes.

Q And when did you graduate?

A 1985.

Q And that is how many years of schooling?
A Four years. Post-college.
Q Right. And after the four years of podiatry school you told us you went to a surgical residency in Denver, Colorado?
A I did a year in New York before I went to Denver, so I did three years total.
Q What is a surgical residency?
A Every residency is slightly different, but a residency is where you are a doctor learning how to perform surgery, how to correct deformities, how to treat patients in a surgical manner.
Q Does every podiatrist who comes out of podiatry school do a surgical residency?
A No.
Q And after you completed your residency, that's when you started to begin your practice and accumulate the cases that you needed to become board certified?
A Yes, I worked for somebody for two years as an associate and went on my own after two years.
Q Tell us what it means to be board certified.
A I don't know what the percentages are of how many people are board certified in podiatric surgery versus not, but it is a small number.

THE COURT: Certified in podiatric surgery?

THE WITNESS: Yes. And if I look at somebody or if I want to refer somebody to another podiatrist, in another state, they are moving, whatever --

MR. MC ANDREW: Objection, your Honor.

THE COURT: Sustained.

Q I'll rephrase, Doctor. Is board certification the highest level of certification that you, as a podiatrist, can achieve from your colleagues in the community in which you practice?

A Yes.

Q Now, in addition to that, Doctor, have you had an opportunity to publish anything in the field of podiatry?

A Yes.

Q Give us an idea of how many different things that you published.

A I wrote a chapter in a book. And I --

THE COURT: What was the name of the book?

THE WITNESS: It is Complications in Foot Surgery, and I wrote an article about fixing a fracture of the fifth metatarsal. An article about a bone tumor and how to manage it. And

I'm trying to think. And also I'm mentioned some research I did in biochemistry in tumors in mice and zinc.

Q In addition to those publications, Doctor, tell us what hospitals you were affiliated with.

A I'm affiliated with North Shore University Hospital and Long Island Jewish Medical Center.

Q And as part of your duties, do you have occasions and opportunities to treat the podiatrists in training, those who are doing a podiatry residency?

MR. MC ANDREW: I object.

THE COURT: Treat them?

MR. OGINSKI: Sorry. Thank you, Judge.

THE COURT: Sustained.

MR. OGINSKI: My apology.

Q Doctor, do you have occasion to teach these residents who are training to become podiatrists?

A They are podiatrists, but to become surgeons they are in the surgical residency. I teach them and I help them and teach them this surgery every week and do some lectures for them.

Q And the board certification, I think you told us that's the American Board of Podiatric Surgery?

A Yes.

Q Is that your understanding of the most important or most prestigious board certification that you can apply to?

A Yes.

THE COURT: In podiatry?

MR. OGINSKI: Did I misspeak?

THE COURT: No. In podiatry?

MR. OGINSKI: Yes, in podiatry, thank you.

THE WITNESS: Yes.

Q Doctor, in the past have you had occasion to review cases for me at my request?

A Yes.

Q Medical/legal cases?

A Yes.

Q And in the course of your career, have you had occasion to review medical/legal cases for other law firms as well?

A Yes, as well as insurance companies.

MR. MC ANDREW: Objection, your Honor.

THE COURT: Yes.

MR. OGINSKI: I'll rephrase it.

THE COURT: Don't rephrase it. Just let it go.

Q Doctor, did you, over the course of your career, have you had occasion to review cases on

behalf of the injured patient? In other words, the attorney is asking you, who represents the injured patient, to look at and determine whether or not there is appropriate care.

A Yes.

Q And have you also had occasion to review cases on behalf of the podiatrist who is being sued to determine whether or not there is appropriate care?

A Yes. More on that side.

Q More for the defense?

A Yes.

Q On behalf of the doctor?

A Yes.

Q And have you ever testified in a courtroom before as a medical/legal expert?

A Yes.

Q Can you give us an idea of how many times before today?

A Maybe five.

Q And have you ever been sued, Doctor?

A Yes.

Q How many times?

A In the last ten years there were two, and they were both in my favor.

Q Okay. Now, are you charging a fee for the

time that you spent having to close your office and come to court here today?

A Yes.

Q Tell us, please, how much your fee is to be here?

A 4,000 for the day.

Q And in addition to that?

MR. MC ANDREW: I did not hear that.

THE WITNESS: 4,000 for the day.

MR. MC ANDREW: Thank you.

Q In addition, Doctor, am I correct that you charged a fee for the time that you spent to review the records and the x-rays that I sent to you?

A Yes.

Q How much do you charge for that fee?

A That's per hour?

Q Yes.

A $275 an hour.

Q And in the last -- you and I have met in person to talk about Annmarie's case, correct?

A Yes.

Q Do you recall how many times we met?

A I think twice.

Q Okay. And we talked this morning briefly before we got started?

A Yes.

Q And now, Doctor, there has been testimony in this case by Dr. Marzano that he removed the necessary amount of bone from the cuneiform. Do you agree or disagree with that statement?

MR. MC ANDREW: Objection, your Honor. This is cumulative at this juncture.

THE COURT: Let me hear the question.

Q There has been testimony -- do you want me to --

THE COURT: Read it back.

(Requested testimony repeated.)

THE COURT: Overruled. You can answer.

THE WITNESS: He did not -- now, I'm confused.

Q I'll rephrase it.

There has been testimony by Dr. Marzano that he said he removed the necessary amount of bone from the cuneiform. Do you agree or disagree with that statement?

A I disagree with that statement.

Q Tell us why.

A Because an average of bone loss from a Lapidus is about 4 millimeters. He took off 10 millimeters.

Q Is that significant?
A Significant. It is a sixth of the bone.
Q Is that a departure from good and accepted podiatric care?
THE COURT: You said significant. What was the answer.
THE WITNESS: Yes, because it was one-sixth of the entire length of the bone.
Q Is that a departure from good and accepted podiatric care?
A Yes.
Q Did that departure, was that departure a substantial factor in causing Annmarie Flannery her injuries?
A Yes.
Q And her pain and the deformity and the problem that she has under the second and third metatarsals?
A Yes.
MR. OGINSKI: Thank you very much, Doctor.
THE WITNESS: Thank you.
THE COURT: Do you want do start cross-examination?
MR. MC ANDREW: Yes, please, your Honor.
THE COURT: Cross-examination for the

defense, Mr. McAndrew.

MR. OGINSKI: Judge, may I just ask one more question? I'm sorry.

THE COURT: Yes.

Q Doctor, in your review of Dr. Marzano's electronic medical records, what did you think about those electronic medical records?

MR. MC ANDREW: Objection, your Honor.

THE COURT: Well, it is kind of inartfully posed, but give us your impression of the medical records.

THE WITNESS: Well, they are electronic, and he did not -- he either did not omit things because he -- there were things in the record that were repeated week after -- or visit after visit after visit that did not make sense, because they were just carried through.

So, failure to really read them and make sure that they were documented properly. Because when she was in a shoe already it also said that her bandage was dry and intact. She was not wearing bandages. She was using crutches when she was walking.

There were things in there that were not appropriate. So the, they were not good

documentation.

MR. OGINSKI: Thank you.

THE COURT: All right now, Mr. McAndrew, cross-examination.

MR. MC ANDREW: Thank you, your Honor.

CROSS-EXAMINATION

CONDUCTED BY MR. MC ANDREW:

Q Good afternoon, Dr. Joseph.

A Good afternoon.

Q It is almost afternoon.

A Just about.

Q We are on the verge.

A Right.

Q You said that you reviewed a number of different records in preparation for your testimony. You told us Dr. Marzano's records, his x-rays, Dr. Roberts' and his x-rays as well. Did you review any other records?

A The deposition.

Q But any medical records, hospital records?

A Yes, there were some.

Q St. John's, where Dr. Marzano operated?

A Yes.

Q Did you review HSS, the Hospital for Special Surgery, those records?

A I think these notes were from his chart, though. It says HSS on it, but I think they were in his chart.

Q Did you review -- the patient had surgery at HSS?

A Yes.

Q Did you review that admission?

A I don't think so.

Q You said you reviewed the depositions of the Plaintiff and Dr. Marzano?

A No, just Dr. Marzano.

Q Just Dr. Marzano?

A Yes.

Q You did not review the deposition of Mrs. Flannery?

A I'm not remembering at this point.

Q So you don't remember what you reviewed?

A No.

Q Did you review Dr. Roberts' deposition testimony?

A No.

Q Did you see any videotape deposition of Dr. Roberts?

A No.

Q Do you think when you come to court that,

and you testify against a doctor, do you think that's serious, that it is a significant thing to do, to testify against another podiatric surgeon?

MR. OGINSKI: Objection.

THE COURT: Sustained.

Q Do you think it is important before you come to court to testify against a physician that you review the testimony of all parties?

A I think that I need to have a good understanding.

Q It is a yes or no.

A So not necessarily to --

THE COURT: Well, do you know what, that's really not a question that the doctor decides, as you know. The lawyer decides.

MR. MC ANDREW: Well, certainly judge the doctor can ask to review anything on a case.

THE COURT: Well, the lawyer generally provides the material.

Q Did you ask Mr. Oginski to provide to you the Plaintiff's deposition transcript?

A I may have. I may have read that. I'm not remembering.

Q But you just don't remember?

A I just don't remember.

Q Fine.
A It was a while ago.
Q Did you review anything else in preparation for coming here to testify?
A No.
Q Do you have any notes?
A No.
Q You committed everything to memory?
A I have reviewed them. They are here in front of me.
Q Now, you and I have never met before, is that right?
A That's correct.
Q You don't know Dr. Marzano?
A No.
Q Okay. And you told us that you reviewed cases for Mr. Oginski previously. How many times did you do that?
A Maybe two other times.
Q Twice before?
A Yes.
Q You have not testified for him previously, however?
A No.
Q But you have testified in Court, at trial,

correct?

A Yes.

Q As an expert, about five times?

A Right.

Q And on your own behalf at least once, is that right?

A Twice.

Q Okay. Two times you testified in Court as a Defendant?

A Um-hum.

Q Yes?

A Yes, sorry.

Q You have to say yes.

A Sorry.

Q How is it that you first became involved with Mr. Oginski?

A He called me. I am not sure where he got my name.

Q You don't know?

A No.

Q Do you advertise?

A No.

Q Now, you said that you testified five times in Court as an expert. Were those for Defendants or Plaintiffs?

A Those were all for Plaintiffs. I have done a ton of review for insurance companies.

MR. MC ANDREW: Again, Judge, I objected to this earlier and here she goes again.

THE WITNESS: I am sorry, I did not realize.

THE COURT: I'm going to strike any mention of insurance companies. They have nothing to do with this case.

THE WITNESS: I'm sorry, your Honor.

THE COURT: All right, so, I think he is asking in particular to Plaintiffs or Defendants.

MR. MC ANDREW: That's right. I think she said Plaintiffs.

Q Have you only come to court and testified for Plaintiffs, is that right so far, you told us five times?

A I want to make sure.

Q Take your time.

A I think it was only Plaintiffs.

Q Now, have you been retained to review cases and actually testify in cases for the Defendants or were you just called to review cases?

A I'm called -- I was in-house and reviewed

about 17 cases a year for Defendants to see whether there was malpractice or not.

Q But what I'm asking is: Were you reviewing those cases to potentially testify at the time of trial?

A No.

Q Right. So, the cases that you have reviewed where you're potentially going to testify at trial, were those only for the Plaintiff or were they for the Defendant as well?

A At this point, only for the Plaintiff, because that's what has come up.

Q Okay. Now, you would agree that every surgery done on every patient has potential complications, correct?

A Correct.

Q And you yourself have experienced surgical complications, isn't that right?

A Of course.

Q You said those two cases that you were sued in and testified in Court on your own behalf, that they were disposed in your favor. What did you mean by that?

A Meaning that --

MR. OGINSKI: Objection.

THE COURT: I don't think we need to go into that.

MR. MC ANDREW: Well, she said they were in her favor.

MR. OGINSKI: Objection, Judge.

