

## PROCEEDINGS

1 SUPREME COURT OF THE STATE OF NEW YORK  
 2 COUNTY OF WESTCHESTER

3 ----- x  
 4 ANNMARIE FLANNERY and DAVID FLANNERY  
 Plaintiffs

5 - against -

INDEX NO.  
 11230/06

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

8 ----- x  
 \*\*\*TESTIMONY OF ROBYN JOSEPH\*\*\*

9 111 Dr. Martin Luther King, Jr. Blvd.  
 10 White Plains, New York 10601  
 July 16, 2010

11 B E F O R E:

HON. MARY H. SMITH,  
 Justice of the Supreme Court.

12  
 13 A P P E A R A N C E S:

14 THE LAW OFFICE OF GERALD M. OGINSKI, LLC  
 15 Attorney for Plaintiff  
 25 Great Neck Road - Suite 4  
 16 Great Neck, NY 11021

17 BY: GERALD M. OGINSKI, ESQ.

18 VOUTE, LOHRFINK, MAGRO & COLLINS, LLP  
 19 Attorney for Defendant  
 170 Hamilton Avenue  
 White Plains, NY 10603-1789

20 BY: MARK McANDREW, ESQ.

21  
 22 CYNTHIA M. HILLS,  
 23 Senior Court Reporter.  
 24  
 25

## PROCEEDINGS

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

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

8                   THE WITNESS: Yes, I do.

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

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

13                  THE WITNESS: I'm fine. Thank you.

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

16                  THE WITNESS: I'm fine.

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

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

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

24                  THE WITNESS: Dr. Robyn Joseph.

25                  THE COURT: And, Doctor, give us your

## PROCEEDINGS

1 professional address.

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

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

11 THE WITNESS: Yes.

12 THE COURT: Thank you.

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

17 MR. MC ANDREW: So stipulated, Judge.

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

20 MR. OGINSKI: And also --

21 THE COURT: This is Matthew Roberts?

22 MR. OGINSKI: Yes, Matthew Roberts, MD.

23 And Plaintiff also offers into evidence the  
24 Hospital for Special Surgery records,  
25 Plaintiff's 6 --

## PROCEEDINGS

1 MR. MC ANDREW: So stipulated.

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

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

6 THE COURT: How do you spell that?

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

8 THE COURT: Dr. Caragine's medical chart?

9 MR. MC ANDREW: Yes.

10 THE COURT: So stipulated?

11 MR. OGINSKI: Yes.

12 THE COURT: That's seven.

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

15 MR. MC ANDREW: Naturally.

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

18 MR. OGINSKI: May I proceed?

19 THE COURT: Yes.

20 DIRECT EXAMINATION

21 CONDUCTED BY MR. OGINSKI:

22 Q Good morning, Dr. Joseph.

23 A Good morning.

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

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1 A Yes, you did.

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

4 A Yes, I did.

5 Q And during the course of the year, since  
6 2006 up until now, have you reviewed additional  
7 records relating to this case?

8 A Yes.

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

12 A Yes, I did.

13 Q Tell us what those conclusions are, Doctor.

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

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

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

2 A Okay.

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

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

9 MR. MC ANDREW: Objection, your Honor.

10 THE COURT: No, no.

11 MR. OGINSKI: I'll rephrase it.

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

14 A Yes.

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

17 A Yes.

18 Q And, Doctor, beyond that, are you  
19 100 percent sure?

20 MR. MC ANDREW: Objection, your Honor.

21 THE COURT: Sustained.

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

24 A Yes, I am.

25 Q And are you also board certified in the

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1 field of podiatric surgery?

2 A Yes, I am.

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

6 A I --

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

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

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

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

20 THE COURT: Yes or no?

21 THE WITNESS: Yes.

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

25 THE COURT: She will be.

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

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

11 THE COURT: Slow down.

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

17 Q And did you pass that?

18 A Yes, I did. Twice.

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

22 A Yes, I have.

23 Q And tell us how often you perform foot  
24 surgery?

25 A Every week.

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

3 A Twenty-two years.

4 Q How long have you been performing Austin  
5 bunionectomies?

6 A Twenty-two years.

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

10 A Hundreds.

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

14 A Fifty to a hundred.

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

18 A Okay. Can I...

19 Q Do you want to use the model?

20 A Please.

21 THE COURT: We have two models.

22 MR. OGINSKI: She brought her own, Judge.

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

24 THE WITNESS: This is actually a right  
25 foot.

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1 THE COURT: A righty, okay.

2 THE WITNESS: It makes it easier.

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

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

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

10 THE COURT: Oh, I see.

11 MR. MC ANDREW: A different type of coil.

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

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

16 BY MR. OGINSKI:

17 Q Doctor, tell us, what is a bunion?

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

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

25 A Can I stand up?

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

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

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

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

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

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1 well.

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

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

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

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

18 Q Okay. And what is a bunionectomy?

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

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

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

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

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

16                   THE COURT:  We know that.

17                   THE WITNESS:  Okay, good.

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

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

24                   THE COURT:  What is the name of that one?

25                   THE WITNESS:  The first cuneiform.

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

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

6 THE COURT: Okay.

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

9 THE COURT: First or medial.

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

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

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

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1 THE COURT: That's a new one.

2 THE WITNESS: Meaning too much movement.

3 Hyper.

4 BY MR. OGINSKI:

5 Q We heard the word unstable.

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

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

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

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

20 THE WITNESS: This is real bone, your  
21 Honor.

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

23 THE WITNESS: No.

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

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1 THE COURT: You can pass it around.

2 THE WITNESS: Of course, please.

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

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

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

13 A JUROR: Right here (indicating).

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

16 THE WITNESS: Yes.

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

19 THE WITNESS: A woman.

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

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

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

3 All right. Super, let's go on.

4 BY MR. OGINSKI:

5 Q Doctor, what is a joint arthrodesis?

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

18 Q And have you done that in your career?

19 A Yes.

20 Q Now, what is an Austin bunionectomy?

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

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

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

10 A Yes.

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

13 A Sometimes, yes.

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

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

ROBYN JOSEPH, D.P.M.-DIRECT

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

3 Q Tell me what that means.

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

9 Q Doctor, I'm sorry.

10 A It goes down. It angles down.

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

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

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

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

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

6 Q You're pointing to what?

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

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

22 Q Let me just stop you for a second.

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

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1 about?

2 A Yes, I think so.

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

5 A That would help. Is there an easel?

6 THE COURT: There is an easel over there.

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

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

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

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

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

21 THE COURT: Do you want to put a  
22 foundation?

23 THE WITNESS: There is a label.

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

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1 and postoperative x-rays, correct?

2 A Yes, I did.

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

5 A Yes, I did.

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

9 A Yes, it does, down here.

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

12 A Correct.

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

16 A Just larger, yes.

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

19 A Yes.

20 THE COURT: So those are postoperative  
21 x-rays?

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

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

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1 MR. OGINSKI: Yes.

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

4 THE COURT: Of course.

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

7 A Yes.

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

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

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

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

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

18 A Okay.

19 Q Go ahead.

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

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

25 THE COURT: Off the record.

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1 (Off-the-record discussion.)

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

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

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

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

25 When you have a metatarsal in a toe you

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

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

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

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

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

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

16 Q When you say "this?"

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

20 Q Why is that good practice?

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

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

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

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

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

13 THE WITNESS: Yes, your Honor.

14 THE COURT: It is a departure?

15 THE WITNESS: Yes, your Honor.

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

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

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

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

7           Q     Should every podiatrist who treats patients  
8     know this?

9           A     Yes.

10          Q     Should every board certified podiatrist know  
11     this?

12                   MR. MC ANDREW:  Objection.  Asked and  
13     answered.

14                   THE WITNESS:  I think so.

15                   THE COURT:  I'll allow it.

16                   THE WITNESS:  Yes.

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

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

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

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

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1 remove when you're going to do this procedure?

2 A When doing a Lapidus procedure?

3 Q Yes, thank you. A Lapidus procedure.

4 A You want to, in this case --

5 Q Yes.

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

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

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

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

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

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

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

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

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

19 THE WITNESS: Yes.

20 Q What was your opinion, Doctor?

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

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

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1           A     Looking at the postoperative x-rays and  
2     measuring.

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

10          A     I disagree with that statement.

11          Q     Tell us why.

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

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

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

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1 THE COURT: Could you read it back.

2 (Requested testimony repeated.)

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

5 THE COURT: All right, fine.

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

12 MR. MC ANDREW: Same objection.

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

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

20 MR. OGINSKI: Okay.

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

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1 metatarsals in her case until she developed a problem?

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

7 Q Why?

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

13 Q What do you do?

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

17 THE COURT: Overruled.

18 THE WITNESS: Sorry.

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

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

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

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

7 It should be.

8 THE COURT: What does that mean, negative?

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

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

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

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

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1 full --

2 Q Explain that.

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

8 Q What is the significance of that difference?

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

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

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

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

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

14          A     Yes.

15          Q     And --

16                   THE COURT: Is it good and accepted?

17                   THE WITNESS: Good and accepted.

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

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

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

4 MR. MC ANDREW: Objection, your Honor.

5 Most hospitals, what most hospitals do.

6 THE WITNESS: Mine does. Sorry.

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

9 THE WITNESS: Yes.

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

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

16 THE WITNESS: Yes.

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

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

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

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

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

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

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

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

6 Q Let me rephrase it.

7 A Sorry.

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

12 A Yes, it is not correct position.

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

15 A Yes.

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

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

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

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

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

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

14 Q Did Dr. Marzano do that in this case?

15 A No.

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

18 A Yes.

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

21 A Yes.

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

25 A Continued to develop them, yes.

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

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

7 A That it is not correct?

8 Q Yes.

9 A Yes.

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

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

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

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

21 A Yes.

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

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

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

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

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

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

14 A Yes.

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

18 A Correct.

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

23 A Okay.

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





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1           are dealing with --

2           Q     First, Doctor, do you have an opinion?

3           A     Yes, I have an opinion that it is.

4           Q     What is that opinion?

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

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

9           A     Yes.

10          Q     Why?

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

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

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

3 Q Was that done in this case?

4 A No.

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

7 A Failure to keep the length?

8 Q Yes.

9 A Either way, yes.

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

16 A Yes.

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

21 A Yes.

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

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1 and third metatarsals?

2 A Yes.

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

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

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

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

5 THE COURT: Well, what is scoliosis?

6 THE WITNESS: Curvature of the spine.

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

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

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

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

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

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

25 Q Did you also review the deposition testimony

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1 in this case?

2 A Yes, I did.

3 Q Okay.

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

6 THE COURT: Yes. And what exhibit is  
7 that?

8 MR. OGINSKI: This is Exhibit 5.

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

12 MR. OGINSKI: Yes, that's correct.

13 THE COURT: After the surgery?

14 MR. OGINSKI: Correct.

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

18 A Yes.

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

21 A Yes.

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

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1 note as far as what happened to her in the past.

2 Don't read it to us, if you can. Just summarize it  
3 briefly.

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

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

15 A Which date? I'm sorry.

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

18 A Yes.

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

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

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

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

10 A During the surgery.

11 Q During surgery. Okay.

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

16 Is that what you're just saying?

17 A Yes.

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

20 A Yes.

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

25 Tell us what that means.

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

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

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

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

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

25           MR. OGINSKI: I did not ask this.

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1 MR. MC ANDREW: Not in this phraseology.

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

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

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

18 Would orthotics help this particular  
19 problem?

20 A They would not correct the deformity, no.

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

23 THE COURT: This is whose physical  
24 examination?

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

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1 Dr. Matthew Roberts, the orthopedic surgeon.

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

4 A The radiographs?

5 Q No, under Physical Examination.

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

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

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

20 A Right.

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

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

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1 MR. MC ANDREW: Objection, your Honor.

2 THE WITNESS: It is true.

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

5 Q Go ahead, Doctor.

6 A Sorry.

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

15 Q What is arthritis?

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

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

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

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

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

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

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

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

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1 field.

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

6 A Can I look at that?

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

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

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

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

19 MR. OGINSKI: Very good.

20 THE COURT: All right, 15 minutes, please.

21 (Recess taken.)

22 COURT OFFICER: Jury entering.

23 (Jury entering courtroom.)

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

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1 examination.

2 MR. OGINSKI: Yes, your Honor.

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

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

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

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

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

20 A Yes.

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

24 A Yes.

25 Q And what was the purpose of him trying to do

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1 this surgery?

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

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

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

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

23 Q What was the outcome?

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

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1 metatarsals and shortening to the first metatarsal.

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

6 A Yes.

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

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

15 MR. MC ANDREW: Objection.

16 THE COURT: I did not --

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

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

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

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

25 A Yes.

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

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

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

9 A Correct.

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

13 A Correct.

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

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

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1 second and the third metatarsals.

2 Q Would you like to show the jury?

3 A May I?

4 THE COURT: Sure.

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

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

23 A Yes.

24 Q And when did you graduate?

25 A 1985.

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1 Q And that is how many years of schooling?

2 A Four years. Post-college.

3 Q Right. And after the four years of podiatry  
4 school you told us you went to a surgical residency in  
5 Denver, Colorado?

6 A I did a year in New York before I went to  
7 Denver, so I did three years total.

8 Q What is a surgical residency?

9 A Every residency is slightly different, but a  
10 residency is where you are a doctor learning how to  
11 perform surgery, how to correct deformities, how to  
12 treat patients in a surgical manner.

13 Q Does every podiatrist who comes out of  
14 podiatry school do a surgical residency?

15 A No.

16 Q And after you completed your residency,  
17 that's when you started to begin your practice and  
18 accumulate the cases that you needed to become board  
19 certified?

20 A Yes, I worked for somebody for two years as  
21 an associate and went on my own after two years.

22 Q Tell us what it means to be board certified.

23 A I don't know what the percentages are of how  
24 many people are board certified in podiatric surgery  
25 versus not, but it is a small number.

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1 THE COURT: Certified in podiatric  
2 surgery?

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

7 MR. MC ANDREW: Objection, your Honor.

8 THE COURT: Sustained.

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

13 A Yes.

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

17 A Yes.

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

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

21 THE COURT: What was the name of the book?

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

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

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

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

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

11 MR. MC ANDREW: I object.

12 THE COURT: Treat them?

13 MR. OGINSKI: Sorry. Thank you, Judge.

14 THE COURT: Sustained.

15 MR. OGINSKI: My apology.

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

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

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

25 A Yes.

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

4 A Yes.

5 THE COURT: In podiatry?

6 MR. OGINSKI: Did I misspeak?

7 THE COURT: No. In podiatry?

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

9 THE WITNESS: Yes.

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

12 A Yes.

13 Q Medical/legal cases?

14 A Yes.

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

18 A Yes, as well as insurance companies.

19 MR. MC ANDREW: Objection, your Honor.

20 THE COURT: Yes.

21 MR. OGINSKI: I'll rephrase it.

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

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

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

5             A     Yes.

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

9             A     Yes. More on that side.

10            Q     More for the defense?

11            A     Yes.

12            Q     On behalf of the doctor?

13            A     Yes.

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

16            A     Yes.

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

19            A     Maybe five.

20            Q     And have you ever been sued, Doctor?

21            A     Yes.

22            Q     How many times?

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

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

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

3 A Yes.

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

6 A 4,000 for the day.

7 Q And in addition to that?

8 MR. MC ANDREW: I did not hear that.

9 THE WITNESS: 4,000 for the day.

10 MR. MC ANDREW: Thank you.

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

14 A Yes.

15 Q How much do you charge for that fee?

16 A That's per hour?

17 Q Yes.

18 A \$275 an hour.

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

21 A Yes.

22 Q Do you recall how many times we met?

23 A I think twice.

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

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1 A Yes.

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

6 MR. MC ANDREW: Objection, your Honor.

7 This is cumulative at this juncture.

8 THE COURT: Let me hear the question.

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

11 THE COURT: Read it back.

12 (Requested testimony repeated.)

13 THE COURT: Overruled. You can answer.

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

16 Q I'll rephrase it.

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

21 A I disagree with that statement.

22 Q Tell us why.

23 A Because an average of bone loss from a  
24 Lapidus is about 4 millimeters. He took off  
25 10 millimeters.

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1 Q Is that significant?

2 A Significant. It is a sixth of the bone.

3 Q Is that a departure from good and accepted  
4 podiatric care?

5 THE COURT: You said significant. What  
6 was the answer.

7 THE WITNESS: Yes, because it was  
8 one-sixth of the entire length of the bone.

9 Q Is that a departure from good and accepted  
10 podiatric care?

11 A Yes.

12 Q Did that departure, was that departure a  
13 substantial factor in causing Anmarie Flannery her  
14 injuries?

15 A Yes.

16 Q And her pain and the deformity and the  
17 problem that she has under the second and third  
18 metatarsals?

19 A Yes.

20 MR. OGINSKI: Thank you very much, Doctor.

21 THE WITNESS: Thank you.

22 THE COURT: Do you want do start  
23 cross-examination?

24 MR. MC ANDREW: Yes, please, your Honor.

25 THE COURT: Cross-examination for the

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1 defense, Mr. McAndrew.

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

4 THE COURT: Yes.

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

8 MR. MC ANDREW: Objection, your Honor.

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

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

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

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

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1 documentation.

2 MR. OGINSKI: Thank you.

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

5 MR. MC ANDREW: Thank you, your Honor.

6 CROSS-EXAMINATION

7 CONDUCTED BY MR. MC ANDREW:

8 Q Good afternoon, Dr. Joseph.

9 A Good afternoon.

10 Q It is almost afternoon.

11 A Just about.

12 Q We are on the verge.

13 A Right.

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

19 A The deposition.

20 Q But any medical records, hospital records?

21 A Yes, there were some.

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

23 A Yes.

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

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

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

6           A     Yes.

7           Q     Did you review that admission?

8           A     I don't think so.

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

11          A     No, just Dr. Marzano.

12          Q     Just Dr. Marzano?

13          A     Yes.

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

16          A     I'm not remembering at this point.

17          Q     So you don't remember what you reviewed?

18          A     No.

19          Q     Did you review Dr. Roberts' deposition  
20    testimony?

21          A     No.

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

24          A     No.

25          Q     Do you think when you come to court that,

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

4 MR. OGINSKI: Objection.

5 THE COURT: Sustained.

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

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

11 Q It is a yes or no.

12 A So not necessarily to --

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

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

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

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

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

24 Q But you just don't remember?

25 A I just don't remember.

ROBYN JOSEPH, D.P.M.-CROSS

1 Q Fine.

2 A It was a while ago.

3 Q Did you review anything else in preparation  
4 for coming here to testify?

5 A No.

6 Q Do you have any notes?

7 A No.

8 Q You committed everything to memory?

9 A I have reviewed them. They are here in  
10 front of me.

11 Q Now, you and I have never met before, is  
12 that right?

13 A That's correct.

14 Q You don't know Dr. Marzano?

15 A No.

16 Q Okay. And you told us that you reviewed  
17 cases for Mr. Oginski previously. How many times did  
18 you do that?

19 A Maybe two other times.

20 Q Twice before?

21 A Yes.

22 Q You have not testified for him previously,  
23 however?

24 A No.

25 Q But you have testified in Court, at trial,

## ROBYN JOSEPH, D.P.M.-CROSS

1 correct?

2 A Yes.

3 Q As an expert, about five times?

4 A Right.

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

7 A Twice.

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

10 A Um-hum.

11 Q Yes?

12 A Yes, sorry.

13 Q You have to say yes.

14 A Sorry.

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

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

19 Q You don't know?

20 A No.

21 Q Do you advertise?

22 A No.

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

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

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

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

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

10          THE WITNESS: I'm sorry, your Honor.

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

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

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

19          A     I want to make sure.

20          Q     Take your time.

21          A     I think it was only Plaintiffs.

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

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

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

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

6 A No.

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

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

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

16 A Correct.

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

19 A Of course.

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

24 A Meaning that --

25 MR. OGINSKI: Objection.

ROBYN JOSEPH, D.P.M.-CROSS

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

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

5 MR. OGINSKI: Objection, Judge.

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

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

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

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

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

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

18 Q Both cases?

19 A Both cases.

20 Q Now, in direct examination by Mr. Oginski  
21 you said that your prior experience with Lapidus was  
22 50 to a hundred, and you kind of rattled that off  
23 pretty quickly. What do you mean 50 to a hundred? Is  
24 it 50, is it 99, which is?

25 A I did not count them.

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1 Q You don't know?

2 A I don't know.

3 Q So you're guessing, is that right?

4 A I am -- with some certainty, yes.

5 Q It is your best guess --

6 A Fine.

7 Q -- right?

8 A Fine.

9 Q Okay. So it could be 50, it could be a  
10 little less than 50, it could be a little more, it  
11 could be a hundred?

12 A I said between 50 and a hundred. So that  
13 would be above 50.

14 Q So you certainly did not do less than 50?

15 A I don't think so, no. We would have to sit  
16 down and count them.

17 Q Now, with regard -- give me one moment, your  
18 Honor.

19 Doctor, with regard to Mrs. Flannery, I know  
20 you're not sure if you read her testimony or not, but  
21 were you aware that her problems with her feet first  
22 started back in about 1985 when she was 18 years of  
23 age? Did you know that?

24 A I can see that her deformities of her foot  
25 did not happen overnight, so, yes, I can imagine that

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1 there were years in there.

2 Q But were you -- let me move this.

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

8 A Not the exact age of 18, no.

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

13 A Sure.

14 Q And she had severe deformity, correct?

15 A Moderate to severe.

16 Q On the right?

17 A On the right foot.

18 Q And the left foot was moderate, less severe?

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

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

23 A The right was worse than the left, yes.

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

1 surgeon?

2 A No.

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

5 A No.

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

9 A I have never reviewed his chart.

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

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

15 MR. OGINSKI: No, Judge.

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

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

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

25 THE COURT: I am going to sustain the

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1 objection.

2 MR. MC ANDREW: Fair enough.

3 THE COURT: Strike anything about another  
4 treating physician.

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

7 A No.

8 Q You have no idea?

9 A No.

10 Q Did you know that she is a nurse?

11 A (Inaudible answer.)

12 THE COURT: You are becoming inaudible.

13 Do you know she is a nurse? The answer?

14 THE WITNESS: No.

15 Q Are you learning that for the first time  
16 today?

17 A Yes.

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

21 MR. OGINSKI: Objection.

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

23 MR. MC ANDREW: Okay, your Honor.

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

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1 informed consent.

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

4 THE COURT: Is that true or not?

5 MR. OGINSKI: That is true, Judge.

6 (Side bar conference.)

7 THE COURT: Okay, we are at side bar.

8 Yes, Mr. McAndrew.

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

17 THE COURT: Okay.

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

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

## SIDE BAR CONFERENCE

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

3 THE COURT: Credibility.

4 MR. OGINSKI: Absolutely.

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

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

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

19 MR. OGINSKI: She deals with surgical  
20 nurses.

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

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

## SIDE BAR CONFERENCE

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

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

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

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

9 (Back in open Court.)

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

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

## PROCEEDINGS

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

4           MR. MC ANDREW: Thank you, Judge.

5           May I proceed, your Honor?

6           THE COURT: Certainly.

7           CROSS-EXAMINATION

8           CONTINUED BY MR. MC ANDREW:

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

12          A     Sure.

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

16          A     I --

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

20          THE COURT: You know, if she knows.

21          Overruled. Do you know?

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

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

## ROBYN JOSEPH-CROSS

1           A     I don't.

2                   THE COURT: She answered the question.

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

7           A     Not necessarily.

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

10          A     Yes.

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

15          A     I think I did know that, yes.

16          Q     How did you know that?

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

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

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

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

## ROBYN JOSEPH-CROSS

1 A I don't know.

2 Q Is it your understanding that Dr. Marzano  
3 then recommended the patient come in to be formally  
4 evaluated in the office?

5 A Okay.

6 Q You agree with that?

7 A I agree with that.

8 Q Do you have the chart there of Dr. Marzano?

9 A Yes.

10 Q Now, the doctor goes over with --

11 THE COURT: The jurors are having a  
12 problem seeing the board.

13 How is it now?

14 Q So, Dr. Joseph, the patient came in with a  
15 complaint it says CC. That's chief complaint, right?

16 A Yes.

17 Q Bunion bilateral first metatarsal phalangeal  
18 joint?

19 A Yes.

20 Q She tells the doctor that it is unsightly?

21 A Yes.

22 Q And that it limits what shoes she can wear?

23 A Yes.

24 Q And it limits her normal ambulation and  
25 provinced daily activities?

## ROBYN JOSEPH-CROSS

1           A     Normal daily activities.

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

5           A     Yes.

6           Q     She reports pain, correct?

7           A     Correct.

8           Q     And she describes it as sharp and throbbing?

9           A     Yes.

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

13          A     Right.

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

16          A     Correct.

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

21          A     Correct.

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

## ROBYN JOSEPH-CROSS

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

3 A Yes.

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

7 A Yes.

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

10 A Correct.

11 Q Makes it less complicated, right?

12 A Sure.

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

18 A Yes.

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

21 A To some degree, depending on the surgery.

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

24 A Be on crutches.

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

## ROBYN JOSEPH-CROSS

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

4 A Yes.

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

10 A Yes.

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

13 A Yes.

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

19 A Yes.

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

22 A Correct.

23 Q That's good care?

24 A Yes.

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

## ROBYN JOSEPH-CROSS

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

5 A Yes.

6 Q Thank you.

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

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

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

17 MR. MC ANDREW: Thank you, your Honor.

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

22 A Correct.

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

25 A Yes.

## ROBYN JOSEPH-CROSS

1 Q He did that on both sides, right?

2 A Yes.

3 Q Okay. And ultimately he came to a  
4 diagnosis, isn't that right?

5 A Yes.

6 Q And that was a bunion with hallux valgus,  
7 correct?

8 A Yes.

9 Q Now, based upon -- and, again, it says  
10 there, the right foot has significant intermetatarsal  
11 angle and severe deformity which would require Lapidus  
12 to correct. Whereas the left foot is less severe and  
13 could be corrected with Austin.

14 With regard to the right foot, you told us  
15 the right was worse than the left, correct?

16 A Yes.

17 Q Do you agree with that diagnosis that the  
18 doctor noted there?

19 A The diagnosis of hallux valgus bunion, yes,  
20 sure.

21 Q And, Doctor, do you agree that the foot was  
22 unstable with regard to the cuneiform metatarsal  
23 joint?

24 A Let me just read this, please.

25 Q Certainly.

## ROBYN JOSEPH-CROSS

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

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

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

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

13          A     Okay.

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

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

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

24                   THE WITNESS: Sure.

25                   THE COURT: So assuming that that came in.

## ROBYN JOSEPH-CROSS

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

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

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

9 A Right.

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

12 A Correct.

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

16 A When corrected properly, yes.

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

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

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

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

## ROBYN JOSEPH-CROSS

1 the wrong place.

2 Q We all know what your opinion is.

3 MR. OGINSKI: Objection. Argumentative.

4 THE WITNESS: Not related to --

5 THE COURT: Stop. Stop.

6 THE WITNESS: I don't mean to --

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

9 THE WITNESS: Fine. I'm sorry.

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

14 A Not necessarily.

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

18 A Okay.

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

24 A Yes.

25 Q Okay. And it says pronation of the rearfoot

## ROBYN JOSEPH-CROSS

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

4 Is that an appropriate thing to document in  
5 a chart?

6 A Yes.

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

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

14 A The whole metatarsal, not just the tip.

15 Q Okay. So the entire metatarsal is elevated?

16 A Moving up and out he is saying.

17 Q I'm sorry?

18 A Moving up and out.

19 Q Up and out?

20 A Yes.

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

## ROBYN JOSEPH-CROSS

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

3 A That's part of it.

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

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

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

17 A In part.

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

21 A Laterally deviated.

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

23 THE WITNESS: I'm sorry.

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

## ROBYN JOSEPH-CROSS

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

2 Q Would you agree that it was sublaxed?

3 A Yes.

4 THE COURT: What is sublaxed again? What  
5 does that mean?

6 THE WITNESS: Dislocated is completely out  
7 of alignment. Sublaxed is partly.

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

12 A No.

13 Q They don't?

14 A 90 degrees of dorsiflexion is a lot.

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

18 A Yes.

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

21 A Okay.

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

25 A Yes. Her active range of motion is somewhat

## ROBYN JOSEPH-CROSS

1 limited.

2 Q Somewhat limited?

3 A Yes.

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

6 A Yes.

7 Q With the doctor pushing it it could go  
8 90 degrees?

9 A Right.

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

13 A Right.

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

16 A I agree.

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

20 A Correct.

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

23 A Yes.

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

25 A Yes.

## ROBYN JOSEPH-CROSS

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

5 A Correct.

6 Q Including customized inner soles and  
7 orthotics, correct?

8 A Correct.

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

11 A Sure.

12 Q That would be a good practice to do that?

13 A Yes.

14 Q Have you done that in your own practice  
15 right?

16 A Absolutely.

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

21 A Yes.

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

25 A Yes.

## ROBYN JOSEPH-CROSS

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

5           A     Right.

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

13          A     Yes.

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

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

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

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

## ROBYN JOSEPH-CROSS

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

5 A I do.

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

9 MR. OGINSKI: Bunion?

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

12 A Right.

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

14 A Right.

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

17 A Yes.

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

20 A Correct.

21 Q It was always the right foot, right?

22 A Correct.

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

## ROBYN JOSEPH-CROSS

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

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

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

12          Q     We are not there yet.

13          A     Okay.

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

18          A     Yes.

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

22          A     Yes.

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

## ROBYN JOSEPH-CROSS

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

3 A Yes.

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

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

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

17 A Yes.

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

21 A The obvious ones. That was obvious to me.

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

24 A Yes.

25 Q Please do me a favor and turn to a document

## ROBYN JOSEPH-CROSS

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

3 A Do you know where? At the back?

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

6 If you want I can assist you.

7 A The informed consent, that one?

8 Q Yes.

9 A Okay.

10 Q How many pages is that chart, Doctor?

11 MR. OGINSKI: You want her to count them?

12 Q Approximately, yes.

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

15 THE COURT: What record?

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

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

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

22 THE COURT: Sustained, too vague.

23 Q Doctor, are you familiar with that record?

24 A Yes.

25 Q You have reviewed it before today?

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1 A Yes.

2 Q A long time, right?

3 A Yes.

4 Q And were you aware that this Informed  
5 Consent Form was contained in the chart?

6 A Yes.

7 Q Okay. Did you look at it before?

8 A Yes.

9 Q Okay. Now, here there is a reference to --  
10 just give me a moment so that I can find it. It says  
11 callous and pain under the second metatarsal head.  
12 You will see it is under the section second paragraph  
13 from the bottom, All contingencies.

14 A I see it.

15 Q It certainly says callous and pain under the  
16 second metatarsal head. That's indicating that may  
17 develop as a complication, right?

18 A But it was already there.

19 Q We already talked about that. We knew it  
20 was there. But it may also develop subsequently,  
21 right? That's definitely a risk of this procedure,  
22 right? You're not arguing?

23 THE COURT: The question is: Did you  
24 think that that meant in the future or in the  
25 past, that note?

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

3 THE WITNESS: I do.

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

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

9 MR. MC ANDREW: That's right.

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

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

15 Q So we are playing semantics here?

16 MR. OGINSKI: Objection, argumentative.

17 A It is not semantics.

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

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

25 A Can you repeat that, because I did not

## ROBYN JOSEPH-CROSS

1 understand you.

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

6 A Yes.

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

10 A No.

11 Q You did not do that?

12 A No.

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

18 A He said that?

19 Q Yes.

20 A Okay.

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

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1 A Yes.

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

5 A Yes.

6 Q It is good practice to do that, right?

7 A Absolutely.

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

16 A Yes, in any procedure.

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

18 Withdrawn.

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

22 A Yes.

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

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1 A Correct.

2 Q And that can happen no matter what you do,  
3 right?

4 A Right.

5 Q And those scars, those adhesions, can they  
6 cause contracture of a joint? Is that right?

7 A Right.

8 Q And that can cause problems for the patient,  
9 right?

10 THE COURT: What is contracture of the  
11 joint?

12 MR. MC ANDREW: Sorry, Judge. That's a  
13 good point.

14 THE COURT: What is that?

15 THE WITNESS: Where a joint is being  
16 pulled because of the scar tissue, so it comes  
17 up out of alignment. That's not what happened  
18 in this case, but I'm agreeing with that. It  
19 can happen.

20 Q That can happen. And you say that's not  
21 what happened in this case. We know your position is  
22 that the first metatarsal shortened or recessed  
23 causing the first toe to go up, correct?

24 MR. OGINSKI: Objection to form.

25 THE COURT: Overruled.

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

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

5 A Yes.

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

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

12 Q Okay. Would it have contributed in any way?

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

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

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

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

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

25 THE COURT: You have to ask her to assume.

## ROBYN JOSEPH-CROSS

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

6 A You want me to assume that he said that?

7 Q Yes.

8 A Okay.

9 Q Would he be wrong in his opinion?

10 A It is not that he would be wrong.

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

13 A Yes, he can be wrong.

14 Q So Dr. Roberts could possibly be wrong?

15 A Yes.

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

20 A Yes.

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

## ROBYN JOSEPH-CROSS

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

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

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

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

11 MR. OGINSKI: Objection.

12 THE COURT: She answered.

13 THE WITNESS: I'm sorry.

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

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

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

24 A Correct.

25 Q And if that happens to the patient and if

## ROBYN JOSEPH-CROSS

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

3 A Correct.

4 Q That can cause additional surgeries, right?

5 A Sure.

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

8 A Yes.

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

11 A Yes.

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

15 A Correct.

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

18 A Yes.

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

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

23 THE COURT: All right. We are going to  
24 take a break. We will reconvene about  
25 2 o'clock. 2 o'clock. Thank you.

ROBYN JOSEPH-CROSS

1 (Jury excused.)

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

6 THE WITNESS: Okay.

7 THE COURT: Thank you very much.

8 THE WITNESS: Thank you.

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

11 THE COURT: Yes, we will lock it up.

12 (Lunch Recess taken.)

13 COURT OFFICER: Jury entering.

14 (Jury entering courtroom.)

