DE-IDENTIFIED DEPOSITION OF A PODIATRIST IN AN IMPROPERLY PERFORMED BUNION SURGERY CASE

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF WESTCHESTER

,

Plaintiff(s),

-against- Index No.:

and

,

Defendant(s).

DEPOSITION OF
DR.

New York
September 10,

REPORTED BY:

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A P P E A R A N C E S

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New York
BY:

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IT IS HEREBY STIPULATED, by and between the attorneys for the respective parties hereto, that:

All rights provided by the C.P.L.R. and Part 221 of the Uniform Rules for the Conduct of Depositions, including the right to object to any question, except as to form, or to move to strike any testimony at this examination is reserved; and in addition, the failure to object to any question or to move to strike any testimony at this examination shall not be a bar or waiver to make such motion at, and is reserved to, the trial of this action.

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The filing of the original of this deposition is waived.

IT IS FURTHER STIPULATED, that a copy of this examination shall be furnished to the attorney for the witness being examined without charge.

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2 DR.
3 the Defendant herein, having been first duly
4 sworn by , a Notary
5 Public for the State of New York, was
6 examined and testified as follows:
7 EXAMINATION BY
8 MR. OGINSKI:
9 Q Would you please state your name for the
10 record.
11 A .
12 Q Would you please state your address for the
13 record.
14 A , ,
15 , .
16 Q Good morning, Doctor. What is a Lapidus
17 procedure?
18 A Well, good morning to you.
19 And Lapidus procedure is arthrodesis of the
20 first metatarsal cuneiform joint.
21 MR. : Give a general description
22 of Lapidus; you don't have to give a
23 two-hour dissertation.
24 THE WITNESS: Okay.
25 MR. : As general as you can.
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1 6
2 A Usually combined with a bunionectomy.
3 Q What is arthrodesis?
4 A Arthrodesis is the fusion of two bones into
5 one.
6 Q And where is the first cuneiform joint?
7 A The first metatarsal cuneiform joint is on
8 the inside of the foot towards the middle.
9 Q What is a bunion?
10 A Bunion is a general term, usually referring
11 to a subluxation of the first
12 metatarsophalangeal joint.
13 Q And what is subluxation?
14 A A partial mal-positioning. Not complete
15 dislocation, just a mal-positioning.
16 Q Are bunions hereditary?
17 MR. : All bunions?
18 MR. OGINSKI: In general.
19 MR. : Okay.
20 A I believe that there's no consensus on that
21 in the general literature.
22 Q And what do you observe when you diagnose a
23 bunion?
24 A Many things.
25 Q Typically, what do you find?
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1 7
2 A Well, if you ask me more specifically I'll

answer you.
Q Sure. I'll rephrase.
When you do a clinical examination and you find that there is a bunion, what is it that you see?
A I think the most important or -- no. The primary observation is a lump or a prominence on the medial side of the foot.
Q And when you say "medial," can you be any more specific?
A Big toe side, inside.
Q Do bunions typically present with pain?
A It's a variable thing case by case.
Q Are you familiar with the term known as hyperkeratosis?
A Yes.
Q What is that?
A Thickening of skin.
Q And what causes that?
A Well, gee, there's many causes.
Q Can you give me the most common cause?
A Most common cause seen in the foot is friction, pressure, force.

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Q And what is a hallux valgus?
A Hallux valgus is a term referring to the lateral, or outside, deviation of the big toe.
Q Is that a bony abnormality?
A It's a positional abnormality affecting the toe.
Q Are you familiar with the term known as an intermetatarsal angle?
A Yes, sir.
Q What does that mean?
A It's an angle calculated by drawing lines between the bi-section of the second metatarsal and the bi-section of the first metatarsophalangeal joint.
Q And --
A On a AP view.
Q Is that typically seen when you're viewing an X-ray?
A Yes, sir.
Q Are you familiar with an Austin bunionectomy?
A Yes, sir.
Q What is that?

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A Austin bunionectomy involves removal of excessive bone from the inside, or medial, first metatarsal head and a V-shaped osteotomy at the neck of the first metatarsal with transposition of the first metatarsal head laterally.
Q How does the Austin bunionectomy differ from

the Lapidus procedure?
A Well, again, in many ways.
Q If you can generally tell me, it would be helpful.
A Well, Austin is an osteotomy at the distal aspect of the metatarsal. Its ability to correct metatarsal angle is more limited than the Lapidus. Its ability to correct sagittal plane deformity is extremely limited, nonexistent really.
I suppose that will be my answer, unless you have further questions.
MR. : Okay.
Q What is an MPJ release?
A MPJ, metatarsophalangeal joint. It involves surgical cutting of joint capsule, usually to loosen up contracture.

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Q And contracture would be what?
A Tightness. You can consider it tightness.
Q Typically, what causes contracture?
A Well, again --
MR. : Is there something that typically causes it?
THE WITNESS: Many things. Adaptations to abnormal situations, common cause.
Q I'm not asking you for an exhaustive list.
A That's the primary thing. Contracture is usually caused by adaptation.
Q Go ahead.
A Secondary could be contractures of scars.
Q Known as adhesions?
A Well, adhesion is a type of scar, yes.
Q What is a K-wire fixation?
A K-wire is stainless steel pin that's drilled into a bone to maintain a position or -- Well, to maintain a position.
Q And in the Lapidus procedure do you use a K-wire in order to fixate the bone?
A No.
Q In the Austin bunionectomy do you use K-wire to fix the bone?

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A I do not.
Q Where is the talonavicular joint anatomically?
A Well, it's just in front of the ankle. It's the next joint out when you pass the talus on the inside of the foot, inside medial.
Q Can you explain to me, Doctor, what a tendon extension transfer is?
A Tender extension transfer?
Q Yes. If you're familiar with the term.
A I'm familiar with the words. Those words are not usually used together.
Q Tell me what a tendon extension is.

A Well, strictly speaking about the words, a tendon extension involves -- Well, I would not use those terms. I'm sorry, I wouldn't use those terms.
Q What is exostosis?
A A synonym would be bone spur.
Q And have you ever heard the term hypermobile first ray?
A Yes, I have.
Q What does that mean to you?
A It means that the first metatarsal bone will

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move in an upward direction in an excessive degree.
Q When you make a diagnosis that a patient has a bunion, what are your treatment options? And again, I'm asking you as a general question.
A Generally speaking.
MR. : Again, there are many patients. He's asking generally, not this particular patient.
A Generally speaking, I inform the patient that a bunion is a subluxation.
Q No, I'm sorry. Let me interrupt you. Maybe I wasn't clear. I'm not talking about informed consent discussions. I'm not talking about that yet. When you make a diagnosis that a patient has a bunion, what are the treatment options that are available to you to treat that particular condition?
MR. : You can testify what are some of the treatment options. He's not going to get boxed in on every

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treatment option on every patient.
A Treatment options include no treatment; shoe accommodation; controlling the patient's rear foot with orthotics; and various surgical procedures.
Q And typically, when you see patients who have bunions, do they also, at the same time, have hyperkeratosis?
A Did you say "typically"?
Q Yes. Is that something that's common that you see with a bunion?
A I'm not sure how to answer that.
Q Let me rephrase it then.
A Both things happen.
Q Doctor, if there's something that I ask you that's not clear, I'll be happy to rephrase it.
A Uh-huh.

Q In patients who have bunions, as a result of their bunion do you also typically observe that there is evidence of hyperkeratosis?
A In some patients, yes.
Q When you relieve the bunion through whatever

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treatment is chosen to treat it, does the hyperkeratosis go away typically?
A Usually, no.
Q Why is that?
MR. : Now you're asking generally?
MR. OGINSKI: Of course.
MR. : Object to the form, but you can answer the question. Each patient is obviously different.
A Please restate your question and then I'll be able to answer it.
Q Sure. I'm going to go on.
Let's talk about the Lapidus procedure that I asked you about a little while ago.
Can that procedure cause a shortening of the first metatarsophalangeal joint?
A It can.
Q And how does that occur? How does it cause a shortening?
A Well, Lapidus procedure involves removing bone from the first metatarsal cuneiform joint. Removing bone obviously would cause shortening.

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Q What effect does that have on a patient in and of itself?
In other words, you remove the bone. You have a shortening of the first metatarsophalangeal joint. What is the practical effect of that; if anything?
A Correcting of the deformity.
Q As a result of the shortening itself does that affect the patient's balance, gait, walking ability, or anything else?
MR. : I think you mean can it affect it.
MR. OGINSKI: Can it, yes.
A Can it?
Q Yes.
A Theoretically possible it could.
Q Tell me how that occurs or why that occurs.
MR. : These are in general terms.
A All right.
Generally speaking, shortening the first metatarsal --
Perhaps you should ask this question again because I'm not exactly sure what you mean.
Q Sure.

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If the procedure, the Lapidus procedure, causes a shortening of the first metatarsal, can that cause instability in the foot?
A Generally speaking, it's possible that it could cause instability in the foot, yes.
Q With a shortened first metatarsal can it cause the toe to stick up in the air and not lay flat?
A Not by itself.
Q What do you mean?
A Other factors must be also present. Shortening the first metatarsal alone does not cause the big toe to stick up in the air.
Q Okay. Can you give me an idea of some of the other factors you mentioned or you're thinking about that might cause it to stick up in the air?
A Scar contracture is the biggest one.
Q Is there any way to eliminate or reduce the amount of scar tissue someone has following a procedure such as a Lapidus procedure?
MR. : Again, I think you're asking is it possible to --

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MR. OGINSKI: Yes. All my questions for now are general. I'll get very specific in a little while.
MR. The way it's worded I think it's boxing him in. Ask it again. I think it's fine.
MR. OGINSKI: Sure.
Q What are some of the other factors that might cause the first metatarsal to stick up and not lay flat, separate and apart from the actual procedure?
MR. : And the scar?
MR. OGINSKI: Yes, and the scar.
A And the scar contracture?
Q Yes.
A At the most -- I'm not thinking of any.
Q By shortening the first metatarsal, does that create pressure under the second and third metatarsals?
A It could, yes.
Q And how does that actually happen?
A How do I explain this? When the heel is raised off the ground in

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walking, the longer bones sometimes bear more body weight, therefore more pressure.
Q And in the case where you have a Lapidus procedure and you have additional pressure on the second and third metatarsals, do you

find that there is a buildup of callous formation in the second and third metatarsal area?
A In some cases; not all.
Q And is there an increase in the chance that the patient will get bursitis with the shortening of the first metatarsal?
A I wouldn't know.
Q Typically, if there is callous formation on the second and third metatarsals, would you expect the patient to experience any type of pain because of the additional forces on the second and third metatarsal?
A Possible in some cases; doesn't happen in all cases.
Q And can you tell me, Doctor, why someone might experience pain in those areas, the second and third metatarsal area, specifically following a Lapidus procedure?

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A Well, I won't say following a Lapidus procedure. I will say that longer bones that bear more pressure can develop pain below those bones.
Q Why?
A Because they bear more pressure.
Q What is it about the pressure being applied that causes the patient pain?
MR. : Tough to answer, other than there being more pressure.
Q Well, does the pressure itself cause pain or is it pressure upon a particular nerve that causes the pain or something else?
A I think that when you have a pinpoint pressure it's more likely to irritate the tissue below. The metatarsals, two and three, if they irritate the tissue below, person gets pain.
Q And in , did you ever make an observation that she had hyperkeratosis under her second metatarsal?
MR. : Are you asking from memory or --
MR. OGINSKI: Yes, just from memory

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first.
A I don't know. I don't remember that.
Q Do you have an independent memory of Mrs. ?
A I do, yes.
Q Do you remember what she looks like?
A Vaguely.
Q On the occasions that she came to your office and you treated her, did she usually come alone or was she with someone else?
A Usually with her children.

Q And is that how you actually met her the first time, that she had come in with one of her children to see you?
A I believe that's the way, yes.
Q Did you ever meet her husband?
MR. : At any time?
MR. OGINSKI: Yes.
A I believe on one occasion.
Q Before performing surgery on Mrs. , did you make any observation that she had a lateral deviation of her toes, either from a bunion or from some other condition?
MR. : Again, this is all from

independent recollection; correct?
MR. OGINSKI: Yes.
A I do remember that.
Q Did you form any opinion at the time you made that observation as to what caused the lateral deviation either on the right or the left foot?
A I did, yes.
Q What was your opinion? And if you could tell me about when that was I would appreciate that.
MR. : Again, this is from memory. If you can't remember, we'll refresh your recollection.
A From memory when I looked at her first for the first time I saw that it was an extremely unstable collapsing-type foot.
Q Can you tell me or explain any more what you mean by "unstable collapsing-type foot"?
A Just generally speaking or --
MR. : I don't want you to guess what she presented with if you don't remember.
THE WITNESS: That's why I asked about

generally speaking.
MR. : No, he's not asking generally.
Q Tell me what you mean when you say she had an "unstable collapsing-type foot."
A Well, it means that -- generally speaking, of course, it means that the heel bone flips outward, that talus slides down and sub-luxes inward. The metatarsals, especially on the inside, move way up with respect to the rear foot and -- Well, that's sufficient. That's a pretty good description.
Q And did you form any opinion as to the reason she was experiencing this condition?
A No.
MR. : Yes, I want to clarify,

though, he testified that that's an unstable collapsible-type foot generally. He doesn't memorize his whole chart.

MR. OGINSKI: I'm not asking him to.

A The answer is no, I never do that.

Q Did you make this observation on the first

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visit she made to your office?

MR. : Don't guess.

A Honestly, I don't remember. I don't think I remember that.

Q At any time while you were treating her, did you ever form an opinion as to the cause for her condition?

MR. : Which condition is that?

Q The one that you've talked about, the extremely unstable collapsing-type foot.

A Definitely not. I don't know what the cause is, specific to her.

Q Did you learn from Mrs. how long she had been experiencing problems relating to her foot?

A My only recollection, that it was for a long period. Specific, I don't know how long.