MR. MC ANDREW: It was one of those --

THE COURT: There are two or three ways in which you can dispose of something in her favor.

MR. MC ANDREW: Well, you know, Judge, she said it was in her favor. I want to know.

MR. OGINSKI: Objection. I thought there were no speaking objection.

THE COURT: Describe how they were disposed in your favor.

THE WITNESS: We went to court and the jury found that I was not guilty of any malpractice.

Q Both cases?

A Both cases.

Q Now, in direct examination by Mr. Oginski you said that your prior experience with Lapidus was 50 to a hundred, and you kind of rattled that off pretty quickly. What do you mean 50 to a hundred? Is it 50, is it 99, which is?

A I did not count them.

Q You don't know?
A I don't know.
Q So you're guessing, is that right?
A I am -- with some certainty, yes.
Q It is your best guess --
A Fine.
Q -- right?
A Fine.
Q Okay. So it could be 50, it could be a little less than 50, it could be a little more, it could be a hundred?
A I said between 50 and a hundred. So that would be above 50.
Q So you certainly did not do less than 50?
A I don't think so, no. We would have to sit down and count them.
Q Now, with regard -- give me one moment, your Honor.

Doctor, with regard to Mrs. Flannery, I know you're not sure if you read her testimony or not, but were you aware that her problems with her feet first started back in about 1985 when she was 18 years of age? Did you know that?
A I can see that her deformities of her foot did not happen overnight, so, yes, I can imagine that

there were years in there.

Q But were you -- let me move this.

Regardless of what you can ascertain from looking at the x-rays or the records themselves, were you aware that the Plaintiff actually took that position that her bunions had been in existence since the time she was 18?

A Not the exact age of 18, no.

Q And you would agree, again based upon what you saw on the x-rays when she first came to Dr. Marzano, that this had been an ongoing problem for this lady?

A Sure.

Q And she had severe deformity, correct?

A Moderate to severe.

Q On the right?

A On the right foot.

Q And the left foot was moderate, less severe?

A I would have to look at that again as I have really been focusing on the right.

Q Was the right worse than the left? Is that fair to say?

A The right was worse than the left, yes.

Q Now, were you aware that that patient came under the care of Dr. Schneider in 1996, a podiatric

surgeon?

A No.

Q Did you know that the patient visited with that Doctor about four or five times in 1996?

A No.

Q Okay. Were you aware that that doctor spoke to the patient about both orthotics for her feet as well as surgical correction at that time?

A I have never reviewed his chart.

Q And, Doctor, typically when a podiatric surgeon sees a patient over a course of time and recommends to the patient surgery --

THE COURT: I'm sorry, is that in evidence?

MR. OGINSKI: No, Judge.

MR. MC ANDREW: Judge, this is subject to connection with the Plaintiff. She will certainly testify to this.

THE COURT: You can't question somebody on something that is not in evidence. You can't.

MR. MC ANDREW: The Plaintiff is going to testify here. I will do it subject to connecting and having her testify to it, your Honor.

THE COURT: I am going to sustain the

objection.

MR. MC ANDREW: Fair enough.

THE COURT: Strike anything about another treating physician.

Q Dr. Joseph, this, Mrs. Flannery, do you know what her profession is?

A No.

Q You have no idea?

A No.

Q Did you know that she is a nurse?

A (Inaudible answer.)

THE COURT: You are becoming inaudible.

Do you know she is a nurse? The answer?

THE WITNESS: No.

Q Are you learning that for the first time today?

A Yes.

Q Do you understand that nurses, when they are trained, that they are trained with regard to things, such as informed consent, obtaining those forms?

MR. OGINSKI: Objection.

THE COURT: We don't need to go into that.

MR. MC ANDREW: Okay, your Honor.

THE COURT: I guess I should tell the jury that the Plaintiff has decided to withdraw the

informed consent.

MR. MC ANDREW: Judge, may we have a side bar?

THE COURT: Is that true or not?

MR. OGINSKI: That is true, Judge.

(Side bar conference.)

THE COURT: Okay, we are at side bar. Yes, Mr. McAndrew.

MR. MC ANDREW: I understand counsel withdrew his lack of informed consent claim, but that does not impede me from going into those issues. Additionally, he brought up on direct with this very witness that there are risks and you know the offloading to the second and third metatarsals are risks, so I intend on asking this witness questions about informed consent.

THE COURT: Okay.

MR. OGINSKI: We have withdrawn the claim for lack of informed consented. The question that he just posed was whether she knows whether nurses are trained in informed consent issues, to which I objected since it has nothing to do with --

THE COURT: Well, you know what his argument is.

MR. OGINSKI: That she has knowledge and knows. You can ask --

THE COURT: Credibility.

MR. OGINSKI: Absolutely.

THE COURT: Therefore, since she is a nurse, she would perhaps have a little more expertise in asking questions and getting information.

MR. OGINSKI: But it also depends on what kind of nurse and what her duties were. And he can ask the Plaintiff that all he wants, but not this witness. How is he going to ask an expert about whether she -- their podiatrist knows what a nurse's training is and what they need to know in order to formulate an opinion?

MR. MC ANDREW: She deals with nurses all the time, and if she does not know she can tell me she does not know.

MR. OGINSKI: She deals with surgical nurses.

MR. MC ANDREW: If she does not know she does not know.

THE COURT: I'm going to allow limited on informed consent. I mean, I think that's not necessarily a fertile area for you to go into,

for a number of reasons, other than it is being withdrawn.

MR. MC ANDREW: I'm not going to go into it too much.

THE COURT: It does not get you that much ahead, all right, in my opinion.

MR. MC ANDREW: Thank you, I appreciate that, Judge.

(Back in open Court.)

THE COURT: Just to explain, during the course of a trial sometimes, not infrequently, an attorney, who is a Plaintiff, will withdraw a cause of action. In this case, out of the presence of the jury, Mr. Oginski has withdrawn a cause of action. That cause of action is lack of informed consent. So he has narrowed the issue down to just a malpractice, alleged malpractice. All right. So that's what I was trying to say.

However, the cross-examiner in any trial is given wide latitude to cross-examine the Plaintiff's witnesses and vice-versa, when defense witnesses are on about their credibility, their accuracy, their knowledge in the field, their recollection. So there may be

some questions on informed consent that we may have. But, of course, it is not going to be a lengthy inquiry.

MR. MC ANDREW: Thank you, Judge.

May I proceed, your Honor?

THE COURT: Certainly.

CROSS-EXAMINATION

CONTINUED BY MR. MC ANDREW:

Q So, Dr. Joseph, just generally your knowledge of the training -- you deal with nurses a lot in everyday practice, correct?

A Sure.

Q In your general knowledge of nurses, how they train, do they learn things such as informed consent, if you know?

A I --

MR. OGINSKI: Objection as to what type of nurses, what specialty, what hospitals, what area. I object.

THE COURT: You know, if she knows. Overruled. Do you know?

THE WITNESS: I don't think that they do. That's not part of my knowledge of what a nurse does.

Q That's fine. You don't know?

A I don't.

THE COURT: She answered the question.

Q Would you agree that somebody with a nursing background has a better understanding of the issues discussed in informed consent than your average man or woman?

A Not necessarily.

Q Okay. Doctor, you have reviewed Dr. Marzano's chart, have you not?

A Yes.

Q And when this patient came to him -- well, first of all, were you aware that she had come to him in his office with her children prior to coming for a formal visit?

A I think I did know that, yes.

Q How did you know that?

A I am not sure, actually, but I do know that.

Q Okay. And were you aware that during these encounters with the children she also said, You know, I got this problem with my feet as well, Doctor. Would you take a look at that? Do you remember that?

A Well, I think Mr. Oginski told me about that.

Q Okay. Did Mr. Oginski tell you anything else about this case? You don't remember?

A I don't know.
Q Is it your understanding that Dr. Marzano then recommended the patient come in to be formally evaluated in the office?
A Okay.
Q You agree with that?
A I agree with that.
Q Do you have the chart there of Dr. Marzano?
A Yes.
Q Now, the doctor goes over with --
THE COURT: The jurors are having a problem seeing the board.
How is it now?
Q So, Dr. Joseph, the patient came in with a complaint it says CC. That's chief complaint, right?
A Yes.
Q Bunion bilateral first metatarsal phalangeal joint?
A Yes.
Q She tells the doctor that it is unsightly?
A Yes.
Q And that it limits what shoes she can wear?
A Yes.
Q And it limits her normal ambulation and provinced daily activities?

A Normal daily activities.

Q Sorry, normal daily activities. I'm reading that at an angle. And that it has been present for several years and slowly getting worse?

A Yes.

Q She reports pain, correct?

A Correct.

Q And she describes it as sharp and throbbing?

A Yes.

Q Right. And a six over ten. That means six -- one being or zero being no pain, ten being the worse. Six is right there in the middle or above?

A Right.

Q And that these symptoms occur while she is in shoes and on ambulation, right?

A Correct.

Q And would you agree, Doctor, that it was appropriate for Dr. Marzano to review with this patient what her complaints were, what her symptoms were, how long it was going on?

A Correct.

Q Okay. And then the next thing is medical history he goes over with her. And without getting into the details, would you agree that it was appropriate for the doctor to go over with the

patient, a patient who could possibly be coming to him for surgery, her medical history?

A Yes.

Q And then the next section talks about allergies. But there is nothing significant except for sulfur, correct?

A Yes.

Q And then the next one is medications. She is not on any medication, right?

A Correct.

Q Makes it less complicated, right?

A Sure.

Q And then the next thing says social history. And this describes that she is a mom, caring for three children, she is married, et cetera. Is that important to know in a possible surgical patient what their lifestyle is?

A Yes.

Q Because the patient eventually, if they have surgery, have to be immobilized?

A To some degree, depending on the surgery.

Q Sometimes you have to offload or not bear weight, right?

A Be on crutches.

Q So you agree that it is a good thing for the

doctor to go over what is going on in her life before assessing and evaluating what we are going to do for this patient?

A Yes.

Q And then moving right along, Doctor, there is a long section here, review of systems, and it goes into a variety of different aspects of potential problems. But they are essentially normal is, is that right?

A Yes.

Q And that's appropriate to do for Dr. Marzano with a new patient like this, isn't that right?

A Yes.

Q And then there is a physical examination, and I don't want you to go through each and every aspect of this, but evidently the doctor examined the vasculature, the pulse, if there is edema, swelling, lymph nodes. You agree that's appropriate?

A Yes.

Q And then he did something of a neurological exam, correct?

A Correct.

Q That's good care?

A Yes.

Q And then he does what is called a gait exam.

He described that in testimony yesterday or one of the two days before that that he has the patient barefoot and has her walk. Do you agree that's an appropriate evaluation for a podiatric surgeon?

A Yes.

Q Thank you.

MR. OGINSKI: Judge, I'm sorry, I have to object only because there is not an issue in this case. There is no dispute here. We don't contest that there is anything wrong with his initial evaluation.

MR. MC ANDREW: Judge, I'm defending against this expert.

THE COURT: I think, as I said before, cross-examiners may use many different tactics and certainly he can ask these questions.

MR. MC ANDREW: Thank you, your Honor.

Q And the doctor also went through an examination of this patient's feet with regard to range of motion, the joints, that sort of thing, right?

A Correct.

Q And now that would involve actually laying hands on the different aspects of the foot?

A Yes.

Q He did that on both sides, right?
A Yes.
Q Okay. And ultimately he came to a diagnosis, isn't that right?
A Yes.
Q And that was a bunion with hallux valgus, correct?
A Yes.
Q Now, based upon -- and, again, it says there, the right foot has significant intermetatarsal angle and severe deformity which would require Lapidus to correct. Whereas the left foot is less severe and could be corrected with Austin.
With regard to the right foot, you told us the right was worse than the left, correct?
A Yes.
Q Do you agree with that diagnosis that the doctor noted there?
A The diagnosis of hallux valgus bunion, yes, sure.
Q And, Doctor, do you agree that the foot was unstable with regard to the cuneiform metatarsal joint?
A Let me just read this, please.
Q Certainly.