15 THE COURT: Hello. Be seated, everybody.

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

17 THE COURT: Can you remove that scaffold?

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

19 THE COURT: Fine.

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

21 THE COURT: Doctor Joseph is on the stand.

22 You are still under oath. Understood and  
23 agreed.

24 THE WITNESS: Yes, understood and agreed.

25 THE COURT: Try to direct your answers to

## ROBYN JOSEPH-CROSS

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

3 CROSS-EXAMINATION

4 CONDUCTED BY MR. MC ANDREW:

5 Q Good afternoon, Doctor Joseph.

6 A Good afternoon.

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

10 A Let me find it again, please. Okay.

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

13 A Yes.

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

18 MR. OGINSKI: 4/15?

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

20 MR. OGINSKI: 3/15.

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

23 A I will assume that.

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

## ROBYN JOSEPH-CROSS

1 A Fine.

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

7 A I do see that.

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

10 A Sure.

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

13 A Right.

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

18 A Yes, I see that.

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

21 A Sure.

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

25 A Yes.

## ROBYN JOSEPH-CROSS

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

4 Do you see that?

5 A Yes.

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

8 A Yes.

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

11 A It is fine.

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

15 A Correct.

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

20 MR. OGINSKI: Which paragraph is that?

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

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

## ROBYN JOSEPH-CROSS

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

4 Do you see that?

5 A I do see that.

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

10 A Yes.

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

13 THE COURT: Without?

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

16 A With a Lapidus?

17 Q Yes.

18 A No.

19 Q You cannot?

20 A Usually not.

21 Q But you can sometimes?

22 A Mostly not.

23 Q Doctor, this form also addresses anesthesia.

24 And the patient consented to anesthesia; is that  
25 right?

## ROBYN JOSEPH-CROSS

1           A     Yes.

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

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

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

12                   MR. MC ANDREW: Well, your Honor --

13                   THE COURT: What is the relevance?

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

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

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

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

25                   THE COURT: I remember clearly what I said

## ROBYN JOSEPH-CROSS

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

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

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

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

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

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

13 Q It is signed by the patient, right?

14 A Yes.

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

18 A Yes.

19 Q And both of those are executed by the  
20 patient?

21 A Yes.

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

25 A Yes.

## ROBYN JOSEPH-CROSS

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

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

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

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

14 A Yes.

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

18 A Yes.

19 Q The bump?

20 A Yes.

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

23 A Yes.

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

## ROBYN JOSEPH-CROSS

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

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

6           A     Toe. Not just metatarsal, toe as well.

7           Q     Toe and metatarsal?

8           A     Right.

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

17          A     Can you repeat that, please?

18          Q     Certainly.

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

21                         (Requested testimony repeated.)

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

24                 MR. MC ANDREW: Thank you, Judge.

25                         (Requested testimony repeated.)

## ROBYN JOSEPH-CROSS

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

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

7           A     Yes.

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

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

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

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

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

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

25          THE COURT: Well, the question is then is

ROBYN JOSEPH-CROSS

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

3           THE WITNESS: Yes.

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

7           A     Okay.

8           Q     Do you agree with that?

9           A     I could double check and make sure.

10          Q     That's fine by me.

11          A     Yes.

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

14          A     Correct.

15                 THE COURT: March or May?

16                 MR. MC ANDREW: March.

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

19          A     Yes.

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

22          A     Correct.

23          Q     That it is more of an art?

24          A     Correct.

25          Q     You have said that?

## ROBYN JOSEPH-CROSS

1 A Well.

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

5 A Correct.

6 Q Absolutely, right?

7 A Right.

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

11 A Right. And then there are limits.

12 Q Of course, there are limits to everything.  
13 Now, you told us that the first metatarsal  
14 was shorter relative to the second metatarsal?

15 A Can I correct you?

16 Q Is that what you said, yes or no?

17 A No.

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

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

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

24 A Yes.

25 THE COURT: And the first metatarsal is

## ROBYN JOSEPH-CROSS

1 the big toe?

2 THE WITNESS: Behind the big toe.

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

5 THE WITNESS: Yes.

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

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

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

12 A Can they see it.

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

15 THE WITNESS: It is low.

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

18 A Yes.

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

21 A Yes.

22 Q Verses the first metatarsal, this bone right  
23 here?

24 A Yes.

25 Q It appears longer, correct?

## ROBYN JOSEPH-CROSS

1 A Correct.

2 Q Okay. And you may take your seat, Doctor.

3 And is that what you are telling the jury,  
4 that the second metatarsal was longer based upon the  
5 way that it appears on this x-ray?

6 A Yes.

7 Q Okay.

8 THE COURT: Now, is that x-ray post-op or  
9 pre-op.

10 MR. MC ANDREW: Sorry, Judge that's a  
11 pre-op, 3/10/05.

12 THE COURT: Before the surgery.

13 Q But, Doctor, isn't it true that, in fact,  
14 that's not how you measure the length of the first and  
15 second metatarsal?

16 A No.

17 Q Okay. Have you ever heard of something  
18 called a metatarsal protrusion angle?

19 A Right.

20 Q Okay. And, Doctor, isn't that when you draw  
21 a bisection, a line down the middle of the second  
22 metatarsal?

23 A No.

24 Q Just let me finish my question first,  
25 please.

## ROBYN JOSEPH-CROSS

1           A     Sorry.

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

12          A     No, that's not a protrusion.

13          Q     You disagree with that?

14          A     I do.

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

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

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

23                 THE WITNESS:  Yes.

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

## ROBYN JOSEPH-CROSS

1 THE WITNESS: The second is longer than  
2 the first.

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

10 A Yes.

11 Q And an osteotomy is what?

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

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

19 A He said that in Court?

20 Q Yes.

21 MR. OGINSKI: I am going to object.

22 Because that's not what he said in relation to  
23 the timing of doing it during the first surgery.

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

25 THE COURT: Read it back, please.

ROBYN JOSEPH-CROSS

1 (Requested testimony repeated.)

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

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

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

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

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

16 A No, I need to clarify.

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

18 A Okay. Sorry.

19 Q Don't be sorry.

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

24 A Yes.

25 Q I want you to assume that Doctor Marzano

## ROBYN JOSEPH-CROSS

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

7 THE COURT: Well, that is the problem.

8 Sustained.

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

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

15 THE COURT: You did not.

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

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

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

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

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

## ROBYN JOSEPH-CROSS

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

9           A     I follow.

10           THE COURT: Is that all pre-op?

11           MR. OGINSKI: Objection.

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

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

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

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

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

23           All right, overruled.

24           MR. MC ANDREW: Thank you, Judge.

25           Q     Now, with that part of the assumption, I

## ROBYN JOSEPH-CROSS

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

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

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

11 Q That's all right.

12 A It is pre-op, post-op?

13 Q It is difficult because you did not have  
14 an opportunity to be here or read the testimony.

15 That's okay.

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

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

18 A When did he have this discussion?

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

ROBYN JOSEPH-CROSS

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

4 A Okay.

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

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

12 MR. MC ANDREW: Right.

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

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

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

21 Would you agree?

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

24 Q He did not follow through postoperatively,  
25 right?

## ROBYN JOSEPH-CROSS

1 A Right. There was a complication.

2 Q He did not do the shortening, right?

3 A Yes.

4 Q And that's because in December of 2005 the  
5 patient decided to go somewhere else, right?

6 A No, that's not what I'm talking about.

7 Q I understand that's not what you are talking  
8 about.

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

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

16 THE WITNESS: The Lapidus.

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

21 THE WITNESS: Yes, that's correct.

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

## ROBYN JOSEPH-CROSS

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

3           THE COURT:   Intraoperative?

4           Q     Intraoperatively or postoperatively?

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

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

11          THE COURT:   Time.   Intraoperatively?

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

14          THE COURT:   We have to have definitions.

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

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

21          A     Osteotomies, or lengthened the first.

22          Q     One of those two options?

23          A     Yes.

24          Q     It would have been ideal to do it  
25    intraoperatively?

## ROBYN JOSEPH-CROSS

1 A Yes.

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

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

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

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

11 Q We are going to argue semantics?

12 A I don't wanted to argue.

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

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

21 Q I thought you would say that.

22 MR. OGINSKI: Objection to comment.

23 That's not called for.

24 THE COURT: Strike the comment.

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

ROBYN JOSEPH-CROSS

1 second and third metatarsal shortening during this  
2 March 25<sup>th</sup>, 2005 procedure, you would be up there  
3 testifying against him on that case if there was a  
4 complication, right?

5 MR. OGINSKI: Objection, speculation.

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

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

13 A Can you repeat that?

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

16 THE COURT: Read it back, please.

17 (Requested testimony repeated.)

18 THE WITNESS: Correct.

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

22 A Yes.

23 Q That involved a similar situation?

24 MR. OGINSKI: Objection, relevance.

25 THE COURT: You want to go into the facts.

ROBYN JOSEPH-CROSS

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

3                   MR. MC ANDREW: Okay.

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

7           A     Yes.

8           Q     It was a closing base wedge resection?

9           A     Closing base wedge osteotomy.

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

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

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

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

25                   MR. OGINSKI: Again, objection, Judge.

ROBYN JOSEPH-CROSS

1 THE COURT: Overruled.

2 THE WITNESS: Okay. Yes.

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

6 THE COURT: I don't understand that.

7 MR. OGINSKI: Objection. The facts are  
8 different.

9 THE COURT: Sustained.

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

12 MR. OGINSKI: Objection.

13 THE COURT: Overruled.

14 THE WITNESS: I answer?

15 THE COURT: Yes.

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

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

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

22 Q You were there, right?

23 A I was there.

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

## ROBYN JOSEPH-CROSS

1 does not mean it is so, right?

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

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

6 MR. OGINSKI: Objection.

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

10 MR. OGINSKI: Objection, argumentative,  
11 irrelevant.

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

14 MR. MC ANDREW: Okay, Judge.

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

17 Q Doctor, would you agree that preoperatively  
18 the cuneiform bone was abnormally shaped? Do you need  
19 to look at this?

20 A Please.

21 Q You can step down.

22 A The joint adapts. It is not that the  
23 cuneiform is abnormally misshapen, the joint adapts.  
24 Changes.

25 THE COURT: So, is it or is it not

## ROBYN JOSEPH-CROSS

1 misshapen?

2 THE WITNESS: No, it is the joint.

3 THE COURT: The jointly is misshapen?

4 THE WITNESS: The joint -- it is a vague  
5 term, but I'll say that.

6 Q Say what?

7 A That it is misshapen, because it is sort of  
8 misleading, but...

9 Q So -- that's fine. But it is somewhat  
10 misshapen, we agree?

11 A The joint, not the bone.

12 Q Okay. But the bone, if I am not mistaken --  
13 can everyone see this? The bone, the cuneiform bone,  
14 this is the outline here, right?

15 A Yes.

16 Q Okay. And it is certainly not on a  
17 crisscross axis with the metatarsals, it is rounded,  
18 isn't it?

19 A I think you're asking two different things.  
20 You're talking about the joint, or are you?

21 Q I'll ask a different question.

22 A Okay.

23 Q So right here, is this, right as I'm going  
24 along with the pen, is that not the outline of the  
25 cuneiform bone?

## ROBYN JOSEPH-CROSS

1           A     Just to here.  Just these edges.  That's the  
2     cuneiform bone to the metatarsal.

3           Q     So right here?

4           A     Yes.

5           Q     Okay.  And wouldn't you agree that that sort  
6     of curved --

7           A     It is supposed to be.  They sit like that.  
8     The metatarsal base is one curve this way.  It is like  
9     a cup.

10          Q     But you agree it is curved?

11          A     It is supposed to be.

12          Q     I'm not asking if it is supposed to be, it  
13     is curved, right?

14          A     They all are, yes.

15          Q     Okay.  Go ahead and take your seat.

16                 Now, you would agree, Doctor, to get a good  
17     fusion and good positioning, a physician, a surgeon,  
18     must cut that cuneiform bone in order to bring the  
19     metatarsal to a good arthrodesis, to a good fixation,  
20     correct?

21          A     You need to explain what you mean by cut.

22          Q     Okay.  You talked about feathering, right?

23          A     (Nodding affirmatively.)

24          Q     You have to say yes or no.

25          A     Yes, I'm sorry.

## ROBYN JOSEPH-CROSS

1 Q You talked about feathering in your direct  
2 testimony. That's some cutting of the bone, correct?

3 A You're taking the cartilage off.

4 Q Maybe I misunderstood.

5 A You're taking the cartilage off.

6 Q Do you ever remove cuneiform bone during  
7 this Lapidus procedure? Not just the cartilage, not  
8 the covering, the actual bone, is the bone removed?

9 A Just maybe the outer cortex. Just a  
10 millimeter maybe.

11 Q But you do remove bone?

12 A Right. But not that much.

13 Q I am just asking if you remove bone.

14 A Okay.

15 Q Now, as you proceed, as the surgeon, making  
16 a decision on how to align these bones, do you  
17 determine within your discretion how much to remove,  
18 whether it is a millimeter or if it is just the  
19 cartilage or something else? It is up to the surgeon,  
20 is it not?

21 A Yes.

22 Q Okay. And Doctor Marzano told us here in  
23 testimony that it was his discretion, his judgment  
24 that he had to remove some abnormally shaped bone.  
25 And if that is the case, do you agree that it is

## ROBYN JOSEPH-CROSS

1 appropriate to do so to form a good fixation?

2 A Right. In the area where it needed to be  
3 done. Not the whole bone.

4 Q Now, would you agree that the doctor did not  
5 cut away any bone from the actual metatarsal? By the  
6 way, I'm just going to hold this up, Judge. I know,  
7 just so we are clear.

8 THE COURT: Wait a minute. Cuneiform is  
9 not part of the metatarsal?

10 THE WITNESS: No. I'm sorry.

11 THE COURT: All right. It is not?

12 THE WITNESS: It is a separate bone.

13 THE COURT: What --

14 THE WITNESS: It is a separate bone.

15 MR. MC ANDREW: I'm going to try to  
16 straighten that out, Judge. I realize it was  
17 confusing.

18 Q The first metatarsal again is this bone,  
19 right, the long bone here?

20 A Yes.

21 Q Now, during this surgery the doctor did take  
22 off some bone on the distal part of the metatarsal.  
23 That's the part closest to the toes and long bone?

24 A Yes.

25 Q Okay. That's this little bump here he took

## ROBYN JOSEPH-CROSS

1 off?

2 A Yes.

3 Q Now, he did not, however, take any length of  
4 the bone, he just scraped away the cartilage, correct?

5 A I don't know that.

6 Q It is in the operative report, is it not?

7 A Does it say that exactly?

8 Q I'll tell you what. I would like you to  
9 assume for purposes of this question that the doctor  
10 testified that he did not take any length from the  
11 first metatarsal, he just removed the cartilage,  
12 drilled some holes to get some bleeding and  
13 bone-on-bone contact. Would you accept that?

14 A Fine.

15 Q Now, is that good practice when you have to  
16 remove or you determine to remove some cuneiform bone  
17 not to take any bone length from the first metatarsal?  
18 Yes or no? If you can't answer yes or no, just say  
19 so?

20 A Okay. I don't know how to answer that.

21 Q Okay. Go ahead and take a seat.

22 Now, Doctor, if Doctor Marzano, based upon  
23 his clinical assessment, what he saw intraoperatively,  
24 if he felt he had a good result in the operating room  
25 it would be good practice to finish up the procedure,

## ROBYN JOSEPH-CROSS

1 correct, close the patient up?

2 A If he thought he had a good result?

3 Q Yes.

4 A Yes.

5 Q Okay. And, Doctor -- give me one moment.

6 This is going to seem sort of silly, but you  
7 were not in the OR, right?

8 A No, I was not in the OR.

9 Q Of course not. It was only Doctor Marzano  
10 who was there, right, as far as the primary surgeon or  
11 the surgeon, right?

12 A Right.

13 Q He was the guy operating, correct?

14 A I'm assuming.

15 Q Yes. Now, we talked earlier about, I  
16 believe you spoke earlier on direct examination that  
17 the doctor could have undertaken an x-ray  
18 intraoperatively, correct?

19 A Should have, yes.

20 Q Something. He should have. That's what you  
21 said, right?

22 A Yes.

23 Q And that's something called a C-arm?

24 A You could do either, but, yes.

25 THE COURT: What is a "CR?"

## ROBYN JOSEPH-CROSS

1 THE WITNESS: A fluoroscope is something  
2 that, so you can -- it is an x-ray. But it is  
3 portable.

4 THE COURT: Is that what -- he used the  
5 word "CR."

6 THE WITNESS: It is a C-arm. An arm that  
7 comes around with an x-ray tube on it.

8 MR. MC ANDREW: I believe the testimony  
9 was intraoperative x-ray, or C-arm, was used  
10 yesterday.

11 THE COURT: Okay.

12 Q Now, intraoperative x-ray or fluoroscopy  
13 through C-arm, would you agree that you do that in the  
14 operating room, correct?

15 A Correct.

16 Q Okay. And would you agree that the  
17 equipment goes over the operating room table?

18 A Yes.

19 Q And would you agree that it is not like a  
20 true plain film?

21 MR. OGINSKI: Which one, the C-arm?

22 MR. MC ANDREW: Let me clarify.

23 Q Intraoperative x-ray or fluoroscopy.

24 A Well, you can do a printout and make it like  
25 a true film.

## ROBYN JOSEPH-CROSS

1           Q     But you testified in the past in a case  
2     called Walton, as an expert, correct?  Pierre A.  
3     Walton, W-A-L-T-O-N, and Christine Walton, against  
4     Stuarts, S-T-U-A-R-T-S, in Nassau County before Judge  
5     LaMarca back on June 13<sup>th</sup>, 2007.  Do you remember  
6     that?

7           A     I don't remember everything about it, but I  
8     do.

9           Q     But you definitely testified there, right?

10          A     Yes.

11          Q     I'm going to read to you a portion of your  
12     testimony and tell me if this refreshes your  
13     recollection as to having given this testimony.

14                    "This is intraoperative x-ray and it is a  
15     C-arm.  So it is exaggerated.  It is an x-ray that  
16     goes over the table, and so it is not like a true  
17     plain film, so it is a little distorted looking."

18                    Do you remember giving that testimony?

19          A     No, I don't.  But I want to clarify, that  
20     that C-arm film was probably not a good -- it was  
21     exaggerated.

22          Q     Well, I'm just asking.  That's fine.  But  
23     I'm asking, do you recall, yes or no?

24          A     I don't recall it.

25          Q     Okay.  So, you're anticipating my next

## ROBYN JOSEPH-CROSS

1 question which would be if the C-arm is exaggerated or  
2 distorted intraoperatively or an x-ray is distorted  
3 intraoperatively, that would give the doctor faulty  
4 information, right?

5 A Well, you hope it is not exaggerated.  
6 You're hoping you get a right angle and good view.

7 Q But you told us C-arms are exaggerated and  
8 distorted. That's what you said in your testimony?

9 A I was referring to that one film.

10 Q But you did not say that. You said --

11 A I said it, you read it.

12 Q Certainly a C-arm or intraoperative x-ray is  
13 not weightbearing?

14 A Correct.

15 THE COURT: Or it does not show  
16 weightbearing. It is not weightbearing?

17 Q I'll clarify it.

18 A weightbearing film is where the patient is  
19 standing on their foot, right?

20 A Yes.

21 Q And intraoperatively you can't get that,  
22 right?

23 A Correct.

24 Q And ideally to determine the positioning of  
25 the bones in the foot postoperatively, eventually you

## ROBYN JOSEPH-CROSS

1 wanted a weight bearing film, correct?

2 A Eventually.

3 Q That's the most accurate way to get a  
4 picture, correct?

5 A Correct.

6 Q Now, you also said that in addition, or in  
7 the alternative to doing a shortening of the second  
8 and third metatarsals, the doctor could have  
9 considered a bone graft intraoperatively, correct?

10 A Correct.

11 Q And, Doctor, you're aware that in doing a  
12 bone graft you heighten the risks of the procedure,  
13 correct?

14 A Everything has risk, but...

15 Q That's not what I asked. I said in doing a  
16 bone graft in a Lapidus, are you increasing or  
17 heightening the risks generally of the surgery?

18 A But you have to weigh your risks.

19 Q But I'm just asking a simple question,  
20 Doctor. If doing a bone graft in a Lapidus procedure,  
21 does that increase risks, yes or no?

22 A Depends on if you are experienced at it or  
23 not.

24 Q So you can't answer yes or no; is that  
25 right?

## ROBYN JOSEPH-CROSS

1           A     I guess I can't answer yes or no.

2           Q     All right, fine. Just next time if you  
3 could say that.

4           A     It is hard for me, sorry.

5           Q     Understood.

6                     But you do understand that bone grafting  
7 increases the risk of infection in patients regardless  
8 if you are experienced or not, right?

9           A     No, not necessarily.

10          Q     Not necessarily. And bone grafting will  
11 also increase the risk of a failure to heal, for that  
12 arthrodesis to take hold, correct?

13          A     Possible.

14          Q     And often in medicine with doing surgery on  
15 bones and fusing bones, we get something called  
16 nonunion, correct?

17          A     Yes.

18          Q     It is when bones don't unite?

19          A     Right.

20          Q     And there is very little a doctor can do to  
21 prevent that complication from occurring, correct?

22          A     No.

23          Q     No. Is it not true in the literature that  
24 from time and again certain percentages of patients  
25 are going to get nonunion, whether it is fracture or

## ROBYN JOSEPH-CROSS

1 surgical intervention?

2 A Right. But it is a lot of times --

3 Q Yes or no. I'm just asking yes or no. You  
4 know the rules, you have been in Court before, right?

5 A Right.

6 Q So it is a yes?

7 A It is a yes.

8 Q Thank you, Doctor.

9 A You're welcome.

10 Q And, Doctor, to put it simply, if a bone  
11 graft is done intraoperatively, you may not get a good  
12 fusion, right?

13 A Just like -- maybe.

14 Q Yes or no, Doctor, please?

15 A Maybe.

16 Q Maybe, okay. During the testimony of Doctor  
17 Marzano, I would like you to assume that Mr. Oginski  
18 developed with him that he had previously, prior to  
19 Mrs. Flannery's case, undertaken 25 do 30 Lapidus  
20 procedures. Are you with me so far?

21 A Yes.

22 Q And in each of those cases the outcome was  
23 good. Following me?

24 A Okay.

25 Q Okay. And I want you to accept that the

## ROBYN JOSEPH-CROSS

1 doctor had never previously had to do a bone graft or  
2 an osteotomy on the second and third metatarsal and he  
3 nevertheless had optimal outcomes in those cases?

4 A Okay.

5 Q Thank you. And, Doctor, do you agree that  
6 it is appropriate for a surgeon who has experience  
7 doing these procedures to make a decision  
8 intraoperatively to go along with the procedure that  
9 he ordinarily does and that he has had success with?  
10 Do you agree that that's good practice, yes, no or I  
11 can't answer that way?

12 A Yes.

13 Q Thank you. And, nevertheless, you say in  
14 this case that the doctor should have done either an  
15 osteotomy or a bone graft, right?

16 A Yes.

17 Q That's what you are saying?

18 A Yes.

19 Q If you could curtail your answers to yes or  
20 no.

21 Yes or no, that's what you're saying, he  
22 should have done a bone draft graft or osteotomy  
23 intraoperatively or postoperatively?

24 A Yes.

25 Q And, ma'am, you're being paid \$4,000 to be

## ROBYN JOSEPH-CROSS

1 here today, correct?

2 A Yes.

3 Q And, ma'am, in advance of coming here today  
4 you reviewed records, met with Mr. Oginski, I believe  
5 you met him two times?

6 A Yes.

7 Q Charged him 275 an hour for that time?

8 A Yes.

9 Q And reviewing those records you also charged  
10 per hour for reviewing the records?

11 A Yes.

12 Q Do you know how much you billed to date  
13 including, 4,000 for today?

14 A No, I do not.

15 Q You did not tally that up for today's  
16 events?

17 A No.

18 Q But it is your positioned today that the  
19 doctor should have varied from his usual customary  
20 practice with Miss Flannery and undertaken a different  
21 method of doing this Lapidus procedure, right?

22 THE COURT: Objection?

23 MR. OGINSKI: Yes, I'm sorry.

24 THE COURT: There is no evidence to that.

25 There is no evidence as to what his other

ROBYN JOSEPH-CROSS

1 procedures were.

2 MR. MC ANDREW: The doctor did testify he  
3 never did either of those, Judge.

4 THE COURT: I tell you that every  
5 procedure, no matter what it is called, with  
6 every patient, is different. So, you know, I  
7 can't admit that kind of question.

8 MR. MC ANDREW: Well, Judge, if I may.

9 THE COURT: No, I'm not admitting that.

10 MR. MC ANDREW: I'll move on.

11 THE COURT: There was no evidence and  
12 there can be no evidence unless it is fully  
13 explained what the other procedures were.

14 MR. MC ANDREW: I apologize if I  
15 remembered it differently, your Honor.

16 THE COURT: Well.

17 Q And, Doctor, in the field of podiatry is it  
18 sometimes the case where the podiatrist, the surgeon,  
19 has to do an additional procedure postoperatively?  
20 That happens, right?

21 A It can happen.

22 Q It happened to you in the Marks' case, you  
23 recommended an additional procedure?

24 MR. OGINSKI: Objection. Irrelevant,  
25 unrelated. Totally different set of facts.

ROBYN JOSEPH-CROSS

1 THE COURT: I think that's allowable. Is  
2 this intraoperative you are asking?

3 Q In the postoperative time. Not right after  
4 the surgery, but in the Marks' case you had  
5 recommended --

6 A It is very different, you know.

7 Q I'm not saying that it is the same. I'm  
8 just saying in that instance, in that Marks' case, you  
9 recommended to your patient postoperatively who had a  
10 recurrence that she ought to have further surgery,  
11 correct?

12 MR. OGINSKI: Objection, Judge. It is  
13 totally -- you're comparing apples and oranges.  
14 You have nothing to do with this particular  
15 case.

16 MR. MC ANDREW: I'm not asking about this  
17 case.

18 MR. OGINSKI: That's exactly the point.

19 THE COURT: Well, I think that's valid,  
20 actually, because each one of these is  
21 different.

22 MR. MC ANDREW: Okay, Judge.

23 Q Simply put, Doctor, having to do an  
24 additional podiatric procedure is not necessarily  
25 negligence, right?

## ROBYN JOSEPH-CROSS

1 A If you don't address it originally.

2 Q Just -- you know, I'm sorry, but if you  
3 could limit it to yes or no.

4 A I can't answer it. I can't answer that.

5 Q I have given you that option as well?

6 A Okay.

7 Q Just so that we had it clear, just because  
8 postoperatively the patient is required or there is an  
9 option that she have a further podiatric procedure,  
10 that does not necessarily mean the surgeon was  
11 negligent, right, just generally speaking? And if you  
12 can't answer yes or no, that's fine as well.

13 A It is hard to answer that.

14 Q I'm sorry.

15 A It is hard to answer that because it is  
16 going to infer things.

17 Q Fine. So you can't answer it?

18 A I can't answer it.

19 Q That's all you have to say.

20 A Yes.

21 Q Now, with regard to the aspect of this  
22 surgery where, and correct me if I am wrong, where you  
23 testified that that first metatarsal, the long bone, I  
24 think we all know what that is, that it was too far  
25 down, was pointing too far down, right, that's what

ROBYN JOSEPH-CROSS

1 you said?

2 A Yes.

3 THE COURT: Preoperatively.

4 MR. MC ANDREW: Sorry, Judge?

5 THE COURT: That's preoperatively.

6 MR. MC ANDREW: No, no, postoperatively.

7 THE COURT: Postoperatively?

8 MR. MC ANDREW: Or intraoperatively.

9 THE COURT: Let's make this clear. After  
10 the operation you testified earlier that the  
11 Plaintiff's metatarsal, first metatarsal was  
12 pointing too far down.

13 THE WITNESS: Yes.

14 MR. MC ANDREW: Thanks, Judge.

15 Q And then, Doctor, with regard to positioning  
16 that bone, either up or down, there is a certain  
17 amount of variability, correct?

18 A Absolutely.

19 Q And it is not as though the doctor is in  
20 there with the protractor measuring exactly, it is  
21 touch and feel, right? Clinical judgment?

22 MR. OGINSKI: Objection, two separate  
23 questions. You ask touch and feel and then  
24 clinical judgment.

25 THE COURT: I don't really understand the

## ROBYN JOSEPH-CROSS

1 question.

2 MR. MC ANDREW: I'll be happy to rephrase  
3 it, your Honor.

4 Q So intraoperatively when the doctor is  
5 positioning that bone, podiatrists don't use a  
6 protractor to do that, correct?

7 A Some people use different measure.

8 Q Some people do that?

9 A Some do, some don't.

10 Q Do you do that?

11 A I used to. It depends.

12 Q But you don't any more?

13 A No. More experienced.

14 Q So, Doctor, would you agree that in  
15 positioning the bone, the metatarsal, the cuneiform  
16 bone, that there is a certain amount of judgment  
17 and/or touch and feel?

18 A Right. But there is a realm of what is  
19 right and wrong.

20 Q Yes or no? We know about the realm. Just  
21 yes or no?

22 A Yes.

23 Q Or you can't tell me yes or no?

24 A Yes.

25 Q And is it true, Doctor, that if you

## ROBYN JOSEPH-CROSS

1 plantarflex or push that bone down, it is bound to  
2 bear more weight?

3 A No.

4 Q Okay. Is it true, Doctor, that if you  
5 dorsiflex, or that bone is too far up it, it is not  
6 going to bear weight?

7 A No.

8 Q So neither one of those things are true,  
9 right? I did not hear an answer.

10 A Both of them could be true, both of them  
11 could be false.

12 Q That's a noncommittal answer if I ever heard  
13 one.

14 MR. OGINSKI: Come on, counsel.

15 THE COURT: Sustained. Strike it.

16 Q Now, would you agree that you want to bring  
17 that metatarsal down a little bit so that it can bear  
18 more weight?

19 A A little bit, yes.

20 Q A little bit. You would agree with that?

21 A I agree.

22 Q And if you bring it down too much you might  
23 be actually bearing too much weight. That's a  
24 complication, right?

25 A That and that the toe will come up for sure.

ROBYN JOSEPH-CROSS

1 Q Okay. And if you bring it -- if you leave  
2 it up too high, that first metatarsal won't bear any  
3 weight as well, potentially?

4 A Much weight.

5 Q Or much weight.

6 A That's why I could not answer you before.

7 Q Okay. Thank you. That's why I asked the  
8 question.

9 Now, Doctor, preoperatively, I would like  
10 you to come down. Not preoperatively. I would like  
11 you to come down and look at a preoperative film.

12 This film, and I'm going to identify it,  
13 your Honor, it is, I believe, Exhibit 2 in evidence.  
14 And it is from the films contained in Doctor Marzano's  
15 chart. It is from, if you see here, 3/10/05?

16 A Yes.

17 Q And it is of the patient Flannery, correct?

18 A Yes.

19 Q And this is a lateral view of the patient's  
20 right foot. We have the "R" up here?

21 A Yes.

22 Q And, Doctor, please, bear with me and help  
23 me, if you would.

24 Is this the long bone, the metatarsal right  
25 here?

## ROBYN JOSEPH-CROSS

- 1           A     The first metatarsal?
- 2           Q     Yes.
- 3           A     Yes.
- 4           Q     Is that what it is?
- 5           A     Yes.
- 6           Q     And then would that be the bottom right here
- 7     kind of juts down around here?
- 8           A     Yes.
- 9           Q     Okay.
- 10          A     And that's the second. Do you see where it
- 11     ends?
- 12          Q     The second metatarsal is here?
- 13          A     Yes.
- 14          Q     And the bottom of the second metatarsal
- 15     would be down somewhere here?
- 16          A     About there.
- 17          Q     Can you identify any of the other metatarsal
- 18     heads?
- 19          A     That looks like third right there. It is
- 20     hard. You're not going to be able to see that, I'm
- 21     sorry.
- 22          Q     And, Doctor, is that first metatarsal head,
- 23     the bottom, higher up than the second metatarsal and
- 24     the third metatarsal heads where you pointed to?
- 25          A     No, it is about on the same plain as the

## ROBYN JOSEPH-CROSS

1 second. See --

2 Q So you're saying the first is here and the  
3 second is down there?

4 A Well, it is longer. But if you brought it  
5 back up, it is just about the same plain.

6 Q I'm asking on this film.

7 A Because it is longer, you can't -- it is  
8 apples to oranges I again.

9 Q You can explain that on redirect. But I'm  
10 asking you right now, based upon this metatarsal,  
11 where it is, and the other part of the second  
12 metatarsal, is the bottom of it lower down than the  
13 first metatarsal? Simple yes, no or I cannot answer  
14 that, and I would be happy.

15 A Well, it is misleading to say yes, but I'll  
16 agree.

17 THE COURT: Don't say something  
18 misleading.

19 THE WITNESS: I won't. So then I can't  
20 answer it.

21 THE COURT: Okay.

22 Q That's fine. You can take your seat.

23 Doctor, wouldn't you agree that in a patient  
24 with an unstable cuneiform metatarsal joint that the  
25 cuneiform and the metatarsal may be a little bit up,

## ROBYN JOSEPH-CROSS

1 the first metatarsal?

2 THE COURT: What do you mean by up?

3 THE WITNESS: Right.

4 Q Dorsiflexed. You told us earlier that the  
5 tip is not necessarily up but the whole bone may be  
6 elevated, right?

7 A Elevated.

8 Q Right.

9 A Compared to.

10 Q Compared to. Go ahead?

11 A I'm asking you.

12 Q Okay. I did not know.

13 So, I'm comparing it to the second  
14 metatarsal, such as in that film preoperatively where  
15 you see the second metatarsal, the head is lower than  
16 the first metatarsal. Can that not be related or is  
17 that not related to the fact that you have an  
18 instability in the foot causing elevation of the first  
19 metatarsal?

20 A Fine.

21 Q You agree with that?

22 A I agree with that.

23 Q And that, indeed, can contribute to the  
24 second metatarsal bearing more weight, correct?

25 A Contribute, as well as the long second

## ROBYN JOSEPH-CROSS

1 metatarsal.

2 THE COURT: We are going to take a break.

3 I hear the sighs saying time to get up off the  
4 chair. All right, 15 minutes.

5 (Jury excused.)

6 THE COURT: How much longer?

7 MR. MC ANDREW: Twenty minutes, 30  
8 minutes.

9 THE COURT: And you?

10 MR. OGINSKI: A few minutes.

11 THE COURT: Well, I'm going to hold you to  
12 it. It is getting late in the day and enough is  
13 enough. I would expect 20, 25 more minutes, and  
14 maybe tops ten.

15 MR. OGINSKI: I'm not going to be ten  
16 minutes.

17 THE COURT: Lawyers tell me that every day  
18 of the week ten times a day.

19 MR. MC ANDREW: I don't think it will be  
20 more than 30 minutes, but I need to reserve my  
21 right to that. It is cross-examination.