Q Had you learned from her that she had been, whether she had been to any other foot doctor before coming to you?

A Actually, I don't remember that.

Q Typically, when you see a patient who comes in with a complaint relating to their foot, do you ask them whether they have been to

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any other doctor, whether podiatrist or orthopaedist, to treat the foot?

A Generally speaking, I do.

Q If there is a positive response, do you generally make a note in your file regarding that?

A Generally speaking, yes.

Q In April of , your office was operating under the name

?

A I believe that's true, yes.

Q Did you have any partners at that time?

A I don't recall if I did at that time. I did have an associate for a short period. I don't recall the date at the moment.

Q And the associate would be an employee?

A Employee, yes.

Q Were you considered, or did you consider yourself to be an employee of the professional corporation?

A I am an employee of the professional corporation.

Q Are you also a shareholder?

A I am, yes.

Q Is there any other shareholder in the professional corporation?
A No.
Q Do you have more than one office?
A I do.
Q What are the other offices that you have? Is the other one in ?
A I gave you the address a moment ago.
Q Okay.
A And I have another office in . Would you like the exact address.
Q Not right now.
During the time that you treated Mrs. , was the treatment rendered solely at one particular office?
MR. : Other than the surgery, obviously?
MR. OGINSKI: Yes. I'm not talking about the surgery.
A If I can --
I'm not entirely sure. It might have been in two office locations or it might have been just in the office.

Q Now, the office where you saw her for most of the time, was that in the office?
A Yes. For the bulk of her treatment, yes, .
Q In that office did you have X-ray equipment to take X-rays of people's feet?
A No, sir.
Q In the other office, in , did you have X-ray equipment to take X-rays of people's feet?
A No, sir.
Q If you wanted to have X-rays done, what, typically, would you tell the patient?
A I asked them to go to a convenient radiologist place, hospital or X-ray entity, give them an order and they get it done.
Q In addition to receiving a report about the interpretation of their X-rays, do you also receive copies of the films?
A Yes, sir.
Q In your career, Doctor, have you had occasion to review X-ray films?
A Yes, sir.

Q And in the course of your career you have interpreted X-rays?
A Yes, sir.

Q In Mrs. 's case, do you recall, at some point pre-operatively, having her go for X-rays of her feet?
A Yes, sir, I do recall that.
Q Did you, in fact, review the X-rays that she had done pre-operatively?
A I did.
Q As a result of the review of her films, did you make any notes in the chart regarding your observation and interpretation of those films?
A That I don't recall. I'd have to check.
Q In preparation for today's deposition, did you have an opportunity to go through your chart for Mrs. , whether today or days past or weeks past?
A Several months ago, actually.
Q Is there anything you recall specifically about any X-ray results that you observed, separate and apart from what any radiologist interpreted?

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MR. : As he sits here today?
MR. OGINSKI: Yes.
MR. : If you can recall, you recall.
Q I'm not asking for the details.
A Yes. I recall, generally speaking, what the X-ray results showed.
Q Did you bring with you the patient's pre-operative X-rays?
A I believe I did.
Q Could you take those out, please?
A (Witness complied with request.)
Q Can you identify, Doctor, and tell me how many pre-operative X-rays you have in your possession and the dates, please?
A Well, I have one set.
Q Okay.
A And the date here is March 10, .
Q And what views are seen in the X-ray you were just looking at?
A Well, this is an AP medial oblique.
Q And which feet?
A Of the right foot.
Q Okay.

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A I have more views here.
Q Go ahead.
A I have a lateral.
Q And that's also of the right foot?
A Also of the right foot.
Q Same date?
A I'll confirm that for you. 3/10/ . And there's a heel X-ray. It's called a calcaneal axle, also on the same

date.
Q Of the right foot?
A Right foot.
Q Now, do you have contained within your records the radiology report regarding the interpretation of those films?
A I can look.
Q Sure.
A (Witness complied with request.)
I do.
Q And can you tell me what the conclusions were of the radiologist who read each of those films?
A Very specific.
: You can just read his --

you don't have to interpret it.
A (READING FROM RECORD)
Impression, bilateral hallux valgus deformities.
Q And you had mentioned to me earlier that those were outside deviations of the big toe?
A Yes, I did.
Q Okay. And the fact that they're bilateral means that they're on both feet; correct?
A Yes.
Q Were there any other conclusions that the radiologist made?
A No. That was it.
Q Okay. Now, if you can, please turn to your notes for March 15, or March 29, .
MR. : Other than these conclusions that are listed here? I mean, I don't want -- you're saying does he have any other conclusions other than what's on the report?
MR. OGINSKI: Yes.
MR. : Okay.
Just for the record, there's a more

descriptive paragraph under the description he just read.
MR. OGINSKI: I understand that, and we have the radiologist's report so I'm not concerned with that.
Q If you can just turn to the March 15 and March 29 note, please.
MR. : His office note?
MR. OGINSKI: Yes.
Q That's it.
A Okay.
Q Is there anything in your March 15 note, Doctor, that indicates that you reviewed the patient's X-rays of March 10?
A On March 15, no.

Q Okay. Typically, how long does it take for you to get copies of the films and the report following the patient going for X-rays?
A Typically the patient brings the X-rays with him or her on the date of visit.
Q And the report that you just read from, can you tell me what the date of that report was, or the date that it was sent to your

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office?
A I can't tell you the date it was sent to my office I don't think. Let me see. Found that so easily a moment ago. Okay. March 10.
Q In other words, the date of the report is March 10th?
A It is, yes.
Q And it's addressed to you at your office?
A Yes, sir, it is.
Q And is that different than the office?
A It was a predecessor to the office.
Q Does that refresh your memory as to where you were treating Mrs. , at least in the beginning?
A I suppose, yeah. I suppose it was in the office, yes.
Q Can you turn, please, to your March 29th note?
A Okay.
Q Is there anything in your March 29th note

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that indicates that you had reviewed the patient's X-rays or the radiologist's report for the X-rays of March 10th?
A No, sir. Nothing in the note.
Q Okay. Could you please take a look, Doctor, at the March 10th X-rays, and I want to ask you whether there is a short first metatarsal that you had observed compared to the second and third metatarsal?
MR. : Are you asking all three in? Totality.
MR. OGINSKI: No. I'm asking in general, based upon review of the three films.
MR. : Do you recall the question?
A If you don't mind.
Q I'll rephrase it, sure. Looking at the three films taken on March 10, , is there evidence that the patient has a short first metatarsal?
A I'll say the first metatarsal is shorter

than the second metatarsal. It doesn't necessarily mean it's short.
Q Okay. At any time before you operated on

Mrs. , did you happen to measure the actual length of the first metatarsal?
A I did.
Q And what was your observation as to the length of that first metatarsal?
A I don't recall.
Q Do you have any notes that would indicate to you or refresh your memory as to the length of your measurement?
A No, sir.
Q And when did you perform that measurement?
A Pre-operatively.
Q And what was the purpose of that measuring of that first metatarsal?
A It allows me to choose the correct medical procedure.
Let me rephrase it. It's one consideration in choosing my procedure; one consideration.
Q And why would the length of the first metatarsal change your opinion as to what procedure you might use?
MR. : I don't know if that would solely change. Do you want to ask why is it significant?

MR. OGINSKI: Yes, yes.
MR. : Why are you measuring that?
A I'm interested in the functional capacity of the first ray. There are other factors involved.
Q Would you agree, Doctor, as a general matter, that before recommending a particular surgical procedure that you have to take into account the patient's entire foot as to how surgery may affect the entire foot and not just one particular toe?
A I would agree, yes.
Q And is it also important that, when choosing a particular surgical procedure, to understand how that particular procedure will affect the forces on the other remaining toes?
A I would agree, yes.
Q And tell me why that's important.
A Why is it important?
Q To understand how surgery on one toe might affect the entire foot or other toes as well.
A It's important --

MR. : Well --

Okay, if you can answer it.
A It's important because in every surgery my goal is a good functional foot. That's why it's important.
Q And how does assessing the other toes or other forces on the rest of the foot allow you to do that?
A I'm not sure I understand.
MR. : Yes, I'm going to object to form other than the obvious. I think it questions the answer.
MR. OGINSKI: Okay.
Q Would you agree, Doctor, that if a podiatrist such as yourself fails to take into account how a surgery on one toe will affect other toes, that that would constitute a departure from general medical practice?
MR. : I'm going to object.
MR. OGINSKI: Departure questions --
MR. : If you can answer that question. All -- a variety of patients, different patients. You're

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asking in a general sense if he doesn't take into effect --
MR. OGINSKI: I'll rephrase.
Q You told me it's important for you, when choosing a particular procedure, how that procedure is going to affect other toes or the foot. My question is now the reverse. Would the failure to take that information into account when choosing to do a particular surgery, in your opinion would that be a departure from general medical practice?
A I would have to say yes.
Q Let's turn, please, to the first visit that you had with Mrs. .
MR. : So we're on the same page, April 15, ?
MR. OGINSKI: Yes.
Q By the way, Doctor, the notes that you have in front of you, are those the original records that were generated when you treated Mrs. ?
A Yes, they are.
Q And those are computer-generated notes?

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A They are, yes.
Q Tell me the practice that you had at that time about entering notes on the computer at the time that you saw the patient.
MR. : Are you asking timing?
MR. OGINSKI: Yes.
MR. : If it you could be a little

more specific.
MR. OGINSKI: Okay.
Q Were you making the notes as the patient was talking to you, did you wait until the visit was over, or something else?
A Generally speaking, I meet with the patient, gather all the information via conversation. Patient leaves, I sit down at my computer, write it in.
Q When you're having the conversation with the patient, before ever entering any information in on the computer, do you take handwritten notes just to keep track of certain responses that the patient makes?
A I don't take handwritten notes myself, but the patient does fill out a questionnaire, which is typically saved in the patient's

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electronic record.
Q And do you typically have an assistant or nurse or someone else in the room with you when you see a patient for the first time?
A Not --
Not usually, no.
Q And are there occasions when, because of time constraints, you have to see another patient immediately after, and you don't have an opportunity to enter the information from one patient right into the computer, where you'll have to enter it at a later time?
A There are always unexpected situations, yes.
Q And for Mrs. , specifically, do you have any memory as to when it was that you entered the information? Was it immediately after she was seen by you? Was it at some later time during the day or on some other day?
A No, sir, I don't remember exactly when I entered the information.
MR. : Well, each and every note, but if you want generally --

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MR. OGINSKI: Yes, generally.
A Generally, it's at least the same day; maybe not right after the visit.
Q If a patient calls you on non office hours, whether on a weekend or evening, do you customarily make a note in the patient's notes, whether then or at some later time?
A Not customarily, but I'm trying to do that now.
Q I'm not talking about now. I'm talking about back in .
A Probably not.
Q Would there be any other individuals who

would make notes in the patient's chart other than yourself?
A No, sir.
Q If your patient saw -- I'm sorry, was it he or she?
A He.
Q Whenever he was working for you -- what's his name by the way?
A (PHONETIC SPELLING).
Q If he had seen the patient, how would you be able to distinguish that it was he who had

seen the patient and not yourself?
A I honestly don't remember.
Q You --
A I know we had a system, but it was several years ago.
Q Do you recall when he worked for you, from when to when?
A No, I don't. Just several years ago.
Q He's no longer working for you?
A No, sir.
Q Now, at the top of each of your notes I see it says "treating physician"?
A Yes, sir.
Q If this other doctor had treated her, would you expect his name to appear there instead of yours?
A I would expect that.
Q Turn, please, to the second page of your first examination on April 15, . You write that there was -- on the right bunion exam that there was "periarticular cutaneous signs," and then you have written "mild arrhythmia."
Tell me what you mean by that.

A The skin was a bit red.
Q And where was the skin red?
A This particular clarification is designed to look at the skin directly over the first metatarsal head.
Q And when you noted that there was "mild arrhythmia," your understanding, from looking at your notes now, is that it was over the first metatarsal head?
A Yes, sir.
Q Then you write "right foot shows significant lateral deviation of lesser toes."
Tell me what you mean by that.
A Normally, the toes sit perp -- excuse me, parallel to the metatarsals. In this case, the toes were laterally deviated, or abducted, towards the outside of the foot with respect to their respective metatarsals.

Q And just so I'm clear, when you say "abducted," meaning that they're heading towards the pinky side?
A Yes, sir.
Q And you also note that there was

"hyperkeratosis inferior to the second metatarsal head."
Tell me what you meant by that.
A Thickening of the skin below the second metatarsal head.
Q Had you formed an opinion on the cause of that hyperkeratosis inferior to the second metatarsal head at that time?
MR. : Based upon your note, can you tell if you formed an opinion as to the cause?
A Well, based -- based on my recollection I formed an opinion, and my recollection was that her foot was so terribly flat that her first ray was not functional; therefore, she was bearing body weight under the second metatarsal.
Q When you say the foot was "flat," do you mean the arch was flat?
A I'm talking about complete --
Well, let me see how I can best phrase this.
: Was that part of it?
THE WITNESS: Yes, yes, but --
MR. : It's not --

A The arch is not important.
Q Tell me what you meant by the foot was flat.
A What's important is that her rear foot is severely pronated.
Q And if you can just tell me what you mean.
A That means that the talus has slid down in and forward on the calcaneus. Conversely, the calcaneus has slid outward and up on the talus. The first ray and the medial column is left unstable, and completely elevates with respect to the rest of the foot.
Q And on your left bunion exam you wrote that "Left foot shows less lateral deviation of the lesser digits."
Do you see that?
A Yes, sir.
Q Did you form any opinion as to why the right foot had a greater deviation than the left?
A No, I did not. It was just an observation.
Q On the first page, Doctor, under "chief complaint" you wrote "bunion at the first metatarsophalangeal joint --
A Yes, sir.
Q -- on both feet; correct?