A No, I can't tell you that from this review. It does not say anything about that.

Q I would like you to assume that the Doctor has testified here in Court over the last several days and told the jury that, in fact, the rearfoot and the cuneiform metatarsal joint were unstable. Can you assume that?

A I can't assume it. You're telling me that he said that. He did not write it in his notes.

Q I'm asking you for the moment to assume certain testimony was had here. In fact, it was had here.

A Okay.

Q That the doctor came in and testified that the rearfoot, as well as that aspect of the cuneiform metatarsal joint, were unstable?

A If you're telling me he said that, I hear you.

THE COURT: You're going to have to assume. There is no objection. So you are going to have to assume this was testimony and the jury will decide whether it was or not, for sake of a question.

THE WITNESS: Sure.

THE COURT: So assuming that that came in.

Q So assuming he said that, would you agree that with that instability in that cuneiform metatarsal joint that a Lapidus procedure is indicated?

A Is one of the procedures that could be indicated. But, yes.

Q And certain doctors might choose a different procedure from another, is that correct?

A Right.

Q And that's within the judgment and discretion of that particular physician?

A Correct.

Q And when you have an unstable cuneiform metatarsal joint, certainly a Lapidus procedure will provide stability to that joint, correct?

A When corrected properly, yes.

Q Okay. But forget about corrected properly or not. If you fuse that joint and the arthrodesis takes hold and the bones grow together, you have a stable joint, correct?

A At that spot. Not the rest of the foot.

Q That's all I'm talking about, at that spot, it is a stable joint, right?

A Stable. But, you see, you have to say that it is put back in place because it could be stable in

the wrong place.

Q We all know what your opinion is.

MR. OGINSKI: Objection. Argumentative.

THE WITNESS: Not related to --

THE COURT: Stop. Stop.

THE WITNESS: I don't mean to --

THE COURT: If you can't say yes or no, just say I can't say yes or no.

THE WITNESS: Fine. I'm sorry.

Q Does the arthrodesis, if it heals properly, regardless of what position it is in, does it provide stability where that joint, that unstable joint used to be?

A Not necessarily.

Q Okay. And, Doctor, I would like you to take a look through that note with regard to the counseling section. You can take your time and read that.

A Okay.

Q Here the doctor talks -- he explained the influences of pathomechanics and footgear on the deformity. Is that an appropriate thing for a podiatric surgeon to do when evaluating or speaking to a patient after evaluation?

A Yes.

Q Okay. And it says pronation of the rearfoot

during walking causes instability of the, at the base of the first metatarsal allowing it to move up and out of position.

Is that an appropriate thing to document in a chart?

A Yes.

Q Okay. And there it says that given, it says pronation of the rearfoot during walking causes instability at the first metatarsal allowing it to move up and out of position.

Does that mean that the first metatarsal is actually elevating, the tip, the distal end closest to the toe, is that going up?

A The whole metatarsal, not just the tip.

Q Okay. So the entire metatarsal is elevated?

A Moving up and out he is saying.

Q I'm sorry?

A Moving up and out.

Q Up and out?

A Yes.

Q So, Doctor, is it fair to say -- by the way, I would like you to assume that Dr. Marzano explained that because of this instability in the rearfoot, as well as the first metatarsal moving up, in whole or in part, that because of that the patient was already

bearing weight on the second metatarsal. Will you assume that?

A That's part of it.

Q Okay. And with that, because the first metatarsal is now elevated, isn't it only natural that the second metatarsal would bear more pressure and weight and therefore develop a callous, isn't that right?

A Except that she has a longer second metatarsal, which is also adding to it. I'm not disagreeing with you, but it is also part of it.

Q We will get to that, I assure you. But certainly that elevated first metatarsal from this instability in the foot, that's leading to more pressure to be borne by that second metatarsal, correct, at least in part?

A In part.

Q And at that point, even preoperatively, a year before surgery, that first toe joint had become progressively more and more subluxed, correct?

A Laterally deviated.

THE COURT: I can't hear you at all.

THE WITNESS: I'm sorry.

THE COURT: You have to lift your head a little.

THE WITNESS: I'm trying to read. Okay.

Q Would you agree that it was subluxed?

A Yes.

THE COURT: What is subluxed again? What does that mean?

THE WITNESS: Dislocated is completely out of alignment. Subluxed is partly.

Q And by the way, the range of motions, range of motion tests that Dr. Marzano did and documented there in April of 2004, do those show limited range of motion?

A No.

Q They don't?

A 90 degrees of dorsiflexion is a lot.

Q This was somewhat confusing. Passive range of motion is when the doctor pushes the joint through motion, am I correct about that?

A Yes.

Q Then active range of motion is what the patient can do of their own accord, right?

A Okay.

Q So looking at that, do you have a different thought as to whether or not she had limited range of motion?

A Yes. Her active range of motion is somewhat

limited.

Q Somewhat limited?

A Yes.

Q So actively she could only go 10 degrees up. That's dorsiflexion up, right?

A Yes.

Q With the doctor pushing it it could go 90 degrees?

A Right.

Q And then the same thing with bringing the big toe down, she could only go about 5 degrees on her own, the doctor could push 15 degrees?

A Right.

Q So there was certainly a limitation of the range of motion. Do you agree with that?

A I agree.

Q Now, the hallux position was 45 degrees. We will -- I always get this wrong. Abducted, which means going out toward the pinky, right?

A Correct.

Q That's consistent with what you have looked at on the x-rays?

A Yes.

Q That's a fairly abnormal finding, is it not?

A Yes.

Q And getting back down to the counseling section, if you would. The doctor initially in this first visit right away recommended use of sneakers and accommodative footgear, correct?

A Correct.

Q Including customized inner soles and orthotics, correct?

A Correct.

Q That's a good thing to recommend for a patient such as this, right?

A Sure.

Q That would be a good practice to do that?

A Yes.

Q Have you done that in your own practice right?

A Absolutely.

Q And he actually explained, he documents that he explains to the patient that the orthotics will address the biomechanical cause of the problem, right? Is that what it says?

A Yes.

Q And specifically he was talking about the pronation of the foot. Do you agree that's what the note says?

A Yes.

Q And his thought here is documented that he would try to control the pronation and reduce the deforming forces that would make these bunions worse, right?

A Right.

Q And then it is clearly documented here that he explained to the patient surgical correction, including Lapidus and Austin procedures, as well as the postoperative -- you may want to go to the next page -- postoperative course, internal fixation, and two to four months healing period wearing a cast with no weightbearing. Do you see that?

A Yes.

Q You would agree that to explain the procedure or possible procedures you're going to do or recommend or say is indicated, that's an appropriate thing for the surgeon to do, correct?

A Correct. But he said Lapidus and Austin, and he did not perform those. He said in the chart that he did --

Q Doctor, I can't hear you when you speak that fast.

A That throughout his chart record it says Lapidus and Austin were done at the beginning of each office visit note, and he did not do an Austin.

Q We all know, and we were here for Dr. Marzano's testimony here in Court. His notes are not very good postoperative. You would agree with that, right?

A I do.

Q Sometimes he says bunion. We know he did not do a bunion, right? There is no dispute about that?

MR. OGINSKI: Bunion?

Q Excuse me, Austin. We know he did not do an Austin bunionectomy, right?

A Right.

Q We don't dispute that. He did a Lapidus?

A Right.

Q Sometimes it said the left foot instead of the right foot. Those were errors, correct?

A Yes.

Q You don't think he did surgery on the left foot, correct?

A Correct.

Q It was always the right foot, right?

A Correct.

Q That's a better way to say it. So, here we are only talking about what he documented here now in April of '04, that he explained the procedure to the

patient, the Lapidus procedure, and he does comment as well to Austin, but he spoke about doing the Austin on the left potentially, and also said that he described the various or at least two procedures to the patient.

You agree it was good standard of care to talk to the patient about the procedure that he would ultimately do if she agreed, right? It is good practice to do that?

A It is good practice to discuss it, to discuss the whole issue and what he is doing would affect the rest of the foot. He did not.

Q We are not there yet.

A Okay.

Q We are talking about describing the procedure. You agree that is good practice for the doctor to go over with the patient, the procedure he is likely going to do on her, correct?

A Yes.

Q Okay. And also to talk about, you know, how is he going to fix the bones together with two screws. It is a good thing to do?

A Yes.

Q And the healing period, he says here, two to four months of healing period wearing a cast with no weightbearing. Regardless of the timing, you would

agree that it is appropriate to tell the patient there is going to be some recuperative period here, correct?

A Yes.

Q And in the next section he talks about that he explained the potential risks and complications, and it enumerates quite a few risks and possible complications. Wouldn't you agree that before doing surgery on a patient it is appropriate to talk to them, to counsel them about, look, we are going to try to get this desired outcome, but there are certain risks and complications that may ultimately occur, that's good practice, right?

A It is good practice, but he left out some of the complications, which is the second and third.

Q He left out some complications in this note, right?

A Yes.

Q When you write a note, Doctor, do you put every single thing that you discuss with the patient into that note?

A The obvious ones. That was obvious to me.

Q So those obvious ones he left out of his note in April of 2000, right?

A Yes.

Q Please do me a favor and turn to a document

which is dated 3/9/05, which I believe is labeled consent form. It looks like this.

A Do you know where? At the back?

Q I don't know. Just take your time and find it.

If you want I can assist you.

A The informed consent, that one?

Q Yes.

A Okay.

Q How many pages is that chart, Doctor?

MR. OGINSKI: You want her to count them?

Q Approximately, yes.

MR. OGINSKI: Objection. How many pages in the record?

THE COURT: What record?

MR. OGINSKI: Dr. Marzano's entire office chart, he wants her to count it.

MR. MC ANDREW: I'm not asking her to count it.

MR. OGINSKI: You just said how many pages is it.

THE COURT: Sustained, too vague.

Q Doctor, are you familiar with that record?

A Yes.

Q You have reviewed it before today?

A Yes.
Q A long time, right?
A Yes.
Q And were you aware that this Informed Consent Form was contained in the chart?
A Yes.
Q Okay. Did you look at it before?
A Yes.
Q Okay. Now, here there is a reference to -- just give me a moment so that I can find it. It says callous and pain under the second metatarsal head. You will see it is under the section second paragraph from the bottom, All contingencies.
A I see it.
Q It certainly says callous and pain under the second metatarsal head. That's indicating that may develop as a complication, right?
A But it was already there.
Q We already talked about that. We knew it was there. But it may also develop subsequently, right? That's definitely a risk of this procedure, right? You're not arguing?
THE COURT: The question is: Did you think that that meant in the future or in the past, that note?

MR. OGINSKI: Objection to the question, Judge. I'm not sure I understand.

THE WITNESS: I do.

MR. OGINSKI: Okay. I'll withdraw the objection.

THE WITNESS: I think the informed consent, when you are doing that, is what is going to happen in the future.

MR. MC ANDREW: That's right.

THE COURT: So does that mention a future risk concerning the second metatarsal?

THE WITNESS: It does not say increased callous and pain, because she already has that. That's all.

Q So we are playing semantics here?

MR. OGINSKI: Objection, argumentative.

A It is not semantics.

THE COURT: Sustained. She answered the question. Strike the comment.

Q Dr. Joseph, does a physician ordinarily put a risk into an informed consent document that is not something, anticipating something that might occur from the surgery? Is that something that you usually put into a document?

A Can you repeat that, because I did not

understand you.

Q The variety of risks, complications that are put into an informed consent document, the specific risk, is that usually something that the doctor anticipates may happen from the surgery?

A Yes.

Q Okay. And, Doctor, I know you were not here and you had not -- you have not read Dr. Marzano's trial testimony, have you?

A No.

Q You did not do that?

A No.

Q So, you were not here, but we will ask you to assume that the doctor testified that in every single Lapidus procedure his overbearing concern is the shortening of that first metatarsal, okay? You will assume that for me?

A He said that?

Q Yes.

A Okay.

Q He also said that he talked to the patient about that possibility of the first metatarsal shortening as well as the potential for the second and third metatarsals to then bear extra weight, develop pain and callous. Are you with me so far?