22 THE COURT: I'm not going to be draconian  
23 about this, but if you are saying 20 minutes and  
24 you mean an hour and 20 minutes, I will cut you  
25 off. It is Friday afternoon and this witness

ROBYN JOSEPH-CROSS

1 has been on the stand all day.

2 MR. MC ANDREW: You're right, Judge. It  
3 is not going to be an hour and 20 minutes, I  
4 assure you.

5 (Recess taken.)

6 THE COURT: Be seated, everyone. Doctor  
7 Joseph, we will continue with cross-examination.  
8 You are still under oath. Understood and  
9 agreed?

10 THE WITNESS: Understood and agreed.

11 MR. MC ANDREW: Thank you, Judge.

12 Q Doctor, I am going to read to you some  
13 excerpts from Dr. Roberts deposition of June 17<sup>th</sup>,  
14 2008, and I'm going to ask you if you --

15 THE COURT: Haven't we gone over this  
16 already?

17 MR. MC ANDREW: No, not this part. There  
18 is a few sections I need to go over.

19 THE COURT: Have you read Dr. Roberts'  
20 deposition?

21 THE WITNESS: I have not.

22 THE COURT: Is it in evidence?

23 MR. OGINSKI: No.

24 MR. MC ANDREW: Well, it will be when I  
25 read it in. As you know, Judge, we can read in

## ROBYN JOSEPH-CROSS

1 a licensed physician for any purpose.

2 THE COURT: Okay.

3 Q Okay, I'm referring to --

4 THE COURT: And does this reading have a  
5 question attached to it?

6 MR. MC ANDREW: Yes, if she agrees or does  
7 not agree. I will get to that.

8 THE COURT: Okay.

9 Q Doctor Joseph, I'm going to read to you page  
10 78, line 16, of Dr. Roberts' deposition transcript.

11 "Question: What are the risks of a  
12 Lapidus procedure?

13 "Answer: Well, the risks with any surgery  
14 is infection, nerve injury, bone not healing,  
15 bone not healing in the right spot, incomplete  
16 pain relief, new pains, blood clot. There are  
17 lots of --

18 "Question: Okay. With respect to the  
19 foot or toes themselves, what are the risks?

20 "Answer: You can overcorrect it and you  
21 can get a new deformity. You can get -- well,  
22 you can get in the wrong position. So it is  
23 bearing too much weight. Or by plantarflexing  
24 it it can bear too much weight. By dorsiflexing  
25 it it can bear not enough weight. And so you

## ROBYN JOSEPH-CROSS

1           can get what is called a transfer lesion where  
2           you get increased stress on the lesser  
3           metatarsals.

4                   "Question: That's a risk of the Lapidus  
5           procedure?

6                   "Answer: Well, that's a risk with any  
7           bunion surgery."

8                   Do you agree with those excerpts?

9                   THE WITNESS: Yes.

10           Q     And, Doctor, I'm going to read you another  
11           section. Page 75, 15 to 18.

12                   "Question: You don't want to dorsiflex it  
13           either.

14                   "Answer: So it is an art. And it is hard  
15           to objectify what the perfect position is."

16                   Again, talking about that first bone.

17                   Do you agree with that?

18           A     Within reason.

19           Q     Do you agree with Dr. Roberts' testimony  
20           that you don't want to bring it -- I'm sorry, it is  
21           easy to bring it up too far and it is easy to bring it  
22           down too much?

23           A     In surgery, how you finally position it --

24           Q     I'm sorry, doctor, I'm going to ask you to  
25           limit yourself to yes or no.

## ROBYN JOSEPH-CROSS

1 THE COURT: If you can't answer that you  
2 can always say I can't answer that.

3 MR. MC ANDREW: Of course.

4 THE WITNESS: I can't answer because it is  
5 not complete.

6 Q Fine. And, Doctor, do you agree -- hold on  
7 one moment. Do you agree, at page 79 through 80,  
8 lines 23 to 7.

9 "Question: That condition I just  
10 described about the toes pointing upward and not  
11 meeting the ground, is that a risk of the  
12 Lapidus procedure?

13 "Answer: Do you mean with the toe  
14 sticking up?

15 "Question: Correct.

16 "Answer: A toe deformity?

17 "Question: Is that a risk?

18 "Answer: It is a possible complication of  
19 any bunion surgery."

20 Do you agree with that? I know it is  
21 disjuncted, but do you agree with the toe going  
22 up being a risk of any bunion surgery with  
23 Dr. Roberts?

24 A Are we talking about the big toe?

25 Q Yes.

ROBYN JOSEPH-CROSS

1 A Okay. Is it a risk of any surgery?

2 Q Just do you agree with Dr. Roberts, his  
3 testimony that it is a risk of any bunion surgery?

4 A If it is done poorly, yes.

5 Q Again, if you could limit yourself to yes or  
6 no, you agree or not. He did not say anything in his  
7 deposition about being done poorly. He said it is a  
8 risk of any bunion surgery. Do you agree or disagree  
9 or can you not form an agreement or a disagreement?

10 A I cannot form an agreement because it is  
11 disjointed.

12 Q And I'll read from Dr. Roberts' deposition,  
13 Page 80, line 11 through 17.

14 "Question: Being that you did many of  
15 these Lapidus procedures, do you disclose the  
16 risk of the procedure itself? The risks of the  
17 procedure itself to your patients?

18 "Answer: Sure.

19 "Question: Okay. Is one of the risks  
20 that they may need further surgery in the  
21 future?

22 "Answer: Sometimes."

23 Do you agree with that, yes or no?

24 THE WITNESS: I agree.

25 Q And then at page 83 of Dr. Roberts'

ROBYN JOSEPH-CROSS

1 testimony, lines 10 through 20.

2 "Question: You were talking about risks,  
3 or Mr. Levine asked you about risks of the  
4 Lapidus procedure. Would you agree that there  
5 are what doctors consider to be known risks with  
6 any procedure?

7 "Answer: Correct.

8 "Question: And those risks can occur even  
9 in the best of hands and under the best of  
10 circumstance, correct?

11 "Answer: Correct."

12 Do you agree with that?

13 THE WITNESS: I agree.

14 Q And, Doctor, would you agree that among  
15 physicians, whether they be podiatric surgeon or  
16 orthopedic surgeons, there is room for disagreement?

17 A Yes.

18 Q We have heard the old adage, ask five  
19 doctors their opinion and you will get five different  
20 answers?

21 MR. OGINSKI: Objection.

22 THE COURT: Well, I suppose that there is  
23 room for disagreement in some areas, but not in  
24 all areas.

25 MR. MC ANDREW: Can I --

ROBYN JOSEPH-CROSS

1 THE COURT: That question is not really  
2 specific enough to form an answer, in my  
3 opinion. So I'm going to sustain that. Strike  
4 that.

5 MR. MC ANDREW: I'll try to rephrase it in  
6 a more palatable way.

7 Q Do you agree with the old adage that if you  
8 ask five different doctors the question you will get  
9 five different answers?

10 MR. OGINSKI: Objection.

11 THE COURT: Sustained.

12 MR. MC ANDREW: Withdrawn.

13 Q And, Doctor, in your career as a podiatric  
14 surgeon, have you experienced the complication with  
15 your patients of shortening the first metatarsal? Has  
16 that occurred to any of your patients?

17 A Do you want to quantify that?

18 Q I'm sorry?

19 A Do you want to quantify it?

20 Q Just, has it happened in, for instance, the  
21 Marks' case?

22 MR. OGINSKI: Objection. Now we are  
23 talking about different things. First he asked  
24 about everything, then just the Marks' case.  
25 Objection to form.

ROBYN JOSEPH-CROSS

1 MR. MC ANDREW: She asked that I quantify  
2 it.

3 THE COURT: Sustained.

4 Q In the Marks' case was there a shortening of  
5 the first metatarsal?

6 MR. OGINSKI: Objection. Irrelevant.

7 THE COURT: I don't want to get into all  
8 of the specifics of these other cases. I don't  
9 think it is fair to the jurors, so I'm not going  
10 to do it.

11 Q Generally have you had a postoperative  
12 complication where the big toe was going up?

13 MR. OGINSKI: I'm sorry to interrupt you,  
14 I don't mean to, but are you talking about  
15 bunion surgery or Lapidus procedure, or just be  
16 specifically?

17 MR. MC ANDREW: Bunion surgery.

18 A Any bunion surgery?

19 Q Yes.

20 A Not really.

21 Q How about with Lapidus procedure, have you  
22 ever had the toe going up afterwards?

23 A No.

24 Q How about with a closing wedge base  
25 resection, or you called osteotomy?

## ROBYN JOSEPH-CROSS

1 MR. OGINSKI: Objection, that's the same  
2 objection as before.

3 THE COURT: Sustained. That was not the  
4 procedure that was done here.

5 Q Doctor, would you agree that treatment for  
6 an upgoing first toe after a bunionectomy would  
7 include physical therapy as a possible treatment?

8 A Depends on how stuck it is.

9 Q But can that be treatment?

10 A If it is flexible, yes.

11 Q When you say if it is flexible, in other  
12 words, if you can push it down; is that right?

13 A If the metatarsal is not in the way.

14 THE COURT: If the metatarsal is what?

15 THE WITNESS: Is not in the way.

16 THE COURT: Is not in the way?

17 THE WITNESS: Yes.

18 Q Well, when you say if it is flexible, do you  
19 mean that you can get that toe from the upward  
20 position by pressing on it, the doctor pressing on it  
21 to push it down to where it would be in the purchase  
22 position, flat position, is that what you mean by  
23 flexible, or something else?

24 A No.

25 Q All right. If that's not what you mean.

## ROBYN JOSEPH-CROSS

1 That's fine.

2 Doctor, you would agree that in this case  
3 you looked at the facts from hindsight, correct?

4 A Yes.

5 Q You were sitting at your desk when you were  
6 reviewing the documents, the x-rays, you were in your  
7 family room at home, where were you?

8 THE COURT: What does it matter?

9 MR. MC ANDREW: I'm just curious, Judge.

10 THE COURT: I don't think that's a matter  
11 to go into.

12 Q Would it be fair to say that you were able  
13 to review these documents at your leisure?

14 A I was working, it is not leisure.

15 Q Okay. You consider that working, reviewing  
16 these documents, or do you mean you were at your  
17 office working when you reviewed the documents, or  
18 something else?

19 MR. OGINSKI: Objection.

20 THE COURT: Never mind.

21 Q And would you --

22 THE COURT: I don't know what these  
23 questions mean. But do you know what they mean?

24 THE WITNESS: No.

25 MR. MC ANDREW: Judge, I'll withdraw the

ROBYN JOSEPH-CROSS

1 question.

2 THE COURT: Thanks.

3 Q Would you agree that you had the benefit of  
4 hindsight in looking at this case?

5 MR. OGINSKI: Objection, asked and  
6 answered.

7 THE COURT: Sustained.

8 Q Do you agree that having the benefit of  
9 hindsight is a great benefit in reviewing a case like  
10 this?

11 A Like this? The facts are the facts.

12 Q And, Doctor, would you agree that Doctor  
13 Marzano certainly did not have the benefit of  
14 hindsight in caring for this patient in 2004 and 2005?

15 A Postoperatively he did.

16 Q Going forward, each day?

17 A (Nodding affirmatively.)

18 THE COURT: The answer is yes?

19 THE WITNESS: Yes.

20 THE COURT: You have to answer.

21 MR. MC ANDREW: Those are all of the  
22 questions that I have. Thank you.

23 THE COURT: Thank you. Redirect?

24 MR. OGINSKI: Yes, your Honor.

25 REDIRECT EXAMINATION

ROBYN JOSEPH-CROSS

1 CONDUCTED BY MR. OGINSKI:

2 THE COURT: Now, remember, you're  
3 restricted to the questions asked on cross.

4 MR. OGINSKI: I understand.

5 Q Doctor Joseph, you were asked questions by  
6 Mr. McAndrew about the Informed Consent Form that  
7 appears in Doctor Marzano's chart. Is that a  
8 prewritten form, like a fill-in-the-blank form?

9 A Yes, it is.

10 MR. MC ANDREW: Objection, your Honor.

11 THE COURT: Overruled.

12 Q And that form, what do they do? In other  
13 words, what do you do, what information do you put  
14 into that form that is already in existence?

15 A I just want to find it. Okay.

16 Q Tell us how that form -- in other words, is  
17 it a template and you simply put the patient's name in  
18 and the type of procedure?

19 A Yes.

20 MR. MC ANDREW: I objected. I don't think  
21 there is any foundation of how this document was  
22 formulated.

23 THE COURT: No, I gave you latitude to ask  
24 questions about this. You got it. Now he has  
25 information that he can use.

## ROBYN JOSEPH-REDIRECT

1 THE WITNESS: It is computer generated.

2 So it is fill in the blank.

3 Q Okay. And what do we know about the  
4 computer generated electronic medical records from  
5 Doctor Marzano from everything that we have read?

6 A They have been a little lax in completeness  
7 and accuracy.

8 Q Now, you have told us that --

9 THE COURT: Could the jury hear that?

10 THE WITNESS: I will speak louder.

11 Q You told Mr. McAndrew that -- he asked you  
12 whether everything under the sun should be --

13 MR. MC ANDREW: Objection, your Honor.

14 MR. OGINSKI: I'll rephrase.

15 Q He said do you think that everything should  
16 be put into this Informed Consent Form, and you were  
17 going to explain. Tell us what should be put into the  
18 consent form?

19 A What should be put into the consent form is  
20 the procedure, the risks, but the known risks looking  
21 at the patient's foot. Where he knows that certain  
22 things may occur because of the way that her foot is.  
23 Like the long second metatarsal, the out of alignment  
24 second metatarsal toe joint, and that doing a  
25 shortening Lapidus procedure, even if it was done

## ROBYN JOSEPH-REDIRECT

1 without that much shortening, would put more stress on  
2 the second metatarsal. And that needs to be  
3 addressed.

4 Q And the fact that he did not do that, do you  
5 have an opinion within a reasonable degree of  
6 podiatric probability as to whether that represents a  
7 departure?

8 A Yes.

9 MR. MC ANDREW: Objection.

10 Q What is that opinion?

11 THE COURT: Overruled.

12 A My opinion is that he should have explained  
13 all of that preoperatively, and he should have  
14 addressed it even surgically.

15 Q And, Doctor, is there any doubt in your mind  
16 that the Defendant put the metatarsal too far down  
17 during the course of this patient's surgery?

18 A Yes. It was so far down. It was lower than  
19 the second and third metatarsal into the fourth. It  
20 was -- it is angled almost, you know, almost like a  
21 40-degree angle.

22 Q And in your opinion, Doctor, with a  
23 reasonable degree of podiatric probability, is it your  
24 opinion that that represents a departure from good and  
25 accepted podiatric care?

## ROBYN JOSEPH-REDIRECT

1 A Yes.

2 Q And as a result of that departure did  
3 Annmarie Flannery suffer injury?

4 A Yes.

5 MR. MC ANDREW: Objection, your Honor.

6 Q Is there any doubt in your mind, Doctor,  
7 that Annmarie Flannery should have had a second and  
8 third osteotomy during the course of the first  
9 surgery, provided, of course, she had been counseled  
10 in the beginning that this was going to help her foot?

11 A Yes.

12 Q And the fact that that did not occur, do you  
13 have any doubt in your mind that that represents a  
14 departure from good and accepted podiatric care?

15 A Yes.

16 Q And what is that opinion?

17 A My opinion is that it is a departure. She  
18 should have been told and it should have been done and  
19 she would not have had those problems.

20 Q As a result of those departures was that a  
21 substantial factor in causing Annmarie Flannery's  
22 injuries?

23 A Yes.

24 MR. OGINSKI: Thank you, Doctor.

25 THE COURT: Recross.

## ROBYN JOSEPH-REDIRECT

1 MR. MC ANDREW: Two, maybe three.

2 RECROSS-EXAMINATION

3 CONDUCTED BY MR. MC ANDREW:

4 Q Doctor Joseph -- Stretching with the two, I  
5 guess.

6 Doctor Joseph, you said that the angle was  
7 40 degrees, or almost 40 degrees, I think is what you  
8 said, right?

9 A Yes.

10 Q Do you know that Doctor Marzano testified  
11 that he believes it to be 30 degrees and appropriate?  
12 Do you know that? You don't know that, right?

13 A No, I don't know that.

14 MR. MC ANDREW: That's all I have.

15 THE COURT: All right. Thank you very  
16 much.

17 THE WITNESS: Thank you.

18 (Witness excused.)

19 THE COURT: Ladies and gentlemen, we are  
20 going to brake for the day, it is Friday and we  
21 have to work on Monday and possibly Tuesday.

22 I have been doing this sometime now and I  
23 still kind of smile. Lawyers will say don't  
24 worry, Judge, we will only be three days and one  
25 week and no more, and it has never in my

ROBIN JOSEPH, D.P.M.-RECROSS

1           experience been that.

2                       So, nevertheless, we are moving along.

3           And I believe that we will get this case in  
4           hopefully by the end of next week. But I can't  
5           guarantee it. But we are moving along.

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ROBIN JOSEPH, D.P.M.-RECROSS

1 Thank you for your courtesy, I hope you  
2 have a pleasant weekend in the heat and you get  
3 some rest. See you Monday at ten.

4 Any other questions? 10 o'clock.

5 (Jury excused.)  
6  
7

8 \* \* \* \*  
9

10 I, Cynthia M. Hills, do hereby certify  
11 that the within proceedings are a true and accurate  
12 transcript of the original stenographic record.  
13

14 \_\_\_\_\_  
15 Cynthia M. Hills, RPR, CRR  
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<b>2</b>		
<b>2 feet [1]</b> 451/24 <b>2 o'clock [2]</b> 520/25 520/25 <b>20 [5]</b> 573/13 573/23 573/24 574/3 579/1 <b>2000 [2]</b> 510/23 519/23 <b>2004 [4]</b> 504/10 518/23 531/5 584/14 <b>2005 [11]</b> 426/11 437/24 441/18 443/11 461/3 531/6 531/13 542/4 544/14 545/2 584/14 <b>2006 [4]</b> 409/6 453/24 457/16 462/5 <b>2007 [1]</b> 556/5 <b>2008 [1]</b> 574/14 <b>2010 [1]</b> 399/10 <b>23 [2]</b> 453/24 577/8 <b>25 [4]</b> 399/15 443/11 560/19 573/13 <b>25th [4]</b> 441/18 531/13 544/14 545/2 <b>275 [1]</b> 562/7		
<b>3</b>		
<b>3/10/05 [2]</b> 534/11 569/15 <b>3/15 [1]</b> 522/20 <b>3/15/05 [1]</b> 522/21 <b>3/9/05 [2]</b> 511/1 522/14 <b>30 [3]</b> 560/19 573/7 573/20 <b>30 degrees [1]</b> 589/11		
<b>4</b>		
<b>4 inches [1]</b> 451/25 <b>4 millimeters [1]</b> 473/24 <b>4,000 [3]</b> 472/6 472/9 562/13 <b>4/15 [1]</b> 522/18 <b>4/15/05 [1]</b> 522/15		

<p><b>A</b></p> <p><b>ahhh</b> [1] 466/16</p> <p><b>air</b> [4] 438/21 442/15 443/20 455/4</p> <p><b>align</b> [1] 551/16</p> <p><b>aligned</b> [3] 415/11 416/21 442/5</p> <p><b>alignment</b> [16] 416/19 418/22 422/22 423/25 424/3 429/3 439/14 439/19 440/5 440/8 445/15 459/24 465/5 504/7 516/17 586/23</p> <p><b>all</b> [61] 407/10 414/9 414/12 415/11 418/25 419/16 419/22 420/3 420/25 421/3 428/2 431/4 434/9 436/5 436/18 444/5 461/16 461/20 466/16 466/16 476/3 478/8 481/1 481/11 489/11 489/16 490/6 490/18 492/12 500/22 501/2 503/22 508/1 512/13 513/14 515/17 517/13 517/22 520/23 521/5 530/17 539/10 539/12 539/23 540/11 540/19 540/20 550/14 552/11 559/2 565/19 565/24 573/4 574/1 579/24 581/7 582/25 584/21 587/13 589/14 589/15</p> <p><b>alleged</b> [1] 490/17</p> <p><b>allergies</b> [1] 495/5</p> <p><b>alleviate</b> [1] 424/13</p> <p><b>allow</b> [3] 432/15 457/2 489/23</p> <p><b>allowable</b> [1] 564/1</p> <p><b>allowing</b> [2] 502/2 502/9</p> <p><b>almost</b> [6] 429/2 439/11 476/10 587/20 587/20 589/7</p> <p><b>along</b> [7] 459/22 496/5 537/21 549/24 561/8 590/2 590/5</p> <p><b>already</b> [27] 424/5 424/10 424/24 427/5 432/6 433/8 433/8 435/12 435/13 435/14 435/15 439/4 441/20 447/5 451/10 456/8 456/9 456/23 466/8 475/20 502/25 512/18 512/19 513/13 517/10 574/16 585/14</p> <p><b>also</b> [38] 407/20 407/23 408/4 410/25 418/23 428/7 428/13 432/20 435/18 437/2 446/1 447/2 447/2 452/25 455/12 459/12 460/5 460/5 461/3 469/1 471/6 475/20 489/9 492/19 497/18 503/10 503/11 509/3 509/19 512/20 514/21 517/7 518/24 525/23 536/4 558/6 559/11 562/9</p> <p><b>alternative</b> [2] 528/12 558/7</p> <p><b>alternatives</b> [2] 528/3 528/10</p> <p><b>always</b> [3] 505/18 508/21 577/2</p> <p><b>am</b> [20] 410/24 411/2 435/6 435/19 441/17 441/23 472/11 480/17 481/5 484/4 486/25 492/17 504/17 535/22 536/21 540/10 549/12 551/13 565/22 574/12</p> <p><b>ambulation</b> [3] 455/15 493/24 494/15</p> <p><b>American</b> [3] 411/7 411/9 469/23</p> <p><b>among</b> [1] 579/14</p> <p><b>amount</b> [12] 433/7 446/4 447/10 448/2 449/15 457/8 457/9 473/4 473/18 532/9 566/17 567/16</p> <p><b>amputated</b> [1] 520/10</p> <p><b>an opinion</b> [1] 587/5</p> <p><b>an opportunity</b> [1] 540/14</p> <p><b>anatomy</b> [1] 423/20</p> <p><b>and/or</b> [2] 416/5 567/17</p> <p><b>ANDREW</b> [4] 476/7 491/8 522/4 589/3</p> <p><b>anesthesia</b> [3] 525/23 525/24 527/16</p> <p><b>angle</b> [16] 412/13 416/4 422/25 423/17 428/11 438/4 438/10 448/10 448/11 449/18 494/3 498/11 534/18 557/6 587/21 589/6</p> <p><b>angled</b> [4] 423/16 429/22 432/23 587/20</p> <p><b>angles</b> [1] 423/10</p> <p><b>ankle</b> [2] 415/5 422/6</p> <p><b>ANNMARIE</b> [22] 399/3 436/23 443/18 444/23 446/20 450/15 450/25 451/4 453/23 456/20 459/20 462/4 462/23 464/3 464/10 465/8 465/17 474/13 522/12 588/3 588/7 588/21</p> <p><b>Annmarie Flannery</b> [8] 443/18 444/23 446/20</p>	<p>453/23 462/4 462/23 465/8 474/13</p> <p><b>Annmarie Flannery's</b> [2] 450/15 450/25</p> <p><b>Annmarie's</b> [1] 472/20</p> <p><b>another</b> [16] 407/4 416/11 421/8 437/11 449/23 463/6 468/5 468/5 478/3 487/3 500/8 529/14 530/4 547/25 548/8 576/10</p> <p><b>another podiatrist</b> [1] 468/5</p> <p><b>answer</b> [31] 434/17 473/13 474/6 487/11 487/13 518/12 547/14 548/4 553/18 553/20 558/24 559/1 561/11 565/4 565/4 565/12 565/13 565/15 565/17 565/18 568/9 568/12 569/6 571/13 571/20 577/1 577/2 577/4 580/2 584/18 584/20</p> <p><b>answered</b> [5] 432/13 492/2 513/18 519/12 584/6</p> <p><b>answers</b> [4] 521/25 561/19 579/20 580/9</p> <p><b>anterior</b> [1] 533/16</p> <p><b>anticipate</b> [2] 515/24 515/24</p> <p><b>anticipates</b> [1] 514/5</p> <p><b>anticipating</b> [2] 513/22 556/25</p> <p><b>any</b> [47] 407/5 421/1 421/2 431/17 433/25 445/5 447/1 452/16 476/18 476/20 477/22 479/6 481/7 483/16 490/20 495/9 515/2 515/16 517/12 526/3 526/10 541/14 544/16 545/11 552/5 553/3 553/10 553/17 567/12 569/2 570/17 575/1 575/13 576/6 577/19 577/22 578/1 578/3 578/8 579/6 580/16 581/18 585/21 587/15 588/6 588/13 591/4</p> <p><b>anyone</b> [1] 420/22</p> <p><b>anything</b> [9] 420/4 468/15 478/17 479/3 487/3 492/24 497/10 499/2 578/6</p> <p><b>AP</b> [1] 533/10</p> <p><b>apologies</b> [1] 538/24</p> <p><b>apologize</b> [3] 538/17 538/21 563/14</p> <p><b>apology</b> [1] 469/15</p> <p><b>appears</b> [3] 533/25 534/5 585/7</p> <p><b>apples</b> [2] 564/13 571/8</p> <p><b>apply</b> [1] 470/3</p> <p><b>appreciate</b> [2] 490/7 543/16</p> <p><b>appropriate</b> [24] 448/20 471/4 471/8 475/25 494/18 494/25 496/11 496/18 497/3 501/21 502/4 507/16 510/1 510/8 522/24 523/8 524/9 524/13 525/6 528/11 545/11 552/1 561/6 589/11</p> <p><b>appropriately</b> [1] 446/9</p> <p><b>Approximately</b> [1] 511/12</p> <p><b>April</b> [6] 504/10 508/25 510/23 518/19 518/23 519/23</p> <p><b>April 15th</b> [1] 518/19</p> <p><b>arch</b> [6] 415/6 423/7 423/8 423/16 429/22 429/23</p> <p><b>are</b> [180] 406/5 406/11 406/15 406/17 407/6 408/4 409/13 410/6 410/18 410/25 411/13 415/7 415/11 415/11 415/16 416/22 417/18 418/1 419/18 420/24 421/9 421/22 423/15 423/18 424/18 424/24 424/25 425/3 425/8 425/9 425/15 426/10 426/20 426/22 427/21 428/3 428/4 429/1 429/14 429/22 431/4 431/20 431/22 432/19 432/22 432/22 433/7 433/19 435/4 435/17 438/2 438/14 438/15 438/15 439/18 439/19 440/3 440/4 440/11 443/21 444/1 446/16 447/13 447/14 447/18 447/19 448/3 449/1 451/12 451/16 451/19 451/22 451/24 451/25 452/20 453/9 456/20 457/15 459/8 461/17 461/25 462/3 466/16 467/10 467/23 467/24 468/5 469/10 469/17 469/18 469/19 471/25 475/12 476/12 479/9 483/7 487/12 487/15 487/18 487/19 488/7 488/13 488/15 488/21 490/23 493/11 496/2 496/8 499/20 508/2 508/24 509/12 509/14 510/9 510/10 511/23 513/7 513/15 514/2 514/25 515/8 515/10 520/23 521/22 523/16 526/7 526/9 527/8 527/19 528/3 530/14</p>	<p>530/16 530/18 530/20 530/21 530/23</p> <p>532/11 532/12 532/23 534/3 535/6 536/18 537/14 538/6 540/8 541/20 542/7 542/22 543/17 544/11 544/18 547/7 549/20 550/14 552/7 557/7 558/16 558/22 559/8 559/25 560/20 561/17 564/2 568/8 573/2 573/23 574/8 575/11 575/16 575/19 577/24 579/5 580/22 581/14 584/11 584/21 589/19 590/2 590/5 591/11</p> <p><b>area</b> [18] 409/24 416/11 416/11 417/3 423/5 424/4 429/8 429/15 429/21 430/1 430/5 431/23 435/15 459/23 466/9 489/25 491/19 552/2</p> <p><b>areas</b> [2] 579/23 579/24</p> <p><b>argue</b> [2] 544/11 544/12</p> <p><b>arguing</b> [1] 512/22</p> <p><b>argument</b> [1] 488/25</p> <p><b>argumentative</b> [4] 501/3 513/16 545/6 548/10</p> <p><b>arise</b> [1] 435/8</p> <p><b>arm</b> [10] 554/23 555/6 555/6 555/9 555/13 555/21 556/15 556/20 557/1 557/12</p> <p><b>arms</b> [1] 557/7</p> <p><b>around</b> [7] 419/19 420/1 447/16 448/3 448/12 555/7 570/7</p> <p><b>arrive</b> [1] 422/15</p> <p><b>arrow</b> [1] 415/17</p> <p><b>art</b> [2] 531/23 576/14</p> <p><b>arthritis</b> [3] 442/25 459/13 459/15</p> <p><b>Arthro</b> [1] 421/6</p> <p><b>arthrodesis</b> [6] 421/5 421/6 500/18 501/10 550/19 559/12</p> <p><b>article</b> [2] 468/23 468/24</p> <p><b>as</b> [105] 406/10 407/15 408/4 409/9 411/23 415/24 415/25 416/3 421/22 426/18 428/7 430/11 430/11 433/6 433/7 437/15 438/21 443/10 443/16 447/9 447/10 448/20 449/15 449/16 449/16 450/12 452/9 454/1 454/1 457/21 462/10 462/10 463/8 463/8 464/10 465/16 467/20 468/11 469/8 470/17 470/18 470/18 471/15 476/17 478/15 480/3 480/8 480/24 482/10 485/19 486/7 486/8 487/20 491/14 491/17 492/20 494/8 497/14 499/15 499/15 502/23 502/24 504/23 506/10 507/8 507/8 509/1 512/17 514/23 514/23 515/11 515/14 518/25 518/25 528/2 528/3 528/3 529/6 537/21 537/23 544/19 544/20 549/23 551/15 551/15 554/10 554/10 556/2 556/13 562/25 565/5 565/12 566/19 569/3 570/25 572/14 572/25 572/25 574/25 580/13 582/2 582/7 587/6 588/2 588/20</p> <p><b>ascertain</b> [1] 485/3</p> <p><b>ask</b> [30] 408/24 411/11 422/14 424/24 425/24 435/3 445/1 445/12 450/12 454/12 456/25 459/19 475/2 478/17 478/20 489/2 489/11 489/12 497/16 514/13 517/25 519/15 548/5 549/21 566/23 574/14 576/24 579/18 580/8 585/23</p> <p><b>asked</b> [10] 432/12 558/15 569/7 579/3 580/23 581/1 584/5 585/3 585/5 586/11</p> <p><b>asking</b> [19] 471/2 481/12 482/3 488/15 489/7 499/10 511/18 549/19 550/12 551/13 556/22 556/23 558/19 560/3 564/2 564/16 571/6 571/10 572/11</p> <p><b>asks</b> [2] 407/8 517/24</p> <p><b>aspect</b> [4] 496/16 499/15 515/2 565/21</p> <p><b>aspects</b> [2] 496/7 497/24</p> <p><b>assess</b> [2] 440/5 532/3</p> <p><b>assessing</b> [1] 496/2</p> <p><b>assessment</b> [4] 436/25 455/13 459/19 553/23</p> <p><b>assist</b> [2] 432/20 511/6</p> <p><b>associate</b> [1] 467/21</p> <p><b>associated</b> [1] 446/16</p> <p><b>assume</b> [35] 436/21 499/3 499/7 499/8</p>
--	--	--

**A**  
**assume...** [31] 499/10 499/20 499/21 502/22 503/2 514/14 514/17 517/24 517/25 518/1 518/4 518/6 518/21 522/14 522/16 522/22 522/23 528/8 536/14 537/9 537/25 538/9 538/11 538/12 538/18 539/1 540/1 540/19 544/6 553/9 560/17  
**assuming** [5] 436/16 436/18 499/25 500/1 554/14  
**assumption** [3] 538/18 539/13 539/25  
**assurances** [1] 523/17  
**assure** [2] 503/12 574/4  
**at** [121] 406/1 407/6 407/13 409/2 409/2 409/17 409/18 409/20 416/9 417/14 418/25 422/15 422/17 422/19 422/20 422/20 422/21 422/21 422/23 422/23 422/25 423/1 423/21 423/22 423/24 423/25 426/11 426/14 428/17 428/19 431/2 431/16 431/23 432/18 433/17 433/19 434/2 434/3 435/1 435/4 435/12 437/21 439/10 440/6 440/7 440/24 441/11 442/22 445/15 447/15 448/21 451/12 452/12 452/19 453/5 453/19 453/22 454/12 456/6 458/14 460/8 460/18 461/2 461/6 461/7 461/10 462/9 462/15 466/21 468/3 470/11 471/3 473/7 477/4 477/16 479/25 480/5 482/4 482/8 482/11 485/4 485/19 486/8 488/7 492/21 494/3 500/21 500/22 502/1 502/9 503/16 503/18 503/22 504/22 505/22 507/24 509/4 511/3 512/7 517/9 517/15 521/5 522/11 523/22 527/1 533/11 535/21 536/6 544/3 548/19 558/22 569/11 577/7 578/25 583/3 583/5 583/7 583/13 583/16 584/4 586/21 591/3  
**attached** [2] 458/11 575/5  
**attaches** [1] 438/22  
**attempted** [1] 463/7  
**attorney** [4] 399/14 399/18 471/2 490/12  
**Austin** [13] 413/4 413/7 413/16 421/20 498/13 507/8 507/18 507/24 507/25 508/10 508/11 509/2 509/2  
**available** [1] 524/24  
**Avenue** [1] 399/18  
**average** [2] 473/23 492/5  
**aware** [10] 441/23 484/21 485/5 485/24 486/6 492/12 492/18 512/4 517/15 558/11  
**away** [11] 415/14 428/8 448/8 448/10 448/11 451/23 451/25 506/3 528/17 552/5 553/4  
**axis** [1] 549/17

**B**  
**back** [43] 408/24 415/3 416/8 416/20 416/23 418/18 419/9 419/10 422/3 423/13 429/11 433/24 436/1 444/6 444/13 444/17 445/1 445/17 447/13 447/17 449/20 458/11 461/14 461/25 463/9 466/17 473/11 484/22 490/9 500/25 506/1 511/3 518/22 528/21 529/19 529/23 535/4 535/6 536/25 542/24 545/16 556/5 571/5  
**background** [1] 492/4  
**bad** [3] 464/14 464/18 464/22  
**balance** [2] 443/25 454/24  
**ball** [9] 409/23 415/6 417/9 421/25 430/18 432/5 454/6 456/5 460/16  
**bam** [3] 424/20 424/20 424/21  
**bandage** [1] 475/21  
**bandages** [2] 441/19 475/22  
**bank** [2] 430/15 449/24  
**bar** [5] 488/3 488/6 488/7 526/23 527/1  
**barefoot** [1] 497/2  
**base** [5] 502/1 546/8 546/9 550/8 581/24  
**based** [12] 410/4 462/21 464/2 464/7 464/12 465/11 465/14 485/9 498/9 534/4 553/22