A Yes, sir.
Q Did the patient have complaints of pain?
A Well, I don't recall.
Q Is there anything in your note that would suggest that she had pain on this first visit?
A There is, sir. Yes, there is.
Q Where?
A It says "She reports the quality of pain as sharp and throbbing six over ten intensity. Symptoms occur in shoes and ambulation."
Q And I'd asked you questions about prior treatment and prior physicians, and you write "no prior treatment"?
A That's what I wrote, yes, sir.
Q What was your diagnosis, Doctor?
MR. : Based on your note.
A In the medical record it says bilateral bunion with hallux valgus. That was my diagnosis, bilateral bunion with hallux valgus.
Q And then you commented on the significant intermetatarsal angle of the right foot; is that correct, sir?

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A Yes, sir.
Q Had you taken X-rays on that visit?
A No.
Q How were you able to diagnose the significant intermetatarsal angle of the right foot without taking X-rays?
A Preliminary clinical evaluation is how I give general information to the patient. X-rays were not available. I wasn't booking her surgery. I was simply giving her my best clinical assessment at that time.
Q When you write this, "would require Lapidus for correction," tell me what you meant. How would the Lapidus correct the deformities that you write here?
A Two considerations, two primary considerations. Number one was that her first ray was extremely unstable, which means her first metatarsal was severely, severely elevated.
Q Was that from the shortening of the first metatarsal?
A No, sir. Had nothing to do with it.
Q When you said it was "severely elevated,"

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you don't mean that when she has her foot on the floor that the toe is actually sticking up?
A This is not an observation of the toe.
Q Okay. Tell me what you mean when you say

that the first metatarsal was "severely elevated"?

A It means that when the foot is badly pronated and the first metatarsal is mal-positioned in that instead of having a declination it actually has an elevation with respect to the rear foot.

Q And how would a Lapidus correct her problem?

A Lapidus is designed to stabilize her first metatarsal using arthrodesis.

Q Was there any other alternatives that were available to you to treat this particular condition other than a Lapidus procedure?

MR. : Surgically?

MR. OGINSKI: Whatever alternatives there were.

A There are always other alternatives.

Q And what were they?

A Certainly the use of orthotic devices and

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accommodating shoe gear is a primary alternative.

Q Any others?

A Well, there are lots of alternatives, surgically speaking.

Q Okay.

A However --

Well, there are lots of alternatives. I'll just leave it at that.

Q Tell me, please, what other surgical alternatives were there other than the Lapidus procedure to treat the condition that you observed?

MR. : In this patient.

A To treat the condition I observed, that's a very important statement.

Q I'm only asking based upon what you observed.

MR. : He's just asking surgically.

A Actually, actually, other than triple arthrodesis I don't think there is another alternative.

Q What is triple arthrodesis?

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A It's fusion of the entire unstable rear foot.

Q In your career, Doctor, have you ever had occasion to perform a triple arthrodesis?

A Yes, sir.

Q And in the five years before April 15, , had you performed a triple arthrodesis?

A Yes, sir.

Q Can you give me an idea of how many of those procedures you had performed in your career up until that time?

MR. : Approximately.
A Approximately five.
Q And can you tell me how many Lapidus procedures you had performed in your career up until April of ?
A Greater than 25.
Q And when you say "greater than 25," would it be less? I mean, can you give me a range?
A Best guesstimate, between 25 and 30.
Q And was there any --
MR. OGINSKI: Withdrawn.
Q Now, you mentioned in your note that you basically were recommending that the patient

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have a Lapidus procedure, correct, for the right foot?
A Yes, sir.
Q Was there any particular reason as to why you did not feel that a triple arthrodesis would be beneficial for the patient?
A Yes, sir, there was.
Q Tell me.
A First of all, triple arthrodesis significantly changes the patient's mobility. It makes their foot rigid. Certainly it's not a procedure that's done on -- usually done, I should say, on a young woman who is a propulsive walker.
MR. Okay.
Let him follow up.
Q And what is a "propulsive walker"?
A "Propulsive," simply means walking as any normal person would as opposed to walking completely flat-footed, and by "flat-footed," I mean with no motion, not the height of the arch.
Q So part of the foot is actually pushing up off the ground to propel oneself as you

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walk?
A In a propulsive walker?
Q Yes.
A Yes, sir.
MR. OGINSKI: Let's take a two-minute break.
(At which time, a brief recess was taken.)
Q Doctor, you told me earlier that your evaluation of the patient's X-rays indicated a short first metatarsal compared to the second and third metatarsal?
A No, sir, I didn't say that.
Q I'm sorry. If you can refresh my memory.
A My exact words were the first metatarsal was shorter than the second metatarsal.
Q And what was the significance of that; if

any?
A Well, sir, almost everyone's first metatarsal is shorter than the second metatarsal. It's a common find.
Q And in performing a Lapidus procedure, would you expect that the first metatarsal would be shorter than it already was?

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A Yes, sir.
Q In choosing to do a Lapidus procedure, is there some way for you to use, let's say, a bone graft during the course of the procedure so that the first metatarsal is not made shorter than it already is?
A It has been tried historically. I did not consider it to be a viable or an advisable option.
Q Tell me why.
A Well, sir, the goal of Lapidus procedure is to obtain stable arthrodesis between the bones involved. Using a bone graft significantly decreases your ability -- excuse me, the chances that you'll get a completely stable arthrodesis.
Q Why is that?
A First of all, bone grafts are temporary spacers. Bone grafts require complete replacement of the patient's own tissue in order to --
Well, as part of the healing process. Having a bone graft in there significantly increases the healing time before stability

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can be expected, so you increase the potential risks and/or complications by using a bone graft significantly.
Q Had there been any occasions in which you performed a Lapidus procedure in which you used bone graft in order to prevent excessive shortening of the first metatarsal?
A Not for shortening.
Q When would you use it?
A Bone graft is used in the first ray, when pathologic bone is removed and we're trying to replace it.
Q What would be the reason you would replace it?
A Pathological bone; by that I mean infected bone.
MR. : Yes, I wanted to know if you wanted to --
A Bone grafting is not a standard part of Lapidus procedure. It's an optional part.
Q When you measured the first and second metatarsals on the X-rays from March 10,

, as you sit here now do you recall what

those measurements were?

A No, sir.

Q At any time after March 10, , up until today, have you re-measured those metatarsals?

A No, sir.

Q Would it refresh your memory if I told you that the first metatarsal was five millimeters shorter than the second metatarsal, based upon the March 10th, X-ray?

MR. : He's asking if that refreshes your memory if that's actually the case. If it doesn't, it doesn't.

A No, sir.

Q Do you have an opinion, as you sit here now and looking at the films, as to whether that would be an accurate length of the first metatarsal, the difference between the first and second?

MR. : The pre-op films?

MR. OGINSKI: Yes.

MR. : Okay.

Sorry.

A I need a millimeter ruler and a pen, so no, I won't say yes.
The answer is no.

Q Okay. After you performed surgery on Mrs. , did, at some point, you take post-operative X-rays?

A Yes.

Q And at some point did you measure the length of the first metatarsal compared to the second metatarsal?

A No, sir.

Q Did you observe anything on your own when looking at the post-operative X-rays as to the difference in measurement or the difference in length between the first and second metatarsals?

A Yes, sir, I did.

Q What did you observe about the difference in length?

MR. : From memory.

A From memory I do remember seeing that the first metatarsal was nicely aligned but also shortened. Let me add "nicely aligned in

two planes."

Q And what effect, practical effect would that have on Mrs. by the fact that there

was shortening of the first metatarsal?
MR. : Well --
A I don't know if I can answer that with the word "practical" in there.
MR. : Do you want to know ultimately or at the time he took the X-rays or do you want to know as --
MR. OGINSKI: I'll rephrase it.
Q When you observed that the first metatarsal post-operatively was shorter --
A Yes, sir?
Q -- did you form any opinion at that time as to what effect that would have on the rest of her toes or the rest of her foot?
MR. : Or possible effect, can you word it that way?
MR. OGINSKI: Sure.
MR. : He didn't have a crystal ball at the time.
A Well, sir, I took steps during the procedure to minimize the effect of shortening on the

first metatarsal.
Q What steps?
A The first metatarsal was plantar flexed with respect to the rest of the foot. Plantar flexion compensates for shortening to some degree.
MR. : Okay.
Let him follow up with a question. I don't want you to give a narrative.
Q But when you observed the shortened first metatarsal, did you form any opinion as to what effect that would have on the patient from that point forward?
MR. : Or possible effect in the future. He's asking when you first -- if you recall, when you first noticed the shortening of the first metatarsal, did you formulate an opinion as to what possible effects that would have on the patient in the future? Is that okay, Gerald?
MR. OGINSKI: Yes.
A Not at the time -- not at the time of reviewing the post-operative X-ray. I

understand -- understood the ramifications, but I did not have to form an opinion then.
Q What was your understanding of the ramifications?
A My understanding was that the patient could possibly develop increased pain below the second metatarsal or possibly not. All cases don't do that. All cases are not -- don't exhibit those kinds of symptoms.

Q Other than taking the steps that you mentioned that you did intraoperatively, were there any other steps that you could take to minimize the shortening of the first metatarsal any more than necessary?
A Post-operatively --
MR. : I don't know if he testified that he did.
MR. OGINSKI: I'll rephrase.
Q You told me you took steps during the surgery to minimize the effects of the shortening of the first metatarsal.
A In the --
I did not say that.
Q You said the first metatarsal plantar

flexion --
A I said that I took steps to compensate for the shortening of the first metatarsal.
Q Okay. And is that because you expected that this procedure would cause a shortening of the toe?
A Yes.
Q And were there any other steps that you took?
A Excuse me. Correction.
Q The metatarsal?
A The metatarsal, not the toe.
Q Thank you.
Were there any other steps that you took intraoperatively that would compensate for the shortening of the metatarsal?
A Plantar flexion of the first ray was the step.
Q And how do you actually do that?
A That's a long answer.
MR. : Okay.
THE WITNESS: I can try. I can try in a few words.
MR. : I'm thinking is there any

way he can ask it --
MR. OGINSKI: As best you can.
MR. : Generally.
A I'll try to do this short and sweet. The goal is to position the first metatarsal in the right anatomic alignment. In order to do so, you must take wedges out of the bone so that the two bones meet flush and at right angles, and this is what I did to correct the position in both the transverse plane and the sagittal plane.
MR. : Okay. We'll leave it at that.
Q Did you have the ability, when choosing to do this Lapidus procedure, to compensate for

what you expected to be a shortened first metatarsal to also shorten the second and third metatarsals as well? Was that one of the options available to you?

A No.

MR. : I'll object to form but you can answer.

A No, that was not an option available to me.

Q Tell me why.

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A First of all, pre-operatively I informed the patient there was a possibility she could get more pain below or more pressure, not pain, more pressure below the second and third metatarsals post-operatively. I informed her it was a possibility but not a certainty, therefore I did not obtain consent to shorten those bones at that surgical procedure, during that surgical procedure. However, both the patient and I knew that it was possible I would need to go back and do that later.

MR. : Okay.

Q And is there any reason that you did not feel it would be necessary to do everything at once, you do the first metatarsal and then you address the second metatarsal and third metatarsal at the same time?

A Two reasons: Number one, the surgical procedure performed was not guaranteed or not certain to cause excessive pressure below the second metatarsal, therefore I didn't see it necessary to operate on a bone that actually wasn't showing signs and

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symptoms of problems.

Q What is an arthroplasty?

A Removal of joint.

Q And did you ever consider performing an arthroplasty in the second or third toes or the metatarsals in order to help realign the joints pre-operatively?

MR. : Okay.

Before the Lapidus procedure was performed?

MR. OGINSKI: Yes.

MR. : Okay.

A Arthroplasty?

Q Yes.

A Absolutely not.

Q Is there anything else that was available to you that would help decrease the lateral deviation of the toes other than the Lapidus procedure you described?

MR. : I'm going to object, object to the form. You can --

A You're asking me about two different things.
Q Okay. What surgical treatment was available to you in order to minimize or decrease the

0063

lateral deviation of the toes?
A The lesser toes?
Q Yes.
MR. : I'm not sure if I understand it.
THE WITNESS: I can answer that question, and it's pretty straightforward.
MR. : Okay.
A The conservative surgical procedure was simple lateral -- wait a minute -- medial joint capsule release and splintage of the toes, the conservative surgical procedure. The more aggressive surgical procedure would have been implant arthroplasty of the same toes and metatarsals.
MR. : Let him direct you now with a question.
Q You had mentioned that the Lapidus procedure did not guarantee that you were going to get pain or pressure on the second and third metatarsals?
A Yes, sir.
Q What do you do to take into account the

0064

possibility that it could create that additional pressure, ultimately causing pain? In other words, how do you address that pre-operatively other than saying, you know, "If you develop pain later on, we'll take you back in for another procedure"?
MR. : Pre-operatively or post?
MR. OGINSKI: Pre-op.
MR. : Pre-op, okay.
A You're going to have to help me with your question again.
Q I'll ask it again.
You told me in performing a Lapidus procedure there is a possibility that a patient will experience pressure in the second and third metatarsals?
A Yes, sir.
Q But it's not guaranteed to occur?
A That's correct.
Q Is there anything else that you can do as a podiatrist, that you can remember or have in your arsenal of tools available to you to help minimize the pressure in the second and third metatarsals?

0065

A Yes.

Q What is it?
A I could perform prophylactic surgery on those two bones or I could plantar flex the first ray.
Q And what effect would that have, if any?
MR. : With the second one?
MR. OGINSKI: Yes, the plantar flex of the first ray.
A Plantar flexing the first ray is a counter pronation correction, and the pronation I described earlier.
Q And that's something that you do surgically intraoperatively; correct?
A It was done surgically on this patient.
Q And you made a note of that in your operative report?
A Made a note of what, sir.
Q Of doing that plantar flexion?
MR. : Does he remember from his memory or --
Take a look at your chart.
A Can I remember it or should I be looking at it?