A Yes.

Q Would you agree that's an aspect of any Lapidus procedure that a podiatric surgeon should review with the patient preoperatively?

A Yes.

Q It is good practice to do that, right?

A Absolutely.

Q Okay. And, Doctor, additionally, we are not going to go through each and every complication here, but there are several that we do have to talk about, specifically scar formation. He lists that as a potential complication. Would you agree that it is good practice for the doctor to talk to the patient about scar formation as a potential risk or complication of a Lapidus procedure?

A Yes, in any procedure.

Q And we all know -- well, we don't know. Withdrawn.

When doing surgery, scars can develop, adhesions or can be or there can be overscarring, is that right?

A Yes.

Q And that's really something that a doctor can't anticipate. You can't anticipate that with your own patients, correct?

A Correct.
Q And that can happen no matter what you do, right?
A Right.
Q And those scars, those adhesions, can they cause contracture of a joint? Is that right?
A Right.
Q And that can cause problems for the patient, right?
THE COURT: What is contracture of the joint?
MR. MC ANDREW: Sorry, Judge. That's a good point.
THE COURT: What is that?
THE WITNESS: Where a joint is being pulled because of the scar tissue, so it comes up out of alignment. That's not what happened in this case, but I'm agreeing with that. It can happen.
Q That can happen. And you say that's not what happened in this case. We know your position is that the first metatarsal shortened or recessed causing the first toe to go up, correct?
MR. OGINSKI: Objection to form.
THE COURT: Overruled.

THE WITNESS: No, it is both. The shortening and the plantarflexion.

Q I was going to get to that. So the shortening and plantarflexion caused the toe to go up?

A Yes.

Q Do you agree that the contracture, the scarring also caused that first toe to go up or may have contributed to it?

A No. If you look at the post-op x-ray it is already there. It then continued to contract after that. It was not the cause.

Q Okay. Would it have contributed in any way?

A It was all right there. The position did not get worse from the scarring.

Q Were you aware that Dr. Roberts down at HSS testified that the scar tissue caused the toe to go up?

MR. OGINSKI: Objection to the form. Only because he has not yet testified. They have not seen the video deposition, your Honor.

MR. MC ANDREW: Subject to connection, your Honor. We do this all the time.

MR. OGINSKI: So how can she know unless he asks her to assume it.

THE COURT: You have to ask her to assume.

Q Doctor, would you assume that Dr. Roberts will or has testified on video deposition pre-trial that the contracture, the scarring caused or contributed to the toe going up? Would you assume that for us?

A You want me to assume that he said that?

Q Yes.

A Okay.

Q Would he be wrong in his opinion?

A It is not that he would be wrong.

Q A yes or no. I don't mean to interrupt you, but we really need the answer.

A Yes, he can be wrong.

Q So Dr. Roberts could possibly be wrong?

A Yes.

Q Okay. Now, you would agree that this list of complications and risks on the Informed Consent Form is more extensive than what we have on the April 15th, '04 documentation?

A Yes.

Q Okay. And I wanted you to assume that Dr. Marzano testified that he not only back there, April of 2004, reviewed with the patient what he listed there in the note, but also what is contained in this document, as well as an elaboration on that.

Would you agree that reviewing this relatively extensive list of risks and complications, would you agree that's good practice?

A He is omitting things, so it is not good practice.

Q So, Doctor, I guess then it is your position that a physician before operating on a patient must give every single possible complication and risk that can happen?

A No, that's not what I'm saying.

MR. OGINSKI: Objection.

THE COURT: She answered.

THE WITNESS: I'm sorry.

THE COURT: Do you know what, do you want to ask one or two more questions and then we will break for lunch, or do you want to break now?

MR. MC ANDREW: A couple more would be good, Judge. I don't want to go into the afternoon too long.

Q And certainly, Doctor, the risk of possible infection is in this form, and it is even in the note of April of 2000, right?

A Correct.

Q And if that happens to the patient and if

patient gets infected that can cause a lot of trouble for the patient, correct?

A Correct.

Q That can cause additional surgeries, right?

A Sure.

Q Sometimes it can be -- do you know a term named limb threatening?

A Yes.

Q That means your limb or a portions thereof, your leg or foot can actually be amputated, right?

A Yes.

Q And infectious processes, after surgeries, can lead to those sorts of complications where it is limb threatening, correct?

A Correct.

Q So it is important and it is good practice to discuss that with the patient in advance, right?

A Yes.

Q Okay. Now, with regard to the complaints -- withdrawn.

MR. MC ANDREW: Judge, this is probably a good time to take a break.

THE COURT: All right. We are going to take a break. We will reconvene about 2 o'clock. 2 o'clock. Thank you.

(Jury excused.)

THE COURT: I just want to tell the witness, you're under cross-examination, so you cannot discuss your testimony with Plaintiff's counsel at this point, all right.

THE WITNESS: Okay.

THE COURT: Thank you very much.

THE WITNESS: Thank you.

MR. MC ANDREW: Judge, we may leave our stuff here, right? Is it going to be locked up?

THE COURT: Yes, we will lock it up.

(Lunch Recess taken.)

COURT OFFICER: Jury entering.

(Jury entering courtroom.)

THE COURT: Hello. Be seated, everybody.

MR. MC ANDREW: May I proceed, your Honor?

THE COURT: Can you remove that scaffold?

MR. MC ANDREW: I was going to use it.

THE COURT: Fine.

MR. MC ANDREW: That's where we left it.

THE COURT: Doctor Joseph is on the stand. You are still under oath. Understood and agreed.

THE WITNESS: Yes, understood and agreed.

THE COURT: Try to direct your answers to

the questioner and not look down because it becomes hard to understand you.

CROSS-EXAMINATION

CONDUCTED BY MR. MC ANDREW:

Q Good afternoon, Doctor Joseph.

A Good afternoon.

Q We left off talking about the In-Office Consent form that Doctor Marzano had. Could you turn to that, if you would?

A Let me find it again, please. Okay.

Q The patient signed that document. At least it reads her signature, Annmarie Flannery?

A Yes.

Q That was dated 3/9/05. I want you to assume that it was actually signed during the 4/15/05 visit. That has been the testimony to far. Would you assume that?

MR. OGINSKI: 4/15?

MR. MC ANDREW: I'm sorry, pardon me.

MR. OGINSKI: 3/15.

Q 3/15/05, just a couple weeks before the surgery. Would you assume that for us?

A I will assume that.

Q And that's the appropriate time sometime pre-op to get the consent, correct?

A Fine.

Q And, Doctor, specifically turning to the last paragraph. "I further understand that the proposed operation may not produce the intended result and the possibility of additional foot surgery may be necessary in the future." Do you see that?

A I do see that.

Q Is that an appropriate thing for a doctor to discuss with and include in an Informed Consent Form?

A Sure.

Q And, Doctor, doctors can't guarantee surgery, right, an outcome?

A Right.

Q And this form actually speaks to that, the paragraph, I don't know if you can see it, it is about the fifth paragraph. "I acknowledge that there are no guarantees or assurances." Do you see that?

A Yes, I see that.

Q That's a fair thing to contain in a consent form, correct?

A Sure.

Q Okay. And at the bottom it says that the patient certified and read the consent form. Do you see that?

A Yes.

Q And the third, or I think it is fourth paragraph, "My bunion is painful and has failed to respond to more conservative measures."

Do you see that?

A Yes.

Q "Including changes in shoe gear and padding," right?

A Yes.

Q That's an appropriate thing for an Informed Consent Form to contain, correct?

A It is fine.

Q Okay. And the remainder of this form, this is appropriate good practice to get a patient to sign this form, explain it to them preoperatively, correct?

A Correct.

Q And if you would turn to the St. John's forms, or the St. John's chart. Does this form, in the fourth paragraph, address orthotics? It is towards the end of that paragraph? Do you see that?

MR. OGINSKI: Which paragraph is that?

MR. MC ANDREW: I believe it is the fourth paragraph down.

Q "It was explained to me that the surgical correction is the only means available to change the joint. However, orthotic control of my rearfoot is

the only way of controlling the cause of my bunion deformity, and without orthotics recurrence of deformity is possible."

Do you see that?

A I do see that.

Q Do you agree that that is appropriate and good practice to tell a patient that postoperatively orthotics should be used to control the instability of the foot?

A Yes.

Q And, Doctor, do you understand that without orthotics reoccurrence is possible?

THE COURT: Without?

Q Without use of orthotics postoperative sometimes you can have a reoccurrence?

A With a Lapidus?

Q Yes.

A No.

Q You cannot?

A Usually not.

Q But you can sometimes?

A Mostly not.

Q Doctor, this form also addresses anesthesia. And the patient consented to anesthesia; is that right?

A Yes.

THE COURT: Well, let's make this clear. This is not an issue any more. Informed consent is not an issue and this is a hospital informed consent.

MR. MC ANDREW: We did not get to the hospital yet. We are going to move through this.

THE COURT: You said we are moving onto the hospital. I don't see any relevance to the hospital consent form.

MR. MC ANDREW: Well, your Honor --

THE COURT: What is the relevance?

MR. MC ANDREW: Well, it is relevant to the defense, and I don't plan on spending much time on it.

Q Would you turn to the St. John's chart, please.

MR. OGINSKI: Your Honor, since it is not an issue, I'm going to object to his going into the Informed Consent for the hospital.

MR. MC ANDREW: Your Honor, I think we had this on side bar, and it remains an issue with the defense.

THE COURT: I remember clearly what I said

at side bar. Certainly some latitude is given. But, on the other hand, I don't think that much latitude is given.

MR. MC ANDREW: I promise to be brief with these, your Honor.

Q Doctor Joseph, do you see this Informed Consent Form from the St. John's Hospital?

A Can I make sure this is what you are referring to.

Q Oh, yes, I'm sorry, sure. Do you see it?

A Yes. I wanted to make sure that it is the right one.

Q It is signed by the patient, right?

A Yes.

Q And the second, it should be the next page in the chart there, there is an anesthesia consent form. Do you see that? It looks like this?

A Yes.

Q And both of those are executed by the patient?

A Yes.

Q Doctor, is it good practice before the patient has the operation to have the hospital consent form signed?

A Yes.

Q Doctor, Doctor Marzano discussed with this patient in advance, as documented in his consent form, that there are alternatives, correct, as far as orthotics, shoe gear?

MR. OGINSKI: To do what, I'm sorry?

MR. MC ANDREW: I'll rephrase the question. It was imperfectly worded.

Q I want you to assume the testimony has been that Doctor Marzano discussed with the patient the alternatives of using orthotics, instead of surgery. Would you agree that it is appropriate for a doctor to go over with the patient the possible alternative treatments?

A Yes.

Q By the way, the benefits of this procedure would include that the patient would have -- the deformity should be taken away; is that right?

A Yes.

Q The bump?

A Yes.

Q You're going to add stability to that back joint between the cuneiform and the metatarsal?

A Yes.

Q And you're going to straighten out the metatarsal and the toe somewhat?

A You have to correct the entire joint, both ends. So the hallux and the -- it is not just that.

Q Of course. But the desired outcome is you have a more straight toe, less of a deformity, more stability?

A Toe. Not just metatarsal, toe as well.

Q Toe and metatarsal?

A Right.

Q Thank you. Now, given the fact that we know that with the Lapidus procedure there is a potential for shortening of the first ray of the first metatarsal. Is it good practice for the doctor to discuss with that patient that there is a potential that subsequently we may have to do another surgical procedure to address the shortening? Is that good practice?

A Can you repeat that, please?

Q Certainly.

MR. MC ANDREW: Can you read it back, please.

(Requested testimony repeated.)

THE COURT: I'll decide that. Yes, she can read it back.

MR. MC ANDREW: Thank you, Judge.

(Requested testimony repeated.)

THE WITNESS: It is good practice to explain the possibility for other surgeries, but not because you're shortening to the point where now you did this it does need another surgery.

Q We know that's your position, that it was shortened too much, right?

A Yes.