571/10  
**basic** [1] 413/16  
**basically** [2] 458/24 466/18  
**basing** [2] 465/10 535/15  
**be** [126] 406/5 406/14 406/15 406/22 408/14 409/20 411/25 414/23 416/13 417/7 418/7 423/11 424/16 425/16 426/17 428/5 428/21 429/10 430/1 430/6 433/13 435/20 437/9 437/10 438/7 438/10 438/15 438/16 440/4 442/5 443/19 443/21 445/5 447/6 447/17 457/17 460/22 461/24 463/5 466/13 467/22 472/4 484/9 484/9 484/10 484/11 484/13 490/25 491/2 493/3 495/1 495/20 495/24 498/13 500/5 500/25 501/13 503/15 506/12 510/2 515/20 515/20 518/9 518/10 518/13 518/14 519/18 520/6 520/10 521/10 521/15 523/5 525/8 527/4 527/15 528/17 530/10 533/9 537/3 537/10 537/19 539/5 540/10 540/14 541/11 545/2 546/18 546/20 550/7 550/11 550/12 552/2 553/25 557/1 561/25 563/12 567/2 568/10 568/11 568/23 570/6 570/15 570/20 571/14 571/25 572/5 572/16 573/15 573/19 573/22 574/3 574/6 574/24 579/5 579/15 581/15 582/9 582/21 583/12 586/12 586/16 586/17 586/19 587/2 589/11 589/24  
**bear** [10] 495/22 503/6 514/24 568/2 568/6 568/17 569/2 569/22 575/24 575/25  
**bearing** [5] 503/1 558/1 568/23 572/24 575/23  
**became** [1] 480/15  
**because** [79] 407/9 409/16 409/21 415/2 415/15 416/12 419/8 420/23 423/6 423/16 423/19 424/16 424/19 428/14 429/21 433/7 433/22 435/7 438/22 439/4 442/4 443/23 447/20 447/22 448/9 449/11 451/10 454/24 454/25 456/8 456/13 458/6 458/10 458/24 459/9 459/10 459/25 460/1 460/2 460/16 466/5 466/8 473/23 474/7 475/14 475/17 475/20 482/12 495/19 497/8 500/25 502/23 502/25 503/4 513/13 513/25 516/16 517/19 522/1 530/3 536/22 538/22 539/14 539/19 540/13 541/14 542/4 543/5 546/17 547/24 548/7 549/7 564/20 565/7 565/15 571/7 577/4 578/10 586/22  
**become** [10] 412/15 415/25 417/6 419/14 421/8 467/18 469/17 469/18 503/19 537/22  
**becomes** [2] 417/8 522/2  
**becoming** [1] 487/12  
**been** [34] 406/9 411/23 413/2 413/4 439/22 441/12 444/8 447/2 448/14 451/3 466/8 471/20 473/2 473/9 473/17 481/22 485/6 485/11 485/20 494/3 522/16 528/8 536/4 536/5 536/8 543/24 560/4 574/1 586/6 588/9 588/18 588/18 589/22 590/1  
**before** [34] 412/3 424/9 440/24 441/1 452/11 452/16 456/7 467/6 471/15 471/18 472/25 478/6 479/11 479/20 496/1 497/2 497/14 503/19 510/7 511/25 512/7 519/7 522/21 527/22 531/4 531/17 534/12 540/20 543/6 543/13 556/4 560/4 569/6 582/2  
**begin** [2] 430/10 467/17  
**beginning** [4] 433/18 433/19 507/24 588/10  
**behalf** [6] 471/1 471/7 471/12 480/5 482/21 545/20  
**behind** [10] 415/9 416/17 417/19 417/19 417/20 417/23 421/24 438/16 533/2 533/3  
**being** [14] 415/21 460/7 460/16 463/12 471/7 490/1 494/11 494/11 494/11 516/15 561/25 577/22 578/7 578/14  
**believe** [8] 461/25 511/1 524/21 554/16 555/8 562/4 569/13 590/3  
**believed** [1] 545/9

**believes** [1] 589/11  
**benefit** [4] 584/3 584/8 584/9 584/13  
**benefits** [1] 528/15  
**besides** [3] 428/11 434/15 440/21  
**best** [3] 484/5 579/9 579/9  
**better** [5] 430/18 463/4 465/5 492/4 508/23  
**between** [17] 414/19 416/4 418/17 419/6 419/13 421/8 421/12 422/7 427/20 428/11 433/13 438/4 446/1 460/15 484/12 528/22 540/17  
**beyond** [2] 410/18 452/3  
**big** [38] 414/13 414/13 415/7 415/16 416/20 418/16 422/25 427/14 427/20 428/13 433/13 438/20 438/21 442/13 442/22 443/19 443/23 443/24 444/1 444/3 454/22 454/24 455/2 458/9 458/14 458/15 459/10 459/22 460/1 460/3 463/13 505/11 533/1 533/2 533/3 533/4 577/24 581/12  
**bilateral** [1] 493/17  
**billed** [1] 562/12  
**biochemistry** [1] 469/2  
**biomechanical** [1] 506/19  
**bisecting** [1] 535/5  
**bisection** [1] 534/21  
**bit** [15] 410/1 427/16 438/11 438/12 447/15 450/10 462/14 463/4 463/13 463/14 465/20 568/17 568/19 568/20 571/25  
**blade** [2] 421/23 447/14  
**blank** [2] 585/8 586/2  
**bleeding** [1] 553/12  
**bleeds** [1] 448/4  
**blindness** [1] 430/21  
**blocking** [2] 448/7 448/8  
**blood** [1] 575/16  
**blowup** [2] 425/13 426/10  
**blowups** [3] 425/3 425/8 426/6  
**Bld** [1] 399/9  
**board** [18] 410/25 411/4 411/5 411/7 411/9 412/15 432/10 453/16 467/18 467/22 467/24 468/9 469/22 469/23 470/2 493/12 548/2 548/5  
**boards** [1] 412/13  
**bone** [135] 409/18 414/21 415/20 417/14 417/21 418/19 418/20 419/14 419/20 420/15 420/24 421/7 421/8 421/8 421/10 421/16 421/22 421/24 422/1 422/2 422/3 422/5 423/23 424/19 424/19 430/13 430/13 430/15 430/25 431/1 432/25 433/7 433/25 437/3 440/7 445/20 445/23 446/4 446/6 446/8 447/10 447/15 447/16 447/19 447/23 447/23 448/1 448/1 448/2 448/4 448/5 448/8 448/11 448/13 448/21 449/5 449/15 449/19 449/20 449/20 449/22 449/22 449/23 449/24 449/24 451/24 457/8 457/9 460/10 460/22 463/20 465/25 466/8 466/9 468/25 473/4 473/18 473/23 474/2 474/8 533/20 533/22 536/12 546/11 548/18 549/11 549/12 549/13 549/13 549/25 550/2 550/18 551/2 551/6 551/8 551/8 551/11 551/13 551/24 552/3 552/5 552/12 552/14 552/18 552/19 552/22 552/23 553/4 553/13 553/13 553/16 553/17 558/9 558/12 558/16 558/20 559/6 559/10 560/10 561/1 561/15 561/22 565/23 566/16 567/5 567/15 567/16 568/1 568/5 569/24 572/5 575/14 575/15 576/16  
**bone-on-bone** [1] 553/13  
**bones** [19] 415/16 416/13 416/16 419/14 421/8 421/9 428/3 433/23 435/19 438/13 459/7 500/19 509/20 539/8 551/16 557/25 559/15 559/15 559/18  
**book** [2] 468/20 468/21  
**born** [1] 415/11

**B**  
**borne** [1] 503/15  
**both** [12] 425/25 426/22 471/24 483/18 483/19 486/7 498/1 517/1 527/19 529/1 568/10 568/10  
**bottom** [15] 437/12 438/23 450/19 456/4 456/5 456/14 460/18 463/10 512/13 523/22 533/17 570/6 570/14 570/23 571/12  
**bottoms** [1] 423/18  
**Boulevard** [1] 407/2  
**bound** [1] 568/1  
**bow** [2] 415/17 415/17  
**box** [1] 425/12  
**brake** [1] 589/20  
**break** [6] 461/18 519/16 519/16 520/22 520/24 573/2  
**breakup** [1] 417/5  
**brief** [1] 527/4  
**briefly** [2] 454/3 472/24  
**bring** [22] 416/8 418/18 419/9 421/7 421/16 424/15 429/11 447/15 448/2 448/12 463/4 463/8 463/9 463/12 463/17 550/18 568/16 568/22 569/1 576/20 576/21 576/21  
**bringing** [3] 419/13 434/3 505/10  
**brought** [6] 413/22 442/1 442/2 488/12 542/24 571/4  
**buildup** [1] 417/4  
**bump** [3] 415/19 528/19 552/25  
**bunion** [40] 409/17 409/17 409/24 413/17 414/17 414/18 416/2 416/7 418/16 419/8 424/1 424/12 428/10 430/23 431/3 431/21 431/22 433/23 433/25 442/6 443/21 449/16 493/17 498/6 498/19 508/6 508/7 508/9 524/2 525/1 546/6 546/6 576/7 577/19 577/22 578/3 578/8 581/15 581/17 581/18  
**bunionectomies** [5] 413/2 413/5 413/8 413/12 430/9  
**bunionectomy** [7] 416/18 417/11 417/13 421/20 437/5 508/11 582/6  
**bunions** [3] 422/9 485/6 507/3  
**burned** [1] 546/1  
**but** [110] 406/6 411/4 414/4 417/7 424/17 429/13 429/24 437/2 441/21 441/22 447/5 447/17 451/21 461/17 467/9 467/25 469/18 475/10 476/20 477/2 478/24 479/25 482/3 484/20 485/2 488/10 489/9 489/11 491/2 492/17 495/5 496/8 496/16 500/6 500/17 500/24 503/11 503/12 507/18 509/2 510/10 510/13 512/18 512/20 514/13 515/10 516/18 518/12 518/24 525/21 527/2 529/3 530/2 530/8 533/3 534/13 535/20 537/11 538/5 539/6 540/3 540/10 541/20 541/22 544/2 544/18 546/1 547/16 547/18 549/5 549/8 549/9 549/12 550/10 551/11 551/12 554/6 554/24 555/2 556/1 556/7 556/9 556/19 556/22 557/7 557/10 558/14 558/18 558/19 559/6 560/2 562/18 564/4 565/2 567/12 567/18 571/4 571/9 571/15 572/5 573/20 573/23 577/21 579/23 581/14 582/9 583/23 586/20 590/4 590/5

**C**  
**C-A-R-A-G-I-N-E** [1] 408/7  
**C-arm** [9] 554/23 555/6 555/9 555/13 555/21 556/15 556/20 557/1 557/12  
**C-arms** [1] 557/7  
**cadaver** [1] 430/15  
**call** [6] 414/13 422/1 427/9 443/22 455/1 542/15  
**called** [15] 412/10 428/3 465/25 480/17 481/24 481/25 496/25 534/18 544/23 554/23 556/2 559/15 563/5 576/1 581/25

**callous** [20] 409/22 416/24 417/1 417/2 417/6 424/8 424/9 429/15 432/6 435/13 447/3 456/3 456/9 456/15 458/16 503/7 512/11 512/15 513/13 514/25  
**calls** [1] 406/2  
**came** [10] 485/10 485/24 492/11 493/14 498/3 499/14 499/25 540/1 547/10 547/18  
**can** [128] 413/1 413/7 413/11 413/18 414/3 414/25 415/25 417/4 417/5 418/14 419/8 419/10 419/19 419/24 420/1 420/7 422/4 422/6 422/8 423/12 425/12 425/15 426/24 427/14 427/16 427/17 428/11 430/12 431/16 435/22 437/23 439/12 440/5 440/25 441/23 444/2 447/6 449/22 452/18 454/2 457/2 457/14 461/6 465/4 466/11 466/14 466/15 468/11 470/3 471/17 473/13 478/17 483/8 484/24 484/25 485/3 489/2 489/11 489/17 493/22 497/16 499/6 501/17 504/20 511/6 512/10 513/25 515/19 515/20 515/20 516/2 516/5 516/8 516/19 516/20 517/23 518/13 519/9 520/1 520/4 520/6 520/10 520/13 521/17 523/15 525/15 525/21 527/8 529/17 529/19 529/23 532/15 533/9 533/12 533/13 538/12 539/22 540/3 545/13 548/21 549/13 555/2 555/24 559/20 563/12 563/21 568/17 570/17 571/9 571/22 572/16 572/23 574/25 575/20 575/21 575/21 575/22 575/24 575/25 576/1 577/2 578/9 579/8 579/25 582/9 582/12 582/19 585/25  
**can't** [49] 407/9 409/20 419/22 421/11 429/10 430/21 430/22 430/23 437/6 437/8 437/9 442/14 445/17 447/19 448/6 451/17 451/18 454/24 460/2 486/19 486/20 499/1 499/8 501/7 501/8 503/22 507/21 515/24 515/24 523/11 538/11 553/18 557/21 558/24 559/1 561/11 563/7 565/4 565/4 565/12 565/17 565/18 567/23 571/7 571/19 577/1 577/2 577/4 590/4  
**cannot** [7] 429/4 447/12 447/25 521/4 525/19 571/13 578/10  
**Caragine's** [2] 408/5 408/8  
**care** [25] 409/15 422/16 434/14 439/25 440/1 440/20 443/2 443/4 449/8 450/6 450/11 450/14 450/18 450/23 450/24 454/8 471/4 471/8 474/4 474/10 485/25 496/23 509/5 587/25 588/14  
**career** [8] 412/20 412/20 413/9 413/13 421/18 470/15 470/25 580/13  
**careful** [2] 430/6 443/21  
**caring** [3] 495/14 532/10 584/14  
**carpentry** [1] 447/14  
**carried** [1] 475/17  
**cartilage** [17] 421/9 421/11 421/11 421/13 421/13 421/15 447/11 447/22 447/22 447/25 448/3 551/3 551/5 551/7 551/19 553/4 553/11  
**case** [53] 408/25 409/7 409/11 412/1 422/17 433/4 433/6 434/12 435/6 437/1 439/22 440/24 444/14 444/22 446/15 450/3 453/1 472/20 473/3 478/17 481/9 490/13 492/25 497/9 516/18 516/21 540/4 541/16 545/3 545/20 545/21 546/4 546/5 546/11 546/14 547/10 551/25 556/1 560/19 561/14 563/18 563/22 564/4 564/8 564/15 564/17 580/21 580/24 581/4 583/2 584/4 584/9 590/3  
**cases** [21] 412/14 467/18 470/11 470/13 470/16 470/25 471/7 479/17 481/22 481/23 481/24 482/1 482/4 482/7 482/20 483/18 483/19 546/15 560/22 561/3 581/8  
**cast** [2] 507/11 509/24  
**cause** [13] 438/20 442/3 449/17 490/13 490/15 490/15 506/19 516/6 516/8 517/11 520/1 520/4 525/1

**caused** [6] 459/22 517/4 517/7 517/16 518/3 540/6  
**causes** [3] 430/8 502/1 502/8  
**causing** [8] 439/13 450/14 450/19 450/24 474/13 516/23 572/18 588/21  
**CC** [1] 493/15  
**Center** [1] 469/7  
**centimeter** [10] 431/1 434/23 434/25 437/10 439/3 439/4 439/5 445/20 445/23 451/23  
**centimeters** [1] 451/22  
**certain** [12] 409/10 446/16 451/20 499/11 500/7 510/10 532/8 539/19 559/24 566/16 567/16 586/21  
**certainly** [17] 478/16 484/14 486/18 491/6 497/16 498/25 500/14 503/13 505/14 512/15 519/21 527/1 529/18 535/20 549/16 557/12 584/13  
**certainly** [3] 411/14 457/4 484/4  
**certification** [6] 411/5 468/10 468/10 469/22 470/2 548/5  
**certified** [10] 410/25 412/15 432/10 453/16 467/19 467/22 467/24 468/1 523/23 548/2  
**certify** [1] 591/10  
**cetera** [1] 495/15  
**chair** [1] 573/4  
**change** [3] 414/18 524/24 536/13  
**changes** [3] 418/14 524/6 548/24  
**chapter** [1] 468/20  
**characterization** [1] 437/15  
**charge** [1] 472/15  
**charged** [3] 472/12 562/7 562/9  
**charging** [1] 471/25  
**chart** [20] 408/8 424/8 452/22 477/1 477/3 486/9 492/9 493/8 502/5 507/19 507/23 511/10 511/17 512/5 524/17 526/17 527/16 531/5 569/15 585/7  
**check** [1] 531/9  
**chicken** [1] 421/9  
**chief** [1] 493/15  
**child** [1] 420/18  
**children** [3] 492/13 492/19 495/15  
**choice** [2] 417/4 417/5  
**choices** [1] 417/3  
**choose** [1] 500/7  
**Christine** [1] 556/3  
**chunk** [2] 448/13 449/19  
**Cindy** [1] 545/14  
**circumstance** [1] 579/10  
**claim** [3] 488/10 488/18 541/14  
**claims** [1] 446/19  
**clarify** [6] 416/15 465/7 537/16 555/22 556/19 557/17  
**clear** [7] 453/9 526/2 537/10 537/22 552/7 565/7 566/9  
**clearly** [3] 507/6 526/25 533/19  
**client** [1] 453/11  
**clinical** [4] 409/19 553/23 566/21 566/24  
**clinically** [2] 440/6 532/3  
**close** [3] 457/14 472/1 554/1  
**closer** [3] 432/3 460/24 463/5  
**closest** [2] 502/12 552/23  
**closing** [3] 546/8 546/9 581/24  
**clot** [1] 575/16  
**coil** [1] 414/11  
**colleagues** [1] 468/11  
**college** [3] 412/6 466/21 467/2  
**COLLINS** [1] 399/17  
**Colorado** [2] 412/9 467/5  
**column** [1] 460/11  
**come** [24] 418/25 426/14 429/24 429/25 433/23 439/14 442/4 442/13 442/15 449/25 452/19 458/9 460/3 472/2 477/25 478/6 481/16 482/12 492/12 493/3 568/14 568/25