0066

Q First of all, do you remember doing it?
A Yes, sir, I do.
Q Did you see it, that you made a note of that in the patient's operative report?
A I don't remember. I'd have to look.
Q Take a look, please.
A All right. Let's see here. It seems the appropriate paragraph is as follows --
Q What page?
A Page two.
Q Okay.
A Op report.
Q Which paragraph?
A Paragraph number two.
Q Okay.
MR. : Would you like him to read the paragraph?
Q Just point out to me where it is, Doctor.
A Point out? Second paragraph on page two.
Q Where within the paragraph?
MR. : Why don't you just read it.
A Okay. Using the Micro-Aire sagittal saw, on two planes an adductory wedge was cut into the bone removing the distal articular

0067

surface.
Now, that's the sentence that eludes to the sagittal plane correction that I made.
Q Is that the same as you were talking about, putting in plantar flexion?
A Yes, sir.
Well, I was going to say it doesn't

actually use the words "sagittal plane." My intention was two planes meaning sagittal and transfers.

Q Just so we're clear, Doctor, the surgery was performed March 25, ?

A According to the operative report.

Q Correct?

A Yes, sir.

Q And that was done at Hospital in ?

A Yes, sir.

Q Did you have an assistant during that procedure?

A I had a scrub nurse assistant.

Q Anybody assist you with the actual surgery?

A No, sir.

Q Let's go back, please, to your first office

visit with Mrs. .

On the second page of your note at the bottom of the second page you talk about -- I assume you were talking about counselling?

A Yes, sir.

Q The spelling is not right.

A Well, I'm not the best speller.

Q Okay. Tell me, the information that's contained in this note, is this something that you can push a button and you get a template of what you discussed with the patient, or is this something that you input specifically for this particular patient?

A This is exactly what I told the patient.

Q And when you said "explain the influence of pathomechanics and footgear on the deformity," tell me exactly what you meant by that.

A I explained to her that she had a hyper-immobile flatfoot, and that that is a primary cause of her severe bunion deformity. I also explained that controlling the hyper-immobile flatfoot is extremely important in the overall health of

her foot. And of course it's a lot easier to type "explained pathomechanics" than it is to type all of those other things, but in the explanation, "pathomechanics and footgear" means controlling the hypo-immobile flatfoot as respect to how the bunion, you know, manifested itself.

Q Now, you mentioned that you recommended sneakers and accommodative footgear.

A Yes, sir; always do.

Q And was Mrs. receptive to that?

MR. : From memory.

A From memory, if I remember correctly, she

told me that the only thing she could wear without pain was her clogs. Nothing else.
Q Did you feel that custom orthotics would be beneficial for her?
A I certainly did.
Q And did you prescribe them for her?
A I recommended them.
Q And what, if anything, happened as a result of your recommendation?
A Mrs. did not comply with my request to get orthotic devices as a first step.

0070

Q Do you know why?
A No, I wouldn't be able to tell you.
Q Did she tell you why?
A I don't remember.
Q Did you ask her why?
A Actually, I don't remember that either. Sorry.
Q Did you have an opinion, when you made the recommendation for the orthotics, that it might stabilize her condition for a period of time?
A Well, I'm not sure that I'd answer that.
Q Why did you make the recommendation for orthotics?
MR. : He already testified that he always does.
Q I'm asking in this particular case.
A I would love to answer that question. Her rear foot and medial column instability is a very damaging thing, generally speaking, several ways. The current acceptable commonly used method for controlling such a weakness is a functional foot orthotic.

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Q Now, jumping ahead to the surgery again --
A Yes, sir?
Q During the procedure, did you attempt to realign toes two and three during the procedure?
MR. : Are you asking is that his custom and practice?
MR. OGINSKI: No, no. In this particular case.
A I'm going to look at the operative report.
MR. : Just because it's not in the operative report doesn't mean it wasn't done, but --
A Let's see. I did attempt to realign the second and third toes, yes.
Q What was the reason for doing that?
A From memory, because they were laterally deviated.

Q And in your note, in your operative report, does it indicate the reason you were attempting to realign them?
A Does it indicate the reason why I was trying to realign them in my operative note?

Q Yes.
A I don't recall mentioning that in the operative note.
MR. : He's just asking does it reflect that in your operative report.
A Well, I'll read to you the pre-operative diagnosis. I'll get down to the second and third toes, or the second and third metatarsophalangeal joints.
It says, "subluxation of right second and third metatarsophalangeal joints," so I suppose that would be the reason.
Q How did you attempt to realign those toes?
A The extensor hood apparatus was increased -- incised, cut.
Q Where are you reading from, Doctor?
A Fourth paragraph, page two.
Q Okay.
A So last sentence, the extensor hood apparatus of both second and third extensor.
Q You mean those tendons were cut?
A Not the tendons.
Q What was cut?
A The connective tissue that adheres the

tendons to the joint.
Q And what effect would that have?
A Well, not too much on its own, but there's more.
Q Go ahead.
A The tendons were then transposed one centimeter laterally and sutured in a new position. This caused adduction of the toes. It should be "abduction" of the toes though.
Q Adduction or abduction?
A A-B, abduction is right, on the transverse plane. A lateral joint capsulotomy was performed at the second and third metatarsal joints, then superficial tissues were closed, and so on and so forth.
The important facts are extensive hood apparatus was cut, tendons were realigned into a more advantageous position for pulling, joint capsule was cut, and then everything was sutured.
Q Is this known as a tendon transfer?
A A more accurate description would be tendon transposition.

Q When you observed the location of the tendons that you were working on that you just talked about, were they already laterally deviated from their normal anatomical position?
A No.
Q Was it your opinion that they were in the correct anatomic position?
A They were, yes.
Q By doing this tendon transposition, did that laterally deviate those tendons even more laterally?
A Put them in a more advantageous position.
Q And why was that important?
A To help maintain the toes in a more advantageous alignment.
Q By that you mean straightening them?
A Yes.
Q And how would that straighten them?
A By pulling you can actually influence the toes to be straight.
Q Can doing that tendon transposition make the position of the toes worse?
A No. Not possible.

Q Tell me why not.
A It's not physically possible to change their pull enough to make the toes go in an abnormal position.
Q Do you recall after the surgery post-operatively, when you examined Mrs. in your office at any of the post-operative visits, did you ever form an opinion as to the second and third toes, as to whether the alignment of those toes were anatomically correct after the surgery?
A I don't remember.
Q I'll go through your notes in a little while.
Is there anything you remember about the positioning of the second and third toes that you remember seeing after the surgery that suggested the tendon transposition did not work?
A Again, I don't remember. I'm sorry.
Q Was there anything that you saw in your notes in review for preparation for today's deposition that suggested that what you observed indicated to you that the tendon

transposition didn't work?
MR. : Do you recall seeing anything in your notes?
A No, I'm sorry. I don't remember that either.

Q Now, what's the cause, or what are the causes as to why the lesser toes would be laterally deviated?
A Okay.
MR. : It's not all-encompassing. Give some of the causes.
A Bottom line, severe, severe flatfoot, pronated foot.
Q And what are some of the other reasons that you can think of that would cause --
A That is the reason. That was the reason for her lateral deviation of the lesser digits, it was her severe rear foot pathomechanics.
Q Could she experience this lateral deviation of the second and third toes from long second and third metatarsals?
A No, sir.
Q Why not?
A Just like the second and third metatarsals

0077

are a certain length, so are all the soft tissues that connect her toes to the second and third metatarsals.
So no, the answer is no. Nothing's changed.
Q And the tendons that pull those particular toes --
MR. OGINSKI: Withdrawn.
Q Is the tendon transposition the same thing as a tendon release?
MR. I think I'm going to object.
A No, no.
MR. : Okay.
Q At any time pre-operatively did you consider doing a tendon release?
A No.
Q Would a tendon release help with the realignment of the second and third toes?
A No.
Q Tell me why.
A First, let me ask you to define "tendon release."
Q I was going to ask you the question.
A Okay. Let me tell you how I define tendon

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release. Simple transection or cutting of the tendon.
Q And then re-attaching?
A Not re-attaching, just cutting them.
Now, if I were to simply cut tendons --
MR. : Let him ask a question. I don't want you to give a narrative.
Q Would a tendon release have assisted you in realigning the second and third toes?
MR. : At what time?
MR. OGINSKI: Pre-operatively.

A No.
Q Tell me why.
A Tendon release, although it removes the pull of a tendon, does not reposition a toe.
Q It eliminates the force that's causing it to -- moving it from one side?
A One of the forces, but a minor force. Not the main one.
Q Was it your opinion, Doctor, before doing surgery that the second and third toes that were laterally deviated were from, in part, tendon pull?
A No.

Q Let's talk about informed consent. When you're discussing surgical options with a patient --
A Yes, sir?
Q -- would you agree, Doctor, that it's important for you to discuss with a patient all the possible options available to them in order for them to be fully informed about what their options are?
A I would agree that it's generally necessary to do exactly what you said.
Q And that would be good podiatric practice, to discuss with them their options?
A Yes, sir.
Q And would it also be important, Doctor, to discuss with them the risks and the benefits and the alternatives to any surgical procedure that you might be recommending?
A Yes, it will.
Q And why is that important? In other words, why do you discuss the risks and the benefits with the patient?
A I want my patient to understand what she's doing.

MR. : Okay.
Leave it at that.
Q And would you also agree that it's important for you as a podiatrist to give sufficient information to the patient to allow them to make an educated decision about their treatment options?
A Yes, sir, I'll agree that is true.
Q If a patient is not given sufficient information about their treatment options, the risks, the benefits and the alternatives, would you agree then the patient might be making a decision on insufficient information?
A I would agree, yes.
Q Would you also agree it would be a departure from good podiatric practice not to discuss

the risks, benefits and alternatives to any surgery that you are recommending?
MR. : You can answer over objection. "Departure" is a legal term, but you can answer.
A Well, I agree that it's good to do it, yes.
Q Tell me about the risks of the Lapidus

procedure in this case.
A Well --
MR. : Again, you can testify as to the risks. I mean, your answer is -- you don't have to detail every one.
THE WITNESS: Right.
A Failure of the arthrodesis to heal; malposition of the big toe following the surgical procedure; excessive force being placed on the second or and/or third metatarsal from below during walking; excessive scar formation at the surgical site. Of course there's always the possibility of infection of some type.
MR. : Okay.
He'll follow up. Again, those are not all-encompassing.
Q Are there any other risks that you're aware of?
A There's a risk a patient can fall down on her crutches and break her neck.
Q I'm asking about this particular Lapidus procedure.
A I think that's -- that's a pretty

comprehensive list.
Q What were the benefits to performing a Lapidus procedure?
A Stabilization of the first ray; removal of the bony prominence from the inside of the foot.
Q That would be from the bunionectomy?
A Yes, sir.
And positioning of the big toe in a more anatomically correct position.
Q Anything else?
A I think -- I think not.
Q And the alternatives that you told me about, Doctor, other than the orthotics and the shoe gear, were there any other alternatives that you discussed with Mrs. on that first visit?
MR. : That you can recall.
MR. OGINSKI: Well --
Q Well, also based upon your note.
MR. : Well, his note doesn't necessarily mean he didn't discuss it with her.

A No, sir, I don't recall anything else.

Q Did you tell Mrs. during that first office visit that performing a Lapidus procedure could cause excessive force on the second and third metatarsals?
A I don't recall specifically, but I would usually do so.
Q Did you tell Mrs. that the Lapidus procedure would shorten her first metatarsal more than it was already shortened in comparison to the second metatarsal?
MR. : Are you asking on that first visit?
MR. OGINSKI: Yes.
A Again, I don't recall specifically, but normally I would not do so.
Q Now, you told me that everything that's written on the counselling section of your note is exactly what you discussed.
A No, sir. I didn't say -- I didn't use the word "exactly."
Q The information that you have contained about counselling the patient --
MR. : What visit is that?
MR. OGINSKI: The first visit, page two

at the bottom.
MR. : Sorry.
Q Is there anything that you discussed with the patient that does not appear in your office note?
MR. : Again, from memory.
A I can think of one thing in particular from memory.
Q Go ahead.
A And the one thing that I remember, and I would do this with anyone but I specifically remember doing it with Mrs. , is that undergoing -- I told her that undergoing this surgical procedure was an extremely involved -- excuse me, it -- what's the right word? It encompasses, it involves, it's an extremely long and work-intensive recuperation period. She told me she's a mother of several children; I knew that, I treated her children.
I was very specific about how it was going to immobilize her and interfere with her regular lifestyle, especially during the

recovery period, and I also told her that if she had any surgical complications that she would require a second operation, which

would increase her healing period for even longer.
I was very careful, considering the fact that I was treating her children, to warn her about that.
Q What is overcorrection of the hallux?
A Well, overcorrection of the hallux typically means that the big toe sticks out away from the foot as opposed to too much over in the other direction.
Q What did you tell Mrs. about the chances of getting a good result from the procedure you were recommending for the right foot?
MR. : What do you remember telling her?
A What I remember is that I told her that I thought the chances were very high; otherwise, I would not have attempted the surgical procedure.
Q And Doctor, can you tell me, up until April

of , how many Austin bunionectomies you had performed in your career; approximately?
A I don't know.
Q Can you give me a range?
A I don't know, a couple hundred, over -- I don't know. A lot.
Q Other than having privileges to do surgery at this particular hospital --
MR. : ?
MR. OGINSKI: Yes.
Q -- did you have hospital privileges anywhere else at that time?
A At that time?
Q In .
A Honestly, I don't remember.
Q Currently, where are your hospital privileges?
A Hospital, where this procedure was performed; Hospital in ; and I work in an ambulatory surgery facility in , .
Q Did you have privileges at that surgery

center in / ?
A No.
Q Is that a facility that you have an ownership interest?
A No, sir.
Q Am I correct you're board certified?
A Yes.
Q In podiatric surgery?
A Yes.

Q The name of the certifying board?
A
Q When were you board certified?
A as I recall.
Q And did you have to retake --
MR. OGINSKI: Withdrawn.
Q Did you have to take your board examination more than once, either written or oral?
A No, sir.
Q Where did you go to podiatry school?
A .
Q When did you graduate?
A .
Q And where did you go to college?
A .