Q But generally speaking, giving an Informed Consent discussion with the patient, discussing the potential that there may be shortening of that first ray, is that good practice?

MR. OGINSKI: Objection. Again, there is no issue on the Informed Consent.

THE COURT: What are we talking about? Which Informed Consent, please?

MR. MC ANDREW: We are not talking about a piece of paper, your Honor, with all due respect. We are just talking about the discussion that the doctor had.

THE COURT: I thought you said we are going to go onto the hospital, and you are holding that in your hand.

MR. MC ANDREW: No, no, these are my notes I'm not holding the consent.

THE COURT: Well, the question is then is

it good and accepted practice to cover this, this potential possible risk?

THE WITNESS: Yes.

Q Doctor, before the operation, from reviewing the chart, there were two preoperative visits in 2004, two preoperative visits in 2005, right?

A Okay.

Q Do you agree with that?

A I could double check and make sure.

Q That's fine by me.

A Yes.

Q Doctor, moving onto the surgery itself. We know that it was on March 25th, 2005, correct?

A Correct.

THE COURT: March or May?

MR. MC ANDREW: March.

Q Now, you have testified in Court before, right?

A Yes.

Q You would agree, you have testified that podiatric surgery is not an exact science, correct?

A Correct.

Q That it is more of an art?

A Correct.

Q You have said that?

A Well.

Q Would you agree that it is touch and feel? The doctor has to clinically assess what is going on intraoperatively?

A Correct.

Q Absolutely, right?

A Right.

Q Would you agree that there is a certain amount of judgment and discretion that a doctor exercises in caring for a patient?

A Right. And then there are limits.

Q Of course, there are limits to everything.

Now, you told us that the first metatarsal was shorter relative to the second metatarsal?

A Can I correct you?

Q Is that what you said, yes or no?

A No.

Q Was the first metatarsal preoperatively shorter than, equal to, or longer than the second metatarsal?

A Well, the second metatarsal was longer than the first.

Q Did I misspeak, is that what you are saying?

A Yes.

THE COURT: And the first metatarsal is

the big toe?

THE WITNESS: Behind the big toe.

THE COURT: Behind the big toe. But it is the foundation for the big toe?

THE WITNESS: Yes.

MR. MC ANDREW: If the doctor could step down for a moment. Just real quickly.

THE COURT: And you should go to the other side so she can be facing the reporter.

Q Now, this is the AP view, meaning looking down at the foot with x-ray, right?

A Can they see it.

MR. MC ANDREW: Can you guys see it from here?

THE WITNESS: It is low.

Q It is shooting down, anterior to posterior, top of the foot to the bottom?

A Yes.

Q And clearly the second metatarsal, that's this bone right here?

A Yes.

Q Verses the first metatarsal, this bone right here?

A Yes.

Q It appears longer, correct?

A Correct.
Q Okay. And you may take your seat, Doctor.
And is that what you are telling the jury, that the second metatarsal was longer based upon the way that it appears on this x-ray?
A Yes.
Q Okay.
THE COURT: Now, is that x-ray post-op or pre-op.
MR. MC ANDREW: Sorry, Judge that's a pre-op, 3/10/05.
THE COURT: Before the surgery.
Q But, Doctor, isn't it true that, in fact, that's not how you measure the length of the first and second metatarsal?
A No.
Q Okay. Have you ever heard of something called a metatarsal protrusion angle?
A Right.
Q Okay. And, Doctor, isn't that when you draw a bisection, a line down the middle of the second metatarsal?
A No.
Q Just let me finish my question first, please.

A Sorry.

Q Where you draw a line down the middle of the second metatarsal from the front of the foot to the back of the foot, and then you additionally draw a line bisecting the first metatarsal from the front of the foot to the back of the foot, and then there are two points that intersect, and you measure from that point the two -- where the two lines intersect forward to the tip of each metatarsal, and that's how you get the relative length of the metatarsals; isn't that right?

A No, that's not a protrusion.

Q You disagree with that?

A I do.

Q Okay. You're basing it upon what it looks like here on the x-ray, no question about that, right?

MR. OGINSKI: Objection. That's not what she said.

THE COURT: Well, I don't know. I'll let the jury decide what she said. But certainly there was a discussion with counsel looking at an x-ray that was pre-op, am I correct?

THE WITNESS: Yes.

THE COURT: And what did you say about the metatarsal and the first and the second?

THE WITNESS: The second is longer than the first.

Q Now, again, you don't disagree that Lapidus should not have been done, you're saying there also should have been taken now account the longer metatarsal, and at least the second, if not the third, osteotomy of the second and third metatarsal should have been taken intraoperatively, that's your position, right?

A Yes.

Q And an osteotomy is what?

A Cut in the bone. To make a fracture. To do something. To change something.

Q Now, I want you to assume that Doctor Marzano told us in Court, in testimony, that he discussed with this patient that very thing, the possibility of doing a second and third metatarsal shortening or osteotomy. Are you with me so far?

A He said that in Court?

Q Yes.

MR. OGINSKI: I am going to object. Because that's not what he said in relation to the timing of doing it during the first surgery.

MR. MC ANDREW: I did not say it was.

THE COURT: Read it back, please.

(Requested testimony repeated.)

THE WITNESS: Is that pre-op or post-op?

MR. MC ANDREW: There has to be a ruling from the Court first.

THE COURT: Well, the question is unclear. So, sustained.

MR. MC ANDREW: Fair enough. Thank you, Judge.

Q I want you to assume that Doctor Marzano testified, to be clear, it was not during this operation, but he testified in discussions with the Plaintiff, he talked about the shortening, potential shortening of the first metatarsal and the potential of doing a second and third osteotomy. Are you with me so far?

A No, I need to clarify.

Q I will rephrase it. That's not a problem.

A Okay. Sorry.

Q Don't be sorry.

So, the first -- I'm going to give you a couple of sets of facts as we go along, and it will probably become clear. I just wanted to make sure you're getting what I say as I say it, okay?

A Yes.

Q I want you to assume that Doctor Marzano

discussed with the patient that there is a potential for shortening of the first metatarsal and that he discussed with her preoperatively the potential of doing a second and third osteotomy. Not necessarily during the procedure, maybe after, but that discussion was had. Are you with me so fares?

THE COURT: Well, that is the problem. Sustained.

I want you to assume that Doctor Marzano testified that he talked to the Plaintiff about whatever. In other words, you can't assume that that is a fact. You can assume that it was the testimony.

MR. MC ANDREW: That's what I said, Judge.

THE COURT: You did not.

MR. MC ANDREW: If I did not then I apologize. I'm trying to get this right.

THE COURT: It is an assumption. Assume that he testified.

MR. MC ANDREW: I thought I said it. I apologize.

THE COURT: Not that it is a fact, because that's for them to decide.

MR. MC ANDREW: Judge, my apologies. I will withdraw that and rephrase it.

Q Again, I want you to assume that the doctor testified here in Court that he had a discussion with the patient preoperatively, that there is a potential for shortening of the first metatarsal, and that he discussed with her the potential, whether it be during surgery or after surgery, but he did discuss with her doing a second and third osteotomy, shortening those bones. Do you follow me so far?

A I follow.

THE COURT: Is that all pre-op?

MR. OGINSKI: Objection.

MR. MC ANDREW: It is pre-op and it is all an assumption.

MR. OGINSKI: Objection to form because that's not what he testified to.

MR. MC ANDREW: That's for the jury to decide.

MR. OGINSKI: I'm objecting to form because you're leaving out a certain part that I think is important.

THE COURT: Well, why don't you write it down and then on redirect you can correct it.

All right, overruled.

MR. MC ANDREW: Thank you, Judge.

Q Now, with that part of the assumption, I

want you to further assume that the doctor came here and testified that he discussed with this patient that you can do osteotomies intraoperatively, but in this case he discussed with her doing it postoperatively if in the occasion there was a complication and that shortening, which happens in every Lapidus, caused a complication.

Are you with me so far? You don't have it?

A Not a hundred percent. I'm very sorry, I don't mean to be confused, but I am.

Q That's all right.

A It is pre-op, post-op?

Q It is difficult because you did not have an opportunity to be here or read the testimony. That's okay.

A I don't want to say the wrong thing.

Q You're confused between pre and post-op?

A When did he have this discussion?

Q All of the facts I have said so far, assume all of that, and these discussions occurred before the surgery. That he discussed with the patient the shortening of -- the potential shortening of that metatarsal and doing these procedures to shorten the second and third, and that he discussed with her and explained to her that he would only do those

procedures after the surgical operation, after the Lapidus, if there was a complication or some sort of suboptimal outcome. Okay, do you got that so far?

A Okay.

Q Would you agree that discussing such a potentiality with the patient in advance of surgery and obtaining her consent to that plan is good practice?

THE COURT: Would you agree that if he had, in fact, discussed these things, that would be good and accepted podiatric practice?

MR. MC ANDREW: Right.

MR. OGINSKI: I have to object, Judge. Only because there is no claim any more for lack of informed consent, so this addresses an issue that's no longer in the case.

MR. MC ANDREW: It is pivotal to the defense.

THE COURT: I don't think it is pivotal. But I know what you are doing.

Would you agree?

THE WITNESS: If he did that. But he did not follow through.

Q He did not follow through postoperatively, right?

A Right. There was a complication.
Q He did not do the shortening, right?
A Yes.
Q And that's because in December of 2005 the patient decided to go somewhere else, right?
A No, that's not what I'm talking about.
Q I understand that's not what you are talking about.

Now, you told us on direct that immediately postoperatively or during the procedure the doctor should have done the second and third osteotomy, shortening of those two --

THE COURT: Well, no, she did not say that. You said that during the operation, after the, what do you call it?

THE WITNESS: The Lapidus.

THE COURT: The Lapidus was done, that he should have then corrected the length of the second and third metatarsals, that's what you said.

THE WITNESS: Yes, that's correct.

Q So, maybe I'm unclear then. Are you saying that it was not until after the procedure that the doctor should have brought the patient back in, the same day, for the osteotomies?

A He should have known the complication that occurred intraoperatively and addressed it.

THE COURT: Intraoperative?

Q Intraoperatively or postoperatively?

A Well, depending. Because he did not take x-rays intraoperatively. So postoperatively before she left the table when he had the x-rays in his hand he should have addressed it.

Q Ideally he should have either addressed it intraoperatively or postoperatively?

THE COURT: Time. Intraoperatively?

THE WITNESS: In the middle of the surgery before the patient leaves the operating room.

THE COURT: We have to have definitions.

MR. MC ANDREW: You're right, Judge, I appreciate that.

Q So, are you saying ideally he should have either done -- recognized intraoperatively and done the osteotomies, or immediately postoperatively he should have done the osteotomies?

A Osteotomies, or lengthened the first.

Q One of those two options?

A Yes.

Q It would have been ideal to do it intraoperatively?

A Yes.

Q But you know that was never discussed with the patient, doing it at that time, correct, that was not the plan?

A No, it was. It was discussed. You told me that. You just said assume that he testified to that.

Q That he would do it postoperatively. In the postoperative period.

A You said either/or. That's what you said to me. That's what I understood.

Q We are going to argue semantics?

A I don't wanted to argue.

Q What I'm saying is going into this procedure on March 25th, 2005, Doctor Marzano did not have a consent to do a second and third metatarsal shortening, isn't that right? Do you see any consent for that?

A But when you are doing surgery, the consent is you do whatever you have to do to make it as good as possible.

Q I thought you would say that.

MR. OGINSKI: Objection to comment. That's not called for.

THE COURT: Strike the comment.

Q Doctor, isn't it true if he had done the

second and third metatarsal shortening during this March 25th, 2005 procedure, you would be up there testifying against him on that case if there was a complication, right?

MR. OGINSKI: Objection, speculation.

THE COURT: This is argumentative. No, no, no. Strike it.

Q Now, Doctor, if the physician, in his judgment and discretion, believed that he had a good result intraoperatively and postoperatively, you would agree that it was appropriate not to take any further intervention, correct?

A Can you repeat that?

MR. MC ANDREW: Judge, if Cindy could do that.