<p><b>C</b></p> <p><b>come...</b> [2] 569/10 569/11</p> <p><b>comes</b> [6] 429/6 467/13 516/16 547/24 548/7 555/7</p> <p><b>coming</b> [5] 426/3 479/4 492/13 495/1 562/3</p> <p><b>comment</b> [5] 458/25 509/1 513/19 544/22 544/24</p> <p><b>commented</b> [1] 459/4</p> <p><b>comments</b> [1] 459/14</p> <p><b>committed</b> [1] 479/8</p> <p><b>community</b> [1] 468/12</p> <p><b>companies</b> [3] 470/18 481/2 481/8</p> <p><b>comparative</b> [1] 446/1</p> <p><b>compare</b> [1] 440/7</p> <p><b>compared</b> [6] 425/10 428/18 428/18 439/11 572/9 572/10</p> <p><b>comparing</b> [2] 564/13 572/13</p> <p><b>complaint</b> [2] 493/15 493/15</p> <p><b>complaints</b> [4] 453/25 464/3 494/19 520/19</p> <p><b>complete</b> [1] 577/5</p> <p><b>completed</b> [1] 467/16</p> <p><b>completely</b> [3] 439/14 449/11 504/6</p> <p><b>completeness</b> [1] 586/6</p> <p><b>complicated</b> [1] 495/11</p> <p><b>complication</b> [21] 451/9 452/3 512/17 515/9 515/12 515/15 519/8 540/5 540/7 541/2 542/1 543/1 545/4 546/24 547/4 547/17 559/21 568/24 577/18 580/14 581/12</p> <p><b>complications</b> [12] 468/22 482/15 482/18 510/5 510/7 510/11 510/14 510/15 514/2 518/17 519/2 520/13</p> <p><b>computer</b> [2] 586/1 586/4</p> <p><b>concern</b> [2] 412/1 514/15</p> <p><b>concerned</b> [1] 546/18</p> <p><b>concerning</b> [1] 513/11</p> <p><b>conclusion</b> [6] 410/3 410/5 410/8 410/12 434/12 442/18</p> <p><b>conclusions</b> [8] 409/10 409/13 410/3 422/15 422/18 426/4 426/15 452/20</p> <p><b>condition</b> [2] 451/4 577/9</p> <p><b>CONDUCTED</b> [5] 408/21 476/7 522/4 585/1 589/3</p> <p><b>conference</b> [1] 488/6</p> <p><b>confirmation</b> [1] 455/18</p> <p><b>confused</b> [3] 473/15 540/10 540/17</p> <p><b>confusing</b> [2] 504/15 552/17</p> <p><b>connect</b> [1] 415/8</p> <p><b>connected</b> [2] 414/21 415/16</p> <p><b>connecting</b> [1] 486/23</p> <p><b>connection</b> [2] 486/17 517/21</p> <p><b>consent</b> [44] 487/20 488/1 488/10 488/16 488/21 489/24 490/16 491/1 491/15 492/5 511/2 511/7 512/5 513/7 513/21 514/3 518/17 522/8 522/25 523/9 523/19 523/23 524/10 526/3 526/5 526/11 526/21 527/7 527/16 527/23 528/2 530/9 530/13 530/15 530/24 541/7 541/15 544/15 544/16 544/18 585/6 586/16 586/18 586/19</p> <p><b>consented</b> [2] 488/19 525/24</p> <p><b>consequences</b> [1] 447/18</p> <p><b>conservative</b> [2] 454/8 524/3</p> <p><b>consider</b> [2] 579/5 583/15</p> <p><b>considered</b> [1] 558/9</p> <p><b>consistent</b> [1] 505/21</p> <p><b>contact</b> [1] 553/13</p> <p><b>contain</b> [2] 523/19 524/10</p> <p><b>contained</b> [3] 512/5 518/24 569/14</p> <p><b>contest</b> [1] 497/10</p> <p><b>contingencies</b> [1] 512/13</p> <p><b>continue</b> [4] 424/13 429/16 429/17 574/7</p> <p><b>continued</b> [3] 444/25 491/8 517/10</p> <p><b>continues</b> [1] 415/25</p>	<p><b>continuing</b> [1] 412/19</p> <p><b>contract</b> [1] 517/10</p> <p><b>contracted</b> [1] 454/10</p> <p><b>contracture</b> [4] 516/6 516/10 517/6 518/3</p> <p><b>contribute</b> [2] 572/23 572/25</p> <p><b>contributed</b> [3] 517/8 517/12 518/4</p> <p><b>control</b> [6] 411/19 430/7 446/7 507/2 524/25 525/8</p> <p><b>controlling</b> [1] 525/1</p> <p><b>corn</b> [2] 454/7 454/7</p> <p><b>correct</b> [146] 419/8 424/11 424/21 426/1 426/11 426/12 427/6 430/24 430/25 431/2 431/21 431/22 431/24 439/19 440/13 441/1 442/24 443/11 443/12 443/14 445/7 446/17 446/18 449/16 453/12 453/14 455/9 457/20 458/19 459/25 460/22 461/4 461/5 464/11 465/2 465/8 465/9 465/12 465/13 465/18 467/11 472/11 472/20 479/13 480/1 482/15 482/16 485/14 491/11 494/6 494/7 494/16 494/21 495/6 495/10 496/21 496/22 497/22 498/7 498/12 498/15 500/8 500/12 500/15 500/20 503/16 503/20 504/17 505/20 506/4 506/5 506/7 506/8 507/17 507/18 508/16 508/19 508/20 508/22 509/17 510/2 515/25 516/1 516/23 519/24 520/2 520/3 520/14 520/15 522/25 523/20 524/10 524/14 524/15 528/3 529/1 531/13 531/14 531/21 531/22 531/24 532/5 532/15 533/25 534/1 535/22 539/22 542/21 544/3 545/12 545/18 546/6 546/12 546/24 550/20 551/2 553/4 554/1 554/13 554/18 555/14 555/15 556/2 557/14 557/23 558/1 558/4 558/5 558/9 558/10 558/13 559/12 559/16 559/21 562/1 564/11 565/22 566/17 567/6 569/17 572/24 577/15 579/7 579/10 579/11 583/3</p> <p><b>corrected</b> [8] 409/17 430/2 442/25 498/13 500/16 500/17 542/18 547/16</p> <p><b>correcting</b> [3] 431/20 431/22 451/16</p> <p><b>correction</b> [6] 416/19 431/17 486/8 507/7 524/24 546/6</p> <p><b>corrective</b> [1] 462/18</p> <p><b>cortex</b> [1] 551/9</p> <p><b>could</b> [31] 430/14 436/1 484/9 484/9 484/10 484/11 495/1 498/13 500/5 500/25 505/4 505/7 505/11 505/12 518/14 522/8 531/9 533/6 545/14 546/1 554/17 554/24 558/8 559/3 561/19 565/3 568/10 568/11 569/6 578/5 586/9</p> <p><b>counsel</b> [9] 407/8 411/13 436/13 461/16 488/9 510/9 521/5 535/21 568/14</p> <p><b>counseled</b> [1] 588/9</p> <p><b>counseling</b> [2] 501/16 506/1</p> <p><b>count</b> [5] 483/25 484/16 511/11 511/17 511/19</p> <p><b>COUNTY</b> [3] 399/1 545/21 556/4</p> <p><b>couple</b> [4] 437/25 519/18 522/21 537/21</p> <p><b>course</b> [21] 409/5 412/20 413/8 413/12 420/2 427/4 440/10 470/15 470/24 482/19 486/11 490/11 491/2 507/10 529/3 532/12 554/9 577/3 587/17 588/8 588/9</p> <p><b>court</b> [24] 399/1 399/12 399/22 472/2 477/25 478/7 479/25 480/8 480/24 481/16 482/21 483/15 490/9 499/4 508/2 531/17 536/15 536/19 537/4 539/2 547/10 547/25 548/8 560/4</p> <p><b>courtesy</b> [1] 591/1</p> <p><b>courtroom</b> [3] 461/23 471/14 521/14</p> <p><b>cover</b> [1] 531/1</p> <p><b>covering</b> [1] 551/8</p> <p><b>CR</b> [2] 554/25 555/5</p> <p><b>cramping</b> [1] 454/7</p> <p><b>credentials</b> [1] 411/3</p> <p><b>credibility</b> [2] 489/3 490/24</p>	<p><b>crisscross</b> [1] 549/17</p> <p><b>cross</b> [13] 474/23 474/25 476/4 476/6 490/20 490/21 491/7 497/15 521/3 522/3 573/21 574/7 585/3</p> <p><b>cross-examination</b> [9] 474/23 474/25 476/4 476/6 491/7 521/3 522/3 573/21 574/7</p> <p><b>cross-examine</b> [1] 490/21</p> <p><b>cross-examiner</b> [1] 490/20</p> <p><b>cross-examiners</b> [1] 497/15</p> <p><b>CRR</b> [1] 591/15</p> <p><b>crutches</b> [2] 475/23 495/24</p> <p><b>cuboid</b> [1] 417/21</p> <p><b>cumulative</b> [2] 456/23 473/7</p> <p><b>cuneliform</b> [36] 417/15 417/18 417/22 417/23 417/25 418/13 418/21 419/7 419/15 420/9 420/11 420/23 438/3 460/11 460/12 473/4 473/19 498/22 499/6 499/15 500/2 500/13 528/22 546/11 548/18 548/23 549/13 549/25 550/2 550/18 551/6 552/8 553/16 567/15 571/24 571/25</p> <p><b>cup</b> [1] 550/9</p> <p><b>curious</b> [1] 583/9</p> <p><b>curtail</b> [2] 546/16 561/19</p> <p><b>Curvature</b> [1] 452/6</p> <p><b>curve</b> [1] 550/8</p> <p><b>curved</b> [3] 550/6 550/10 550/13</p> <p><b>customary</b> [1] 562/19</p> <p><b>customized</b> [1] 506/6</p> <p><b>cut</b> [10] 419/9 421/21 421/22 422/1 466/8 536/12 550/18 550/21 552/5 573/24</p> <p><b>cuts</b> [2] 448/15 448/16</p> <p><b>cutting</b> [3] 447/16 460/21 551/2</p> <p><b>CYNTHIA</b> [3] 399/22 591/10 591/15</p> <p><b>D</b></p> <p><b>D.P.M</b> [1] 399/6</p> <p><b>daily</b> [3] 493/25 494/1 494/2</p> <p><b>dark</b> [1] 421/12</p> <p><b>date</b> [5] 426/8 453/23 454/15 462/5 562/12</p> <p><b>dated</b> [4] 426/11 443/10 511/1 522/14</p> <p><b>DAVID</b> [1] 399/3</p> <p><b>day</b> [9] 472/6 472/9 542/25 573/12 573/17 573/18 574/1 584/16 589/20</p> <p><b>days</b> [4] 417/11 497/2 499/4 589/24</p> <p><b>deal</b> [3] 433/12 491/10 546/21</p> <p><b>dealing</b> [1] 449/1</p> <p><b>deals</b> [2] 489/16 489/19</p> <p><b>December</b> [4] 454/13 454/16 461/3 542/4</p> <p><b>December 15th</b> [2] 454/13 454/16</p> <p><b>decide</b> [5] 499/22 529/22 535/20 538/23 539/17</p> <p><b>decided</b> [2] 487/25 542/5</p> <p><b>decides</b> [3] 478/14 478/15 548/13</p> <p><b>decision</b> [2] 551/16 561/7</p> <p><b>decreased</b> [2] 462/9 462/15</p> <p><b>Defendant</b> [6] 399/18 411/15 480/9 482/10 545/20 587/16</p> <p><b>Defendants</b> [5] 399/7 480/24 481/13 481/23 482/1</p> <p><b>defending</b> [1] 497/12</p> <p><b>defense</b> [7] 451/3 471/10 475/1 490/23 526/15 526/24 541/18</p> <p><b>definitely</b> [3] 427/14 512/21 556/9</p> <p><b>definitions</b> [1] 543/14</p> <p><b>deforming</b> [1] 507/3</p> <p><b>deformities</b> [3] 431/5 467/11 484/24</p> <p><b>deformity</b> [15] 414/19 422/21 452/4 457/20 463/25 474/16 485/14 498/11 501/21 525/2 525/3 528/17 529/4 575/21 577/16</p> <p><b>deforms</b> [1] 418/14</p> <p><b>degree</b> [15] 410/13 411/14 412/7 417/7 439/24 443/9 444/20 448/19 451/20 457/3 464/9 495/21 587/5 587/21 587/23</p>
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<p><b>D</b></p> <p><b>degrees</b> [9] 504/14 505/4 505/8 505/11 505/12 505/17 589/7 589/7 589/11</p> <p><b>demonstration</b> [1] 421/1</p> <p><b>demonstrative</b> [1] 414/4</p> <p><b>Denver</b> [3] 412/9 467/5 467/7</p> <p><b>departed</b> [1] 411/15</p> <p><b>departure</b> [18] 431/11 431/14 434/13 440/20 443/1 443/13 444/16 449/7 450/6 474/3 474/9 474/12 474/12 587/7 587/24 588/2 588/14 588/17</p> <p><b>departures</b> [5] 450/11 450/13 450/17 450/23 588/20</p> <p><b>depending</b> [2] 495/21 543/5</p> <p><b>depends</b> [4] 489/9 558/22 567/11 582/8</p> <p><b>deposition</b> [13] 452/25 476/19 477/14 477/19 477/22 478/21 517/20 518/2 574/13 574/20 575/10 578/7 578/12</p> <p><b>depositions</b> [1] 477/9</p> <p><b>Describe</b> [1] 483/13</p> <p><b>described</b> [5] 448/16 448/18 497/1 509/3 577/10</p> <p><b>describes</b> [2] 494/8 495/14</p> <p><b>describing</b> [1] 509/14</p> <p><b>description</b> [1] 414/18</p> <p><b>desired</b> [2] 510/10 529/3</p> <p><b>Desis</b> [1] 421/6</p> <p><b>desk</b> [1] 583/5</p> <p><b>destroy</b> [1] 466/18</p> <p><b>destructive</b> [1] 465/22</p> <p><b>detail</b> [1] 410/1</p> <p><b>details</b> [2] 412/4 494/24</p> <p><b>determine</b> [9] 409/19 416/2 440/11 445/22 471/3 471/8 551/17 553/16 557/24</p> <p><b>develop</b> [6] 444/25 503/7 512/17 512/20 514/24 515/19</p> <p><b>developed</b> [6] 437/1 444/23 456/20 457/5 457/11 560/18</p> <p><b>developing</b> [2] 446/21 447/3</p> <p><b>develops</b> [1] 436/10</p> <p><b>deviated</b> [1] 503/21</p> <p><b>diagnosis</b> [3] 498/4 498/17 498/19</p> <p><b>dictate</b> [1] 444/12</p> <p><b>did</b> [123] 408/24 409/1 409/2 409/4 409/9 409/12 409/16 409/18 410/6 411/18 412/8 412/17 412/18 422/15 422/19 426/2 426/5 434/12 434/15 434/18 444/14 445/22 446/6 446/7 446/8 448/17 452/25 453/2 456/25 457/9 462/22 464/3 464/16 466/24 467/6 467/7 469/2 470/6 470/24 472/8 473/14 474/12 475/6 475/13 475/13 475/16 476/17 476/24 477/4 477/7 477/14 477/19 477/22 478/20 479/3 479/17 481/5 482/22 483/25 484/14 484/23 484/25 486/3 487/10 492/15 492/16 492/24 496/20 498/1 499/9 504/9 507/19 507/20 507/25 508/6 508/10 508/13 508/18 509/11 512/7 512/23 513/25 514/11 517/13 526/6 530/4 532/23 535/24 536/24 538/15 538/16 539/6 540/13 540/18 541/22 541/22 541/24 542/2 542/13 543/5 544/14 546/5 547/16 547/20 548/2 548/5 552/4 552/21 553/3 553/10 557/10 562/15 563/2 563/3 568/9 572/12 578/6 578/14 584/13 584/15 587/4 588/2 588/12</p> <p><b>difference</b> [1] 439/8</p> <p><b>different</b> [27] 412/14 414/11 417/21 419/12 467/9 468/18 476/15 496/7 497/15 497/24 500/7 504/22 546/15 546/19 547/8 549/19 549/21 562/20 563/6 563/25 564/6 564/21 567/7 579/19 580/8 580/9 580/23</p> <p><b>differently</b> [1] 563/15</p> <p><b>difficult</b> [3] 449/18 459/21 540/13</p>	<p><b>direct</b> [8] 408/20 461/25 483/20 488/12 521/25 542/9 551/1 554/16</p> <p><b>direction</b> [1] 415/18</p> <p><b>directly</b> [1] 428/5</p> <p><b>disagree</b> [9] 435/9 435/10 435/22 473/5 473/19 473/21 535/13 536/3 578/8</p> <p><b>disagreeing</b> [1] 503/11</p> <p><b>disagreement</b> [3] 578/9 579/16 579/23</p> <p><b>disclose</b> [1] 578/15</p> <p><b>discomfort</b> [2] 450/19 464/4</p> <p><b>discrepancy</b> [3] 433/13 460/14 466/6</p> <p><b>discretion</b> [5] 500/11 532/9 545/9 551/17 551/23</p> <p><b>discuss</b> [8] 509/9 509/10 510/19 520/17 521/4 523/9 529/13 539/6</p> <p><b>discussed</b> [15] 439/17 492/5 528/1 528/9 536/16 538/1 538/3 539/5 540/2 540/4 540/21 540/24 541/10 544/2 544/5</p> <p><b>discussing</b> [2] 530/9 541/5</p> <p><b>discussion</b> [7] 428/1 530/9 530/19 535/21 538/5 539/2 540/18</p> <p><b>discussions</b> [2] 537/11 540/20</p> <p><b>disjointed</b> [2] 577/21 578/11</p> <p><b>dislocated</b> [2] 435/15 504/6</p> <p><b>dispose</b> [1] 483/8</p> <p><b>disposed</b> [2] 482/22 483/14</p> <p><b>dispute</b> [3] 497/9 508/7 508/13</p> <p><b>distal</b> [2] 502/12 552/22</p> <p><b>distally</b> [2] 459/8 459/9</p> <p><b>distance</b> [1] 416/5</p> <p><b>distorted</b> [4] 556/17 557/2 557/2 557/8</p> <p><b>do</b> [236]</p> <p><b>doctor</b> [203]</p> <p><b>Doctor's</b> [1] 412/10</p> <p><b>doctors</b> [5] 500/7 523/11 579/5 579/19 580/8</p> <p><b>document</b> [8] 502/4 510/25 513/21 513/24 514/3 518/25 522/11 585/21</p> <p><b>documentation</b> [2] 476/1 518/19</p> <p><b>documented</b> [6] 475/19 504/9 507/1 507/6 508/24 528/2</p> <p><b>documents</b> [5] 506/17 583/6 583/13 583/16 583/17</p> <p><b>does</b> [47] 410/12 410/15 414/6 416/24 417/13 426/9 433/23 438/8 441/6 443/17 444/11 446/4 454/20 459/23 462/6 462/17 463/18 467/13 488/11 489/17 489/18 489/21 489/22 490/5 491/24 496/25 499/2 501/10 501/11 502/11 504/5 509/1 513/10 513/12 513/20 524/17 530/4 548/1 548/8 553/7 557/15 558/21 561/9 565/10 575/4 575/6 583/8</p> <p><b>doing</b> [34] 411/17 411/18 433/2 442/6 443/21 444/10 446/11 451/17 465/22 469/10 509/2 509/10 510/7 513/7 515/19 536/17 536/23 537/14 538/4 539/7 540/4 540/23 541/20 544/3 544/18 558/7 558/11 558/15 558/20 559/14 561/7 562/21 586/24 589/22</p> <p><b>don't</b> [87] 411/22 414/4 415/1 417/15 418/24 420/3 425/14 431/6 435/8 435/20 439/6 441/2 441/10 448/10 448/12 449/5 449/5 454/2 461/16 467/23 470/22 477/8 477/17 478/24 478/25 479/14 480/19 483/1 484/1 484/2 484/15 487/22 491/22 491/25 492/1 492/25 493/1 496/15 497/9 501/6 504/13 508/13 508/18 511/4 515/17 518/11 519/19 523/15 526/10 526/15 527/2 535/19 536/3 537/19 539/21 540/8 540/10 540/16 541/19 544/12 546/11 547/6 547/20 553/5 553/20 556/7 556/19 556/24 559/18 565/1 566/25 567/5 567/9 567/12 571/17 573/19 576/12 576/20 581/7 581/8 581/14 583/10 583/22 585/20 589/12 589/13 589/23</p>	<p><b>done</b> [32] 408/14 409/20 412/2 412/3 421/18 436/13 439/16 443/3 447/6 448/17 450/3 456/17 481/1 482/14 506/14 507/24 536/4 542/11 542/17 543/18 543/18 543/20 544/25 552/3 560/11 561/14 561/22 578/4 578/7 582/4 586/25 588/18</p> <p><b>dorsal</b> [2] 458/8 458/13</p> <p><b>dorsiflex</b> [2] 568/5 576/12</p> <p><b>Dorsiflexed</b> [1] 572/4</p> <p><b>dorsiflexing</b> [1] 575/24</p> <p><b>dorsiflexion</b> [2] 504/14 505/5</p> <p><b>double</b> [1] 531/9</p> <p><b>doubt</b> [3] 587/15 588/6 588/13</p> <p><b>down</b> [58] 412/11 422/8 423/10 423/10 423/16 426/9 427/10 429/22 429/24 429/25 436/24 438/16 439/10 442/1 442/2 442/15 447/24 454/25 457/21 458/8 458/18 458/24 460/2 460/3 463/12 466/13 484/16 490/17 505/11 506/1 517/15 522/1 524/22 533/7 533/11 533/16 534/21 535/2 539/22 548/21 565/25 565/25 566/12 566/16 568/1 568/17 568/22 569/10 569/11 570/7 570/15 571/3 571/12 576/22 582/12 582/21 587/16 587/18</p> <p><b>DP</b> [1] 427/10</p> <p><b>Dr</b> [3] 399/9 453/15 485/25</p> <p><b>Dr. [82]</b> 406/24 407/15 408/5 408/8 408/22 409/3 409/11 410/6 412/3 434/11 435/6 435/18 436/7 436/21 441/23 444/14 445/19 446/19 448/15 452/9 452/22 452/23 453/5 453/16 453/25 454/12 454/13 456/17 457/15 458/1 459/18 459/20 461/2 461/3 461/15 462/5 462/6 462/22 464/2 464/8 464/8 465/15 473/3 473/17 475/5 476/8 476/16 476/17 476/22 477/10 477/11 477/12 477/19 477/23 479/14 485/11 487/5 491/9 492/9 493/2 493/8 493/14 494/18 496/11 502/22 504/9 508/2 511/16 513/20 514/8 517/15 518/1 518/14 518/22 574/13 574/19 575/10 576/19 577/23 578/2 578/12 578/25</p> <p><b>Dr. Caragine's</b> [2] 408/5 408/8</p> <p><b>Dr. Joseph</b> [6] 408/22 476/8 487/5 491/9 493/14 513/20</p> <p><b>Dr. Marzano</b> [31] 409/11 410/6 412/3 434/11 435/6 435/18 436/7 436/21 441/23 444/14 445/19 446/19 448/15 448/15 452/22 456/17 461/3 473/3 473/17 476/22 477/10 477/11 477/12 479/14 485/11 493/2 493/8 494/18 496/11 502/22 504/9 518/22</p> <p><b>Dr. Marzano's</b> [10] 409/3 454/12 454/13 461/2 475/5 476/16 492/9 508/2 511/16 514/8</p> <p><b>Dr. Matthew</b> [1] 453/16</p> <p><b>Dr. Matthew Roberts</b> [2] 458/1 462/5</p> <p><b>Dr. Matthew Roberts'</b> [2] 407/15 452/9</p> <p><b>Dr. Roberts</b> [12] 453/25 459/20 461/15 462/6 464/8 477/23 517/15 518/1 518/14 574/13 577/23 578/2</p> <p><b>Dr. Roberts'</b> [15] 452/23 453/5 457/15 459/18 462/22 464/2 464/8 465/15 476/17 477/19 574/19 575/10 576/19 578/12 578/25</p> <p><b>Dr. Robyn Joseph</b> [1] 406/24</p> <p><b>draconian</b> [1] 573/22</p> <p><b>draft</b> [1] 561/22</p> <p><b>draw</b> [3] 534/20 535/2 535/4</p> <p><b>drifting</b> [1] 459/21</p> <p><b>drilled</b> [1] 553/12</p> <p><b>driving</b> [2] 437/12 437/15</p> <p><b>dry</b> [1] 475/21</p> <p><b>due</b> [1] 530/17</p> <p><b>duly</b> [1] 406/9</p> <p><b>during</b> [27] 409/5 412/20 417/10 440/10 440/13 455/10 455/11 455/15 490/10</p>
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<b>D</b>	<b>everyday</b> [1] 491/11 <b>everyone</b> [5] 415/2 421/9 461/24 549/13 574/6 <b>everything</b> [12] 416/9 434/5 446/12 466/17 479/8 532/12 556/7 558/14 580/24 586/5 586/12 586/15 <b>evidence</b> [19] 407/14 407/16 407/19 407/23 408/2 408/4 408/17 424/24 425/9 452/8 452/10 486/14 486/20 562/24 562/25 563/11 563/12 569/13 574/22 <b>evidently</b> [1] 496/16 <b>exact</b> [2] 485/8 531/21 <b>exactly</b> [5] 440/23 452/19 553/7 564/18 566/20 <b>exaggerated</b> [5] 556/15 556/21 557/1 557/5 557/7 <b>exaggerating</b> [1] 429/24 <b>exam</b> [4] 412/16 453/23 496/21 496/25 <b>examination</b> [21] 408/20 457/22 457/24 458/5 458/6 462/1 474/23 474/25 476/4 476/6 483/20 491/7 496/14 497/19 521/3 522/3 554/16 573/21 574/7 584/25 589/2 <b>examine</b> [1] 490/21 <b>examined</b> [4] 406/10 441/15 465/8 496/16 <b>examiner</b> [1] 490/20 <b>examiners</b> [1] 497/15 <b>except</b> [2] 495/5 503/9 <b>excerpts</b> [2] 574/13 576/8 <b>excessive</b> [1] 451/14 <b>excuse</b> [3] 429/13 508/10 546/10 <b>excused</b> [4] 521/1 573/5 589/18 591/5 <b>executed</b> [1] 527/19 <b>exercises</b> [1] 532/10 <b>exhibit</b> [6] 407/18 408/16 420/20 453/6 453/8 569/13 <b>Exhibit 2</b> [1] 569/13 <b>Exhibit 5</b> [1] 453/8 <b>exhibits</b> [1] 426/18 <b>existence</b> [2] 485/6 585/14 <b>exists</b> [1] 464/12 <b>expect</b> [2] 439/12 573/13 <b>experience</b> [5] 441/7 441/12 483/21 561/6 590/1 <b>experienced</b> [8] 445/5 482/17 546/24 547/4 558/22 559/8 567/13 580/14 <b>expert</b> [9] 407/7 411/24 471/15 480/3 480/24 489/12 497/13 548/7 556/2 <b>expertise</b> [1] 489/7 <b>explain</b> [11] 423/6 424/25 429/18 439/2 490/10 507/14 524/14 530/2 550/21 571/9 586/17 <b>explained</b> [10] 501/19 502/22 506/17 507/7 508/25 510/5 524/23 540/25 563/13 587/12 <b>explaining</b> [1] 432/20 <b>explains</b> [1] 506/18 <b>explanation</b> [2] 407/8 407/9 <b>extensive</b> [2] 518/18 519/2 <b>extra</b> [4] 424/4 430/12 430/13 514/24 <b>extremely</b> [1] 417/8	537/7 581/9 583/12 <b>fairly</b> [1] 505/24 <b>fall</b> [1] 444/2 <b>false</b> [1] 568/11 <b>familiar</b> [1] 511/23 <b>family</b> [1] 583/7 <b>far</b> [23] 418/13 422/23 422/25 454/1 481/17 514/25 522/16 528/3 536/18 537/15 539/8 540/8 540/19 541/3 554/10 560/20 565/24 565/25 566/12 568/5 576/21 587/16 587/18 <b>fares</b> [1] 538/6 <b>fashion</b> [1] 449/8 <b>fast</b> [1] 507/22 <b>faulty</b> [1] 557/3 <b>favor</b> [7] 471/24 482/22 483/4 483/8 483/10 483/14 510/25 <b>feathering</b> [4] 447/14 448/18 550/22 551/1 <b>fee</b> [4] 471/25 472/4 472/12 472/15 <b>feel</b> [9] 409/14 442/21 464/14 464/18 464/21 532/2 566/21 566/23 567/17 <b>feelings</b> [1] 464/20 <b>feels</b> [1] 454/10 <b>feet</b> [5] 451/24 484/21 486/7 492/20 497/19 <b>felt</b> [1] 553/24 <b>fertile</b> [1] 489/25 <b>few</b> [4] 417/11 510/6 573/10 574/18 <b>field</b> [8] 411/1 432/1 457/11 461/1 463/3 468/15 490/25 563/17 <b>fifth</b> [3] 417/21 468/24 523/16 <b>Fifty</b> [1] 413/14 <b>fill</b> [2] 585/8 586/2 <b>fill-in-the-blank</b> [1] 585/8 <b>film</b> [11] 555/20 555/25 556/17 556/20 557/9 557/18 558/1 569/11 569/12 571/6 572/14 <b>films</b> [1] 569/14 <b>finally</b> [1] 576/23 <b>find</b> [4] 511/4 512/10 522/10 585/15 <b>finding</b> [2] 420/23 505/24 <b>findings</b> [1] 451/6 <b>finds</b> [1] 458/2 <b>fine</b> [27] 406/13 406/15 406/16 418/10 419/25 425/16 433/24 436/5 479/1 484/6 484/8 491/25 501/9 521/19 523/1 524/11 531/10 549/9 553/14 556/22 559/2 565/12 565/17 571/22 572/20 577/6 583/1 <b>fingers</b> [1] 415/9 <b>finish</b> [2] 534/24 553/25 <b>firms</b> [1] 470/17 <b>first</b> [135] 406/9 409/24 414/19 414/20 415/13 415/20 415/23 416/4 417/19 417/22 417/23 417/25 418/3 418/4 418/8 418/9 418/17 418/20 419/7 419/14 420/8 422/2 422/7 422/23 423/5 424/2 424/15 424/17 424/20 427/21 428/5 428/6 428/7 428/12 428/18 429/11 430/3 433/8 433/12 434/21 437/23 437/25 437/25 438/2 438/4 438/16 438/24 441/24 444/7 445/25 446/1 446/2 449/2 449/12 451/16 453/23 454/25 455/14 455/21 456/19 457/10 458/3 458/7 458/15 458/23 458/23 459/12 459/21 460/2 460/7 460/12 460/24 462/8 462/9 463/8 464/1 466/6 480/15 484/21 485/10 487/15 492/12 493/17 502/2 502/9 502/11 502/24 503/4 503/13 503/19 506/3 514/16 514/22 516/22 516/23 517/7 529/11 529/11 530/10 532/13 532/18 532/22 532/25 533/22 534/14 534/24 535/5 535/25 536/2 536/23 537/4 537/13 537/20 538/2 539/4 543/21 552/18 553/11 553/17 565/23 566/11 569/2 570/1 570/22 571/2 571/13 572/1 572/16 572/18 576/16 580/15 580/23 581/5 582/6 588/8 <b>fit</b> [2] 466/16 466/17 <b>five</b> [13] 408/2 415/7 415/8 415/10 471/19
<b>E</b>	<b>each</b> [7] 496/15 507/24 515/9 535/9 560/22 564/20 584/16 <b>earlier</b> [6] 454/22 481/4 554/15 554/16 566/10 572/4 <b>easel</b> [2] 425/5 425/6 <b>easier</b> [5] 414/2 414/23 418/7 423/11 447/17 <b>easy</b> [2] 576/21 576/21 <b>edema</b> [1] 496/17 <b>edges</b> [2] 421/16 550/1 <b>effect</b> [2] 431/3 443/17 <b>either</b> [17] 417/4 421/14 421/15 430/12 446/7 450/9 465/21 475/13 543/9 543/18 544/9 548/4 554/24 561/14 563/3 566/16 576/13 <b>either/or</b> [1] 544/9 <b>elaboration</b> [1] 518/25 <b>electronic</b> [4] 475/6 475/7 475/12 586/4 <b>elevated</b> [5] 502/15 503/5 503/13 572/6 572/7 <b>elevating</b> [1] 502/12 <b>elevation</b> [2] 458/15 572/18 <b>elicited</b> [1] 411/12 <b>else</b> [7] 409/19 479/3 492/25 542/5 551/19 582/23 583/18 <b>encounters</b> [1] 492/19 <b>end</b> [17] 415/20 416/13 416/13 421/10 421/15 428/20 428/20 431/1 431/4 440/24 442/24 452/1 465/25 466/18 502/12 524/19 590/4 <b>ends</b> [2] 529/2 570/11 <b>enlargement</b> [2] 426/6 441/17 <b>enlargements</b> [2] 424/23 425/3 <b>enough</b> [10] 446/7 446/7 487/2 537/7 546/17 546/21 573/12 573/13 575/25 580/2 <b>entering</b> [4] 461/22 461/23 521/13 521/14 <b>entire</b> [5] 422/22 474/8 502/15 511/16 529/1 <b>enumerates</b> [1] 510/6 <b>equal</b> [2] 433/10 532/19 <b>equipment</b> [1] 555/17 <b>equivalent</b> [2] 425/16 452/1 <b>errors</b> [1] 508/16 <b>especially</b> [1] 448/25 <b>ESQ</b> [2] 399/16 399/20 <b>essentially</b> [1] 496/8 <b>establish</b> [1] 425/7 <b>established</b> [1] 427/5 <b>estimate</b> [1] 416/3 <b>et</b> [1] 495/15 <b>evaluate</b> [1] 546/19 <b>evaluated</b> [1] 493/4 <b>evaluating</b> [3] 412/2 496/2 501/22 <b>evaluation</b> [3] 497/4 497/11 501/23 <b>even</b> [13] 412/4 413/16 415/22 442/7 442/7 460/25 463/20 465/20 503/18 519/22 579/8 586/25 587/14 <b>events</b> [1] 562/16 <b>eventually</b> [3] 495/19 557/25 558/2 <b>ever</b> [6] 471/14 471/20 534/17 551/6 568/12 581/22 <b>every</b> [19] 412/25 432/4 432/7 432/10 442/12 467/9 467/13 469/20 482/13 482/14 496/15 510/19 514/14 515/9 519/8 540/6 563/4 563/6 573/17 <b>everybody</b> [2] 427/16 521/15	<b>everyday</b> [1] 491/11 <b>everyone</b> [5] 415/2 421/9 461/24 549/13 574/6 <b>everything</b> [12] 416/9 434/5 446/12 466/17 479/8 532/12 556/7 558/14 580/24 586/5 586/12 586/15 <b>evidence</b> [19] 407/14 407/16 407/19 407/23 408/2 408/4 408/17 424/24 425/9 452/8 452/10 486/14 486/20 562/24 562/25 563/11 563/12 569/13 574/22 <b>evidently</b> [1] 496/16 <b>exact</b> [2] 485/8 531/21 <b>exactly</b> [5] 440/23 452/19 553/7 564/18 566/20 <b>exaggerated</b> [5] 556/15 556/21 557/1 557/5 557/7 <b>exaggerating</b> [1] 429/24 <b>exam</b> [4] 412/16 453/23 496/21 496/25 <b>examination</b> [21] 408/20 457/22 457/24 458/5 458/6 462/1 474/23 474/25 476/4 476/6 483/20 491/7 496/14 497/19 521/3 522/3 554/16 573/21 574/7 584/25 589/2 <b>examine</b> [1] 490/21 <b>examined</b> [4] 406/10 441/15 465/8 496/16 <b>examiner</b> [1] 490/20 <b>examiners</b> [1] 497/15 <b>except</b> [2] 495/5 503/9 <b>excerpts</b> [2] 574/13 576/8 <b>excessive</b> [1] 451/14 <b>excuse</b> [3] 429/13 508/10 546/10 <b>excused</b> [4] 521/1 573/5 589/18 591/5 <b>executed</b> [1] 527/19 <b>exercises</b> [1] 532/10 <b>exhibit</b> [6] 407/18 408/16 420/20 453/6 453/8 569/13 <b>Exhibit 2</b> [1] 569/13 <b>Exhibit 5</b> [1] 453/8 <b>exhibits</b> [1] 426/18 <b>existence</b> [2] 485/6 585/14 <b>exists</b> [1] 464/12 <b>expect</b> [2] 439/12 573/13 <b>experience</b> [5] 441/7 441/12 483/21 561/6 590/1 <b>experienced</b> [8] 445/5 482/17 546/24 547/4 558/22 559/8 567/13 580/14 <b>expert</b> [9] 407/7 411/24 471/15 480/3 480/24 489/12 497/13 548/7 556/2 <b>expertise</b> [1] 489/7 <b>explain</b> [11] 423/6 424/25 429/18 439/2 490/10 507/14 524/14 530/2 550/21 571/9 586/17 <b>explained</b> [10] 501/19 502/22 506/17 507/7 508/25 510/5 524/23 540/25 563/13 587/12 <b>explaining</b> [1] 432/20 <b>explains</b> [1] 506/18 <b>explanation</b> [2] 407/8 407/9 <b>extensive</b> [2] 518/18 519/2 <b>extra</b> [4] 424/4 430/12 430/13 514/24 <b>extremely</b> [1] 417/8
<b>F</b>	<b>facing</b> [2] 438/11 533/9 <b>fact</b> [10] 499/5 499/11 529/9 534/13 538/12 538/22 541/10 572/17 587/4 588/12 <b>factor</b> [5] 450/14 450/18 450/24 474/13 588/21 <b>facts</b> [9] 537/21 540/19 545/25 546/19 547/7 563/25 583/3 584/11 584/11 <b>failed</b> [1] 524/2 <b>fails</b> [1] 454/20 <b>failure</b> [7] 434/11 440/18 450/5 450/7 455/14 475/18 559/11 <b>fair</b> [8] 411/15 485/22 487/2 502/21 523/19	

**F**  
**five...** [8] 480/3 480/23 481/17 486/4 579/18 579/19 580/8 580/9  
**fix** [4] 444/13 444/17 445/18 509/20  
**fixation** [3] 507/10 550/19 552/1  
**fixed** [1] 444/8  
**fixing** [1] 468/23  
**FLANNERY** [20] 399/3 399/3 436/23 443/18 444/23 446/20 453/23 459/20 462/4 462/23 465/8 474/13 477/15 484/19 487/5 522/12 562/20 569/17 588/3 588/7  
**Flannery's** [4] 450/15 450/25 560/19 588/21  
**flat** [2] 466/13 582/22  
**flatfooted** [1] 423/17  
**flexed** [5] 455/1 458/8 458/24 459/21 462/8  
**flexible** [5] 418/23 582/10 582/11 582/18 582/23  
**floor** [1] 406/18  
**fluoroscope** [1] 555/1  
**fluoroscopy** [2] 555/12 555/23  
**focusing** [1] 485/20  
**follow** [4] 539/8 539/9 541/23 541/24  
**following** [2] 444/24 560/23  
**follows** [1] 406/10  
**foot** [83] 409/16 409/21 409/23 412/5 412/12 412/21 412/23 413/25 414/12 414/19 414/21 415/7 415/12 415/19 416/17 416/21 417/9 418/23 419/11 420/17 421/25 422/22 423/7 427/9 427/10 427/11 429/23 430/19 430/22 431/2 431/16 432/5 433/22 437/12 437/16 440/6 443/25 449/23 450/19 451/13 454/6 454/6 454/10 456/5 456/5 456/14 458/14 460/16 463/22 468/22 484/24 485/17 485/18 497/24 498/10 498/12 498/14 498/21 500/21 503/14 506/23 508/15 508/16 508/19 508/21 509/11 520/10 523/5 525/9 533/11 533/17 535/3 535/4 535/6 535/6 557/19 557/25 569/20 572/18 575/19 586/21 586/22 588/10  
**footgear** [2] 501/20 506/4  
**force** [6] 423/19 424/4 429/3 429/5 429/8 432/3  
**forces** [3] 424/18 436/10 507/3  
**forget** [1] 500/17  
**form** [39] 426/13 452/13 511/2 512/5 516/24 517/18 518/18 519/22 522/8 523/9 523/14 523/20 523/23 524/10 524/12 524/14 524/17 525/23 526/11 527/7 527/17 527/24 528/2 539/14 539/18 552/1 578/9 578/10 580/2 580/25 585/6 585/8 585/8 585/12 585/14 585/16 586/16 586/18 586/19  
**formal** [1] 492/14  
**formally** [1] 493/3  
**formation** [5] 429/15 456/3 456/15 515/11 515/14  
**forms** [2] 487/20 524/17  
**formulate** [1] 489/15  
**formulated** [1] 585/22  
**forward** [2] 535/8 584/16  
**found** [1] 483/16  
**foundation** [3] 425/22 533/4 585/21  
**four** [7] 412/7 426/17 467/2 467/3 486/4 507/11 509/24  
**fourth** [5] 417/20 524/1 524/18 524/21 587/19  
**fracture** [4] 421/23 468/24 536/12 559/25  
**fracturing** [1] 460/21  
**fragile** [1] 419/19  
**frankly** [1] 441/11  
**Friday** [2] 573/25 589/20  
**frog** [1] 406/19  
**front** [4] 423/11 479/10 535/3 535/5

**fully** [1] 563/12  
**further** [9] 415/23 457/21 458/18 523/3 540/1 545/11 564/10 565/9 578/20  
**fuse** [5] 418/21 419/6 447/23 500/18 546/11  
**fusing** [1] 559/15  
**fusion** [5] 419/10 419/13 421/7 550/17 560/12  
**future** [7] 435/9 465/18 512/24 513/8 513/10 523/6 578/21

**G**  
**gait** [1] 496/25  
**gap** [2] 427/15 427/20  
**gave** [1] 585/23  
**gear** [2] 524/6 528/4  
**general** [1] 491/13  
**generally** [6] 478/18 491/9 530/8 558/17 565/11 581/11  
**generated** [2] 586/1 586/4  
**Generically** [1] 546/23  
**gentlemen** [1] 589/19  
**GERALD** [2] 399/14 399/16  
**get** [48] 411/3 412/4 413/16 417/2 417/21 429/17 430/4 441/23 442/14 443/22 449/12 454/25 460/2 460/23 465/4 490/5 503/12 505/18 510/10 517/3 517/14 522/25 524/13 526/6 535/9 538/17 546/1 550/16 553/12 557/6 557/21 558/3 559/15 559/25 560/11 573/3 575/7 575/21 575/21 575/22 576/1 576/2 579/19 580/8 581/7 582/19 590/3 591/2  
**gets** [2] 417/7 520/1  
**getting** [10] 423/5 423/23 452/14 456/9 489/7 494/4 494/23 506/1 537/23 573/12  
**give** [17] 406/5 406/21 406/22 406/25 413/7 413/11 416/2 430/18 468/18 471/17 475/10 484/17 512/10 519/8 537/20 554/5 557/3  
**given** [8] 448/14 490/21 502/7 527/1 527/3 529/9 556/13 565/5  
**gives** [3] 407/7 428/6 432/23  
**giving** [2] 530/8 556/18  
**glare** [1] 427/23  
**glistening** [1] 421/10  
**go** [46] 410/1 421/3 427/19 431/7 442/10 444/13 444/17 445/1 457/15 457/21 459/5 460/4 461/14 466/11 466/16 470/23 483/1 487/22 489/25 490/3 494/25 496/1 496/15 505/4 505/7 505/11 507/9 509/16 515/9 516/23 517/4 517/7 517/16 519/19 528/12 530/21 533/8 537/21 542/5 545/25 550/15 553/21 561/8 572/10 574/18 583/11  
**God** [1] 406/7  
**goes** [8] 423/8 423/10 481/4 493/10 494/23 496/6 555/17 556/16  
**going** [127] 406/11 406/15 408/4 408/24 410/1 417/18 420/5 420/9 423/1 424/11 424/13 424/16 424/20 429/14 429/16 429/16 430/1 431/3 431/4 431/10 431/18 433/1 433/13 433/20 435/3 435/7 435/19 436/8 436/22 437/9 440/22 442/3 442/8 442/10 442/11 442/24 443/19 444/6 447/18 447/19 449/11 449/12 449/13 451/19 451/25 452/1 456/7 456/14 456/22 460/15 461/17 462/3 463/16 463/19 464/13 464/17 464/23 481/7 482/8 486/21 486/25 488/11 489/12 489/23 490/3 491/2 494/20 496/1 496/2 499/19 499/21 502/13 505/19 507/15 509/17 509/20 510/2 510/9 513/8 515/9 517/3 518/4 520/23 521/10 521/18 526/7 526/20 526/20 528/21 528/24 530/21 532/3 536/21 537/20 544/11 544/13 546/16 546/20 549/23 552/6 552/15 554/6 556/11

559/25 565/16 568/6 569/12 570/20 573/2 573/11 573/15 573/22 574/3 574/12 574/14 575/9 576/10 576/24 577/21 580/3 581/9 581/12 581/22 584/16 586/17 588/10 589/20  
**gone** [2] 456/24 574/15  
**good** [88] 406/21 408/22 408/23 417/17 418/21 420/14 430/20 431/9 431/11 434/8 434/13 434/22 440/3 440/12 440/16 440/17 440/20 443/1 443/4 443/13 443/22 444/12 444/16 446/13 449/7 450/6 450/11 450/13 450/17 450/23 450/23 461/19 474/3 474/9 475/25 476/8 476/9 478/9 495/25 496/23 506/9 506/12 508/3 509/5 509/7 509/9 509/15 509/21 510/12 510/13 515/6 515/13 516/13 519/3 519/4 519/19 520/16 520/22 522/5 522/6 524/13 525/7 527/22 529/12 529/15 530/1 530/11 531/1 541/7 541/11 544/19 545/9 550/16 550/17 550/19 550/19 552/1 553/15 553/24 553/25 554/2 556/20 557/6 560/11 560/23 561/10 587/24 588/14  
**got** [5] 472/25 480/17 492/20 541/3 585/24  
**graduate** [2] 412/9 466/24  
**graft** [9] 430/13 558/9 558/12 558/16 558/20 560/11 561/1 561/15 561/22  
**grafting** [2] 559/6 559/10  
**great** [11] 399/15 399/15 414/20 414/22 415/21 433/12 440/23 442/4 459/22 460/15 584/9  
**gripping** [2] 455/5 455/6  
**ground** [12] 424/20 428/24 442/11 442/11 443/23 444/4 454/20 454/23 454/25 455/4 455/6 577/11  
**grow** [1] 500/19  
**guarantee** [2] 523/11 590/5  
**guarantees** [1] 523/17  
**guess** [6] 484/5 487/24 519/6 547/20 559/1 589/5  
**guessing** [1] 484/3  
**guidance** [1] 425/19  
**guide** [1] 428/7  
**guilty** [1] 483/16  
**guy** [1] 554/13  
**guys** [1] 533/13

**H**  
**had** [65] 406/19 409/22 412/20 422/9 424/1 432/6 435/6 435/18 436/6 436/23 441/23 442/21 445/19 445/19 446/15 447/5 450/25 451/10 454/5 454/14 456/17 457/6 457/10 462/4 468/15 470/10 470/16 470/25 471/6 477/4 485/6 485/11 485/14 492/12 499/11 499/11 503/19 504/23 514/8 522/8 526/22 530/19 538/6 539/2 541/10 543/7 544/25 545/9 551/24 553/24 554/2 560/18 561/1 561/1 561/3 561/9 564/4 564/9 565/7 581/11 581/22 584/3 588/7 588/9 588/19  
**hallux** [6] 454/19 455/14 498/6 498/19 505/17 529/2  
**Hamilton** [1] 399/18  
**hand** [4] 415/9 527/2 530/22 543/7  
**hands** [2] 497/24 579/9  
**happen** [12] 420/4 420/6 428/16 456/8 484/25 513/8 514/5 516/2 516/19 516/20 519/9 563/21  
**happened** [5] 454/1 516/17 516/21 563/22 580/20  
**happening** [1] 429/7  
**happens** [10] 414/22 415/10 415/13 418/12 423/15 431/6 435/21 519/25 540/6 563/20  
**happy** [2] 567/2 571/14  
**hard** [7] 427/24 522/2 559/4 565/13 565/15 570/20 576/14