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Q When did you graduate?
A .
Q What did you do between ' and '
Sorry.
MR. OGINSKI: Withdrawn.
Q After completing podiatry school, did you go on to do any post-graduate training?
A I did.
Q Where?
A It was in
.
Q Where?
A It was with .
Q How long did you do that?
A One year, sir.
Q Did you do any type of residency training or internship?
A No, sir.
Q And other than the preceptorship with , did you do any other post-graduate training?
A No, sir.
Q And from to --
MR. OGINSKI: Withdrawn.

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Q As part of the board certification process did you need to accumulate a certain number of cases to submit to the Board to show that you had competency in treating various types of cases?
A Yes, sir, I had.
Q Do you recall, as you sit here now, how long it took you to accumulate those cases?
A I think it was
Q Had you applied to the for certification more than once?
A No, sir.
Q Are you board certified in any other field of podiatric medicine or subspecialty of

podiatry?
A No, sir.
Q In your career, Doctor, have you published anything in the field of podiatry?
A No.
Q Have you --
That would include peer review journals, textbooks, chapters of textbooks?
A No, sir. I'm not a writer. I treat

0090

people. Every day. Seven days a week.
Q In preparation for performing this Lapidus procedure did you consult and review any textbooks prior to performing the surgery?
A How prior?
Q Well, from the time you recommended the procedure --
A No, sir.
Q -- up until the time you performed the procedure?
A No, sir.
Q Did you review any medical literature prior to performing the surgery?
A No, sir.
MR. : This surgery.
A Not between the time I recommended it and the time I performed it, no.
Q In deciding what treatment would best be suitable for Mrs. , did you utilize any type of algorithm or chart to determine what would be best for her, you know, like a checklist to formulate your treatment options or treatment plan?
A No, sir.

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Q Have you given any lectures to any national bodies of podiatrists?
A National bodies? That's an interesting way to put it.
Not pertaining national bodies, no, sir.
Q Like any national convention of podiatry or physicians or the yearly meetings?
A No, nothing that large.
Q Are you required, as a podiatrist, to take continuing education classes?
A Yes, sir.
Q And from to , did you take any ongoing classes to keep you up to date?
A Yes, sir. I fulfilled all my requirements for continuing medical education.
Q Have you ever testified before?
A Yes, sir.
Q How many times?
A As I recall, twice.
MR. : I'm not going to allow questioning too much further on this.

You can establish that he testified.
Q Were either of those occasions that you testified, were they as expert witnesses,

where you were testifying on behalf of a patient or on behalf of another doctor, or something else?
MR. : You can establish that you did.
MR. OGINSKI: I'm not going to go into details.
A Both times as an expert witness, yes.
MR. : Okay.
Q Was that on behalf of a plaintiff or a defendant?
MR. : You know what? I'm going to stop the questioning on that here. He's told you he testified before, he told you he testified as an expert. I'm not going to let you get into whether he testified for a plaintiff or a defendant.
MR. OGINSKI: You can't --
MR. : You can mark it and we can go into court and do it on paper. I was just in court on this issue. It's prejudicial.
Off the record.

(Discussion held off the record.)
Q Doctor, the times that you did testify as an expert witness, were they both in County?
A Yes.
Q How long ago were those occasions?
MR. : You can approximate.
A I don't know.
I'm sorry to be so vague, but somewhere between five and 15 years ago.
Q Separate and apart from the actual testifying, have you had occasion to review records on behalf of attorneys over the course of your career?
A Yes, sir, I have.
Q Let's turn, please, to your June 2nd note.
Oh, I'm sorry. Before we get there, am I correct that after your initial consultation with Mrs. she chose to wait awhile before making any decision about the surgery?
A I believe that's correct.

Q And she ultimately came back to you on May

6, and then she does not return to your office until March 8, ; correct?

A Yes, I think that's correct.

Q And in March of , March 8th of , she now is requesting the bunion correction on the right foot; correct?

A I believe that's correct, yes.

Q And she made complaints that her bunion is extremely painful?

A Yes, sir.

Q And she also had an ulceration where she had the bunion?

MR. : I'm sorry. You said March 8th?

A 3/8/ .

Q You write "the bunion ulcerates the skin and shoes and she can't stand the pain any longer"?

A Correct.
These are the words she used.

Q Correct. That's what I'm asking.

A These are words on her part, not my observations.

0095

Q Did you examine her on March 8th?

A Normally I would. I don't recall.

Q Is there anything on your March 8th note to indicate that you performed the physical examination?

A No, sir.

Q And does that suggest to you or indicate to you that you did not perform a physical examination at that time?

A It suggests to me that I didn't notice any changes.

Q Would you agree, Doctor, when you perform a physical examination it's important for you to make a note of any findings?

A Yes, sir, I would.

Q Why is that important?

A Well --

MR. : Significant findings or --

Q When you do an exam, why is it important for you to note it in the chart?

MR. : Why is it important to note significant findings in the chart?

A These significant findings guide my decision-making.

0096

Q And as far as record keeping and note taking why is it important for you to make?

A It guides me in making decisions.

Q And does it also assist you to be able to look back and see what a patient's condition was at a particular time?

A Yes, sir, I believe that's a correct

statement.
Q Okay. And typically, in , Doctor, if you had examined a patient and felt that there were no changes to the patient's condition, would you make no entries in the chart about your examination?
MR. : Are you asking does he have a custom and practice?
MR. OGINSKI: Yes.
Q Is that what you customarily did?
A Well, I have to admit you're confusing me. I don't understand.
Q I'll rephrase the question. I'm sorry. You've told me that there's nothing in your March 8, note to indicate that there was a physical examination. My question is -- and you told me that if there's no

significant changes you don't write a note, or you may not write a note.
MR. : I think he said no "significant" findings.
Q All I'm trying to establish is why isn't there a note about your physical exam?
MR. : Is there a reason? If there's not, there's not.
THE WITNESS: I'm trying to think of a --
MR. : I don't want you to guess.
A I'm trying to think of an accurate way of describing it to you.
Quite frankly, I was a bit concerned -- not concerned, confused by what you were asking me.
Generally speaking, when I have an encounter with a patient, if the encounter shows me a previously established parameters or signs and symptoms or whatever or what have you, I may or may not write them down depending on whether or not I think they're significant at the time.
Certainly if I think something is

significant, something I think I'm going to need to remember, I write it down if I can, and that's general practice.
Q Would one other explanation for not having notes about a physical exam possibly be that you did not conduct an exam on that particular date?
MR. : I'll object. He can answer, but he already asked and answered that.
MR. OGINSKI: I understand that. I'm asking as one other possibility.
A If I made an entry I gave her an exam.

Q The fact --
MR. : No.
A If I make this entry here (Indicating).
Q I see.
A It means that I did an exam, didn't find anything different, didn't think I needed to write anything down, and so I didn't. Perhaps it wouldn't -- That's my answer. Excuse me.
(At which time, a brief recess

0099

was taken.)
Q Doctor, again on the March 8, note, when the patient mentioned that the bunion ulcerates the skin, did you note any finding of your own as to whether there was any ulceration?
A I did not note it, no, sir.
Q And just so I'm clear, that does not mean that you didn't observe it, it simply means you didn't make a notation about it; correct?
A I think that's a correct statement, yes.
Q Now, going to the next visit on March 15, the patient -- Explain this to me. The note for the March 15th visit happens to be exactly the same as the March 8th visit. Can you explain why that is?
A Actually, it's not exactly the same.
Q In which way?
A On this day, according to the note, the informed consent was obtained. Patient came in for that purpose I would suspect.
Q Other than the informed consent on that

0100

date, was anything different about the note?
A No, sir.
Q And is there any particular reason why the note would be the same except for the informed consent?
A I'm sorry.
Q Sure. Is there any reason as to why just the informed consent matter was not listed as the only reason the patient was there and why the other information appears there?
A Oh, no.
MR. the form. He can answer. He already testified that he performs an exam that corresponds with each entry.
A I simply attempted to give a reason for why she was there. She told me her bunion was bothering her and I noted that I explained

the Lapidus procedure to her yet again, and then I obtained an informed consent for a Lapidus procedure as noted there.

Q Did she then point out to you that she had an ulceration of the skin at the bunion area?

A No, sir. She simply explained -- My note indicates that she complained that it ulcerates, not that it was ulcerated at that time.

Q You have noted in both the March 8th and March 15th notes, it says the bunion ulcerates the skin and shoes and she can't stand the pain any longer. This is exactly the same?

A Yes.

Q Did she make the exact same complaint on each visit?

A I don't recall. I would assume yes.

Q Is there any reason that you can think of, Doctor, as to why the first paragraph is exactly the same on both visits?

A Because those are the facts I would imagine.

Q On your computer program that you have, when you make an entry and notes, do you have the ability to copy --

A Copy and paste?

Q Wait a minute. -- paragraphs?

A Sure. Of course.

Q Is that what happened in this particular instance on March 15th?

MR. : I'm going to object.

Q Did that happen on March 15th?

A If I recall --

MR. : No, he's asking if you recall.

A No, I don't recall.

Q Who was Mrs. with on the 8th?

A On the 8th?

Q If anyone.

MR. : If you recall.

A I don't recall, sir.

Q Who was Mrs. with, if anyone, on March 15th?

A Sir, I don't recall that either.

Q Let's go, please, to your March 29th note.

A Okay.

Q 3/29 is now four days post-operatively; correct?

A Yes, sir, that would make sense.

Q And your diagnosis number one was subluxation of the left talonavicular joint;

correct?
A Correct.
Q Number two is bunion with hallux valgus?
A Yes.
Q Three is dislocation of the metatarsophalangeal joint?
A Yes, sir.
Q Which toe, which foot? Do you indicate that?
A It's not indicated there, no.
Q Am I correct that you were referring to the right foot?
A Yes, sir.
Q Which toe are you referring to?
A Well, I would imagine that the toes that are operated on would be the toes that I was referring to.
Q And the dislocation, specifically which toe or toes are you referring to?
A Well, first of all, let me say that these diagnoses refer to their corresponding procedures below, so it's assumed that it's a second and third -- second and third toes.

0104

Q Okay. Now, under the procedure of right foot you have as number one "arthrodesis of the first metatarsal cuneiform joint"; correct, sir?
A Yes, sir.
Q And number two you have "bunionectomy, Austin"; do you see that?
A Yes, sir.
Q Did you perform an Austin bunionectomy?
A No.
Q Why does that appear here now?
A Well, I have my computer set --
MR. : Was that an error?
A Well, I have my computer set so it puts things in automatically in the diagnosis and procedures, and that was an error; an error that I didn't catch.
Q And when you make these entries, is there some way for you to print out the page and then sign it, indicating that you have read it and reviewed it?
A It's not my practice to print them, sir, but I do make every attempt to review them and make sure they're correct; like anyone else,

0105

I'm not perfect.
Q And underneath a little further down when you say the site, you put down "right first metatarsophalangeal joint, first MPJ"; correct?

A Yes, sir.
Q So we're only talking about the right foot that you operated on; correct?
A Yes.
Q All right. Now, on the second page under "Patient Reports," what is that section for?
A Patient's telling me how she's doing.
Q And number four you write "not walking at all, using crutches, non weight-bearing."
A Yes, sir.
Q Tell me what that means.
A Patient was in a cast and she was instructed to use crutches and not walk to protect her first metatarsal cuneiform joint arthrodesis.
Q And as far as you were aware, Doctor, did Mrs. indicate to you that she was complying with your instructions post-operatively?

0106

A I was under the impression from her that she was very compliant.
MR. : I think he said did she indicate to you. Do you recall that? Did she tell you, I think that's what you meant.
MR. OGINSKI: Either way.
MR. : Okay.
A That was my impression. I didn't have any complaints with her compliance.
Q At any time while you were treating her post-operatively, did you have any issue with her compliance in following your instructions?
A No, I don't recall any.
Q Going to the April 5th, note, under "Procedure, right foot," again you have listed "Austin bunionectomy"?
A Yes.
Q Again, that's incorrect?
A Incorrect.
Q You performed the Lapidus procedure?
A I surely did, yes.
Q Going now to the May 2nd visit, under

0107

"Procedure, right foot," again you still have listed "Austin bunionectomy"; correct?
A Yes, uh-huh.
Q Now, at the bottom, the very last line of the page under "Patient Reports."
MR. : This is still 5/2?
MR. OGINSKI: Yes.
Q On number two you write, "tolerable amount of pain."
This was something the patient was expressing to you?

A I suppose she was; that's why I wrote it there.
Q And do you ever, in your notes, indicate a scaling, a scale of the amount of pain they're experiencing? Let's say on a scale of one to five, one to ten?
MR. : Are you asking has he ever done that?
MR. OGINSKI: In this time period.
A I suppose on occasion I would, if I thought it was appropriate.
Q Is there anything in this particular note to suggest to you the extent of the pain that

she was experiencing other than that it was tolerable?
A "Tolerable," was a general term, and it has the connotation to me of not significant to her.
Q Was she weight-bearing as of May 2nd of ?
A I don't remember, sir.
Q Look at the second page.
A Yes. It says, "not walking at all. Using crutches. Non weight-bearing."
Q How long did you intend for her to be non weight-bearing?
A My standard instructions in cases like this are two months minimum.
Q Can you tell me why Mrs. returned to your office on the following day?
A No, I can't. It may have been an error.
Q What may have been an error?
A The date.
Q Is there anything in your note that is listed as the following day, May 3rd, , to indicate any complaints the patient may have had on this particular visit?