THE COURT: Read it back, please.

(Requested testimony repeated.)

THE WITNESS: Correct.

Q And, Doctor, you have testified on your own behalf where you were a Defendant in the Marks' case, Nassau County case, right?

A Yes.

Q That involved a similar situation?

MR. OGINSKI: Objection, relevance.

THE COURT: You want to go into the facts.

You could get burned by this, but if you want to do it, I'll let you do it.

MR. MC ANDREW: Okay.

Q And that case, Marks against Doctor Joseph involved a case where you did a procedure for a bunion, correct, a bunion correction?

A Yes.

Q It was a closing base wedge resection?

A Closing base wedge osteotomy.

Q Wedge osteotomy. Excuse the phraseology. In that case you don't fuse the cuneiform bone with the metatarsal, correct?

MR. OGINSKI: Objection, irrelevant. Has nothing to do with this case. You're talking about totally different cases unrelated.

THE COURT: I'm going to curtail this. I'll tell you why. Because the jury has enough to be concerned about other than now having to evaluate the facts of a totally different operation on. That's going to be my ruling. It is just too much. We have enough to deal with here.

Q Generically, during that procedure you experienced a complication, correct?

MR. OGINSKI: Again, objection, Judge.

THE COURT: Overruled.

THE WITNESS: Okay. Yes.

Q And you would agree that it was not negligence that you experienced a complication during that procedure, right?

THE COURT: I don't understand that.

MR. OGINSKI: Objection. The facts are different.

THE COURT: Sustained.

Q In that case a podiatrist came to court and said that you were negligent, right?

MR. OGINSKI: Objection.

THE COURT: Overruled.

THE WITNESS: I answer?

THE COURT: Yes.

THE WITNESS: He did, but I corrected that complication.

Q I understand. But a podiatrist came in and testified against you, that you were negligent, right?

A Did she use those words? I guess. I don't know.

Q You were there, right?

A I was there.

Q And just because a podiatrist comes into Court and testifies another podiatrist was negligent,

does not mean it is so, right?

A She was not board certified. She did not have the training.

Q Either way, Doctor, answer my question. I did not ask about board certification.

MR. OGINSKI: Objection.

Q Just because a supposed expert comes into Court and testifies against another surgeon does not actually mean it was negligence, right?

MR. OGINSKI: Objection, argumentative, irrelevant.

THE COURT: Well, that is true. It is the jury that decides.

MR. MC ANDREW: Okay, Judge.

THE COURT: And when they say negligence, they mean medical malpractice.

Q Doctor, would you agree that preoperatively the cuneiform bone was abnormally shaped? Do you need to look at this?

A Please.

Q You can step down.

A The joint adepts. It is not that the cuneiform is abnormally misshapen, the joint adapts. Changes.

THE COURT: So, is it or is it not

misshapen?

THE WITNESS: No, it is the joint.

THE COURT: The jointly is misshapen?

THE WITNESS: The joint -- it is a vague term, but I'll say that.

Q Say what?

A That it is misshapen, because it is sort of misleading, but...

Q So -- that's fine. But it is somewhat misshapen, we agree?

A The joint, not the bone.

Q Okay. But the bone, if I am not mistaken -- can everyone see this? The bone, the cuneiform bone, this is the outline here, right?

A Yes.

Q Okay. And it is certainly not on a crisscross axis with the metatarsals, it is rounded, isn't it?

A I think you're asking two different things. You're talking about the joint, or are you?

Q I'll ask a different question.

A Okay.

Q So right here, is this, right as I'm going along with the pen, is that not the outline of the cuneiform bone?

A Just to here. Just these edges. That's the cuneiform bone to the metatarsal.

Q So right here?

A Yes.

Q Okay. And wouldn't you agree that that sort of curved --

A It is supposed to be. They sit like that. The metatarsal base is one curve this way. It is like a cup.

Q But you agree it is curved?

A It is supposed to be.

Q I'm not asking if it is supposed to be, it is curved, right?

A They all are, yes.

Q Okay. Go ahead and take your seat.

Now, you would agree, Doctor, to get a good fusion and good positioning, a physician, a surgeon, must cut that cuneiform bone in order to bring the metatarsal to a good arthrodesis, to a good fixation, correct?

A You need to explain what you mean by cut.

Q Okay. You talked about feathering, right?

A (Nodding affirmatively.)

Q You have to say yes or no.

A Yes, I'm sorry.

Q You talked about feathering in your direct testimony. That's some cutting of the bone, correct?

A You're taking the cartilage off.

Q Maybe I misunderstood.

A You're taking the cartilage off.

Q Do you ever remove cuneiform bone during this Lapidus procedure? Not just the cartilage, not the covering, the actual bone, is the bone removed?

A Just maybe the outer cortex. Just a millimeter maybe.

Q But you do remove bone?

A Right. But not that much.

Q I am just asking if you remove bone.

A Okay.

Q Now, as you proceed, as the surgeon, making a decision on how to align these bones, do you determine within your discretion how much to remove, whether it is a millimeter or if it is just the cartilage or something else? It is up to the surgeon, is it not?

A Yes.

Q Okay. And Doctor Marzano told us here in testimony that it was his discretion, his judgment that he had to remove some abnormally shaped bone. And if that is the case, do you agree that it is

appropriate to do so to form a good fixation?

A Right. In the area where it needed to be done. Not the whole bone.

Q Now, would you agree that the doctor did not cut away any bone from the actual metatarsal? By the way, I'm just going to hold this up, Judge. I know, just so we are clear.

THE COURT: Wait a minute. Cuneiform is not part of the metatarsal?

THE WITNESS: No. I'm sorry.

THE COURT: All right. It is not?

THE WITNESS: It is a separate bone.

THE COURT: What --

THE WITNESS: It is a separate bone.

MR. MC ANDREW: I'm going to try to straighten that out, Judge. I realize it was confusing.

Q The first metatarsal again is this bone, right, the long bone here?

A Yes.

Q Now, during this surgery the doctor did take off some bone on the distal part of the metatarsal. That's the part closest to the toes and long bone?

A Yes.

Q Okay. That's this little bump here he took

off?

A Yes.

Q Now, he did not, however, take any length of the bone, he just scraped away the cartilage, correct?

A I don't know that.

Q It is in the operative report, is it not?

A Does it say that exactly?

Q I'll tell you what. I would like you to assume for purposes of this question that the doctor testified that he did not take any length from the first metatarsal, he just removed the cartilage, drilled some holes to get some bleeding and bone-on-bone contact. Would you accept that?

A Fine.

Q Now, is that good practice when you have to remove or you determine to remove some cuneiform bone not to take any bone length from the first metatarsal? Yes or no? If you can't answer yes or no, just say so?

A Okay. I don't know how to answer that.

Q Okay. Go ahead and take a seat.

Now, Doctor, if Doctor Marzano, based upon his clinical assessment, what he saw intraoperatively, if he felt he had a good result in the operating room it would be good practice to finish up the procedure,

correct, close the patient up?

A If he thought he had a good result?

Q Yes.

A Yes.

Q Okay. And, Doctor -- give me one moment.

This is going to seem sort of silly, but you were not in the OR, right?

A No, I was not in the OR.

Q Of course not. It was only Doctor Marzano who was there, right, as far as the primary surgeon or the surgeon, right?

A Right.

Q He was the guy operating, correct?

A I'm assuming.

Q Yes. Now, we talked earlier about, I believe you spoke earlier on direct examination that the doctor could have undertaken an x-ray intraoperatively, correct?

A Should have, yes.

Q Something. He should have. That's what you said, right?

A Yes.

Q And that's something called a C-arm?

A You could do either, but, yes.

THE COURT: What is a "CR?"

THE WITNESS: A fluoroscope is something that, so you can -- it is an x-ray. But it is portable.

THE COURT: Is that what -- he used the word "CR."

THE WITNESS: It is a C-arm. An arm that comes around with an x-ray tube on it.

MR. MC ANDREW: I believe the testimony was intraoperative x-ray, or C-arm, was used yesterday.

THE COURT: Okay.

Q Now, intraoperative x-ray or fluoroscopy through C-arm, would you agree that you do that in the operating room, correct?

A Correct.

Q Okay. And would you agree that the equipment goes over the operating room table?

A Yes.

Q And would you agree that it is not like a true plain film?

MR. OGINSKI: Which one, the C-arm?

MR. MC ANDREW: Let me clarify.

Q Intraoperative x-ray or fluoroscopy.

A Well, you can do a printout and make it like a true film.

Q But you testified in the past in a case called Walton, as an expert, correct? Pierre A. Walton, W-A-L-T-O-N, and Christine Walton, against Stuarts, S-T-U-A-R-T-S, in Nassau County before Judge LaMarca back on June 13th, 2007. Do you remember that?

A I don't remember everything about it, but I do.

Q But you definitely testified there, right?

A Yes.

Q I'm going to read to you a portion of your testimony and tell me if this refreshes your recollection as to having given this testimony.

"This is intraoperative x-ray and it is a C-arm. So it is exaggerated. It is an x-ray that goes over the table, and so it is not like a true plain film, so it is a little distorted looking."

Do you remember giving that testimony?

A No, I don't. But I want to clarify, that that C-arm film was probably not a good -- it was exaggerated.

Q Well, I'm just asking. That's fine. But I'm asking, do you recall, yes or no?

A I don't recall it.

Q Okay. So, you're anticipating my next

question which would be if the C-arm is exaggerated or distorted intraoperatively or an x-ray is distorted intraoperatively, that would give the doctor faulty information, right?

A Well, you hope it is not exaggerated. You're hoping you get a right angle and good view.

Q But you told us C-arms are exaggerated and distorted. That's what you said in your testimony?

A I was referring to that one film.

Q But you did not say that. You said --

A I said it, you read it.

Q Certainly a C-arm or intraoperative x-ray is not weightbearing?

A Correct.

THE COURT: Or it does not show weightbearing. It is not weightbearing?

Q I'll clarify it.

A weightbearing film is where the patient is standing on their foot, right?

A Yes.

Q And intraoperatively you can't get that, right?

A Correct.

Q And ideally to determine the positioning of the bones in the foot postoperatively, eventually you

wanted a weight bearing film, correct?

A Eventually.

Q That's the most accurate way to get a picture, correct?

A Correct.

Q Now, you also said that in addition, or in the alternative to doing a shortening of the second and third metatarsals, the doctor could have considered a bone graft intraoperatively, correct?

A Correct.

Q And, Doctor, you're aware that in doing a bone graft you heighten the risks of the procedure, correct?

A Everything has risk, but...

Q That's not what I asked. I said in doing a bone graft in a Lapidus, are you increasing or heightening the risks generally of the surgery?

A But you have to weigh your risks.

Q But I'm just asking a simple question, Doctor. If doing a bone graft in a Lapidus procedure, does that increase risks, yes or no?

A Depends on if you are experienced at it or not.

Q So you can't answer yes or no; is that right?

A I guess I can't answer yes or no.
Q All right, fine. Just next time if you could say that.
A It is hard for me, sorry.
Q Understood.
But you do understand that bone grafting increases the risk of infection in patients regardless if you are experienced or not, right?
A No, not necessarily.
Q Not necessarily. And bone grafting will also increase the risk of a failure to heal, for that arthrodesis to take hold, correct?
A Possible.
Q And often in medicine with doing surgery on bones and fusing bones, we get something called nonunion, correct?
A Yes.
Q It is when bones don't unite?
A Right.
Q And there is very little a doctor can do to prevent that complication from occurring, correct?
A No.
Q No. Is it not true in the literature that from time and again certain percentages of patients are going to get nonunion, whether it is fracture or

surgical intervention?

A Right. But it is a lot of times --

Q Yes or no. I'm just asking yes or no. You know the rules, you have been in Court before, right?

A Right.

Q So it is a yes?

A It is a yes.

Q Thank you, Doctor.

A You're welcome.

Q And, Doctor, to put it simply, if a bone graft is done intraoperatively, you may not get a good fusion, right?

A Just like -- maybe.

Q Yes or no, Doctor, please?

A Maybe.