<p><b>H</b></p> <p><b>has</b> [80] 411/23 417/3 418/25 420/8 421/9 424/8 424/10 425/10 426/8 428/11 430/23 435/12 435/13 435/14 435/15 435/20 436/7 436/21 439/22 441/12 441/19 447/2 448/14 451/3 454/5 454/8 454/9 455/14 455/22 456/1 457/16 458/9 458/13 458/14 458/16 459/11 459/20 459/22 460/5 462/8 462/15 466/8 473/2 473/9 473/17 474/17 482/12 482/14 487/25 488/22 489/1 490/14 490/16 492/4 494/3 497/2 497/3 498/10 499/4 503/9 513/13 517/19 518/2 522/16 524/2 527/23 528/8 532/3 537/3 546/13 546/17 558/14 561/6 561/9 563/19 574/1 580/15 580/20 585/24 589/25</p> <p><b>have</b> [254]</p> <p><b>Haven't</b> [1] 574/15</p> <p><b>having</b> [14] 406/9 416/10 420/22 429/19 439/13 466/14 466/18 472/1 486/23 493/11 546/18 556/13 564/23 584/8</p> <p><b>he</b> [205]</p> <p><b>head</b> [15] 415/23 421/24 422/2 424/7 434/2 438/16 455/23 465/25 465/25 466/10 503/24 512/11 512/16 570/22 572/15</p> <p><b>heads</b> [2] 570/18 570/24</p> <p><b>heal</b> [1] 559/11</p> <p><b>healing</b> [7] 434/6 448/5 507/11 509/23 509/24 575/14 575/15</p> <p><b>heals</b> [1] 501/10</p> <p><b>healthy</b> [2] 417/4 417/5</p> <p><b>hear</b> [8] 472/8 473/8 499/17 503/22 507/21 568/9 573/3 586/9</p> <p><b>heard</b> [6] 417/10 418/24 419/5 534/17 568/12 579/18</p> <p><b>heat</b> [1] 591/2</p> <p><b>heel</b> [2] 415/5 423/7</p> <p><b>heighten</b> [1] 558/12</p> <p><b>heightening</b> [1] 558/17</p> <p><b>Hello</b> [1] 521/15</p> <p><b>help</b> [8] 406/6 424/25 425/5 457/18 465/19 469/20 569/22 588/10</p> <p><b>helped</b> [1] 454/9</p> <p><b>helping</b> [1] 457/17</p> <p><b>helps</b> [2] 424/13 424/16</p> <p><b>her</b> [73] 409/18 409/19 413/22 423/25 424/1 424/2 437/1 437/12 437/16 439/10 439/11 443/19 444/23 446/21 447/3 450/19 450/19 451/6 452/13 454/1 454/9 454/10 455/6 456/6 457/5 459/24 459/24 461/4 463/24 464/18 465/3 474/13 474/16 475/21 483/4 483/8 483/10 484/20 484/21 484/21 484/24 484/24 485/6 486/7 486/23 487/6 489/10 492/13 493/24 494/19 494/19 494/23 495/2 496/1 497/3 504/25 505/11 509/17 511/11 511/17 511/18 517/24 517/25 522/12 538/3 539/5 539/6 540/4 540/24 540/25 541/7 586/22 588/10</p> <p><b>here</b> [74] 411/15 416/14 416/22 420/13 422/1 423/14 424/9 425/9 426/7 426/9 426/18 431/18 432/22 438/1 438/17 443/3 443/5 443/10 452/20 455/12 458/21 466/11 472/2 472/5 479/4 479/9 481/4 486/22 496/6 497/9 499/4 499/11 499/12 501/19 507/1 507/6 508/1 508/2 508/23 508/24 509/23 510/2 512/9 513/15 514/7 514/13 515/9 521/10 533/14 533/20 533/23 535/16 539/2 540/1 540/14 546/22 549/14 549/23 550/1 550/3 551/22 552/19 552/25 562/1 562/3 569/15 569/20 569/25 570/6 570/7 570/12 570/15 571/2 582/4</p> <p><b>hereby</b> [1] 591/10</p> <p><b>high</b> [1] 569/2</p>	<p><b>higher</b> [2] 570/23</p> <p><b>highest</b> [1] 468/10</p> <p><b>HILLS</b> [3] 399/22 591/10 591/15</p> <p><b>him</b> [9] 462/25 479/22 492/11 492/12 495/1 545/3 560/18 562/5 562/7</p> <p><b>hindsight</b> [4] 583/3 584/4 584/9 584/14</p> <p><b>hip</b> [2] 449/22 452/2</p> <p><b>his</b> [34] 409/3 409/15 452/22 453/23 453/25 455/12 457/22 476/16 476/17 477/1 477/3 486/9 488/10 488/24 492/13 497/10 499/9 507/1 507/23 508/2 510/22 514/15 518/9 526/20 528/2 543/7 545/8 551/23 551/23 553/23 562/19 562/25 578/2 578/6</p> <p><b>history</b> [4] 462/7 494/23 495/2 495/13</p> <p><b>hit</b> [1] 424/20</p> <p><b>hitting</b> [1] 428/23</p> <p><b>hold</b> [9] 414/8 419/8 434/5 438/2 500/19 552/6 559/12 573/11 577/6</p> <p><b>holding</b> [2] 530/22 530/24</p> <p><b>holds</b> [1] 429/2</p> <p><b>hole</b> [1] 442/11</p> <p><b>holes</b> [2] 448/4 553/12</p> <p><b>home</b> [1] 583/7</p> <p><b>HON</b> [1] 399/11</p> <p><b>Honor</b> [42] 406/1 407/13 410/9 410/20 419/21 426/22 431/13 431/15 435/25 436/4 437/14 441/4 448/23 459/1 462/2 468/7 470/19 473/6 474/24 475/8 476/5 481/10 484/18 486/24 487/23 491/5 497/17 517/20 517/22 521/16 526/12 526/19 526/22 527/5 530/17 563/15 567/3 569/13 584/24 585/10 586/13 588/5</p> <p><b>hope</b> [2] 557/5 591/1</p> <p><b>hopefully</b> [3] 415/10 446/12 590/4</p> <p><b>hoping</b> [1] 557/6</p> <p><b>hospital</b> [14] 407/24 412/10 453/19 469/7 476/20 476/24 526/4 526/7 526/10 526/11 526/21 527/7 527/23 530/21</p> <p><b>hospitals</b> [8] 441/2 441/5 441/5 441/8 441/11 441/13 469/5 491/18</p> <p><b>hour</b> [7] 412/16 472/16 472/18 562/7 562/10 573/24 574/3</p> <p><b>house</b> [1] 481/25</p> <p><b>how</b> [61] 408/6 412/5 412/23 413/1 413/4 413/7 413/11 416/6 422/6 422/23 422/25 428/7 428/10 430/3 432/25 432/25 434/24 437/19 439/12 439/20 439/20 440/2 445/22 467/1 467/10 467/11 467/11 467/23 468/18 468/25 471/17 471/22 472/4 472/15 472/22 479/17 480/15 483/13 489/12 491/13 492/16 493/13 494/20 509/19 511/10 511/13 511/20 517/23 534/14 535/9 551/16 551/17 553/20 562/12 573/6 576/23 581/21 581/24 582/8 585/16 585/21</p> <p><b>however</b> [4] 479/23 490/20 524/25 553/3</p> <p><b>HSS</b> [4] 476/24 477/2 477/5 517/15</p> <p><b>hugely</b> [1] 438/25</p> <p><b>hum</b> [1] 480/10</p> <p><b>hundred</b> [6] 413/14 483/22 483/23 484/11 484/12 540/9</p> <p><b>Hundreds</b> [1] 413/10</p> <p><b>hurts</b> [1] 415/24</p> <p><b>Hyper</b> [1] 419/3</p> <p><b>hyperkeratosis</b> [3] 455/24 456/1 456/9</p> <p><b>hypermobility</b> [1] 418/24</p>	<p>414/23 418/10 420/9 423/9 429/24 435/3 436/13 438/17 453/25 454/15 456/22 457/25 461/14 463/2 465/6 469/1 469/1 469/6 473/14 475/3 477/16 478/22 481/7 481/10 481/25 482/3 486/13 489/23 490/3 494/2 497/7 497/12 499/10 500/22 501/9 502/17 503/10 503/23 504/1 511/18 513/2 516/18 519/10 519/13 522/19 526/20 527/10 528/5 530/24 537/20 538/17 539/18 540/9 542/6 542/22 544/13 546/16 549/23 550/12 550/25 552/6 552/10 552/15 554/14 556/11 556/22 556/23 558/19 560/3 562/23 563/9 564/7 564/7 564/16 565/2 565/14 569/12 570/20 571/6 571/9 572/11 572/13 573/11 573/15 573/22 574/14 575/3 575/9 576/10 576/20 576/24 576/24 580/3 580/18 581/9 581/13 583/9</p> <p><b>Idea</b> [7] 413/7 413/11 425/17 441/23 468/18 471/17 487/8</p> <p><b>Ideal</b> [1] 543/24</p> <p><b>ideally</b> [3] 543/9 543/17 557/24</p> <p><b>identify</b> [3] 426/25 569/12 570/17</p> <p><b>If</b> [122] 407/4 411/22 414/23 417/12 418/23 418/25 419/10 424/17 425/15 428/17 428/19 430/9 431/6 433/12 433/17 435/21 436/9 436/13 437/23 439/9 440/21 440/25 442/4 442/6 442/21 442/25 444/9 445/17 447/12 447/22 448/6 449/17 451/21 451/24 454/2 455/3 455/3 456/17 457/6 460/3 463/2 468/3 468/4 484/20 489/17 489/21 491/15 491/20 495/19 496/17 499/17 500/18 501/7 501/10 506/2 509/7 511/6 517/9 519/25 519/25 522/9 523/15 524/16 533/6 536/6 538/16 540/4 541/2 541/9 541/22 544/25 545/3 545/8 545/14 546/1 549/12 550/12 551/13 551/18 551/25 553/18 553/22 553/24 554/2 556/12 557/1 558/20 558/22 559/2 559/8 560/10 561/19 563/8 563/14 565/1 565/2 565/11 565/22 567/25 568/4 568/12 568/22 569/1 569/1 569/15 569/23 571/4 573/23 574/14 575/6 577/1 578/4 578/5 580/7 582/10 582/11 582/12 582/13 582/14 582/18 582/25 586/25</p> <p><b>illness</b> [1] 462/7</p> <p><b>imagine</b> [1] 484/25</p> <p><b>immediately</b> [2] 542/9 543/19</p> <p><b>immobilized</b> [1] 495/20</p> <p><b>impede</b> [1] 488/11</p> <p><b>imperfectly</b> [1] 528/7</p> <p><b>important</b> [8] 420/24 443/25 446/10 470/2 478/6 495/16 520/16 539/20</p> <p><b>impossible</b> [1] 439/15</p> <p><b>Impression</b> [2] 455/13 475/10</p> <p><b>improper</b> [1] 443/16</p> <p><b>improperly</b> [1] 442/19</p> <p><b>in</b> [414]</p> <p><b>in-house</b> [1] 481/25</p> <p><b>In-Office</b> [1] 522/7</p> <p><b>Inartfully</b> [1] 475/9</p> <p><b>inaudible</b> [2] 487/11 487/12</p> <p><b>inch</b> [1] 430/25</p> <p><b>Inches</b> [1] 451/25</p> <p><b>include</b> [3] 523/9 528/16 582/7</p> <p><b>Including</b> [4] 506/6 507/8 524/6 562/13</p> <p><b>incomplete</b> [1] 575/15</p> <p><b>Incorporate</b> [1] 450/1</p> <p><b>incorrect</b> [2] 444/11 445/14</p> <p><b>Increase</b> [4] 430/4 455/22 558/21 559/11</p> <p><b>Increased</b> [6] 416/10 456/4 456/14 457/12 513/12 576/2</p> <p><b>Increases</b> [1] 559/7</p> <p><b>increasing</b> [1] 558/16</p>
<p><b>I</b></p> <p><b>I'll</b> [28] 410/11 423/13 425/19 430/24 430/24 432/15 436/3 457/2 468/9 470/21 473/16 513/4 528/6 529/22 535/19 546/2 546/17 549/5 549/21 553/8 557/17 563/10 567/2 571/15 578/12 580/5 583/25 586/14</p> <p><b>I'm</b> [102] 406/13 406/16 406/21 410/1 411/7</p>		

<p><b>I</b></p> <p><b>Indeed</b> [1] 572/23</p> <p><b>INDEX</b> [1] 399/4</p> <p><b>indicate</b> [1] 448/17</p> <p><b>Indicated</b> [3] 500/4 500/6 507/16</p> <p><b>indicating</b> [8] 415/18 415/22 418/15 420/13 424/5 438/17 442/3 512/16</p> <p><b>indication</b> [1] 422/11</p> <p><b>indicator</b> [1] 446/5</p> <p><b>infected</b> [1] 520/1</p> <p><b>Infection</b> [3] 519/22 559/7 575/14</p> <p><b>infectious</b> [1] 520/12</p> <p><b>infer</b> [1] 565/16</p> <p><b>Influences</b> [1] 501/20</p> <p><b>information</b> [6] 431/7 432/24 489/8 557/4 585/13 585/25</p> <p><b>informed</b> [30] 461/8 487/20 488/1 488/10 488/16 488/19 488/21 489/24 490/16 491/1 491/14 492/5 511/7 512/4 513/6 513/21 514/3 518/17 523/9 524/9 526/3 526/4 526/21 527/6 530/8 530/13 530/15 541/15 585/6 586/16</p> <p><b>Infrequently</b> [1] 490/11</p> <p><b>initial</b> [2] 451/6 497/11</p> <p><b>Initially</b> [1] 506/2</p> <p><b>Injured</b> [2] 471/1 471/2</p> <p><b>injuries</b> [2] 474/14 588/22</p> <p><b>Injury</b> [4] 444/1 450/15 575/14 588/3</p> <p><b>Inner</b> [1] 506/6</p> <p><b>Inquiry</b> [1] 491/3</p> <p><b>Instability</b> [7] 500/2 502/1 502/9 502/23 503/14 525/8 572/18</p> <p><b>Instance</b> [2] 564/8 580/20</p> <p><b>instead</b> [4] 463/12 466/7 508/15 528/10</p> <p><b>Insurance</b> [3] 470/18 481/2 481/8</p> <p><b>intact</b> [1] 475/21</p> <p><b>Intend</b> [1] 488/15</p> <p><b>intended</b> [2] 423/20 523/4</p> <p><b>Intermetatarsal</b> [1] 498/10</p> <p><b>Internal</b> [1] 507/10</p> <p><b>interrupt</b> [4] 461/17 465/6 518/11 581/13</p> <p><b>Intersect</b> [2] 535/7 535/8</p> <p><b>intervention</b> [2] 545/12 560/1</p> <p><b>into</b> [39] 407/14 407/23 408/4 410/1 411/3 412/4 415/9 416/8 431/7 438/14 440/4 442/10 447/13 459/10 465/5 483/2 487/22 488/11 489/25 490/3 494/24 496/7 510/20 513/21 513/24 514/3 519/19 526/20 544/13 545/25 547/24 548/7 581/7 583/11 585/14 586/16 586/17 586/19 587/19</p> <p><b>Intraop</b> [1] 440/23</p> <p><b>intraoperative</b> [9] 439/23 442/22 543/3 555/9 555/12 555/23 556/14 557/12 564/2</p> <p><b>Intraoperatively</b> [25] 437/2 440/19 445/14 532/4 536/8 540/3 543/2 543/4 543/6 543/10 543/11 543/18 543/25 545/10 553/23 554/18 557/2 557/3 557/21 558/9 560/11 561/8 561/23 566/8 567/4</p> <p><b>Introduce</b> [2] 452/16 453/4</p> <p><b>involve</b> [1] 497/23</p> <p><b>Involved</b> [3] 480/15 545/23 546/5</p> <p><b>irrelevant</b> [4] 546/13 548/11 563/24 581/6</p> <p><b>Is</b> [740]</p> <p><b>Island</b> [1] 469/7</p> <p><b>Isn't</b> [11] 482/18 496/12 498/4 503/5 503/7 534/13 534/20 535/10 544/16 544/25 549/18</p> <p><b>Issue</b> [12] 429/9 433/20 447/12 490/17 497/8 509/10 526/3 526/4 526/20 526/23 530/13 541/15</p> <p><b>issues</b> [3] 488/12 488/21 492/4</p> <p><b>It</b> [635]</p>	<p><b>J</b></p> <p><b>January</b> [3] 453/24 457/16 462/13</p> <p><b>January 23</b> [1] 453/24</p> <p><b>Jewish</b> [1] 469/7</p> <p><b>JOHN</b> [1] 399/6</p> <p><b>John's</b> [5] 476/22 524/16 524/17 526/17 527/7</p> <p><b>joint</b> [55] 415/25 416/13 418/19 421/5 421/6 423/22 429/2 429/4 430/17 433/16 435/13 435/15 435/16 438/14 440/5 442/15 458/3 458/15 459/10 459/16 459/24 460/9 460/12 462/10 462/16 465/22 465/23 493/18 498/23 499/6 499/16 500/3 500/14 500/15 500/18 500/20 500/23 501/12 501/12 503/19 504/16 516/6 516/11 516/15 524/25 528/22 529/1 548/22 548/23 549/2 549/4 549/11 549/20 571/24 586/24</p> <p><b>Jointly</b> [1] 549/3</p> <p><b>joints</b> [3] 421/12 466/19 497/20</p> <p><b>JOSEPH</b> [20] 399/8 406/3 406/9 406/24 408/22 453/15 476/8 487/5 491/9 493/14 513/20 521/21 522/5 527/6 546/4 574/7 575/9 585/5 589/4 589/6</p> <p><b>Jr</b> [1] 399/9</p> <p><b>Judge</b> [60] 407/17 408/3 411/22 413/22 415/4 419/24 425/7 425/20 427/2 427/23 441/10 452/15 453/5 456/22 464/19 469/13 475/2 478/16 481/3 483/5 483/9 486/15 486/16 488/2 488/5 490/8 491/4 497/7 497/12 513/2 516/12 519/19 520/21 521/9 529/24 534/10 537/8 538/14 538/24 539/24 541/13 543/15 545/14 546/25 548/14 552/6 552/16 556/4 563/3 563/8 564/12 564/22 566/4 566/14 574/2 574/11 574/25 583/9 583/25 589/24</p> <p><b>Judgment</b> [7] 500/10 532/9 545/9 551/23 566/21 566/24 567/16</p> <p><b>July</b> [1] 399/10</p> <p><b>Juncture</b> [1] 473/7</p> <p><b>June</b> [3] 437/24 556/5 574/13</p> <p><b>June 1</b> [1] 437/24</p> <p><b>June 13th</b> [1] 556/5</p> <p><b>Juror</b> [1] 420/8</p> <p><b>jurors</b> [3] 407/10 493/11 581/9</p> <p><b>Jury</b> [25] 414/24 419/19 420/21 423/12 424/25 432/20 461/22 461/23 466/2 483/16 487/24 490/14 499/5 499/22 521/1 521/13 521/14 534/3 535/20 539/16 546/17 548/13 573/5 586/9 591/5</p> <p><b>Jury's</b> [1] 436/17</p> <p><b>just</b> [93] 406/18 406/19 409/14 409/16 409/20 411/24 419/7 420/7 422/23 423/6 423/19 424/22 425/24 426/13 426/16 427/11 429/11 430/24 432/22 435/3 437/11 447/15 448/3 448/8 448/9 449/5 454/2 455/16 455/18 465/4 465/7 470/22 475/2 475/17 476/11 477/11 477/12 478/24 478/25 481/24 488/20 490/10 490/17 491/9 498/24 501/8 502/14 511/4 511/20 512/10 521/2 522/21 529/2 529/6 530/18 533/7 534/24 537/22 544/6 546/21 547/24 548/7 550/1 550/1 551/7 551/9 551/9 551/13 551/18 552/6 552/7 553/4 553/11 553/18 556/22 558/19 559/2 560/3 560/13 564/8 565/2 565/7 565/7 565/11 567/20 571/5 577/9 578/2 580/20 580/24 581/15 583/9 585/15</p> <p><b>Justice</b> [1] 399/12</p> <p><b>Juts</b> [1] 570/7</p> <p><b>K</b></p> <p><b>keep</b> [5] 406/12 418/14 450/1 450/7 463/13</p>	<p><b>keeping</b> [3] 416/9 416/12 451/15</p> <p><b>Keratin</b> [1] 456/2</p> <p><b>kind</b> [8] 407/7 431/3 475/9 483/22 489/10 563/7 570/7 589/23</p> <p><b>kinds</b> [1] 431/4</p> <p><b>King</b> [1] 399/9</p> <p><b>knee</b> [1] 451/17</p> <p><b>kneecap</b> [1] 428/4</p> <p><b>knew</b> [1] 512/19</p> <p><b>know</b> [98] 407/9 417/15 417/16 418/25 420/24 430/9 432/8 432/10 432/25 434/24 435/8 437/11 439/6 440/2 444/22 449/17 451/12 451/13 451/17 451/21 454/11 461/2 465/24 467/23 478/13 478/15 479/14 480/19 483/9 483/10 484/1 484/2 484/19 484/23 486/3 487/5 487/10 487/13 488/14 488/24 489/14 489/17 489/18 489/21 489/22 491/15 491/20 491/21 491/25 492/15 492/16 492/17 492/19 493/1 495/16 501/2 508/1 508/6 508/10 509/19 511/3 511/4 514/7 515/17 515/17 516/21 517/23 519/14 520/6 523/15 529/9 530/5 531/13 535/19 541/20 544/2 547/21 552/6 553/5 553/20 560/4 562/12 563/6 564/6 565/2 565/24 567/20 572/12 574/25 577/20 583/22 583/23 586/3 587/20 589/10 589/12 589/12 589/13</p> <p><b>knowledge</b> [5] 489/1 490/24 491/10 491/13 491/23</p> <p><b>known</b> [4] 451/5 543/1 579/5 586/20</p> <p><b>knows</b> [5] 488/20 489/2 489/13 491/20 586/21</p> <p><b>L</b></p> <p><b>label</b> [1] 425/23</p> <p><b>labeled</b> [1] 511/1</p> <p><b>lack</b> [4] 488/10 488/19 490/15 541/14</p> <p><b>Ladies</b> [1] 589/19</p> <p><b>lady</b> [1] 485/12</p> <p><b>LaMarca</b> [1] 556/5</p> <p><b>Lapldus</b> [49] 413/2 413/11 413/16 417/11 417/13 419/13 422/12 430/8 433/2 433/3 433/22 437/5 445/13 447/11 447/20 454/5 473/24 483/21 498/11 500/3 500/14 507/8 507/18 507/24 508/13 509/1 514/15 515/3 515/15 525/16 529/10 536/3 540/6 541/2 542/16 542/17 551/7 558/16 558/20 560/19 562/21 575/12 576/4 577/12 578/15 579/4 581/15 581/21 586/25</p> <p><b>larger</b> [1] 426/16</p> <p><b>last</b> [8] 437/15 454/14 461/7 461/11 471/23 472/19 499/4 523/3</p> <p><b>late</b> [1] 573/12</p> <p><b>later</b> [6] 411/4 435/21 435/21 436/24 442/16 453/10</p> <p><b>lateral</b> [2] 418/5 569/19</p> <p><b>Laterally</b> [1] 503/21</p> <p><b>latitude</b> [4] 490/21 527/1 527/3 585/23</p> <p><b>law</b> [2] 399/14 470/17</p> <p><b>lawyer</b> [2] 478/15 478/18</p> <p><b>Lawyers</b> [2] 573/17 589/23</p> <p><b>lax</b> [1] 586/6</p> <p><b>laying</b> [1] 497/23</p> <p><b>lead</b> [4] 455/14 455/22 456/14 520/13</p> <p><b>leading</b> [1] 503/14</p> <p><b>leaning</b> [1] 466/12</p> <p><b>learn</b> [1] 491/14</p> <p><b>learned</b> [1] 412/5</p> <p><b>learning</b> [2] 467/10 487/15</p> <p><b>least</b> [7] 431/23 434/3 480/5 503/16 509/4 522/11 536/6</p> <p><b>leave</b> [10] 422/3 437/6 437/8 439/20 441/1 441/2 441/8 441/14 521/9 569/1</p>
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<p><b>L</b></p> <p><b>leaves</b> [2] 440/25 543/13</p> <p><b>leaving</b> [1] 539/19</p> <p><b>lectures</b> [1] 469/21</p> <p><b>left</b> [17] 427/9 462/3 463/24 485/18 485/21 485/23 498/12 498/15 508/15 508/18 509/3 510/13 510/15 510/22 521/20 522/7 543/7</p> <p><b>leg</b> [3] 451/20 451/24 520/10</p> <p><b>legal</b> [3] 470/13 470/16 471/15</p> <p><b>leisure</b> [2] 583/13 583/14</p> <p><b>length</b> [20] 429/25 433/9 438/24 439/6 445/24 445/25 450/2 450/7 451/15 463/5 463/25 465/21 466/6 474/8 534/14 535/10 542/18 553/3 553/10 553/17</p> <p><b>lengthened</b> [1] 543/21</p> <p><b>lengths</b> [4] 423/2 423/22 432/2 460/15</p> <p><b>lengthy</b> [1] 491/3</p> <p><b>lesion</b> [1] 576/1</p> <p><b>less</b> [12] 421/14 430/4 432/3 449/13 460/24 463/5 484/10 484/14 485/18 495/11 498/12 529/4</p> <p><b>lesser</b> [1] 576/2</p> <p><b>let</b> [26] 409/25 411/11 413/16 414/5 422/14 424/22 425/24 441/2 441/8 441/14 443/6 445/1 445/12 452/7 454/11 459/19 465/7 470/22 473/8 485/2 498/24 522/10 534/24 535/19 546/2 555/22</p> <p><b>let's</b> [11] 421/3 429/2 436/15 437/21 457/14 457/21 460/11 461/14 463/22 526/2 566/9</p> <p><b>level</b> [10] 416/9 416/12 416/23 432/1 434/3 435/16 457/11 463/10 463/15 468/10</p> <p><b>leveling</b> [1] 463/3</p> <p><b>Levine</b> [1] 579/3</p> <p><b>licensed</b> [2] 410/22 575/1</p> <p><b>lie</b> [1] 410/12</p> <p><b>lies</b> [1] 410/16</p> <p><b>life</b> [1] 496/1</p> <p><b>lifestyle</b> [1] 495/17</p> <p><b>lift</b> [1] 503/24</p> <p><b>ligaments</b> [2] 429/1 429/6</p> <p><b>light</b> [2] 425/12 451/6</p> <p><b>like</b> [50] 415/9 415/17 418/15 423/6 423/7 423/8 428/4 437/11 437/22 439/7 439/10 439/11 439/21 442/3 442/10 442/14 447/14 449/21 451/11 452/7 453/22 453/24 454/10 456/6 463/10 466/2 466/14 496/12 499/3 501/15 502/22 511/2 527/17 535/16 550/7 550/8 553/8 555/19 555/24 556/16 560/13 560/17 569/9 569/10 570/19 584/9 584/11 585/8 586/23 587/20</p> <p><b>likely</b> [2] 410/7 509/17</p> <p><b>limb</b> [3] 520/7 520/9 520/14</p> <p><b>limit</b> [4] 447/7 565/3 576/25 578/5</p> <p><b>limitation</b> [1] 505/14</p> <p><b>limited</b> [6] 422/6 489/23 504/10 504/23 505/1 505/2</p> <p><b>limits</b> [4] 493/22 493/24 532/11 532/12</p> <p><b>limp</b> [1] 452/1</p> <p><b>line</b> [6] 462/6 534/21 535/2 535/5 575/10 578/13</p> <p><b>lined</b> [1] 435/17</p> <p><b>lines</b> [3] 535/8 577/8 579/1</p> <p><b>list</b> [2] 518/16 519/2</p> <p><b>listed</b> [1] 518/24</p> <p><b>lists</b> [1] 515/11</p> <p><b>literature</b> [1] 559/23</p> <p><b>little</b> [33] 410/1 411/4 427/16 428/3 428/14 432/3 438/3 438/5 438/11 438/12 441/22 447/15 449/25 457/21 458/18 459/7 462/14 463/4 463/13 463/14 465/20 484/10 484/10 489/6 503/25 552/25 556/17 559/20 568/17 568/19 568/20 571/25 586/6</p>	<p><b>LLC</b> [1] 399/14</p> <p><b>LLP</b> [1] 399/17</p> <p><b>lock</b> [1] 521/11</p> <p><b>locked</b> [1] 521/10</p> <p><b>LOHRFINK</b> [1] 399/17</p> <p><b>long</b> [22] 413/1 413/4 416/16 423/6 424/18 429/19 430/10 434/1 437/4 459/11 460/7 469/7 494/20 496/6 512/2 519/20 552/19 552/23 565/23 569/24 572/25 586/23</p> <p><b>longer</b> [19] 423/4 424/2 424/19 428/19 433/11 437/10 439/5 456/13 503/9 532/19 532/21 533/25 534/4 536/1 536/5 541/16 571/4 571/7 573/6</p> <p><b>longest</b> [1] 424/19</p> <p><b>look</b> [41] 409/2 409/18 409/20 422/19 422/20 422/20 422/21 422/21 422/22 422/25 423/1 423/21 423/22 423/24 428/13 428/17 428/19 431/2 433/19 435/19 437/21 440/7 442/22 452/7 452/11 453/5 453/22 454/12 457/15 461/6 468/3 471/3 485/19 492/21 501/16 510/9 512/7 517/9 522/1 548/19 569/11</p> <p><b>looked</b> [9] 409/17 422/17 423/25 426/14 432/18 452/12 452/19 505/21 583/3</p> <p><b>looking</b> [17] 426/11 427/10 431/16 435/1 435/4 439/10 440/6 451/12 456/6 461/2 485/4 504/22 533/10 535/21 556/17 584/4 586/20</p> <p><b>looks</b> [4] 511/2 527/17 535/15 570/19</p> <p><b>lose</b> [1] 444/1</p> <p><b>loss</b> [2] 448/2 473/23</p> <p><b>lot</b> [4] 491/11 504/14 520/1 560/2</p> <p><b>lots</b> [1] 575/17</p> <p><b>louder</b> [1] 586/10</p> <p><b>low</b> [6] 441/25 442/9 455/1 455/1 460/3 533/15</p> <p><b>lower</b> [4] 441/25 571/12 572/15 587/18</p> <p><b>lunch</b> [2] 519/16 521/12</p> <p><b>Luther</b> [1] 399/9</p> <p><b>lymph</b> [1] 496/18</p>	<p><b>Marks</b> [7] 545/20 563/22 564/4 564/8 580/21 580/24 581/4</p> <p><b>married</b> [1] 495/15</p> <p><b>Martin</b> [1] 399/9</p> <p><b>MARY</b> [1] 399/11</p> <p><b>MARZANO</b> [47] 399/6 409/11 410/6 412/3 434/11 435/6 435/18 436/7 436/21 441/23 444/14 445/19 446/19 448/15 452/22 456/17 461/3 473/3 473/17 476/22 477/10 477/11 477/12 479/14 485/11 493/2 493/8 494/18 496/11 502/22 504/9 518/22 522/8 528/1 528/9 536/15 537/9 537/25 538/9 544/14 551/22 553/22 554/9 560/17 584/13 586/5 589/10</p> <p><b>Marzano's</b> [12] 409/3 454/12 454/13 461/2 475/5 476/16 492/9 508/2 511/16 514/8 569/14 585/7</p> <p><b>material</b> [2] 429/1 478/19</p> <p><b>matrimonial</b> [1] 406/17</p> <p><b>matter</b> [4] 516/2 563/5 583/8 583/10</p> <p><b>Matthew</b> [7] 407/15 407/21 407/22 452/9 453/16 458/1 462/5</p> <p><b>may</b> [38] 408/14 408/18 411/22 418/7 418/24 425/7 427/2 447/16 453/4 466/3 475/2 478/22 478/22 488/2 490/25 491/1 491/5 497/15 507/9 510/11 512/16 512/20 514/5 517/7 521/9 521/16 523/4 523/5 529/14 530/10 531/15 534/2 560/11 563/8 571/25 572/5 578/20 586/22</p> <p><b>maybe</b> [15] 421/14 448/9 462/14 471/19 479/19 538/5 542/22 551/4 551/9 551/10 560/13 560/15 560/16 573/14 589/1</p> <p><b>MC</b> [4] 476/7 491/8 522/4 589/3</p> <p><b>McANDREW</b> [6] 399/20 475/1 476/3 488/8 585/6 586/11</p> <p><b>MD</b> [1] 407/22</p> <p><b>me</b> [66] 409/25 411/11 413/16 414/5 419/18 422/14 423/3 423/13 424/4 424/22 425/16 425/24 428/10 429/9 429/13 438/19 443/6 445/1 445/12 452/8 454/11 459/19 465/7 470/11 473/8 473/9 479/10 480/17 484/17 485/2 488/11 489/18 492/22 498/24 499/8 499/17 508/10 510/21 510/25 512/10 514/17 514/25 518/6 522/10 522/19 524/23 531/10 534/24 536/18 537/15 538/6 539/8 540/8 544/5 544/10 554/5 555/22 556/12 559/4 560/20 560/23 565/22 567/23 569/22 569/23 573/17</p> <p><b>mean</b> [36] 410/15 416/25 417/13 423/21 429/18 431/16 431/25 438/8 443/17 454/20 459/23 463/18 465/23 482/22 483/23 489/24 501/6 502/11 504/5 518/11 540/10 548/1 548/9 548/16 550/21 565/10 572/2 573/24 577/13 581/14 582/19 582/22 582/25 583/16 583/23 583/23</p> <p><b>meaning</b> [10] 419/2 423/4 435/16 438/4 438/9 443/23 449/12 455/5 482/24 533/10</p> <p><b>means</b> [22] 421/6 423/3 424/3 424/10 443/19 455/5 455/25 456/1 456/5 458/8 458/9 459/9 459/9 459/24 460/9 460/21 463/19 467/22 494/10 505/19 520/9 524/24</p> <p><b>meant</b> [2] 429/5 512/24</p> <p><b>measure</b> [5] 416/4 428/11 534/14 535/7 567/7</p> <p><b>measured</b> [1] 445/24</p> <p><b>measures</b> [1] 524/3</p> <p><b>measuring</b> [2] 435/2 566/20</p> <p><b>medial</b> [12] 418/2 418/3 418/4 418/9 418/20 419/7 419/15 420/9 420/11 420/23 438/2 460/11</p> <p><b>medical</b> [23] 407/6 407/15 408/8 410/13 410/15 411/16 431/9 439/25 440/1 443/9 452/24 469/7 470/13 470/16 471/15 475/6</p>
<p><b>M</b></p> <p><b>ma'am</b> [2] 561/25 562/3</p> <p><b>made</b> [3] 441/25 448/15 448/17</p> <p><b>MAGRO</b> [1] 399/17</p> <p><b>make</b> [25] 424/12 432/2 438/3 439/18 439/19 440/8 442/11 450/1 453/9 465/20 466/17 475/16 475/18 481/19 507/3 526/2 527/8 527/11 531/9 536/12 537/22 544/19 555/24 561/7 566/9</p> <p><b>makes</b> [5] 414/2 428/16 448/5 454/8 495/11</p> <p><b>making</b> [7] 419/9 421/22 421/22 433/23 441/25 452/3 551/15</p> <p><b>malpractice</b> [5] 482/2 483/17 490/17 490/18 548/16</p> <p><b>man</b> [1] 492/5</p> <p><b>manage</b> [1] 468/25</p> <p><b>Manhasset</b> [1] 407/3</p> <p><b>manner</b> [1] 467/12</p> <p><b>many</b> [15] 413/7 413/11 466/14 467/1 467/24 468/18 471/17 471/22 472/22 479/17 497/15 511/10 511/13 511/20 578/14</p> <p><b>March</b> [10] 426/11 427/6 441/18 443/11 462/5 531/13 531/15 531/16 544/14 545/2</p> <p><b>March 10th</b> [2] 426/11 427/6</p> <p><b>March 25</b> [1] 443/11</p> <p><b>March 25th</b> [4] 441/18 531/13 544/14 545/2</p> <p><b>March 8th</b> [1] 462/5</p> <p><b>March or</b> [1] 531/15</p> <p><b>mark</b> [4] 399/20 408/4 413/23 414/3</p> <p><b>marked</b> [4] 407/18 408/16 452/8 452/9</p> <p><b>Marks</b> [1] 546/4</p>	<p><b>M</b></p> <p><b>ma'am</b> [2] 561/25 562/3</p> <p><b>made</b> [3] 441/25 448/15 448/17</p> <p><b>MAGRO</b> [1] 399/17</p> <p><b>make</b> [25] 424/12 432/2 438/3 439/18 439/19 440/8 442/11 450/1 453/9 465/20 466/17 475/16 475/18 481/19 507/3 526/2 527/8 527/11 531/9 536/12 537/22 544/19 555/24 561/7 566/9</p> <p><b>makes</b> [5] 414/2 428/16 448/5 454/8 495/11</p> <p><b>making</b> [7] 419/9 421/22 421/22 433/23 441/25 452/3 551/15</p> <p><b>malpractice</b> [5] 482/2 483/17 490/17 490/18 548/16</p> <p><b>man</b> [1] 492/5</p> <p><b>manage</b> [1] 468/25</p> <p><b>Manhasset</b> [1] 407/3</p> <p><b>manner</b> [1] 467/12</p> <p><b>many</b> [15] 413/7 413/11 466/14 467/1 467/24 468/18 471/17 471/22 472/22 479/17 497/15 511/10 511/13 511/20 578/14</p> <p><b>March</b> [10] 426/11 427/6 441/18 443/11 462/5 531/13 531/15 531/16 544/14 545/2</p> <p><b>March 10th</b> [2] 426/11 427/6</p> <p><b>March 25</b> [1] 443/11</p> <p><b>March 25th</b> [4] 441/18 531/13 544/14 545/2</p> <p><b>March 8th</b> [1] 462/5</p> <p><b>March or</b> [1] 531/15</p> <p><b>mark</b> [4] 399/20 408/4 413/23 414/3</p> <p><b>marked</b> [4] 407/18 408/16 452/8 452/9</p> <p><b>Marks</b> [1] 546/4</p>	<p><b>M</b></p> <p><b>ma'am</b> [2] 561/25 562/3</p> <p><b>made</b> [3] 441/25 448/15 448/17</p> <p><b>MAGRO</b> [1] 399/17</p> <p><b>make</b> [25] 424/12 432/2 438/3 439/18 439/19 440/8 442/11 450/1 453/9 465/20 466/17 475/16 475/18 481/19 507/3 526/2 527/8 527/11 531/9 536/12 537/22 544/19 555/24 561/7 566/9</p> <p><b>makes</b> [5] 414/2 428/16 448/5 454/8 495/11</p> <p><b>making</b> [7] 419/9 421/22 421/22 433/23 441/25 452/3 551/15</p> <p><b>malpractice</b> [5] 482/2 483/17 490/17 490/18 548/16</p> <p><b>man</b> [1] 492/5</p> <p><b>manage</b> [1] 468/25</p> <p><b>Manhasset</b> [1] 407/3</p> <p><b>manner</b> [1] 467/12</p> <p><b>many</b> [15] 413/7 413/11 466/14 467/1 467/24 468/18 471/17 471/22 472/22 479/17 497/15 511/10 511/13 511/20 578/14</p> <p><b>March</b> [10] 426/11 427/6 441/18 443/11 462/5 531/13 531/15 531/16 544/14 545/2</p> <p><b>March 10th</b> [2] 426/11 427/6</p> <p><b>March 25</b> [1] 443/11</p> <p><b>March 25th</b> [4] 441/18 531/13 544/14 545/2</p> <p><b>March 8th</b> [1] 462/5</p> <p><b>March or</b> [1] 531/15</p> <p><b>mark</b> [4] 399/20 408/4 413/23 414/3</p> <p><b>marked</b> [4] 407/18 408/16 452/8 452/9</p> <p><b>Marks</b> [1] 546/4</p>