A No, sir. Nothing.
MR. : He's just asking -- can you read it back, or do you remember the question?
MR. OGINSKI: I just want to know what complaints she made, if any, on May 3rd.
A She didn't really make many in the way of complaints. She just told me she was okay.
Q Now, under "Patient Reports," under May 2nd and May 3rd they're exactly the same; correct?
A Uh-huh.
Q What does that mean, if anything, that they're exactly the same?
A It means that the situation was the same.
Q Right above where you have "Patient

Reports," for the May 3rd visit under post-op it says "18 days"?
A Yes.
Q That means the patient is now 18 days post-surgery; correct?
A I will expect that to be true, yes.
Q Go back one more visit to the May 2nd visit,

and under "post-op" it says the exact same thing, "18 days."
Now, there's --
A Like I said, I have a suspicion that this note was an error, and I can't give you an explanation why.
MR. : Okay.
That's all. It's a mistake.
Q Do you have your billing records with you, Doctor?
A Yes, sir.
Q Can I see them, please?
A (Handing.)
Q Was it customary that you billed the patient's health insurance company after each visit?
A It's not customary. I don't think I do.
Q On what occasions do you bill and what occasions don't you bill?
A Well, sir, first of all, that's a very broad -- that's a very broad question.
MR. : I don't think he is concerned with what you bill and what you don't. I think it's just a timing

question.
Q Okay. If a patient comes in to see you and you examine them, am I correct that at some point you bill for your services?
A I do, yes, sir.
Q Doctor, in going through your billing notes that your attorney has provided, there appears to be a bill for May 3rd, , and nothing for May 2nd, .
Does that suggest to you that the error in the entry in the notes would have been the May 2nd visit and not the May 3rd visit?
A That's a likely explanation.
Q Let's turn please to the 6/2/ note.
I'm sorry, Doctor. Go back one moment.
On the May 3rd visit on the second page under the plan you write " is to be semi-weight bearing. Off-loading as previously described."
Tell me what you mean by that.
A Mrs. had a walking heel incorporated into the bottom of her cast. A walking heel allows her to bear some body

25 weight on the, you know, the mid foot or the
0112
1 112
2 heel of the cast, but not full body weight.
3 Q Okay.
4 A Semi weight-bearing, which means not full
5 body weight.
6 Q On the following visit, on May 26, , go
7 down to the bottom, please, under "Patient
8 Reports," number four.
9 A Okay.
10 Q Same page it says, "Not walking at all.
11 Using crutches. Non weight-bearing."
12 Is that consistent with the note you had up
13 top?
14 A The note I had up top, semi-weight bearing,
15 were my instructions to her. If she chose
16 to do something differently, I may have
17 reported that.
18 Q Did you bill Mrs. or her insurance
19 company for the May 26, visit?
20 A I don't know, sir. You'd have to look at
21 the file.
22 MR. : He's not going to know.
23 Q I'm looking at your report, generator
24 report, your billing records that your
25 attorney has provided to me, and I can't
0113
1 113
2 find any bill for the May 26 visit, Doctor.
3 If you can take a look at that, please,
4 Doctor, and see if you can find one.
5 A I don't see it either.
6 Q The fact that there's no billing record for
7 the May 26, noted visit, what, if
8 anything, does that suggest to you?
9 A It suggests I may have forgotten or maybe I
10 didn't think there was a billable service at
11 the time. I couldn't say which.
12 MR. : Again, he's surmising.
13 I'll object, but I'll let the answer
14 stand.
15 Q Did you perform an examination of
16 Mrs. on May 26?
17 A I did.
18 Q And you have your findings listed, correct,
19 on the second page?
20 A I did, yes.
21 Q And customarily, Doctor, when you conduct an
22 examination, you would typically bill the
23 patient or her insurance company for that
24 exam; correct?
25 A No, sir, not necessarily.
0114
1 114
2 Q Under what circumstances would you not bill
3 her?
4 MR. : Including making a mistake,

as he already testified to?
MR. OGINSKI: Yes.
A Some post-operative services are billable; some are not. During the post-operative period, if you're simply checking the patient, it's usually not a billable procedure. If I perform some service, it's possibly billable.
MR. : Let him follow up.
Q Under the "Treatment" section of the May 26 visit you write down you're prescribing semi-weight bearing, correct, and that the patient will wear her shoes?
A Yes, that's what's written there.
Q And did you learn from Mrs. as to whether she had started to weight-bear as you had instructed her?
MR. : From recollection or your note.
A Well, I don't recall, but according to the note, she has not been weight-bearing.

Q And what makes you conclude that?
A It says so right here (Indicating).
Q Okay. Now, on June 2nd, , under "Procedure, right foot" --
MR. OGINSKI: Withdrawn.
Q Under the June 2nd, note, under "Diagnosis" you write down "subluxation left talonavicular joint"; is that correct?
A Yes, that's correct.
Q Is it the right joint or the left joint?
A Well, it says left joint.
Q And --
MR. : When you say "is it," you mean Mrs. s condition is it concerning the right or the left; correct?
MR. OGINSKI: Correct.
MR. : He's just asking is it the right or the left.
THE WITNESS: It says the left.
MR. : Yes, but he's asking is it the left or the right.
THE WITNESS: Well, all of these notes should be referring to the right foot.

Q So am I correct, Doctor, that technically the diagnosis should be "subluxation right talonavicular joint"; right?
A I would expect that to be the case. Therefore, this is just an error.
Q And then again you have listed Austin bunionectomy?
A Correct.
Q We talked about that earlier. It should be

the Lapidus procedure, not the Austin bunionectomy?
A We talked about that, yes.
Q You have "Patient not walking at all, using crutches, non weight-bearing"?
A That's correct.
Q That tells you what, that the patient was not weight-bearing?
A That's what it says; however, again, that might be an error.
Q Tell me why.
A Because I may have copied it from the previous note.
Q Is there anything on June 2nd, to indicate that the patient had begun her

semi-weight bearing ever?
A There's nothing --
Wait a minute. Let's see.
There's nothing in my note that I can see that suggests to me that the patient began semi-weight bearing.
MR. : Prior to that visit; right?
MR. OGINSKI: Yes.
MR. : Okay.
Q I'm going to ask you to go back with me for a few visits, Doctor.
A Uh-huh.
Q We talked about earlier the March 10, X-rays that you had reviewed prior to performing surgery. Is there anything in your notes anywhere to suggest that you reviewed the patient's X-rays and you reached certain conclusions about what was shown there?
MR. : I'll object. I think you asked and he answered this, but you can review all your records again. He'll review, but I think he answered that he didn't.

A There's nothing in a note to signify that I reviewed the X-rays; however, I do recall doing that.
Q Now, on June 2nd, , on your second page you indicate that you did take X-rays; correct?
A No.
Q Or that X-rays were taken?
A Yes, sir.
Q And did you review the X-rays at that time?
A I did, yes.
Q And according to your note, it says shows normal anatomic position of the first ray and hallux; correct?
A Well --

Q I'm going to continue in a moment.
A Okay.
Q But this was --
A Yeah, okay, I see it now.
Yes.
Q This was your reading of the post-operative X-rays?
A Yes.
Q And you also noted that there was mild

lateral deviation of the lesser toes?
A Yes, sir.
Q Did you form any opinion, as of that visit, as to the reason why there was mild lateral deviation of the lesser toes?
A Did I form an opinion on that day?
MR. : At that time.
MR. OGINSKI: Yes.
MR. : If you can recall.
A I can recall.
Soft tissue procedures for transverse plane lesser toe correction are never perfect, and I simply noted that her lesser toe positioning on the transverse plane was not perfect.
Q In your initial discussion or discussions with Mrs. about this particular procedure, did you ever advise her that the outcome was certainly not going to be as you mentioned, it would not be perfect?
A I certainly did.
Q You mentioned also that there was significant first metatarsal shortening noted as expected; right? That's what you

wrote?
A Well, I'm not looking at it.
Q Let's look at it, Doctor.
The first four lines down the top paragraph, it says "significant first metatarsal shortening is noted as expected"?
A Uh-huh.
Q This is something that you expected to occur with this Lapidus procedure; correct?
A The expectation came intraoperatively.
Q Am I correct that you did not have a discussion with Mrs.
pre-operatively --
A No, that is not correct.
Q Let me finish.
That this is one possible outcome as a result of the Lapidus procedure?
MR. : I'll object as to asked and answered, but you can answer it again.
A Well, that is incorrect, because I clearly remember explaining that the first

metatarsal would be shortened, increasing the chances of excessive pressure below the second.

Q Would you agree with me, Doctor, that if you did not discuss with Mrs. the possibility of this first metatarsal shortening could occur as a result of this Lapidus procedure prior that would be insufficient informed consent?

MR. : I'm going to object. Please rephrase.

Q Doctor, you told me during your discussion with Mrs. about the surgery about the Lapidus procedure you told her that she could have a shortening of the first metatarsal; is that correct?

A That's correct.

Q Again, turning the question around --

A May I ask you a question, sir?

MR. : No, no.

Q -- if you had not discussed that aspect of the procedure with her, would you agree, then, that she would not have had sufficient enough information in order to make an educated enough decision about the particular surgery that you were recommending; that she wouldn't have full

and informed consent?

MR. : I'm not going to let him answer. You can't box him into -- you can ask him if he discussed it or not, it's a factual question, but he's not going to make a legal determination.

MR. OGINSKI: I'm not asking him to make a legal --

MR. : You're asking him a legal opinion as to whether he discussed that one thing and whether or not that would be -- you can ask him the facts.

Q Doctor, you told me previously that failure to disclose and discuss with a patient about the patient's risks, benefits, options and alternatives would be departure from good care. I'm only asking specifically, when you were discussing a procedure such as a Lapidus procedure to Mrs. , if you did not disclose to the patient that you expect there would be a shortening of the first metatarsal, would that be improper and improper informed consent?

MR. : I'm going to object.

Q Would the failure to disclose --
A Sir, all I'll say --
Q Sir, let me finish.
MR. : I can see you're still asking it the way I'm uncomfortable with.
MR. OGINSKI: I am, because I'm entitled to ask departure questions and his opinion about the treatment that was rendered. I'll try again.
MR. : You cannot disclose every risk. You can go through --
MR. OGINSKI: I'll tell you why I'm asking. The reason I'm asking it is the patient has specifically testified about those things she believes and remembers the doctor telling her.
MR. : I understand.
MR. OGINSKI: So now my question is focused solely to that issue, that if, in fact, you discussed with her only certain things and did not disclose to Mrs. the fact she would have

a shortened first metatarsal, in your opinion would that be a departure from good practice.
MR. : I'm not going to let him testify to that. He's not going to determine what's legally informed consent. You can ask him factually. Did you tell her about this risk? Did you tell her about that risk? He can say "I don't recall," or "it's not itemized," but I'm not going to let you pin him in.
MR. OGINSKI: I'm entitled to ask him departure questions, that if certain things weren't done would he, in his opinion, think that was a departure. Now I'm asking if, in fact, and here's the question --
Q If, during your discussion with Mrs. when you were talking about the Lapidus procedure, you did not disclose to her the fact that the first metatarsal would be shortened, would that, in your opinion, be a departure from good care?

MR. : I'm going to object. Can you answer that question?
THE WITNESS: I can answer.
MR. : Okay. Answer over my objection.
THE WITNESS: It sounds to me like it's a legal question, and I'm going to

take your advice.
MR. : Okay.
Q When you discussed the Lapidus procedure with Mrs. , would it be good podiatric care to leave out the fact that you expected that she would have a shortened first metatarsal?
MR. : Would it be good --
I'm sorry, can you read it back?
(At which time, the requested portion of testimony was read back by the stenographer.)
MR. : Would it be good podiatric care to leave that out? Keep in mind that he testified he did tell her that.
MR. OGINSKI: I know.

MR. : Can you answer that?
THE WITNESS: I can.
A It would not be good podiatric care.
Q Why?
A Primarily because of the risk of getting excessive pressure below second and third metatarsals.
Q You continue your note by stating that "the arthrodesis seems intact with normal healing for the period."
I just want to see if we can clarify or I can clarify that.
So you're saying that even though this first metatarsal shortening the arthrodesis was still in place?
A Yes, sir.
Q And it was holding in place; correct?
A Yes, sir.
Q Why did you recommend orthotics at this point under the treatment plan?
A For the same reason I recommended orthotics initially, because the patient needs rear foot control. She did initially and she did now at this point, and I took this point in

her treatment to recommend it again to her because I thought it was important.
Q The surgery that you performed, wasn't that to stabilize the foot as you had observed it on the first visit?
A It was the surgical approach to stabilizing. It was one aspect of many.
Q Right. And once the surgery had been --
MR. OGINSKI: Withdrawn.
Q Once the foot had been totally healed, why, then, would orthotics continue to help?
A Orthotics treat her rear foot function. The surgery treats her forefoot function.

And they work synergistically.
MR. OGINSKI: Off the record.
(Discussion held off the record.)
Q Doctor, besides the loose computer sheets that you have in front of you, do you have a patient chart, an actual chart, like a folder?
A No, sir.
Q Everything is electronic?
A Yes, everything is electronic records.