Q Maybe, okay. During the testimony of Doctor Marzano, I would like you to assume that Mr. Oginski developed with him that he had previously, prior to Mrs. Flannery's case, undertaken 25 do 30 Lapidus procedures. Are you with me so far?

A Yes.

Q And in each of those cases the outcome was good. Following me?

A Okay.

Q Okay. And I want you to accept that the

doctor had never previously had to do a bone graft or an osteotomy on the second and third metatarsal and he nevertheless had optimal outcomes in those cases?

A Okay.

Q Thank you. And, Doctor, do you agree that it is appropriate for a surgeon who has experience doing these procedures to make a decision intraoperatively to go along with the procedure that he ordinarily does and that he has had success with? Do you agree that that's good practice, yes, no or I can't answer that way?

A Yes.

Q Thank you. And, nevertheless, you say in this case that the doctor should have done either an osteotomy or a bone graft, right?

A Yes.

Q That's what you are saying?

A Yes.

Q If you could curtail your answers to yes or no.

Yes or no, that's what you're saying, he should have done a bone draft graft or osteotomy intraoperatively or postoperatively?

A Yes.

Q And, ma'am, you're being paid $4,000 to be

here today, correct?

A Yes.

Q And, ma'am, in advance of coming here today you reviewed records, met with Mr. Oginski, I believe you met him two times?

A Yes.

Q Charged him 275 an hour for that time?

A Yes.

Q And reviewing those records you also charged per hour for reviewing the records?

A Yes.

Q Do you know how much you billed to date including, 4,000 for today?

A No, I do not.

Q You did not tally that up for today's events?

A No.

Q But it is your positioned today that the doctor should have varied from his usual customary practice with Miss Flannery and undertaken a different method of doing this Lapidus procedure, right?

THE COURT: Objection?

MR. OGINSKI: Yes, I'm sorry.

THE COURT: There is no evidence to that. There is no evidence as to what his other

procedures were.

MR. MC ANDREW: The doctor did testify he never did either of those, Judge.

THE COURT: I tell you that every procedure, no matter what it is called, with every patient, is different. So, you know, I can't admit that kind of question.

MR. MC ANDREW: Well, Judge, if I may.

THE COURT: No, I'm not admitting that.

MR. MC ANDREW: I'll move on.

THE COURT: There was no evidence and there can be no evidence unless it is fully explained what the other procedures were.

MR. MC ANDREW: I apologize if I remembered it differently, your Honor.

THE COURT: Well.

Q And, Doctor, in the field of podiatry is it sometimes the case where the podiatrist, the surgeon, has to do an additional procedure postoperatively? That happens, right?

A It can happen.

Q It happened to you in the Marks' case, you recommended an additional procedure?

MR. OGINSKI: Objection. Irrelevant, unrelated. Totally different set of facts.

THE COURT: I think that's allowable. Is this intraoperative you are asking?

Q In the postoperative time. Not right after the surgery, but in the Marks' case you had recommended --

A It is very different, you know.

Q I'm not saying that it is the same. I'm just saying in that instance, in that Marks' case, you recommended to your patient postoperatively who had a recurrence that she ought to have further surgery, correct?

MR. OGINSKI: Objection, Judge. It is totally -- you're comparing apples and oranges. You have nothing to do with this particular case.

MR. MC ANDREW: I'm not asking about this case.

MR. OGINSKI: That's exactly the point.

THE COURT: Well, I think that's valid, actually, because each one of these is different.

MR. MC ANDREW: Okay, Judge.

Q Simply put, Doctor, having to do an additional podiatric procedure is not necessarily negligence, right?

A If you don't address it originally.
Q Just -- you know, I'm sorry, but if you could limit it to yes or no.
A I can't answer it. I can't answer that.
Q I have given you that option as well?
A Okay.
Q Just so that we had it clear, just because postoperatively the patient is required or there is an option that she have a further podiatric procedure, that does not necessarily mean the surgeon was negligent, right, just generally speaking? And if you can't answer yes or no, that's fine as well.
A It is hard to answer that.
Q I'm sorry.
A It is hard to answer that because it is going to infer things.
Q Fine. So you can't answer it?
A I can't answer it.
Q That's all you have to say.
A Yes.
Q Now, with regard to the aspect of this surgery where, and correct me if I am wrong, where you testified that that first metatarsal, the long bone, I think we all know what that is, that it was too far down, was pointing too far down, right, that's what

you said?

A Yes.

THE COURT: Preoperatively.

MR. MC ANDREW: Sorry, Judge?

THE COURT: That's preoperatively.

MR. MC ANDREW: No, no, postoperatively.

THE COURT: Postoperatively?

MR. MC ANDREW: Or intraoperatively.

THE COURT: Let's make this clear. After the operation you testified earlier that the Plaintiff's metatarsal, first metatarsal was pointing too far down.

THE WITNESS: Yes.

MR. MC ANDREW: Thanks, Judge.

Q And then, Doctor, with regard to positioning that bone, either up or down, there is a certain amount of variability, correct?

A Absolutely.

Q And it is not as though the doctor is in there with the protractor measuring exactly, it is touch and feel, right? Clinical judgment?

MR. OGINSKI: Objection, two separate questions. You ask touch and feel and then clinical judgment.

THE COURT: I don't really understand the

question.

MR. MC ANDREW: I'll be happy to rephrase it, your Honor.

Q So intraoperatively when the doctor is positioning that bone, podiatrists don't use a protractor to do that, correct?

A Some people use different measure.

Q Some people do that?

A Some do, some don't.

Q Do you do that?

A I used to. It depends.

Q But you don't any more?

A No. More experienced.

Q So, Doctor, would you agree that in positioning the bone, the metatarsal, the cuneiform bone, that there is a certain amount of judgment and/or touch and feel?

A Right. But there is a realm of what is right and wrong.

Q Yes or no? We know about the realm. Just yes or no?

A Yes.

Q Or you can't tell me yes or no?

A Yes.

Q And is it true, Doctor, that if you

plantarflex or push that bone down, it is bound to bear more weight?

A No.

Q Okay. Is it true, Doctor, that if you dorsiflex, or that bone is too far up it, it is not going to bear weight?

A No.

Q So neither one of those things are true, right? I did not hear an answer.

A Both of them could be true, both of them could be false.

Q That's a noncommittal answer if I ever heard one.

MR. OGINSKI: Come on, counsel.

THE COURT: Sustained. Strike it.

Q Now, would you agree that you want to bring that metatarsal down a little bit so that it can bear more weight?

A A little bit, yes.

Q A little bit. You would agree with that?

A I agree.

Q And if you bring it down too much you might be actually bearing too much weight. That's a complication, right?

A That and that the toe will come up for sure.

Q Okay. And if you bring it -- if you leave it up too high, that first metatarsal won't bear any weight as well, potentially?

A Much weight.

Q Or much weight.

A That's why I could not answer you before.

Q Okay. Thank you. That's why I asked the question.

Now, Doctor, preoperatively, I would like you to come down. Not preoperatively. I would like you to come down and look at a preoperative film.

This film, and I'm going to identify it, your Honor, it is, I believe, Exhibit 2 in evidence. And it is from the films contained in Doctor Marzano's chart. It is from, if you see here, 3/10/05?

A Yes.

Q And it is of the patient Flannery, correct?

A Yes.

Q And this is a lateral view of the patient's right foot. We have the "R" up here?

A Yes.

Q And, Doctor, please, bear with me and help me, if you would.

Is this the long bone, the metatarsal right here?

A The first metatarsal?
Q Yes.
A Yes.
Q Is that what it is?
A Yes.
Q And then would that be the bottom right here kind of juts down around here?
A Yes.
Q Okay.
A And that's the second. Do you see where it ends?
Q The second metatarsal is here?
A Yes.
Q And the bottom of the second metatarsal would be down somewhere here?
A About there.
Q Can you identify any of the other metatarsal heads?
A That looks like third right there. It is hard. You're not going to be able to see that, I'm sorry.
Q And, Doctor, is that first metatarsal head, the bottom, higher up than the second metatarsal and the third metatarsal heads where you pointed to?
A No, it is about on the same plain as the

second. See --

Q So you're saying the first is here and the second is down there?

A Well, it is longer. But if you brought it back up, it is just about the same plain.

Q I'm asking on this film.

A Because it is longer, you can't -- it is apples to oranges I again.

Q You can explain that on redirect. But I'm asking you right now, based upon this metatarsal, where it is, and the other part of the second metatarsal, is the bottom of it lower down than the first metatarsal? Simple yes, no or I cannot answer that, and I would be happy.

A Well, it is misleading to say yes, but I'll agree.

THE COURT: Don't say something misleading.

THE WITNESS: I won't. So then I can't answer it.

THE COURT: Okay.

Q That's fine. You can take your seat.

Doctor, wouldn't you agree that in a patient with an unstable cuneiform metatarsal joint that the cuneiform and the metatarsal may be a little bit up,

the first metatarsal?

THE COURT: What do you mean by up?

THE WITNESS: Right.

Q Dorsiflexed. You told us earlier that the tip is not necessarily up but the whole bone may be elevated, right?

A Elevated.

Q Right.

A Compared to.

Q Compared to. Go ahead?

A I'm asking you.

Q Okay. I did not know.

So, I'm comparing it to the second metatarsal, such as in that film preoperatively where you see the second metatarsal, the head is lower than the first metatarsal. Can that not be related or is that not related to the fact that you have an instability in the foot causing elevation of the first metatarsal?

A Fine.

Q You agree with that?

A I agree with that.

Q And that, indeed, can contribute to the second metatarsal bearing more weight, correct?

A Contribute, as well as the long second

metatarsal.

THE COURT: We are going to take a break. I hear the sighs saying time to get up off the chair. All right, 15 minutes.

(Jury excused.)

THE COURT: How much longer?

MR. MC ANDREW: Twenty minutes, 30 minutes.

THE COURT: And you?

MR. OGINSKI: A few minutes.

THE COURT: Well, I'm going to hold you to it. It is getting late in the day and enough is enough. I would expect 20, 25 more minutes, and maybe tops ten.

MR. OGINSKI: I'm not going to be ten minutes.

THE COURT: Lawyers tell me that every day of the week ten times a day.

MR. MC ANDREW: I don't think it will be more than 30 minutes, but I need to reserve my right to that. It is cross-examination.

THE COURT: I'm not going to be draconian about this, but if you are saying 20 minutes and you mean an hour and 20 minutes, I will cut you off. It is Friday afternoon and this witness

has been on the stand all day.

MR. MC ANDREW: You're right, Judge. It is not going to be an hour and 20 minutes, I assure you.

(Recess taken.)

THE COURT: Be seated, everyone. Doctor Joseph, we will continue with cross-examination. You are still under oath. Understood and agreed?

THE WITNESS: Understood and agreed.

MR. MC ANDREW: Thank you, Judge.

Q Doctor, I am going to read to you some excerpts from Dr. Roberts deposition of June 17th, 2008, and I'm going to ask you if you --

THE COURT: Haven't we gone over this already?

MR. MC ANDREW: No, not this part. There is a few sections I need to go over.

THE COURT: Have you read Dr. Roberts' deposition?

THE WITNESS: I have not.

THE COURT: Is it in evidence?

MR. OGINSKI: No.

MR. MC ANDREW: Well, it will be when I read it in. As you know, Judge, we can read in

a licensed physician for any purpose.

THE COURT: Okay.

Q Okay, I'm referring to --

THE COURT: And does this reading have a question attached to it?

MR. MC ANDREW: Yes, if she agrees or does not agree. I will get to that.

THE COURT: Okay.

Q Doctor Joseph, I'm going to read to you page 78, line 16, of Dr. Roberts' deposition transcript.

"Question: What are the risks of a Lapidus procedure?

"Answer: Well, the risks with any surgery is infection, nerve injury, bone not healing, bone not healing in the right spot, incomplete pain relief, new pains, blood clot. There are lots of --

"Question: Okay. With respect to the foot or toes themselves, what are the risks?