<p><b>M</b></p> <p><b>medical...</b> [7] 475/7 475/11 476/20 494/22 495/2 548/16 586/4</p> <p><b>medical/legal</b> [3] 470/13 470/16 471/15</p> <p><b>medication</b> [1] 495/9</p> <p><b>medications</b> [1] 495/8</p> <p><b>medicine</b> [5] 399/6 412/7 412/8 466/22 559/14</p> <p><b>meeting</b> [1] 577/11</p> <p><b>memory</b> [1] 479/8</p> <p><b>mention</b> [2] 481/8 513/10</p> <p><b>mentioned</b> [5] 420/20 440/9 445/19 463/16 469/1</p> <p><b>met</b> [5] 472/19 472/22 479/11 562/4 562/5</p> <p><b>metatarsal</b> [239]</p> <p><b>metatarsals</b> [36] 415/8 415/10 417/21 423/2 423/15 423/18 429/22 429/24 432/2 433/14 436/9 437/1 439/10 442/8 450/20 451/1 457/7 460/23 462/11 463/4 463/7 463/21 464/1 464/5 465/5 465/20 465/22 466/1 474/18 488/15 514/24 535/10 542/19 549/17 558/8 576/3</p> <p><b>method</b> [2] 448/18 562/21</p> <p><b>mice</b> [1] 469/3</p> <p><b>mid</b> [1] 416/16</p> <p><b>middle</b> [6] 418/4 429/23 494/12 534/21 535/2 543/12</p> <p><b>might</b> [4] 423/11 500/7 513/22 568/22</p> <p><b>migrated</b> [1] 459/8</p> <p><b>mild</b> [1] 416/3</p> <p><b>millimeter</b> [5] 421/15 447/21 447/21 551/10 551/18</p> <p><b>millimeters</b> [2] 473/24 473/25</p> <p><b>mind</b> [4] 583/20 587/15 588/6 588/13</p> <p><b>Mine</b> [1] 441/6</p> <p><b>minimal</b> [3] 433/7 449/15 457/8</p> <p><b>minimize</b> [3] 430/3 447/7 448/2</p> <p><b>minimum</b> [2] 430/11 447/9</p> <p><b>minute</b> [1] 552/8</p> <p><b>minutes</b> [11] 461/20 573/4 573/7 573/8 573/10 573/13 573/16 573/20 573/23 573/24 574/3</p> <p><b>misleading</b> [3] 549/8 571/15 571/18</p> <p><b>Miss</b> [1] 562/20</p> <p><b>misshapen</b> [5] 548/23 549/1 549/3 549/7 549/10</p> <p><b>misspeak</b> [2] 470/6 532/23</p> <p><b>mistaken</b> [1] 549/12</p> <p><b>misunderstood</b> [1] 551/4</p> <p><b>model</b> [2] 413/19 417/12</p> <p><b>models</b> [2] 413/21 419/18</p> <p><b>moderate</b> [3] 416/3 485/15 485/18</p> <p><b>modified</b> [1] 450/22</p> <p><b>mom</b> [1] 495/14</p> <p><b>moment</b> [7] 435/4 484/17 499/10 512/10 533/7 554/5 577/7</p> <p><b>Monday</b> [2] 589/21 591/3</p> <p><b>months</b> [3] 456/21 507/11 509/24</p> <p><b>more</b> [48] 410/7 413/16 416/11 417/14 423/5 424/16 429/21 430/8 433/10 433/25 437/4 439/4 449/13 456/11 457/10 462/14 463/10 463/14 463/20 465/20 471/9 471/10 475/3 484/10 489/6 503/6 503/14 503/20 503/20 518/18 519/15 519/18 524/3 526/3 529/4 529/4 531/23 541/14 567/12 567/13 568/2 568/18 572/24 573/13 573/20 580/6 587/1 589/25</p> <p><b>morning</b> [3] 408/22 408/23 472/24</p> <p><b>most</b> [13] 423/23 424/20 428/24 441/1 441/5 441/5 441/8 441/11 443/24 465/3 470/1 470/2 558/3</p> <p><b>mostly</b> [2] 428/22 525/22</p>	<p><b>motion</b> [11] 462/9 462/15 497/20 504/9 504/11 504/16 504/17 504/19 504/24 504/25 505/15</p> <p><b>motions</b> [1] 504/8</p> <p><b>move</b> [8] 422/2 422/4 422/4 485/2 502/2 502/10 526/7 563/10</p> <p><b>movement</b> [1] 419/2</p> <p><b>moving</b> [9] 468/6 496/5 502/16 502/18 502/24 526/9 531/12 590/2 590/5</p> <p><b>MIR</b> [18] 408/21 475/1 476/7 478/20 479/17 480/16 483/20 490/14 491/8 492/22 492/24 522/4 560/17 562/4 585/1 585/6 586/11 589/3</p> <p><b>Mr.</b> [4] 420/10 476/3 488/8 579/3</p> <p><b>Mr. Levine</b> [1] 579/3</p> <p><b>Mr. McAndrew</b> [2] 476/3 488/8</p> <p><b>Mr. Provensano</b> [1] 420/10</p> <p><b>Mrs.</b> [4] 477/15 484/19 487/5 560/19</p> <p><b>Mrs. Flannery</b> [3] 477/15 484/19 487/5</p> <p><b>Mrs. Flannery's</b> [1] 560/19</p> <p><b>much</b> [47] 409/18 416/6 419/2 420/25 422/6 428/7 428/10 428/19 429/3 429/5 429/8 429/25 430/1 430/3 432/23 432/25 435/14 437/3 440/6 446/6 446/8 449/5 457/10 458/24 472/4 472/15 474/20 490/4 490/5 521/7 526/15 527/2 530/6 546/21 551/12 551/17 562/12 568/22 568/23 569/4 569/5 573/6 575/23 575/24 576/22 587/1 589/16</p> <p><b>must</b> [3] 407/5 519/7 550/18</p> <p><b>my</b> [26] 406/20 409/2 412/13 415/3 467/21 469/15 470/11 471/24 480/17 490/6 491/23 492/20 524/2 524/25 525/1 530/23 534/24 538/24 546/20 548/4 556/25 573/20 580/2 587/12 588/17 589/25</p> <p><b>N</b></p> <p><b>nail</b> [2] 437/12 437/15</p> <p><b>name</b> [7] 406/22 417/15 417/24 426/7 468/21 480/18 585/17</p> <p><b>named</b> [1] 520/7</p> <p><b>narrow</b> [1] 415/12</p> <p><b>narrowed</b> [1] 490/16</p> <p><b>Nassau</b> [2] 545/21 556/4</p> <p><b>natural</b> [1] 503/5</p> <p><b>Naturally</b> [1] 408/15</p> <p><b>nature</b> [1] 407/6</p> <p><b>necessarily</b> [10] 478/12 489/25 492/7 501/14 538/4 559/9 559/10 564/24 565/10 572/5</p> <p><b>necessary</b> [5] 425/15 446/12 473/3 473/18 523/6</p> <p><b>neck</b> [3] 399/15 399/15 421/25</p> <p><b>need</b> [36] 408/14 414/5 416/13 417/12 431/20 431/22 431/24 432/1 432/2 433/21 434/1 435/20 440/2 440/5 440/7 449/15 449/19 451/11 451/15 464/13 464/17 464/23 465/1 465/4 478/9 483/1 487/22 489/14 518/12 530/4 537/16 548/18 550/21 573/20 574/18 578/20</p> <p><b>needed</b> [3] 409/20 467/18 552/2</p> <p><b>needing</b> [1] 446/21</p> <p><b>needs</b> [3] 429/10 465/19 587/2</p> <p><b>negative</b> [3] 438/5 438/8 438/9</p> <p><b>negligence</b> [4] 547/4 548/9 548/15 564/25</p> <p><b>negligent</b> [5] 409/15 547/11 547/19 547/25 565/11</p> <p><b>neither</b> [1] 568/8</p> <p><b>nerve</b> [1] 575/14</p> <p><b>neurological</b> [1] 496/20</p> <p><b>never</b> [8] 465/7 479/11 486/9 544/2 561/1 563/3 583/20 589/25</p> <p><b>nevertheless</b> [3] 561/3 561/13 590/2</p> <p><b>new</b> [11] 399/1 399/9 407/3 410/23 419/1 445/17 452/4 467/6 496/12 575/16 575/21</p>	<p><b>next</b> [14] 409/23 440/4 440/7 452/22 494/22 495/4 495/8 495/13 507/9 510/4 527/15 556/25 559/2 590/4</p> <p><b>nine</b> [1] 456/21</p> <p><b>no</b> [131] 399/4 407/18 408/16 410/10 410/10 411/20 419/23 420/5 425/17 432/22 437/2 439/3 439/23 442/12 444/15 450/4 457/20 458/5 460/4 467/15 470/7 477/11 477/18 477/21 477/24 478/11 479/5 479/7 479/15 479/24 480/20 480/22 482/6 483/12 484/15 485/8 486/2 486/5 486/15 487/7 487/8 487/9 487/14 494/11 497/9 499/1 499/20 501/7 501/8 504/12 507/12 508/7 509/24 514/10 514/12 516/2 517/1 517/9 518/11 519/10 523/16 525/18 530/13 530/23 530/23 532/16 532/17 534/16 534/23 535/12 535/16 537/16 541/14 541/16 542/6 542/13 544/5 545/6 545/7 545/7 549/2 550/24 552/10 553/18 553/18 554/8 556/19 556/23 558/21 558/24 559/1 559/9 559/22 559/23 560/3 560/3 560/14 561/10 561/20 561/21 562/14 562/17 562/24 562/25 563/5 563/9 563/11 563/12 565/3 565/12 566/6 566/6 567/13 567/20 567/21 567/23 568/3 568/7 570/25 571/13 574/17 574/23 576/25 578/6 578/23 581/23 582/24 583/24 585/23 589/13 589/25</p> <p><b>Nodding</b> [2] 550/23 584/17</p> <p><b>nodes</b> [1] 496/18</p> <p><b>non</b> [1] 417/5</p> <p><b>non-healthy</b> [1] 417/5</p> <p><b>noncommittal</b> [1] 568/12</p> <p><b>nonunion</b> [2] 559/16 559/25</p> <p><b>normal</b> [5] 423/20 493/24 494/1 494/2 496/8</p> <p><b>North</b> [1] 469/6</p> <p><b>Northern</b> [1] 407/2</p> <p><b>not</b> [298]</p> <p><b>note</b> [12] 454/1 461/3 501/16 506/24 507/25 510/15 510/18 510/20 510/23 512/25 518/24 519/22</p> <p><b>noted</b> [2] 453/25 498/18</p> <p><b>notes</b> [8] 457/15 461/12 461/15 477/1 479/6 499/9 508/2 530/23</p> <p><b>nothing</b> [7] 406/6 420/5 481/9 488/22 495/5 546/14 564/14</p> <p><b>now</b> [97] 406/11 409/6 413/15 416/24 417/10 419/16 420/7 421/2 421/20 424/11 424/16 430/10 432/17 432/25 433/20 437/3 438/10 438/13 439/9 439/17 442/9 444/3 444/22 445/19 446/15 446/24 450/10 450/12 451/3 452/3 452/7 453/4 455/12 455/21 456/13 456/17 456/20 457/15 457/21 458/9 459/11 462/3 468/14 471/25 473/2 473/14 476/3 479/11 480/23 481/22 482/13 483/20 484/17 485/24 493/10 493/13 497/23 498/9 503/5 505/17 508/24 512/9 518/16 519/17 520/19 529/9 530/4 531/17 532/13 533/10 534/8 536/3 536/5 536/14 539/25 542/9 545/8 546/18 550/16 551/15 552/4 552/21 553/3 553/15 553/22 554/15 555/12 558/6 565/21 568/16 569/9 571/10 580/22 585/2 585/24 586/8 589/22</p> <p><b>number</b> [7] 408/24 431/9 431/10 438/6 467/25 476/14 490/1</p> <p><b>Number 1</b> [1] 438/6</p> <p><b>number two</b> [1] 431/10</p> <p><b>nurse</b> [5] 487/10 487/13 489/6 489/10 491/23</p> <p><b>nurse's</b> [1] 489/14</p> <p><b>nurses</b> [7] 487/18 488/21 489/16 489/20 491/10 491/13 491/18</p> <p><b>nursing</b> [1] 492/3</p> <p><b>NY</b> [2] 399/15 399/19</p>
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<p><b>O</b></p> <p><b>o'clock [3]</b> 520/25 520/25 591/4</p> <p><b>oath [2]</b> 521/22 574/8</p> <p><b>object [10]</b> 416/8 435/24 448/22 456/23 469/11 491/19 497/8 526/20 536/21 541/13</p> <p><b>objected [3]</b> 481/3 488/22 585/20</p> <p><b>objectify [1]</b> 576/15</p> <p><b>objecting [1]</b> 539/18</p> <p><b>objection [61]</b> 410/9 410/20 432/12 436/12 436/14 437/14 441/4 459/1 464/15 464/19 468/7 470/19 473/6 475/8 478/4 482/25 483/5 483/11 483/12 487/1 487/21 491/17 499/20 501/3 511/13 513/1 513/5 513/16 516/24 517/18 519/11 530/12 535/17 539/11 539/14 544/22 545/5 545/24 546/13 546/25 547/7 547/12 548/6 548/10 562/22 563/24 564/12 566/22 579/21 580/10 580/22 580/25 581/6 582/1 582/2 583/19 584/5 585/10 586/13 587/9 588/5</p> <p><b>obligated [1]</b> 437/5</p> <p><b>observations [2]</b> 464/7 465/16</p> <p><b>obtaining [2]</b> 487/20 541/7</p> <p><b>obvious [3]</b> 510/21 510/21 510/22</p> <p><b>obviously [1]</b> 422/19</p> <p><b>occasion [7]</b> 412/21 469/16 470/10 470/16 470/25 471/6 540/5</p> <p><b>occasions [1]</b> 469/9</p> <p><b>occur [6]</b> 494/14 510/11 513/22 579/8 586/22 588/12</p> <p><b>occurred [3]</b> 540/20 543/2 580/16</p> <p><b>occurring [1]</b> 559/21</p> <p><b>off [18]</b> 427/25 428/1 428/20 428/21 433/9 435/17 437/23 449/18 462/3 473/24 483/22 522/7 551/3 551/5 552/22 553/1 573/3 573/25</p> <p><b>Off-the-record [1]</b> 428/1</p> <p><b>offer [1]</b> 407/14</p> <p><b>offers [1]</b> 407/23</p> <p><b>office [11]</b> 399/14 453/23 454/13 454/13 472/1 492/13 493/4 507/25 511/16 522/7 583/17</p> <p><b>offload [2]</b> 449/11 495/22</p> <p><b>offloading [1]</b> 488/14</p> <p><b>often [2]</b> 412/23 559/14</p> <p><b>OGINSKI [13]</b> 399/14 399/16 408/21 478/20 479/17 480/16 483/20 490/14 492/22 492/24 560/17 562/4 585/1</p> <p><b>oh [3]</b> 414/10 430/23 527/10</p> <p><b>okay [127]</b> 406/11 410/2 413/18 414/1 414/6 414/15 414/18 416/18 417/17 417/22 418/6 418/10 420/14 422/14 424/21 427/12 427/18 432/25 433/17 436/20 437/25 446/23 446/24 447/6 450/10 451/8 451/10 453/3 455/11 458/7 459/18 462/21 471/25 472/24 479/16 480/8 482/13 484/9 486/6 487/23 488/7 488/17 492/8 492/18 492/24 493/5 494/22 498/3 499/13 500/17 501/15 501/18 501/25 502/7 502/15 503/4 504/1 504/21 509/13 509/19 511/9 512/7 512/9 513/4 514/7 514/16 514/20 515/8 517/12 518/8 518/16 518/21 520/19 521/6 522/10 523/22 524/12 531/7 534/2 534/7 534/17 534/20 535/15 537/18 537/23 540/15 541/3 541/4 546/3 547/2 548/14 549/12 549/16 549/22 550/5 550/15 550/22 551/14 551/22 552/25 553/20 553/21 554/5 555/11 555/16 556/25 560/16 560/24 560/25 561/4 564/22 565/6 568/4 569/1 569/7 570/9 571/21 572/12 575/2 575/3 575/8 575/18 578/1 578/19 583/15 585/15 586/3</p> <p><b>old [2]</b> 579/18 580/7</p> <p><b>omit [1]</b> 475/13</p>	<p><b>omitting [1]</b> 519/4</p> <p><b>on [144]</b> 406/17 407/14 415/19 415/23 416/10 417/3 417/9 421/1 421/3 421/11 421/13 421/15 421/15 423/19 424/19 426/7 427/8 427/10 427/12 429/4 429/8 430/1 430/18 430/21 432/4 433/15 435/21 435/21 436/24 437/4 438/22 439/13 441/18 441/20 442/23 443/10 443/23 443/25 444/4 447/21 447/21 447/23 448/1 449/13 451/7 452/12 454/6 454/19 454/25 455/2 455/12 456/4 457/9 458/25 459/4 460/17 460/24 461/25 462/23 463/13 467/21 470/25 471/7 471/9 471/12 476/12 477/2 478/17 480/5 482/14 482/21 485/10 485/16 485/17 485/20 486/19 488/12 488/15 489/9 489/23 490/23 491/1 494/15 494/20 495/9 495/21 495/24 496/1 497/24 498/1 501/20 503/1 505/11 505/22 508/18 509/2 509/17 510/8 518/2 518/17 518/18 518/25 519/7 521/21 526/15 526/16 526/23 527/2 530/13 531/13 532/3 534/5 535/16 539/22 542/9 544/14 545/3 545/19 546/20 549/16 551/16 552/22 553/13 554/16 555/7 556/5 557/19 558/22 559/14 561/2 563/10 568/14 570/25 571/6 571/9 574/1 576/2 577/6 582/8 582/20 582/20 585/3 587/1 589/21</p> <p><b>once [2]</b> 458/10 480/5</p> <p><b>one [52]</b> 409/20 409/21 416/11 416/11 417/14 417/18 417/19 417/20 417/24 419/1 419/14 421/7 421/8 427/6 429/5 430/1 431/9 433/23 438/3 440/7 443/20 443/24 446/19 447/9 447/21 448/21 448/21 451/23 454/11 463/6 474/8 475/2 483/6 484/17 494/11 495/8 497/1 500/5 511/7 519/15 527/12 543/22 550/8 554/5 555/21 557/9 564/20 568/8 568/13 577/7 578/19 589/24</p> <p><b>one-sixth [2]</b> 451/23 474/8</p> <p><b>ones [2]</b> 510/21 510/22</p> <p><b>ongoing [1]</b> 485/11</p> <p><b>only [24]</b> 409/14 414/4 418/18 422/4 440/6 445/11 447/12 481/16 481/21 482/9 482/11 497/8 503/5 505/4 505/11 508/24 517/18 518/22 524/24 525/1 540/25 541/14 554/9 589/24</p> <p><b>onto [4]</b> 422/5 526/9 530/21 531/12</p> <p><b>op [17]</b> 426/23 426/23 452/21 456/6 517/9 522/25 534/8 534/9 534/11 535/22 537/2 537/2 539/10 539/12 540/12 540/12 540/17</p> <p><b>open [2]</b> 466/15 490/9</p> <p><b>opened [1]</b> 454/16</p> <p><b>operated [1]</b> 476/22</p> <p><b>operating [9]</b> 439/17 441/1 441/3 519/7 543/13 553/24 554/13 555/14 555/17</p> <p><b>operation [8]</b> 523/4 527/23 531/4 537/11 541/1 542/14 546/20 566/10</p> <p><b>operative [1]</b> 553/6</p> <p><b>opinion [28]</b> 434/7 434/18 434/20 439/23 440/19 443/8 444/19 448/19 449/2 449/3 449/4 450/12 452/13 464/9 465/16 489/15 490/6 501/2 518/9 579/19 580/3 587/5 587/10 587/12 587/22 587/24 588/16 588/17</p> <p><b>opinions [1]</b> 465/10</p> <p><b>opportunities [1]</b> 469/9</p> <p><b>opportunity [2]</b> 468/15 540/14</p> <p><b>optimal [1]</b> 561/3</p> <p><b>option [2]</b> 565/5 565/9</p> <p><b>options [1]</b> 543/22</p> <p><b>or [186]</b> 407/8 409/24 411/20 412/2 414/19 416/5 416/21 417/4 417/6 418/3 418/4 418/4 418/9 418/23 419/13 421/21 421/24 423/17 424/13 425/3 427/10 427/20 429/11 430/14 430/15 431/4 432/5 433/14 435/9</p>	<p>435/22 436/17 439/16 442/7 446/8 446/21 447/7 447/7 448/10 449/23 452/23 456/7 456/9 457/4 458/23 458/24 460/10 460/21 463/4 465/7 465/22 468/4 470/2 471/3 471/8 473/4 473/19 475/15 478/11 480/24 481/12 481/23 482/2 482/9 483/7 484/20 485/4 486/4 488/4 492/5 494/11 494/12 495/22 497/1 499/22 500/18 501/7 501/8 501/22 502/24 504/23 507/15 507/15 507/16 509/4 512/24 515/14 515/20 515/20 516/22 517/7 518/2 518/3 518/11 519/15 519/16 520/9 520/10 523/17 524/1 524/17 531/15 532/16 532/19 534/8 536/18 537/2 539/6 540/14 541/2 542/10 543/4 543/10 543/19 543/21 544/9 548/25 549/20 550/24 551/18 551/19 553/16 553/18 553/18 554/7 554/8 554/10 555/9 555/12 555/23 556/23 557/1 557/2 557/12 557/15 558/6 558/16 558/21 558/22 558/24 559/1 559/8 559/25 560/3 560/3 560/14 561/1 561/10 561/15 561/19 561/21 561/22 561/23 565/3 565/8 565/12 566/8 566/16 567/17 567/20 567/21 567/23 567/23 568/1 568/5 569/5 571/13 572/16 575/6 575/19 575/23 576/25 578/5 578/6 578/8 578/9 578/9 578/23 579/3 579/15 581/15 581/15 581/25 582/23 583/16 583/17 589/7</p> <p><b>oral [1]</b> 412/16</p> <p><b>oranges [2]</b> 564/13 571/8</p> <p><b>order [10]</b> 422/15 426/14 440/11 447/6 452/13 452/19 462/19 466/19 489/15 550/18</p> <p><b>ordinarily [2]</b> 513/20 561/9</p> <p><b>original [1]</b> 591/12</p> <p><b>originally [3]</b> 444/8 446/2 565/1</p> <p><b>orthopedic [3]</b> 453/16 458/1 579/16</p> <p><b>orthopedist [1]</b> 453/10</p> <p><b>orthotic [1]</b> 524/25</p> <p><b>orthotics [13]</b> 454/9 457/17 457/18 486/7 506/7 506/18 524/18 525/2 525/8 525/12 525/14 528/4 528/10</p> <p><b>osteotomies [5]</b> 540/3 542/25 543/19 543/20 543/21</p> <p><b>osteotomy [17]</b> 421/21 460/19 460/21 536/7 536/11 536/18 537/14 538/4 539/7 542/11 546/9 546/10 561/2 561/15 561/22 581/25 588/8</p> <p><b>other [30]</b> 414/15 426/17 430/9 430/22 432/19 433/25 440/8 445/10 447/21 449/17 452/16 470/16 471/1 476/18 479/19 490/1 527/2 530/2 533/8 538/11 546/18 562/25 563/13 570/17 571/11 581/8 582/11 585/12 585/16 591/4</p> <p><b>otherwise [2]</b> 458/25 459/3</p> <p><b>ought [1]</b> 564/10</p> <p><b>our [3]</b> 412/1 443/25 521/9</p> <p><b>out [45]</b> 415/14 415/21 416/6 418/13 418/15 419/10 420/11 422/23 423/25 424/3 429/7 430/7 432/1 434/4 438/25 439/14 445/16 445/20 445/22 447/11 448/21 460/25 463/8 465/23 465/24 466/9 466/12 466/15 467/13 490/13 502/2 502/10 502/16 502/18 502/19 504/6 505/19 510/13 510/15 510/22 516/17 528/24 539/19 552/16 586/23</p> <p><b>outcome [8]</b> 446/13 463/23 463/24 510/10 523/12 529/3 541/3 560/22</p> <p><b>outcomes [1]</b> 561/3</p> <p><b>outer [1]</b> 551/9</p> <p><b>outline [2]</b> 549/14 549/24</p> <p><b>over [22]</b> 414/22 415/22 418/18 422/4 422/25 425/6 444/2 456/24 470/24 486/11 493/10 494/10 494/23 494/25 496/1 499/4 509/16 528/12 555/17 556/16 574/15</p>
---	--	--

<p><b>O</b></p> <p>over... [1] 574/18</p> <p>overbearing [1] 514/15</p> <p>overcorrect [1] 575/20</p> <p>overcorrected [2] 438/4 438/12</p> <p>overnight [1] 484/25</p> <p>overruled [11] 437/17 437/19 448/24 473/13 491/21 516/25 539/23 547/1 547/13 585/11 587/11</p> <p>overscarring [1] 515/20</p> <p>overshortened [1] 434/21</p> <p>own [10] 413/22 449/21 467/21 480/5 482/21 504/20 505/12 506/14 515/25 545/19</p>	<p>people [4] 443/25 467/24 567/7 567/8</p> <p>per [2] 472/16 562/10</p> <p>percent [2] 410/19 540/9</p> <p>percentages [2] 467/23 559/24</p> <p>perfect [2] 440/22 576/15</p> <p>perform [6] 410/6 412/21 412/23 422/11 467/11 507/19</p> <p>performed [5] 413/8 413/12 444/9 445/12 462/23</p> <p>performing [2] 413/2 413/4</p> <p>perhaps [1] 489/6</p> <p>period [5] 507/11 509/23 509/24 510/2 544/8</p> <p>person [2] 430/14 472/20</p> <p>person's [1] 449/21</p> <p>phalangeal [1] 493/17</p> <p>phrased [1] 437/20</p> <p>phraseology [2] 457/1 546/10</p> <p>physical [6] 457/22 457/23 458/5 458/6 496/14 582/7</p> <p>physician [8] 478/7 487/4 500/11 513/20 519/7 545/8 550/17 575/1</p> <p>physicians [1] 579/15</p> <p>picture [1] 558/4</p> <p>piece [2] 448/21 530/17</p> <p>pieces [1] 449/25</p> <p>Pierre [1] 556/2</p> <p>pin [1] 434/5</p> <p>pinky [5] 414/14 423/1 428/22 466/12 505/19</p> <p>pivotal [2] 541/17 541/19</p> <p>place [11] 416/9 419/8 434/5 443/14 444/7 447/13 447/17 460/4 466/17 500/25 501/1</p> <p>plain [5] 442/7 555/20 556/17 570/25 571/5</p> <p>Plains [2] 399/9 399/19</p> <p>Plaintiff [14] 399/14 406/2 407/23 477/10 482/9 482/11 485/5 486/17 486/21 487/25 489/11 490/12 537/12 538/10</p> <p>Plaintiff's [9] 407/16 407/18 407/25 408/16 452/9 478/21 490/22 521/4 566/11</p> <p>Plaintiff's 5 [2] 407/16 452/9</p> <p>Plaintiff's 6 [1] 407/25</p> <p>Plaintiffs [7] 399/3 480/25 481/1 481/12 481/15 481/17 481/21</p> <p>plan [8] 430/7 446/8 446/11 449/20 459/19 526/15 541/7 544/4</p> <p>plantar [9] 455/1 455/23 455/24 456/4 458/7 458/24 459/21 461/9 462/8</p> <p>plantarflex [1] 568/1</p> <p>plantarflexed [1] 463/9</p> <p>plantarflexing [1] 575/23</p> <p>plantarflexion [3] 463/17 517/2 517/4</p> <p>plastic [1] 414/7</p> <p>plate [1] 445/18</p> <p>playing [5] 432/1 457/11 460/25 463/3 513/15</p> <p>pleasant [1] 591/2</p> <p>please [26] 406/23 413/17 413/20 417/12 420/2 437/23 452/10 452/18 453/22 461/20 465/16 472/4 474/24 498/24 510/25 522/10 526/18 529/17 529/20 530/15 534/25 536/25 545/16 548/20 560/14 569/22</p> <p>podiatric [40] 399/6 411/1 411/8 411/9 412/7 412/8 431/12 434/8 434/13 439/24 440/12 444/20 448/19 450/14 450/18 450/23 457/3 464/10 466/22 467/24 468/1 469/23 474/4 474/10 478/3 485/25 486/10 497/4 501/22 515/3 531/21 541/11 564/24 565/9 579/15 580/13 587/6 587/23 587/25 588/14</p> <p>podiatrist [15] 432/7 432/10 444/9 445/5 446/10 467/13 468/5 468/11 471/7 489/13 547/10 547/18 547/24 547/25 563/18</p> <p>podiatrists [4] 469/9 469/17 469/18 567/5</p> <p>podiatry [11] 410/23 411/17 466/21 467/3 467/14 468/16 469/10 470/5 470/7 470/8</p>	<p>563/17</p> <p>point [12] 407/7 420/11 445/15 460/8 477/16 482/11 503/18 516/13 521/5 530/3 535/8 564/18</p> <p>pointed [1] 570/24</p> <p>pointing [5] 424/6 438/17 565/25 566/12 577/10</p> <p>points [1] 535/7</p> <p>poor [2] 409/15 460/1</p> <p>poorly [3] 409/17 578/4 578/7</p> <p>portable [1] 555/3</p> <p>portion [2] 448/8 556/11</p> <p>portions [1] 520/9</p> <p>posed [2] 475/10 488/20</p> <p>position [34] 427/3 427/11 443/2 443/4 443/5 443/9 443/11 443/12 443/14 443/16 448/6 448/7 458/10 458/12 459/17 460/1 463/9 463/20 485/6 501/11 502/3 502/10 505/17 516/21 517/13 519/6 530/5 536/9 575/22 576/15 576/23 582/20 582/22 582/22</p> <p>positioned [1] 562/18</p> <p>positioning [10] 440/12 442/17 442/19 445/3 445/4 550/17 557/24 566/15 567/5 567/15</p> <p>positive [1] 438/9</p> <p>possibility [4] 514/22 523/5 530/2 536/17</p> <p>possible [16] 430/11 433/7 447/10 495/16 507/15 510/6 519/8 519/21 525/3 525/12 528/12 531/2 544/20 559/13 577/18 582/7</p> <p>possibly [3] 495/1 518/14 589/21</p> <p>post [9] 412/9 426/23 452/21 467/2 517/9 534/8 537/2 540/12 540/17</p> <p>Post-college [1] 467/2</p> <p>post-op [7] 426/23 452/21 517/9 534/8 537/2 540/12 540/17</p> <p>posterior [1] 533/16</p> <p>postoperative [14] 426/1 426/20 435/1 437/22 441/18 445/25 455/9 507/9 507/10 508/3 525/14 544/8 564/3 581/11</p> <p>postoperatively [19] 446/3 525/7 540/4 541/24 542/10 543/4 543/6 543/10 543/19 544/7 545/10 557/25 561/23 563/19 564/9 565/8 566/6 566/7 584/15</p> <p>potential [17] 482/14 496/7 510/5 514/23 515/12 515/14 529/10 529/13 530/10 531/2 537/12 537/13 538/1 538/3 539/3 539/5 540/22</p> <p>potentiality [1] 541/6</p> <p>potentially [4] 482/4 482/8 509/3 569/3</p> <p>pounding [2] 417/3 430/1</p> <p>practice [39] 410/23 411/16 430/20 431/9 434/8 434/22 440/12 443/14 444/12 444/16 467/17 468/12 491/11 506/12 506/14 509/8 509/9 509/15 510/12 510/13 515/6 515/13 519/3 519/5 520/16 524/13 525/7 527/22 529/12 529/16 530/1 530/11 531/1 541/8 541/11 553/15 553/25 561/10 562/20</p> <p>practices [1] 453/19</p> <p>pre [13] 426/23 452/21 456/6 518/2 522/25 534/9 534/11 535/22 537/2 539/10 539/12 540/12 540/17</p> <p>pre-op [10] 426/23 456/6 522/25 534/9 534/11 535/22 537/2 539/10 539/12 540/12</p> <p>pre-trial [1] 518/2</p> <p>preoperative [7] 425/25 427/6 432/19 445/24 531/5 531/6 569/11</p> <p>preoperatively [17] 435/4 439/6 439/17 446/2 503/18 515/4 524/14 532/18 538/3 539/3 548/17 566/3 566/5 569/9 569/10 572/14 587/13</p> <p>preparation [3] 446/11 476/15 479/3</p> <p>presence [1] 490/14</p> <p>present [2] 462/7 494/3</p> <p>pressing [2] 582/20 582/20</p>
---	---	---