Q Okay.
MR. OGINSKI: Why don't we mark your set of records as Plaintiff's Exhibit 1 for identification.
(Marked for identification, Plaintiff's Exhibit 1, Doctor's Notes.)
Q Do you know a Dr. (PHONETIC SPELLING)?
A I don't know Dr. personally, but certainly I have interaction with Dr. .
Q From time to time he refers patients to you?
A Yes, sir.
Q Did you ever speak to him on the telephone about Mrs. and her treatment?
MR. : Do you recall ever speaking to him?
A No, I don't recall.
Q Do you recall speaking to him in person about Mrs. 's treatment?
A Again, I do not recall doing that.
Q In your review of the records, did you see any notes or letters that you may have sent

to Dr. informing him of the patient's progress?
A I sometimes do that.
MR. : He's asking if you recall doing that for this patient. Can he look through his chart?
MR. OGINSKI: Yes.
MR. : Just for the record, there's some -- forget it. Withdrawn. I'll let him answer.
Q Doctor, I'm not asking about letters to him for pre-op clearance. I'm just asking for updates and on her progress.
MR. : Post-op?
MR. OGINSKI: Yes.
A I see none other than the request for post -- pre-op clearance.
MR. : Just for the record, there's a letter "To whom it may

concern." I'm not sure who that's
referring to. It could possibly be
Dr. or someone else.
Q Okay. Let's go to the June 14,

A Did you say June 14th?
Q Yes.
Under the "Patient Reports," do you see that the "Patient Reports" you have listed there are the identical ones as you have listed for the June 2nd visit?
MR. : Would you hold up for a second. Did you see this?
THE WITNESS: Yes. That's pre-operative.
MR. : Okay.
Sorry.
Q Do you see that the June 14th, "Patient Reports," the five things listed there are the identical things listed on the June 2nd visit?
A Yes, sir, I see that.
Q Do you know why they are identical? Is this a cut and paste situation or did the patient make the exact same complaints on that visit?
MR. : Did the patient make the same complaints?
THE WITNESS: I would suspect that the

patient gave the same report; therefore, I wrote the same stuff or cut and pasted the same stuff.
Q Now, you mentioned that the patient was not walking or "the patient's not walking at all, using crutches, non weight-bearing"?
A Yes. That may have been an error in my haste to cut and paste and not change it.
Q Did you learn from that she had been walking as you had directed?
MR. : Do you recall?
A Yes, as I recall she had been walking.
Q Did she have any pain when she was doing the limited weight-bearing that you instructed?
MR. : If you recall, or refer to your note.
A I can't recall.
Q Let's go to the July 7, note.
A Okay.
Q Under "Patient Reports" on number three she's wearing sneakers at that time; correct?
A That's what it says, yes, sir.
Q Number four it says, "right foot is

significantly thicker than left"?
A Yes, sir.
Q Did you observe that?
A Yes, sir.
Q Did you form an opinion as to why that condition existed?
A Yes, sir, I did.
Q What was that opinion?
A Post-operative fibrosis.
Q And that's normal post-operative healing?
A Yes, sir. It's not considered an abnormality.
Q And that's something that you would expect to dissipate over time?
A Yes.
Q How are you able to determine that there is subcutaneous fibrosis?
A It's a clinical assessment.
Q What is it that you observe that suggests to you it's fibrosis as opposed to some other reason for the swelling?
A Well, first of all, swelling is not a correct answer -- a correct description. It wasn't swelling, it was thickening.

Thickening has the connotation of growth or proliferation of fibrosis around the surgical site, which is a common post-operative finding, and this certainly appeared to be a quite, you know, common appearance post-operatively. She had a lot of fibrosis.
Q Under "Treatment" it says, "sports orthotics were dispensed"?
A Yes, sir.
Q You created those?
Were they custom?
A Yes. They were ordered from a laboratory secondary to casting.
Q When you tried to put them in the shoes they didn't fit?
A I don't remember that.
Q It says under "Treatment," Doctor --
MR. : According to your notes, Doctor.
A Yes, they didn't fit in the shoes she had on that day.
Q Let's go, please, to the August 9, note.

Second page, please.
A Yes, sir.
Q Your examination where you write "dorsal skin scar contracture keeps hallux in dorsiflex position," tell me what you mean by that.

A Well, the surgical incision involved crossing the joint in order to expose the joint obviously, and she had developed what I considered to be a significant amount of fibrosis below the skin at the surgical incision, and when scars or fibrosis start to consolidate, they frequently contract, and the contracture of those scars is a part of normal healing of scar tissue. And sometimes it can be excessive, just like the scar tissue development can be excessive, and when that happens and it contracts, it can sometimes pull a digit out of place.
Q You write that "it is reducible by plantar manipulation"?
A Yes.
Q You mean by massaging the area it would soften up?

A No.
Q Tell me what you mean.
A "Reducible" means that the big toe can be pulled down into normal anatomical position.
Q Is there any way to minimize scar contracture?
A Well, pre-operatively or post-operatively?
Q Either post-operatively or pre-operatively.
A Well, the most specific way to minimize it is to exert physical forces to it to guide it.
Q Like what?
A Like stretching, and that's why you go to physical therapy.
Q Other than stretching, is there any other way to do it or to minimize it?
A There are surgical ways. There are injection methods, injection of steroids. I understand now there are topical methods that are available, but --
Q I'm only talking about back in ' .
A Okay. Yeah, injections, surgery and stretching.
Q Okay. Let's go to the December 15,

visit.
A Okay.
Q Under "Patient Reports" number five she continues to go for weekly therapy treatments; correct?
A Yes.
Q And you note "She's been unable to improve plantar flexion capability of the first MPJ."
First, Doctor, which direction, if you could show me on your hand, is plantar flexion?
A Downward (Indicating).

Q And did you form an opinion at that time as to why the patient was having that particular problem back in December of ?
A Again, it was because of scar contraction.
Q And the patient also reported difficulty with propulsive running.
Do you see that?
A Yes.
Q Did you form an opinion as to why she was having that type of problem?
A I did.
Q What was your opinion?

A The hallux, the big toe, because it was dorsiflexed somewhat, wasn't purchasing the ground sufficiently.
Q Did you form an opinion as to why it wasn't purchasing the ground sufficiently?
A I did.
Q What was your opinion?
A Dorsal scar contracture of the -- Dorsal scar contracture.
Q You write in your note on your examination that "On weight-bearing, the hallux fails to purchase the ground."
When you examined her before weight-bearing, what did you observe as far as whether her toes were in normal position?
A Please be more specific with that question.
Q Sure.
When you examine a patient post-operatively, am I correct that you examine them when they're non weight-bearing and also weight-bearing?
A No.
Q You only examine them when they're weight-bearing?

A Non weight-bearing. Non weight-bearing.
Q Let me rephrase the question.
You performed an examination where the patient was weight-bearing; correct?
A Yes.
Q Am I also correct that you performed an examination when the patient was non weight-bearing as well?
A On this day?
Q On this visit.
A Yes, sir.
Q On the portion of your exam when the patient was non weight-bearing, what conclusions or observations did you make regarding the hallux?
A Well, it says here in my note, and it makes sense to me, that the dorsiflexion ability of that big toe was 90 degrees. Means it

goes up 90 degrees, and that's a good thing, but it's plantar flexion ability was zero degrees, and that's -- that was abnormal.

Q And it was your opinion that the reason for this abnormality was from the scar tissue?

A It was.

Q Was there any other possibility you considered, other than the scar tissue, to account for this abnormality?

A Please ask that again.

Q Other than the scar tissue, was there anything else that could be causing this abnormality regarding the zero-degree plantar flexion?

MR. : Possible causes.

A Possible contributory cause could be shortening of the first metatarsal, but that doesn't always cause this problem.

Q But in this case had you formed any opinion that there was contributory factors other than the scar tissue to account for the abnormality in the plantar flexion?

A It was my opinion that the combination of both factors were contributory, yes.

Q The X-rays that you observed and noted in this visit, were these additional X-rays separate and apart from the films that you had talked about earlier, back in June?

MR. If you know.

A I'm not entirely sure.

Q Can we take a look, please?

THE WITNESS: May I?

MR. : Yes.

(At which time, there was a brief pause on the record.)

Q Doctor, you've now looked through all of your X-rays and you've told me off the record that the only X-rays post-operatively are the June 1st, X-rays; correct?

MR. : The ones that he's in possession of?

MR. OGINSKI: Yes.

A Yes. I'm in possession of that one.

Q Are you aware of any other X-rays that you had ordered or the patient had taken after June 1st, ?

A No, sir.

Q And when you comment in your December 15 note that "the X-rays show relative shortening of the first metatarsal that's visible," you're referring now to the June 1st X-rays; is that correct?

A I would surmise that to be true, yes.

Q Is there a particular view that you're

looking at that shows that?
A The AP view.
Q You also mention in your note that "Hyperkeratosis was present inferior to prominent right metatarsal."
Is that a clinical examination that you made or is that something based upon the X-rays?
A Clinical.
Q And that mild tenderness that is noted on palpation, that's also clinical examination; correct?
A That's correct, yes.
Q Did you form an opinion as to why the patient was experiencing the mild tenderness on the second and third metatarsal heads?
A Yes, sir, I did.
Q What was that opinion?
A The shortening of the first ray was a likely explanation for why.
Q You again, under your impression and assessment, you make a recommendation that additional surgery would fix this problem; correct?
A Yes, sir.

Q Why would the additional surgery fix this problem?
A Well --
MR. : Or how.
A The surgical procedures that I recommended at the time were shortening of the second, third metatarsals to lessen their weight-bearing load.
Q You're talking about recommending on December 15th?
A That's correct.
Q Go ahead.
A I recommended that shortening the second and third metatarsals would be appropriate to lessen their weight-bearing load, and that soft tissue, cutting of the scar tissue, elongation of the dorsal structures on the top of the first metatarsal would get the hallux back in normal anatomic position.
Q When you first recommended the Lapidus procedure with Mrs. , did you discuss with her the percentage of the likelihood that she could experience this outcome?

A I -- I recall saying that it was a possibility. I do not --
MR. : Okay.
Q Other than possibility, did you actually use

any numbers or percentages as to what you believed chances were that she had of experiencing this particular outcome?
A No, sir.
Q Did you have any further discussion with Mrs. about that particular possibility of this complication?
A Well --
Q Did you go into any more detail about this particular possibility?
MR. : At any time?
MR. OGINSKI: No, no. Just during the initial consultation or the consultations prior to the actual surgery.
MR. : If you recall.
A I recall telling her that the second and third metatarsals may become more painful after the surgery. Each time I discussed Lapidus procedure, I said the same thing.

Q And in your impression and assessment, Doctor, you write "the resulting shortening of the first ray has lead to; correct? The middle of the paragraph under "Impression."
A I'm sorry, I'm looking at the wrong paragraph.
I'll be okay, here.
Q It's right here.
A That's one of two sentences that apply to the situation.
Q Right. Then you indicate that the soft tissue contractures contribute to that?
A Yes.
Q I had asked you a question about whether or not you felt it was appropriate to recommend a shortening of the second and third metatarsal in the initial procedure, and you said you didn't feel it was appropriate at that point --
A That's true.
Q -- because the person hadn't experienced those problems.
MR. : You don't have to comment.

The testimony will stand the way it is. You can ask your question.
Q Are there occasions, Doctor, when you will perform a shortening of the second and third metatarsals as a preventive measure so that the patient would not have the complications that Mrs. experienced?
In other words if you're going and recommending a Lapidus procedure and you know that she's got a short first metatarsal

in relation to the second, could you perform a second and third metatarsal shortening at the same time in order to prevent the possibility that she'll get the type of outcome that she did?

MR. : I'll object to form, asked and answered, but he's asking could you. You can answer.

A Anything could be done. It's not my practice to perform prophylactic surgery on things that aren't problems that could become problems.

Q Would it be considered good podiatric practice if a podiatrist did that?

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A You could argue that pro and con.

Q And when you said you wouldn't do that, tell me why?

A You increase the risk of surgical complications by performing -- possible complications. You increase pain and discomfort.

MR. : Note my objection on that because it was asked and answered and he explained his reasoning.

Q Now, the procedures that you were recommending, that she have the shortening of the second and third metatarsals, are there risks involved with that procedure?

A Yes, sir, there are risks.

Q What are those risks?

A More scar; infection; failure of bone to heal; malposition of toes; pain under adjacent metatarsals.

Q Were there any alternatives other than the surgery that you were recommending on this visit?

A Yes, there were.

Q What were they?

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A Functional foot orthotics.

Q And how would that be different than the orthotics that you had already prescribed and recommended for Mrs. ?

A Not different.

I might -- I might add a forefoot accommodation below the second and third metatarsals; take weight off of it.

Q Was Mrs. receptive to those orthotics?

MR. : If you recall.

A Well, I don't remember.

Q Okay. Did you indicate in your note that orthotics would be an alternative?

MR. : You can review your note.

A Well, I dispensed orthotics.

Q I'm only asking about your December 15, note, as to whether you indicated anywhere in there the alternatives to the surgeries that you were now recommending.
A No, no. That's not applicable.
MR. : All right. Then you can answer his question.
A It's not noted in the counselling that I --

it's not noted in the counselling.
Q Do you remember who, if anyone, was with Mrs. y on this occasion?
A I do not.
Q Now, on the February 8, note, that is a note about a phone call that you received; is that correct?
A Yes, sir.
Q And that was from Mrs. ?
A It was.
Q And during that conversation you --
A I --
I'm --
Q What, Doctor?
A I'm sorry, I shouldn't have interrupted you.
Q During that conversation, you suggested that she should consult with someone at ?
A I did make that recommendation.
Q Now, regarding this post-operative complication, which one are you referring to here?
A All of the ones made in the previous note at the previous encounter.

Q At any time while you were treating Mrs. did you ever take photographs of her foot or feet pre-operatively?
A I don't think so.
Q Did you post-operatively?
A No, I don't think so.
Q If you had taken photographs, would you expect one of two things, to have a note in the chart about it and a photograph somewhere in the chart or somewhere in your office?
A The photographs, in my practice, my general practice, it's my custom to keep the photographs in the patient's medical records.
Q Your computer record that would be?
A Yes. They're digital.
But I don't recall taking photographs on Mrs. , and if I did, I would have included them in these records.
Q Did you ever have a conversation with --
MR. OGINSKI: Withdrawn.

Q Did you ever learn, from Mrs. or anyone else, whether she had gone to

at your suggestion?

A I do not --
I did not learn that, no.

Q Did you ever have a conversation with any doctor that Mrs. saw after you for any reason about her condition?

A No, sir, I don't recall.

Q Do you know a Dr. ?

A I do yes.

Q Who is Dr. ,sir?

A A podiatrist in , if I recall correctly.

Q Did you ever have a conversation with Dr. about Mrs. ?

A I did not.

Q Did you ever receive any documents or correspondence from Dr. about Mrs. ?

A No.

Q Did you ever learn from anyone, other than your attorney, that Mrs. had gone to Dr. on February 3rd, , for a consultation?

A No, sir.

Q Did you ever review a copy of Dr. 's findings for his exam on February 3rd, ?

A No, sir.

Q In preparation for today's deposition, Doctor, did you review any textbooks?

A No, sir.