"Answer: You can overcorrect it and you can get a new deformity. You can get -- well, you can get in the wrong position. So it is bearing too much weight. Or by plantarflexing it it can bear too much weight. By dorsiflexing it it can bear not enough weight. And so you

can get what is called a transfer lesion where you get increased stress on the lesser metatarsals.

"Question: That's a risk of the Lapidus procedure?

"Answer: Well, that's a risk with any bunion surgery."

Do you agree with those excerpts?

THE WITNESS: Yes.

Q And, Doctor, I'm going to read you another section. Page 75, 15 to 18.

"Question: You don't want to dorsiflex it either.

"Answer: So it is an art. And it is hard to objectify what the perfect position is."

Again, talking about that first bone.

Do you agree with that?

A Within reason.

Q Do you agree with Dr. Roberts' testimony that you don't want to bring it -- I'm sorry, it is easy to bring it up too far and it is easy to bring it down too much?

A In surgery, how you finally position it --

Q I'm sorry, doctor, I'm going to ask you to limit yourself to yes or no.

THE COURT: If you can't answer that you can always say I can't answer that.

MR. MC ANDREW: Of course.

THE WITNESS: I can't answer because it is not complete.

Q Fine. And, Doctor, do you agree -- hold on one moment. Do you agree, at page 79 through 80, lines 23 to 7.

"Question: That condition I just described about the toes pointing upward and not meeting the ground, is that a risk of the Lapidus procedure?

"Answer: Do you mean with the toe sticking up?

"Question: Correct.

"Answer: A toe deformity?

"Question: Is that a risk?

"Answer: It is a possible complication of any bunion surgery."

Do you agree with that? I know it is disjointed, but do you agree with the toe going up being a risk of any bunion surgery with Dr. Roberts?

A Are we talking about the big toe?

Q Yes.

A Okay. Is it a risk of any surgery?

Q Just do you agree with Dr. Roberts, his testimony that it is a risk of any bunion surgery?

A If it is done poorly, yes.

Q Again, if you could limit yourself to yes or no, you agree or not. He did not say anything in his deposition about being done poorly. He said it is a risk of any bunion surgery. Do you agree or disagree or can you not form an agreement or a disagreement?

A I cannot form an agreement because it is disjointed.

Q And I'll read from Dr. Roberts' deposition, Page 80, line 11 through 17.

"Question: Being that you did many of these Lapidus procedures, do you disclose the risk of the procedure itself? The risks of the procedure itself to your patients?

"Answer: Sure.

"Question: Okay. Is one of the risks that they may need further surgery in the future?

"Answer: Sometimes."

Do you agree with that, yes or no?

THE WITNESS: I agree.

Q And then at page 83 of Dr. Roberts'

testimony, lines 10 through 20.

"Question: You were talking about risks, or Mr. Levine asked you about risks of the Lapidus procedure. Would you agree that there are what doctors consider to be known risks with any procedure?

"Answer: Correct.

"Question: And those risks can occur even in the best of hands and under the best of circumstance, correct?

"Answer: Correct."

Do you agree with that?

THE WITNESS: I agree.

Q And, Doctor, would you agree that among physicians, whether they be podiatric surgeon or orthopedic surgeons, there is room for disagreement?

A Yes.

Q We have heard the old adage, ask five doctors their opinion and you will get five different answers?

MR. OGINSKI: Objection.

THE COURT: Well, I suppose that there is room for disagreement in some areas, but not in all areas.

MR. MC ANDREW: Can I --

THE COURT: That question is not really specific enough to form an answer, in my opinion. So I'm going to sustain that. Strike that.

MR. MC ANDREW: I'll try to rephrase it in a more palatable way.

Q Do you agree with the old adage that if you ask five different doctors the question you will get five different answers?

MR. OGINSKI: Objection.

THE COURT: Sustained.

MR. MC ANDREW: Withdrawn.

Q And, Doctor, in your career as a podiatric surgeon, have you experienced the complication with your patients of shortening the first metatarsal? Has that occurred to any of your patients?

A Do you want to quantify that?

Q I'm sorry?

A Do you want to quantify it?

Q Just, has it happened in, for instance, the Marks' case?

MR. OGINSKI: Objection. Now we are talking about different things. First he asked about everything, then just the Marks' case. Objection to form.

MR. MC ANDREW: She asked that I quantify it.

THE COURT: Sustained.

Q In the Marks' case was there a shortening of the first metatarsal?

MR. OGINSKI: Objection. Irrelevant.

THE COURT: I don't want to get into all of the specifics of these other cases. I don't think it is fair to the jurors, so I'm not going to do it.

Q Generally have you had a postoperative complication where the big toe was going up?

MR. OGINSKI: I'm sorry to interrupt you, I don't mean to, but are you talking about bunion surgery or Lapidus procedure, or just be specifically?

MR. MC ANDREW: Bunion surgery.

A Any bunion surgery?

Q Yes.

A Not really.

Q How about with Lapidus procedure, have you ever had the toe going up afterwards?

A No.

Q How about with a closing wedge base resection, or you called osteotomy?

MR. OGINSKI: Objection, that's the same objection as before.

THE COURT: Sustained. That was not the procedure that was done here.

Q Doctor, would you agree that treatment for an upgoing first toe after a bunionectomy would include physical therapy as a possible treatment?

A Depends on how stuck it is.

Q But can that be treatment?

A If it is flexible, yes.

Q When you say if it is flexible, in other words, if you can push it down; is that right?

A If the metatarsal is not in the way.

THE COURT: If the metatarsal is what?

THE WITNESS: Is not in the way.

THE COURT: Is not in the way?

THE WITNESS: Yes.

Q Well, when you say if it is flexible, do you mean that you can get that toe from the upward position by pressing on it, the doctor pressing on it to push it down to where it would be in the purchase position, flat position, is that what you mean by flexible, or something else?

A No.

Q All right. If that's not what you mean.

That's fine.

Doctor, you would agree that in this case you looked at the facts from hindsight, correct?

A Yes.

Q You were sitting at your desk when you were reviewing the documents, the x-rays, you were in your family room at home, where were you?

THE COURT: What does it matter?

MR. MC ANDREW: I'm just curious, Judge.

THE COURT: I don't think that's a matter to go into.

Q Would it be fair to say that you were able to review these documents at your leisure?

A I was working, it is not leisure.

Q Okay. You consider that working, reviewing these documents, or do you mean you were at your office working when you reviewed the documents, or something else?

MR. OGINSKI: Objection.

THE COURT: Never mind.

Q And would you --

THE COURT: I don't know what these questions mean. But do you know what they mean?

THE WITNESS: No.

MR. MC ANDREW: Judge, I'll withdraw the

question.

THE COURT: Thanks.

Q Would you agree that you had the benefit of hindsight in looking at this case?

MR. OGINSKI: Objection, asked and answered.

THE COURT: Sustained.

Q Do you agree that having the benefit of hindsight is a great benefit in reviewing a case like this?

A Like this? The facts are the facts.

Q And, Doctor, would you agree that Doctor Marzano certainly did not have the benefit of hindsight in caring for this patient in 2004 and 2005?

A Postoperatively he did.

Q Going forward, each day?

A (Nodding affirmatively.)

THE COURT: The answer is yes?

THE WITNESS: Yes.

THE COURT: You have to answer.

MR. MC ANDREW: Those are all of the questions that I have. Thank you.

THE COURT: Thank you. Redirect?

MR. OGINSKI: Yes, your Honor.

REDIRECT EXAMINATION

CONDUCTED BY MR. OGINSKI:

THE COURT: Now, remember, you're restricted to the questions asked on cross.

MR. OGINSKI: I understand.

Q Doctor Joseph, you were asked questions by Mr. McAndrew about the Informed Consent Form that appears in Doctor Marzano's chart. Is that a prewritten form, like a fill-in-the-blank form?

A Yes, it is.

MR. MC ANDREW: Objection, your Honor.

THE COURT: Overruled.

Q And that form, what do they do? In other words, what do you do, what information do you put into that form that is already in existence?

A I just want to find it. Okay.

Q Tell us how that form -- in other words, is it a template and you simply put the patient's name in and the type of procedure?

A Yes.

MR. MC ANDREW: I objected. I don't think there is any foundation of how this document was formulated.

THE COURT: No, I gave you latitude to ask questions about this. You got it. Now he has information that he can use.

THE WITNESS: It is computer generated. So it is fill in the blank.

Q Okay. And what do we know about the computer generated electronic medical records from Doctor Marzano from everything that we have read?

A They have been a little lax in completeness and accuracy.

Q Now, you have told us that --

THE COURT: Could the jury hear that?

THE WITNESS: I will speak louder.

Q You told Mr. McAndrew that -- he asked you whether everything under the sun should be --

MR. MC ANDREW: Objection, your Honor.

MR. OGINSKI: I'll rephrase.

Q He said do you think that everything should be put into this Informed Consent Form, and you were going to explain. Tell us what should be put into the consent form?

A What should be put into the consent form is the procedure, the risks, but the known risks looking at the patient's foot. Where he knows that certain things may occur because of the way that her foot is. Like the long second metatarsal, the out of alignment second metatarsal toe joint, and that doing a shortening Lapidus procedure, even if it was done

without that much shortening, would put more stress on the second metatarsal. And that needs to be addressed.

Q And the fact that he did not do that, do you have an opinion within a reasonable degree of podiatric probability as to whether that represents a departure?

A Yes.

MR. MC ANDREW: Objection.

Q What is that opinion?

THE COURT: Overruled.

A My opinion is that he should have explained all of that preoperatively, and he should have addressed it even surgically.

Q And, Doctor, is there any doubt in your mind that the Defendant put the metatarsal too far down during the course of this patient's surgery?

A Yes. It was so far down. It was lower than the second and third metatarsal into the fourth. It was -- it is angled almost, you know, almost like a 40-degree angle.

Q And in your opinion, Doctor, with a reasonable degree of podiatric probability, is it your opinion that that represents a departure from good and accepted podiatric care?

A Yes.

Q And as a result of that departure did Annmarie Flannery suffer injury?

A Yes.

MR. MC ANDREW: Objection, your Honor.

Q Is there any doubt in your mind, Doctor, that Annmarie Flannery should have had a second and third osteotomy during the course of the first surgery, provided, of course, she had been counseled in the beginning that this was going to help her foot?

A Yes.

Q And the fact that that did not occur, do you have any doubt in your mind that that represents a departure from good and accepted podiatric care?

A Yes.

Q And what is that opinion?

A My opinion is that it is a departure. She should have been told and it should have been done and she would not have had those problems.

Q As a result of those departures was that a substantial factor in causing Annmarie Flannery's injuries?

A Yes.

MR. OGINSKI: Thank you, Doctor.

THE COURT: Recross.

MR. MC ANDREW: Two, maybe three.

RECROSS-EXAMINATION

CONDUCTED BY MR. MC ANDREW:

Q Doctor Joseph -- Stretching with the two, I guess.

Doctor Joseph, you said that the angle was 40 degrees, or almost 40 degrees, I think is what you said, right?

A Yes.

Q Do you know that Doctor Marzano testified that he believes it to be 30 degrees and appropriate? Do you know that? You don't know that, right?

A No, I don't know that.

MR. MC ANDREW: That's all I have.

THE COURT: All right. Thank you very much.

THE WITNESS: Thank you.

(Witness excused.)

THE COURT: Ladies and gentlemen, we are going to brake for the day, it is Friday and we have to work on Monday and possibly Tuesday.

I have been doing this sometime now and I still kind of smile. Lawyers will say don't worry, Judge, we will only be three days and one week and no more, and it has never in my

experience been that.

So, nevertheless, we are moving along. And I believe that we will get this case in hopefully by the end of next week. But I can't guarantee it. But we are moving along.

Thank you for your courtesy, I hope you have a pleasant weekend in the heat and you get some rest. See you Monday at ten.

Any other questions? 10 o'clock.

(Jury excused.)

* * * *

I, Cynthia M. Hills, do hereby certify that the within proceedings are a true and accurate transcript of the original stenographic record.

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Cynthia M. Hills, RPR, CRR