Q In preparation for today's deposition, Doctor, did you review any medical or podiatric literature?

A No, sir.

Q Did you have any other notes regarding Mrs. other than the computer-generated notes that you have in front of you?

A No, sir.

Q Do you know a Dr. , an orthopedist?

A No, I don't.

Q Have you ever spoken with a Dr. regarding Mrs. ?

A No, sir.

Q Have you ever learned from anyone, other than your attorney, that Mrs. underwent a second surgical procedure to her

foot in April of by Dr. ?

A No.
Q Did you ever review or read any operative report by Dr. from the regarding a procedure done on April 28, ?
A No, sir.
Q Do you know what "cavus" is, C-A-V-U-S?
A Yes, sir.
Q What is that?
A "Cavus" is a term applied to the foot. Might signify a high-arched foot.
Q Did Mrs. have evidence of cavus at any time while you were treating her?
A No, sir.
Q Are you familiar with the term "iatrogenic cavus"?
A Yes, sir.
Q What does that mean to you, sir?
A Means that a cavus foot was caused.
Q What is metatarsalgia?
A Pain under the metatarsal.
Q In the complaints of pain that Mrs.

exhibited, did she have evidence of metatarsalgia?
A I would say yes.
Q Can this condition, metatarsalgia, cause abnormal weight distribution?
A Yes, it could.
Q How?
A In an attempt to protect sore metatarsal bones, a person could walk differently.
Q And could that cause a patient to overpronate?
A No.
Q Can abnormal weight distribution --
MR. OGINSKI: Withdrawn.
Q Can metatarsalgia cause abnormal weight distribution due to overpronation?
A Well, sir, that question doesn't make sense. You're giving me two causes.
Q Okay. Can overpronation cause pain under the metatarsals?
A Yes, sir, it can.
Q Did Mrs. have overpronation?
A She had a significant case of it, yes.
Q And in a situation where a patient has

metatarsalgia, do you often see a patient develop cavus in the affected joint?
A In a case of overpronation?
Q No, no.
In a case of metatarsalgia do you often see cavus?
A Yes. They're frequently linked.
Q What's the treatment for metatarsalgia?

A Physical protection using orthotics and shoe gear or surgical correction of the metatarsal in some way.
Q Are you familiar with a condition known as claw toe?
A Yes, sir.
Q What is that?
A It's plantar flexion of two joints in a toe.
Q Did Mrs. have evidence of claw toe at any time while she was under your care?
MR. : If you recall.
A I don't think -- I don't recall.
Q Anything you recall reviewing in your notes, anything we discussed that suggests she had claw toe?

A I had no reason to use that term. It's not in my note.
Q Is that a term that you've used in the past?
A It's a term that I'm familiar with. I don't commonly use it.
Q When you explain to patients about the condition, do you use the term "claw toe"?
A Occasionally I have, yes.
Q Are you familiar with a condition known as equinus deformity?
A Yes, sir.
Q What is that?
A It's a tightness of the Achilles' tendon as it applies to the foot.
Q Did Mrs. have equinus deformity in her right foot?
A I don't recall that she did.
Q What is "pens planus" (sic)?
A It's pes planus.
Q I'm sorry, P-E-S?
A Yes.
Q What is that?
A Very bad flatfoot. It's very bad flatfoot.

Q Was it your opinion that the patient had this condition, pes planus?
A Yes, sir.
Q And what lead you to believe that she had this condition?
MR. : I'll object. You can answer over objection. I think he testified to this already.
A I observed it on her first encounter with me and multiple times afterwards.
Q Did the surgery you perform make any attempt to correct that condition?
A No.
Q When you performed the Lapidus procedure,

how do you know how much plantar flexion to put the toes in?
A Plantar flexion to put the toes? I don't plantar flexion the toes.
Q What do you plantar flexion?
A The metatarsal.
Q Let me rephrase.
When you performed the Lapidus procedure, how do you know how much plantar flexion to put the metatarsal in?

A I want the metatarsal on the sagittal plane to be aligned with the rest of the medial column.
MR. : Okay.
Q Other than eyeballing it during the course of surgery, is there any device that you use to line up the planes?
A No, sir.
Q If the metatarsal --
MR. : Other than his hands?
MR. OGINSKI: What?
MR. : Other than his hands?
MR. OGINSKI: Eyeballing it, using your hands.
MR. : Okay.
Q If the metatarsals are put into too much plantar flexion, how do the toes heal in terms of positioning?
A One does not affect the other, sir.
Q Post-operatively Mrs. had a, I think you mentioned, a mild deviation of the lesser toes?
A Yes, sir.
Q Did that have anything to do with the

positioning of the metatarsals during the surgery?
A No, sir. Unrelated.
Q Did that have anything to do with the actual procedure that you performed, the Lapidus procedure?
A The positioning of the toes?
Q Of the lesser toes, yes, sir.
A No, sir. Unrelated.
Q Did Mrs. have excessive rear foot pronation?
A She did.
Q What is a "transfer lesion"?
A Transfer lesion is a common term to describe a callous that begins to develop under a metatarsal bone when an adjacent metatarsal bone is not bearing enough weight.
Q So there's a weight shifting?
A Yes, sir.
Q I'd like you to take a look, please, at

photographs I have of Mrs. 's right
foot, which were taken on March 22nd, .
Let's start with the first one.
MR. : You might as well mark
them.
MR. OGINSKI: Fine.
MR. : Well, let's mark it.
You're going to ask him about every
one?
MR. OGINSKI: There's only four.
MR. : You can mark them as one.
MR. OGINSKI: There's four of them.
Plaintiff's Exhibit 2-A B, C, and D.
(Marked for identification, Plaintiff's
Exhibits 2-A, 2-B, 2-C and 2-D,
Photographs.)
Q Okay. Doctor, I want you to assume that the
four photographs you have in front of you
are of taken on March
22nd, .
This is pre second surgery.
Tell me what you observe just looking at the
photograph in Plaintiff's Exhibit 2-D for
identification.
MR. : I'm going to let the
Doctor answer, but it's assuming they
were taken on March 22nd.
MR. OGINSKI: In fact, the plaintiff did
testify about that.
MR. : Okay.
He wants to know what you observed.
A Should I take them one at a time?
Q Yes, please.
A 2-D I see a foot positioned in a pronated
orientation, mild lateral shift of all her
digits, and a relatively well-healed scar on
the dorsal aspect of the right foot
(Indicating).
MR. : Okay.
Do you want him to move to the next one?
Q Is there any evidence of a hallux present on
the photograph?
A A hallux?
Q A hallux valgus.
MR. : Can you answer that
question?
A In this particular view there's mild hallux
valgus, but let me just qualify that by
saying the orientation of the foot
predisposes to that type of appearance.
Q Tell me what you mean.
A When you rotate the foot down like this and

take a picture, the big toe always looks like it's on the side.
Q You believe the picture as taken was not with her foot flat?
A This picture is a bit misleading, yes.
Q Let's take a look at Plaintiff's Exhibit 2-C for identification, and tell me what you can observe about that photograph.
A I see -- first thing I see ask a non-purchased hallux. I see a mild lateral deviation.
Q That would be of the lesser toes?
A Of all the toes.
And I see a first metatarsal that nicely purchases the ground.
MR. : Do you want him to comment on the bunion or lack thereof?
MR. OGINSKI: Whatever he sees.
MR. : I mean, he sees a lot of things, but I don't know how extensive you want him to be.
MR. OGINSKI: Okay.
A I think that's sufficient.
Q At the time of your last visit with

Mrs. , in December of , were your observations about her condition consistent with the two photographs you just described and see in front of you?
A As I recall somewhat similar, very similar.
Q Let's take a look at the third and fourth photographs, and tell me what you see please.
That's 2-B?
A 2-B.
Q Let's start with the right foot specifically.
A Okay. In this foot this orientation I see very similar situation, lateral deviation of -- mild lateral deviation of all the toes and failure of the hallux to purchase.
Q What causes deviation of the large toe, Doctor, in this particular case?
A Well --
MR. : What can cause it?
A I believe in this particular case scar contracture on the toe pulled the toe up and in.
Q When you say --

A Laterally.
Q Laterally deviated?
A Yes.
Q Was it your opinion, as of the 15th of December, by doing some type of contractual release that that would release or eliminate

the lateral deviation?
A Yes, I believe that it would have.
Q What do you observe on the left foot in that photograph?
A Left foot I see bunion lateral deviation of all the toes similar to the right.
Q And is the deviation on the right foot greater, less than, or equal to the left foot as is shown in 2-B?
A I would say it's about equal, more or less.
Q Let's take a look at the last photograph please, 2-A.
A 2-A.
Q Tell me what you see.
A I think the only thing visible is the plan -- the failure of the hallux to purchase, and perhaps a slighter shortening of the hallux with -- compared to the second digit.

Q Explain to me why or how the second and third toes, if they are shortened, would correct the problem or problems that Mrs. was experiencing.
A The second and third toes need not be corrected. I never described that type of correction.
But the second and third metatarsals were determined to be exerting a little bit more force than appropriate, and therefore she was sensitive or painful underneath there. Shortening them would allow them to bear less body weight and therefore make her more comfortable.
Q Would that allow the toe to lay flat and purchase the ground?
A Depending on whether or not it was a flexible toe.
Q How would you determine that?
A Clinical examination would show that.
Q Did you make any assessment on December 15th as to whether or not this was a flexible toe?
A I did not. Toe was not the compliant.

Q What is "sesamoiditis"?
MR. : I'm going to just make copies.
MR. OGINSKI: Yes, please.
A "Sesamoiditis" is a term used to describe pain below the sesamoid bone, or actually pain in the sesamoid bone itself.
Q And at any of the times that Mrs. made complaints to you about pain she was experiencing, did you ever conclude that she had pain in the sesamoid bone area?
A No, sir.

Q Was there evidence in any of your post-operative visits that Mrs. had evidence of a hallux hammertoe?
MR. : If you recall. Now, he's not asking what's just in the chart but he's asking during all your post-operative examinations.
A Mrs. never showed signs of a hallux hammertoe. She does show sign of hallux extension.
Q What do you mean by that?
A Big toe not touching.

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Q Did you discuss with Mrs. during the conversations about the procedure that there was a possibility --
A I discussed with her specifically that the big toe may not stay in the desired anatomic position.
Q When you said that, were you any more descriptive as to the fact that the toe might be sticking up, it may not be purchasing the ground, or something along those lines?
MR. : If you recall.
A I don't recall saying anything more specific than what I said to you before.
Q In your opinion, Doctor, was the physical therapy that was going for, did that help her condition?
A My impression was that it did not.
Q Did you form an opinion as to why it did not?
A No.
Q At any time from the time that she was under the care of the physical therapist up until today, did you form an opinion as to why the

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physical therapy wasn't helping?
A No. I have not formed an opinion about that.
Q You had mentioned that stretching would reduce the scar tissue, the fibrosis that had built up.
Do you have any reason to believe or conclude as to why the stretching would not have reduced or minimized the fibrosis?
A I have no -- I have no theory as to why it did not work.
Q Was it your understanding that Mrs. was going to therapy on a regular basis?
A That's what she reported to me.
Q Did you receive copies of the physical therapy progress notes from time to time?
A I did not. I did receive a report, a single report.

Q Did you learn that she had been undergoing the exercises that were recommended?
A Well, I don't recall that.
Q Did you ever have any conversation with any physical therapists about her progress at Sports Med Rehab?

MR. : Do you recall any conversations.
A No, sir, I don't recall any conversation.
Q Did you ever consult with any orthopedists about Mrs. ?
A No, sir.
Q On any of the photographs that you looked at, Doctor, is there evidence of a claw toe?
A One might consider this photograph, item 2-A, to be representative of a minor claw toe. Extremely minor. I think it's a stretch, but yes, the toe is not perfectly flat (Indicating).
Q What happens to the foot or toes or metatarsals, any way you want to describe it, if you have too much plantar flexion in the metatarsal? In other words, more than what should be?
A Too much plantar flexion in the metatarsal?
Q Yes.
A Well, not necessarily anything, but possibly excessive pressure, and therefore callous and pain below that metatarsal.
Q Doctor, in your letterhead, your office

letterhead, I think there's another typo.

It says, "Fellow, of

" That should be

" "; correct?

A Certainly should be.

Some of those common things I do over and

over.

MR. : , plural.

MR. OGINSKI: Thank you.

(Time noted: 1:18 P.M.)

C A P T I O N

This is the Deposition of
, D.P.M.
taken in the matter, on the date, and at the time
and place set out on the title page hereof.

It was requested that the deposition be taken by
the reporter and that same be reduced to
typewritten form.

It was agreed by and between counsel and
the parties that the Deponent will read
and sign the transcript of said
deposition.

C E R T I F I C A T E

STATE OF_____:
COUNTY/CITY OF_____:

Before me, this day, personally appeared
, D.P.M., who, being duly sworn,
states that the foregoing transcript of
his/her Deposition, taken in the matter, on
the date, and at the time and place set out
on the title page hereof, constitutes a true
and accurate transcript of said deposition.

_____
, D.P.M.

Signed and subscribed to before me
this____day of_____,20___.
_____
NOTARY PUBLIC, STATE OF NEW YORK

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ERRATA SHEET FOR THE TRANSCRIPT OF:
CASE: v.
DATE: 9/10/
DEPONENT: , D.P.M.

CORRECTIONS:

PAGE:	LINE:	NOW READS:	SHOULD READ:

_____
Signature of Deponent

Sworn to before me this ____ day of _____, 20

_____
NOTARY PUBLIC, STATE OF NEW YORK

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C E R T I F I C A T E

STATE OF NEW YORK)
) ss.
COUNTY OF)

I, ,a Court Reporter and Notary Public of the State of New York, do hereby certify that I recorded stenographically the proceedings herein at the time and place noted in the heading hereof, and that the foregoing transcript is true and accurate to the best of my knowledge, skill and ability.

IN WITNESS WHEREOF, I have hereunto set my hand.

_____