<p><b>P</b></p> <p><b>pressure [16]</b> 416/10 417/2 424/10 424/11 428/23 429/8 429/14 429/21 432/3 433/15 456/4 456/15 457/12 463/6 503/6 503/15</p> <p><b>pressures [2]</b> 455/23 461/10</p> <p><b>prestigious [1]</b> 470/2</p> <p><b>pretty [2]</b> 432/23 483/23</p> <p><b>prevent [2]</b> 447/6 559/21</p> <p><b>previously [4]</b> 479/17 479/22 560/18 561/1</p> <p><b>prewritten [1]</b> 585/8</p> <p><b>primary [1]</b> 554/10</p> <p><b>printout [1]</b> 555/24</p> <p><b>prior [5]</b> 432/21 462/13 483/21 492/13 560/18</p> <p><b>probability [9]</b> 410/13 410/15 439/25 443/9 444/20 448/20 464/10 587/6 587/23</p> <p><b>probably [3]</b> 520/21 537/22 556/20</p> <p><b>problem [27]</b> 431/18 435/8 435/12 435/21 436/8 436/11 436/23 437/1 437/9 440/25 451/5 451/12 456/20 457/4 457/19 461/5 462/19 464/11 465/2 465/18 474/17 485/11 492/20 493/12 506/19 537/17 538/7</p> <p><b>problems [7]</b> 424/14 444/23 449/17 484/21 496/8 516/8 588/19</p> <p><b>procedure [66]</b> 422/12 430/8 431/8 433/1 433/2 433/3 433/21 433/24 433/25 444/10 444/24 446/17 446/25 447/8 451/6 454/5 461/4 500/3 500/8 500/14 507/15 508/25 509/1 509/6 509/15 509/16 512/21 514/15 515/3 515/15 515/16 528/15 529/10 529/15 538/5 542/10 542/23 544/13 545/2 546/5 546/23 547/5 551/7 553/25 558/12 558/20 561/8 562/21 563/5 563/19 563/23 564/24 565/9 575/12 576/5 577/12 578/16 578/17 579/4 579/6 581/15 581/21 582/4 585/18 586/20 586/25</p> <p><b>procedures [15]</b> 445/13 447/11 465/19 465/22 500/5 507/8 507/15 509/4 540/23 541/1 560/20 561/7 563/1 563/13 578/15</p> <p><b>proceed [4]</b> 408/18 491/5 521/16 551/15</p> <p><b>proceedings [1]</b> 591/11</p> <p><b>process [1]</b> 412/19</p> <p><b>processes [1]</b> 520/12</p> <p><b>produce [1]</b> 523/4</p> <p><b>profession [1]</b> 487/6</p> <p><b>professional [1]</b> 407/1</p> <p><b>progressively [1]</b> 503/20</p> <p><b>project [1]</b> 406/18</p> <p><b>promise [1]</b> 527/4</p> <p><b>pronation [4]</b> 501/25 502/8 506/23 507/2</p> <p><b>properly [6]</b> 410/6 412/3 475/19 500/16 500/17 501/10</p> <p><b>proportion [1]</b> 438/25</p> <p><b>proposed [1]</b> 523/4</p> <p><b>protective [1]</b> 417/7</p> <p><b>protractor [2]</b> 566/20 567/6</p> <p><b>protruding [1]</b> 456/13</p> <p><b>protrusion [2]</b> 534/18 535/12</p> <p><b>Provensano [1]</b> 420/10</p> <p><b>provide [3]</b> 478/20 500/15 501/11</p> <p><b>provided [1]</b> 588/9</p> <p><b>provides [1]</b> 478/19</p> <p><b>provinced [1]</b> 493/25</p> <p><b>publications [1]</b> 469/4</p> <p><b>publish [1]</b> 468/15</p> <p><b>published [2]</b> 420/21 468/19</p> <p><b>pull [4]</b> 415/17 428/15 445/16 458/11</p> <p><b>pulled [2]</b> 415/22 516/16</p> <p><b>pulls [1]</b> 438/21</p> <p><b>pulse [1]</b> 496/17</p> <p><b>purchase [7]</b> 440/3 443/22 454/20 455/5 455/5 455/14 582/21</p>	<p><b>purpose [4]</b> 423/19 442/6 462/25 575/1</p> <p><b>purposes [2]</b> 414/4 553/9</p> <p><b>push [4]</b> 505/12 568/1 582/12 582/21</p> <p><b>pushes [1]</b> 504/16</p> <p><b>pushing [2]</b> 415/22 505/7</p> <p><b>put [36]</b> 416/20 425/12 425/18 425/21 430/12 434/4 436/15 445/16 445/17 445/17 447/12 447/17 448/4 448/6 448/6 448/12 449/13 449/20 449/24 449/25 452/12 463/22 500/25 510/18 513/20 513/24 514/3 560/10 564/23 585/13 585/17 586/16 586/17 586/19 587/1 587/16</p> <p><b>putting [3]</b> 416/23 434/5 456/11</p> <p><b>Q</b></p> <p><b>qualified [1]</b> 411/23</p> <p><b>qualifies [1]</b> 411/4</p> <p><b>quantify [3]</b> 580/17 580/19 581/1</p> <p><b>question [33]</b> 411/11 414/6 419/17 436/19 448/22 450/22 473/8 475/3 478/14 486/19 488/19 492/2 499/23 512/23 513/1 513/19 528/7 530/25 534/24 535/16 537/5 548/4 549/21 553/9 557/1 558/19 563/7 567/1 569/8 575/5 580/1 580/8 584/1</p> <p><b>questioner [1]</b> 522/1</p> <p><b>questions [14]</b> 412/16 421/1 488/16 489/7 491/1 497/16 519/15 566/23 583/23 584/22 585/3 585/5 585/24 591/4</p> <p><b>quickly [2]</b> 483/23 533/7</p> <p><b>quite [1]</b> 510/6</p> <p><b>R</b></p> <p><b>radiographs [1]</b> 458/4</p> <p><b>range [9]</b> 497/20 504/8 504/8 504/10 504/15 504/19 504/23 504/25 505/15</p> <p><b>rattled [1]</b> 483/22</p> <p><b>ray [40]</b> 421/11 425/12 426/13 427/8 427/13 437/22 437/23 437/24 441/18 441/20 442/18 443/10 451/7 455/9 455/14 455/21 458/3 458/23 459/21 460/7 462/8 465/3 517/9 529/11 530/11 533/11 534/5 534/8 535/16 535/22 554/17 555/2 555/7 555/9 555/12 555/23 556/14 556/15 557/2 557/12</p> <p><b>rays [39]</b> 409/3 409/19 422/20 424/1 424/23 425/4 425/9 425/25 426/1 426/3 426/21 432/17 432/19 432/22 435/1 439/18 439/23 440/7 440/13 440/18 441/3 441/14 442/22 445/2 445/13 452/21 452/23 456/7 458/19 458/22 472/13 476/16 476/17 485/4 485/10 505/22 543/6 543/7 583/6</p> <p><b>reach [3]</b> 409/10 422/17 434/12</p> <p><b>reached [1]</b> 410/5</p> <p><b>read [27]</b> 424/8 436/1 454/2 473/11 475/18 478/22 484/20 498/24 501/17 504/1 514/8 523/23 529/19 529/23 536/25 540/14 545/16 556/11 557/11 574/12 574/19 574/25 574/25 575/9 576/10 578/12 586/5</p> <p><b>reading [3]</b> 456/21 494/2 575/4</p> <p><b>reads [1]</b> 522/12</p> <p><b>real [3]</b> 419/20 420/14 533/7</p> <p><b>realign [3]</b> 418/18 430/17 445/16</p> <p><b>realize [2]</b> 481/6 552/16</p> <p><b>really [10]</b> 415/20 421/23 475/18 478/14 485/20 515/23 518/12 566/25 580/1 581/20</p> <p><b>realm [2]</b> 567/18 567/20</p> <p><b>rearfoot [6]</b> 499/5 499/15 501/25 502/8 502/23 524/25</p> <p><b>reason [5]</b> 410/16 417/2 440/22 449/17 576/18</p> <p><b>reasonable [10]</b> 410/13 411/13 439/24 443/8 444/20 448/19 457/3 464/9 587/5 587/23</p> <p><b>reasons [2]</b> 419/12 490/1</p> <p><b>reattach [1]</b> 422/4</p>	<p><b>recall [3]</b> 472/22 556/23 556/24</p> <p><b>recent [1]</b> 465/3</p> <p><b>Recess [3]</b> 461/21 521/12 574/5</p> <p><b>recessed [1]</b> 516/22</p> <p><b>recognize [2]</b> 433/17 445/6</p> <p><b>recognized [2]</b> 455/8 543/18</p> <p><b>recognizes [1]</b> 444/10</p> <p><b>recollection [3]</b> 436/17 490/25 556/13</p> <p><b>recommend [3]</b> 462/17 506/9 507/16</p> <p><b>recommended [6]</b> 461/4 493/3 506/3 563/23 564/5 564/9</p> <p><b>recommends [2]</b> 460/18 486/12</p> <p><b>reconvene [1]</b> 520/24</p> <p><b>record [12]</b> 427/25 428/1 452/12 452/24 454/13 462/6 475/14 507/23 511/14 511/15 511/23 591/12</p> <p><b>records [37]</b> 407/15 407/24 408/5 408/25 409/3 409/3 409/7 432/18 451/7 452/9 452/17 452/19 452/22 453/5 453/10 462/22 464/3 464/8 464/12 465/11 465/14 465/15 472/13 475/6 475/7 475/11 476/15 476/16 476/18 476/20 476/20 476/25 485/4 562/4 562/9 562/10 586/4</p> <p><b>Recross [2]</b> 588/25 589/2</p> <p><b>RECROSS-EXAMINATION [1]</b> 589/2</p> <p><b>recuperative [1]</b> 510/2</p> <p><b>recurrence [2]</b> 525/2 564/10</p> <p><b>recurring [1]</b> 447/7</p> <p><b>recut [2]</b> 463/19 466/8</p> <p><b>redaction [1]</b> 408/14</p> <p><b>redirect [4]</b> 539/22 571/9 584/23 584/25</p> <p><b>reduce [5]</b> 422/6 430/12 461/9 461/10 507/2</p> <p><b>refer [1]</b> 468/4</p> <p><b>reference [1]</b> 512/9</p> <p><b>referring [3]</b> 527/9 557/9 575/3</p> <p><b>refreshes [1]</b> 556/12</p> <p><b>regard [13]</b> 411/12 444/5 458/2 484/17 484/19 487/19 497/19 498/14 498/22 501/16 520/19 565/21 566/15</p> <p><b>regarding [2]</b> 422/16 425/25</p> <p><b>regardless [4]</b> 485/3 501/11 509/25 559/7</p> <p><b>region [3]</b> 422/1 438/17 460/6</p> <p><b>regular [1]</b> 452/3</p> <p><b>reiterating [1]</b> 454/4</p> <p><b>related [4]</b> 460/6 501/4 572/16 572/17</p> <p><b>relating [1]</b> 409/7</p> <p><b>relation [1]</b> 536/22</p> <p><b>relative [6]</b> 423/2 423/22 433/9 459/12 532/14 535/10</p> <p><b>relatively [2]</b> 460/7 519/1</p> <p><b>relevance [3]</b> 526/10 526/13 545/24</p> <p><b>relevant [1]</b> 526/14</p> <p><b>relief [2]</b> 429/14 575/16</p> <p><b>remainder [1]</b> 524/12</p> <p><b>remains [1]</b> 526/23</p> <p><b>remember [12]</b> 428/15 465/24 477/17 478/24 478/25 492/21 492/25 526/25 556/5 556/7 556/18 585/2</p> <p><b>remembered [1]</b> 563/15</p> <p><b>remembering [2]</b> 477/16 478/23</p> <p><b>remove [10]</b> 421/13 433/1 521/17 551/6 551/11 551/13 551/17 551/24 553/16 553/16</p> <p><b>removed [4]</b> 473/3 473/18 551/8 553/11</p> <p><b>rendered [2]</b> 409/11 422/16</p> <p><b>reoccurrence [2]</b> 525/12 525/15</p> <p><b>repeat [3]</b> 513/25 529/17 545/13</p> <p><b>repeated [7]</b> 436/2 473/12 475/15 529/21 529/25 537/1 545/17</p> <p><b>rephrase [13]</b> 410/11 436/3 443/6 468/9 470/21 470/22 473/16 528/6 537/17 538/25 567/2 580/5 586/14</p> <p><b>replace [1]</b> 449/19</p>
--	---	--

R	S	
<p>replacement [1] 451/18  report [1] 553/6  reporter [2] 399/22 533/9  reports [1] 494/6  represents [4] 471/2 587/6 587/24 588/13  request [3] 407/4 409/2 470/11  Requested [6] 436/2 473/12 529/21 529/25 537/1 545/17  require [4] 407/6 464/11 465/17 498/11  required [1] 565/8  research [1] 469/2  resection [2] 546/8 581/25  reserve [1] 573/20  reshortening [1] 465/21  residency [9] 412/12 467/4 467/8 467/9 467/10 467/14 467/16 469/10 469/19  residents [1] 469/17  respect [2] 530/18 575/18  respond [1] 524/3  rest [7] 409/22 431/4 436/19 442/8 500/21 509/11 591/3  restricted [1] 585/3  result [12] 409/9 409/15 440/23 441/15 443/16 444/11 523/4 545/10 553/24 554/2 588/2 588/20  resultant [2] 455/13 455/23  retained [1] 481/22  review [31] 408/25 409/9 409/16 452/25 462/21 464/2 464/8 465/14 470/11 470/16 470/25 471/6 472/12 475/5 476/17 476/24 477/4 477/7 477/14 477/19 478/8 478/17 479/3 481/2 481/22 481/24 494/18 496/6 499/1 515/4 583/13  reviewed [17] 409/6 425/24 451/7 464/12 476/14 477/9 477/17 479/9 479/16 481/25 482/7 486/9 492/8 511/25 518/23 562/4 583/17  reviewing [8] 482/3 519/1 531/4 562/9 562/10 583/6 583/15 584/9  reviews [1] 465/10  right [211]  righty [1] 414/1  risk [27] 446/21 446/24 447/1 447/3 447/7 451/5 451/18 512/21 513/11 513/21 514/4 515/14 519/8 519/21 531/2 558/14 559/7 559/11 576/4 576/6 577/11 577/17 577/22 578/1 578/3 578/8 578/16  risks [26] 430/12 446/16 446/19 488/13 488/15 510/5 510/6 510/11 514/2 518/17 519/2 558/12 558/17 558/18 558/21 575/11 575/13 575/19 578/16 578/19 579/2 579/3 579/5 579/8 586/20 586/20  road [2] 399/15 436/24  Roberts [17] 407/21 407/22 453/16 453/25 458/1 459/20 461/15 462/5 462/6 464/8 477/23 517/15 518/1 518/14 574/13 577/23 578/2  Roberts' [17] 407/15 452/9 452/23 453/5 457/15 459/18 462/22 464/2 464/8 465/15 476/17 477/19 574/19 575/10 576/19 578/12 578/25  ROBYN [4] 399/8 406/2 406/9 406/24  room [10] 439/18 441/1 441/3 543/13 553/24 555/14 555/17 579/16 579/23 583/7  rough [2] 416/3 421/16  round [1] 421/24  rounded [2] 423/18 549/17  RPR [1] 591/15  rules [1] 560/4  ruling [2] 537/3 546/20</p>	<p><b>ST-U-A-R-T-S</b> [1] 556/4  said [68] 424/9 429/21 435/6 435/19 436/7 436/16 436/17 436/18 441/24 445/20 449/21 451/11 454/22 456/6 473/18 474/5 475/21 476/14 477/9 480/23 481/15 482/20 483/3 483/10 483/21 484/12 492/19 497/14 499/9 499/17 500/1 507/18 507/19 508/15 509/3 511/20 514/18 514/21 518/6 526/9 526/25 530/20 531/25 532/16 535/18 535/20 536/19 536/22 538/14 538/20 540/19 542/14 542/20 544/6 544/9 544/9 547/11 554/21 557/8 557/10 557/11 558/6 558/15 566/1 578/7 586/15 589/6 589/8  sake [1] 499/23  same [16] 416/9 417/3 421/21 426/13 426/17 432/24 436/12 450/22 462/12 463/5 505/10 542/25 564/7 570/25 571/5 582/1  same area [1] 417/3  sardines [2] 466/14 466/15  saw [4] 421/23 448/15 485/10 553/23  say [50] 418/7 429/2 430/16 430/23 431/24 433/19 433/21 451/17 451/18 451/21 457/2 460/12 480/13 485/22 490/19 499/2 500/24 501/7 501/8 501/8 502/21 507/16 508/23 513/12 516/20 535/24 536/24 537/23 537/23 540/16 542/13 544/21 548/15 549/5 549/6 550/24 553/7 553/18 557/10 559/3 561/13 565/19 571/15 571/17 577/2 578/6 582/11 582/18 583/12 589/23  saying [18] 411/13 455/16 462/15 463/3 502/16 510/10 532/23 536/4 542/22 543/17 544/13 561/17 561/21 564/7 564/8 571/2 573/3 573/23  says [20] 454/4 455/12 458/21 460/18 461/8 477/2 493/15 495/13 498/9 501/25 502/7 502/7 506/20 506/24 507/23 508/6 509/23 512/10 512/15 523/22  scaffold [1] 521/17  scar [6] 458/12 458/13 515/11 515/14 516/16 517/16  scarring [4] 458/8 517/7 517/14 518/3  scars [2] 515/19 516/5  Schneider [1] 485/25  school [3] 466/21 467/4 467/14  schooling [1] 467/1  science [1] 531/21  scientific [1] 411/14  scolliosis [2] 452/2 452/5  scraped [1] 553/4  screws [7] 438/1 439/19 440/3 440/11 445/16 445/17 509/20  seat [4] 534/2 550/15 553/21 571/22  seated [5] 406/14 406/22 461/24 521/15 574/6  second [140] 409/22 409/25 415/14 415/15 416/5 416/21 417/20 418/4 418/17 422/7 422/24 423/4 424/1 424/2 424/2 424/7 424/17 424/22 427/21 428/8 428/12 428/17 428/19 429/12 429/19 430/10 430/17 431/18 431/19 431/21 431/23 432/5 433/9 433/10 433/11 433/15 434/1 434/2 435/7 435/12 436/8 436/22 436/25 438/5 438/11 438/24 439/12 439/14 442/2 444/6 444/6 444/23 445/2 446/2 446/21 447/4 449/14 450/20 450/25 451/5 451/14 454/12 455/22 456/10 456/12 456/15 456/18 457/5 457/7 457/12 458/16 459/11 460/6 460/19 460/23 461/9 461/11 462/4 462/6 462/10 463/7 463/21 463/25 464/4 465/21 466/1 466/7 466/10 474/17 488/14 503/1 503/6 503/9 503/15 510/14 512/11 512/12 512/16</p>	<p>513/11 514/23 527/15 532/14 532/19 532/21 533/19 534/4 534/15 534/21 535/3 535/25 536/1 536/6 536/7 536/17 537/14 538/4 539/7 540/24 542/11 542/19 544/15 545/1 558/7 561/2 570/10 570/12 570/14 570/23 571/1 571/3 571/11 572/13 572/15 572/24 572/25 586/23 586/24 587/2 587/19 588/7  section [7] 495/4 496/6 501/17 506/2 510/4 512/12 576/11  sections [1] 574/18  see [62] 414/5 414/10 415/19 419/24 420/7 420/8 420/10 421/11 423/12 424/8 426/7 427/13 427/14 427/17 427/24 428/7 428/13 432/21 437/3 437/24 438/1 438/1 440/6 441/3 441/19 441/20 445/14 447/18 461/11 462/22 465/15 477/22 482/1 484/24 500/24 507/12 512/12 512/14 523/6 523/7 523/15 523/17 523/18 523/24 524/4 524/19 525/4 525/5 526/10 527/6 527/10 527/17 533/12 533/13 544/16 549/13 569/15 570/10 570/20 571/1 572/15 591/3  seeing [1] 493/12  seem [2] 457/17 554/6  seen [8] 421/9 422/8 442/20 442/21 462/12 465/3 465/7 517/20  sees [1] 486/11  semantics [3] 513/15 513/17 544/11  Senior [1] 399/22  sense [1] 475/16  sent [1] 472/13  separate [3] 552/12 552/14 566/22  serious [1] 478/2  sesamoids [5] 428/3 438/13 438/21 459/7 459/13  set [4] 442/19 451/11 456/8 563/25  sets [1] 537/21  seven [2] 408/4 408/12  several [5] 412/14 447/9 494/4 499/4 515/10  severe [8] 416/3 418/16 422/9 485/14 485/15 485/18 498/11 498/12  shaped [2] 548/18 551/24  sharp [1] 494/8  she [119] 409/22 411/25 413/22 424/1 424/8 424/10 424/13 425/10 425/15 428/10 430/23 431/17 432/6 433/15 435/12 435/13 435/14 435/15 437/1 437/19 441/10 442/12 444/4 447/5 450/25 451/8 451/10 452/11 452/12 454/4 454/5 454/5 454/8 454/10 454/23 454/24 456/1 456/8 457/10 457/16 458/7 458/13 458/14 458/16 459/11 459/25 460/5 462/8 462/15 464/13 464/17 464/23 465/1 465/19 474/17 475/20 475/21 475/22 475/23 481/4 481/14 483/3 483/9 484/22 485/7 485/10 485/14 486/17 487/10 487/13 488/20 489/1 489/5 489/6 489/13 489/16 489/17 489/17 489/18 489/19 489/21 489/21 491/20 492/2 492/12 492/19 493/20 493/22 494/6 494/8 494/14 495/8 495/14 495/15 503/9 504/23 505/4 505/11 509/7 513/13 513/18 517/23 519/12 529/22 533/9 535/18 535/20 542/13 543/7 547/20 548/2 548/2 564/10 565/9 575/6 581/1 588/9 588/17 588/19  shift [1] 436/9  shoe [4] 415/24 475/20 524/6 528/4  shoes [2] 493/22 494/15  shooting [1] 533/16  Shore [1] 469/6  short [3] 429/11 438/19 447/19  shorten [6] 430/3 430/11 430/15 433/12 463/7 540/23  shortened [9] 434/15 434/23 434/24 437/3</p>

<p><b>S</b></p> <p><b>shortened...</b> [5] 441/24 460/8 460/13 516/22 530/6</p> <p><b>shortening</b> [37] 430/8 434/2 451/19 455/13 455/21 456/11 457/7 460/19 460/22 461/8 464/1 514/16 514/23 517/2 517/4 529/11 529/15 530/3 530/10 536/18 537/12 537/13 538/2 539/4 539/7 540/6 540/22 540/22 542/2 542/12 544/16 545/1 558/7 580/15 581/4 586/25 587/1</p> <p><b>shortens</b> [1] 433/24</p> <p><b>shorter</b> [5] 439/3 439/5 460/23 532/14 532/19</p> <p><b>shot</b> [1] 437/4</p> <p><b>should</b> [40] 428/21 432/7 432/10 438/7 444/7 445/5 455/8 456/18 466/13 487/24 515/3 525/8 527/15 528/17 533/8 536/4 536/5 536/7 542/11 542/18 542/24 543/1 543/8 543/9 543/17 543/20 554/19 554/20 561/14 561/22 562/19 586/12 586/15 586/17 586/19 587/12 587/13 588/7 588/18 588/18</p> <p><b>show</b> [7] 414/24 423/11 437/22 452/8 466/2 504/10 557/15</p> <p><b>showing</b> [1] 441/17</p> <p><b>shown</b> [1] 443/10</p> <p><b>shows</b> [3] 428/10 429/9 438/19</p> <p><b>side</b> [11] 414/15 421/14 447/21 463/21 471/9 488/2 488/6 488/7 526/23 527/1 533/9</p> <p><b>sides</b> [1] 498/1</p> <p><b>sideview</b> [2] 441/21 441/22</p> <p><b>sighs</b> [1] 573/3</p> <p><b>sign</b> [1] 524/13</p> <p><b>signature</b> [1] 522/12</p> <p><b>signed</b> [4] 522/11 522/15 527/13 527/24</p> <p><b>significance</b> [2] 429/19 439/8</p> <p><b>significant</b> [8] 433/14 457/9 474/1 474/2 474/5 478/2 495/5 498/10</p> <p><b>signify</b> [1] 446/5</p> <p><b>signs</b> [1] 409/19</p> <p><b>silly</b> [1] 554/6</p> <p><b>similar</b> [2] 461/4 545/23</p> <p><b>simple</b> [2] 558/19 571/13</p> <p><b>simplify</b> [1] 422/23</p> <p><b>simply</b> [4] 425/3 560/10 564/23 585/17</p> <p><b>since</b> [5] 409/5 485/6 488/22 489/5 526/19</p> <p><b>single</b> [3] 510/19 514/15 519/8</p> <p><b>sit</b> [5] 422/8 442/8 442/14 484/15 550/7</p> <p><b>sites</b> [1] 461/10</p> <p><b>sits</b> [3] 442/15 443/5 443/23</p> <p><b>sitting</b> [12] 423/24 428/20 428/20 428/21 442/23 443/20 444/4 455/2 463/13 463/14 466/13 583/5</p> <p><b>situation</b> [2] 451/11 545/23</p> <p><b>six</b> [4] 408/2 494/10 494/11 494/12</p> <p><b>sixth</b> [3] 451/23 474/2 474/8</p> <p><b>skewed</b> [1] 441/22</p> <p><b>skin</b> [4] 417/1 417/3 456/2 456/3</p> <p><b>slightly</b> [3] 432/23 450/22 467/9</p> <p><b>slow</b> [2] 412/11 447/24</p> <p><b>slowly</b> [1] 494/4</p> <p><b>small</b> [2] 420/17 467/25</p> <p><b>smile</b> [1] 589/23</p> <p><b>SMITH</b> [1] 399/11</p> <p><b>sneakers</b> [1] 506/3</p> <p><b>so</b> [185] 406/6 406/18 407/17 408/1 408/10 411/11 414/22 415/9 415/12 415/19 416/2 416/10 416/22 417/6 417/18 417/22 417/22 418/7 418/12 418/15 419/12 420/7 421/11 421/13 421/22 422/20 423/7 423/12 423/15 423/17 423/21 424/10 424/11 424/15 425/2 425/12 426/20 427/11 427/16 428/10 429/9</p>	<p>429/25 430/4 430/6 430/9 431/20 432/3 432/14 433/11 433/17 433/23 437/3 439/5 439/9 439/16 440/6 440/25 441/22 441/25 442/2 442/13 442/15 444/3 448/3 448/4 449/18 452/1 454/23 455/1 455/1 455/3 455/4 455/6 456/2 456/6 457/13 458/9 458/13 459/10 460/13 461/13 461/14 463/5 463/6 463/9 463/12 463/13 465/4 466/11 466/17 466/18 467/7 475/18 475/25 477/8 477/17 478/12 481/11 481/17 482/7 484/3 484/9 484/12 484/14 484/15 484/25 488/15 490/16 490/18 490/25 491/9 493/14 495/25 499/20 499/25 500/1 502/15 502/21 504/22 505/4 505/14 508/23 510/22 512/10 513/10 513/15 514/13 514/25 516/16 517/3 517/23 518/14 519/4 519/6 520/16 521/3 529/2 533/9 536/18 537/6 537/15 537/20 538/6 539/8 540/8 540/19 541/3 541/15 542/22 543/6 543/17 548/1 548/25 549/9 549/23 550/3 552/1 552/7 553/19 555/2 556/15 556/16 556/17 556/25 558/24 560/6 560/20 563/6 565/7 565/17 567/4 567/14 568/8 568/17 571/2 571/19 572/13 575/22 575/25 576/14 580/3 581/9 586/2 587/18 590/2</p> <p><b>social</b> [1] 495/13</p> <p><b>soles</b> [1] 506/6</p> <p><b>some</b> [40] 407/7 417/7 417/10 423/17 430/9 440/21 448/4 449/17 449/22 449/22 451/19 457/16 459/12 463/24 465/23 466/15 469/2 469/21 476/21 484/4 491/1 495/21 510/2 510/13 510/15 527/1 541/2 551/2 551/24 552/22 553/12 553/12 553/16 567/7 567/8 567/9 567/9 574/12 579/23 591/3</p> <p><b>somebody</b> [8] 437/6 437/8 439/12 467/20 468/4 468/4 486/19 492/3</p> <p><b>something</b> [26] 430/14 437/6 437/8 445/4 445/10 448/7 455/7 483/8 486/20 496/20 513/22 513/22 513/23 514/4 515/23 534/17 536/13 536/13 551/19 554/20 554/23 555/1 559/15 571/17 582/23 583/18</p> <p><b>sometime</b> [2] 522/24 589/22</p> <p><b>sometimes</b> [11] 418/12 422/13 490/11 495/22 508/6 508/15 520/6 525/15 525/21 563/18 578/22</p> <p><b>somewhat</b> [5] 504/15 504/25 505/2 528/25 549/9</p> <p><b>somewhere</b> [2] 542/5 570/15</p> <p><b>sore</b> [1] 417/6</p> <p><b>sorry</b> [51] 411/7 414/15 414/23 415/3 418/11 423/9 423/13 436/13 437/18 441/6 443/7 453/25 454/15 457/25 459/6 461/14 465/6 469/13 475/3 480/12 480/14 481/5 481/10 486/13 494/2 497/7 501/9 502/17 503/23 516/12 519/13 522/19 527/10 528/5 534/10 535/1 537/18 537/19 540/9 550/25 552/10 559/4 562/23 565/2 565/14 566/4 570/21 576/20 576/24 580/18 581/13</p> <p><b>sort</b> [5] 497/20 541/2 549/7 550/5 554/6</p> <p><b>sorts</b> [1] 520/13</p> <p><b>space</b> [3] 421/12 421/12 427/20</p> <p><b>speak</b> [2] 507/21 586/10</p> <p><b>speaking</b> [4] 483/12 501/22 530/8 565/11</p> <p><b>speaks</b> [1] 523/14</p> <p><b>Special</b> [3] 407/24 453/20 476/24</p> <p><b>specialty</b> [1] 491/18</p> <p><b>specific</b> [2] 514/3 580/2</p> <p><b>specifically</b> [4] 506/22 515/11 523/2 581/16</p> <p><b>specifics</b> [1] 581/8</p> <p><b>speculation</b> [1] 545/5</p> <p><b>spell</b> [1] 408/6</p> <p><b>spending</b> [1] 526/15</p> <p><b>spent</b> [2] 472/1 472/12</p> <p><b>spine</b> [1] 452/6</p>	<p><b>splayed</b> [1] 428/8</p> <p><b>spoke</b> [3] 486/6 509/2 554/16</p> <p><b>spot</b> [7] 429/5 430/2 463/6 463/6 500/21 500/22 575/15</p> <p><b>spread</b> [5] 415/14 416/6 418/17 419/10 422/23</p> <p><b>spur</b> [1] 448/10</p> <p><b>square</b> [1] 449/25</p> <p><b>St</b> [5] 476/22 524/16 524/17 526/17 527/7</p> <p><b>stability</b> [4] 500/15 501/12 528/21 529/5</p> <p><b>stabilize</b> [2] 433/22 449/16</p> <p><b>stabilizing</b> [1] 455/6</p> <p><b>stable</b> [4] 500/20 500/23 500/24 500/25</p> <p><b>stand</b> [5] 414/25 423/13 423/14 521/21 574/1</p> <p><b>standard</b> [1] 509/5</p> <p><b>standards</b> [1] 411/16</p> <p><b>standing</b> [2] 427/11 557/19</p> <p><b>start</b> [4] 415/1 415/17 429/6 474/22</p> <p><b>started</b> [3] 467/17 472/25 484/22</p> <p><b>starts</b> [4] 415/14 442/13 442/14 458/11</p> <p><b>state</b> [4] 399/1 410/23 425/15 468/5</p> <p><b>statement</b> [6] 435/9 435/10 435/23 473/5 473/20 473/21</p> <p><b>statements</b> [1] 406/4</p> <p><b>stenographic</b> [1] 591/12</p> <p><b>step</b> [4] 432/4 442/12 533/6 548/21</p> <p><b>sticking</b> [2] 415/21 577/14</p> <p><b>stiffness</b> [1] 458/14</p> <p><b>still</b> [8] 423/17 424/18 461/25 463/24 464/3 521/22 574/8 589/23</p> <p><b>stipulated</b> [3] 407/17 408/1 408/10</p> <p><b>stipulation</b> [1] 407/14</p> <p><b>stop</b> [5] 409/25 424/22 454/11 501/5 501/5</p> <p><b>straight</b> [5] 416/12 427/10 427/12 442/9 529/4</p> <p><b>straight-on</b> [1] 427/12</p> <p><b>straighten</b> [3] 434/4 528/24 552/16</p> <p><b>stress</b> [3] 430/4 576/2 587/1</p> <p><b>Stretching</b> [1] 589/4</p> <p><b>stretchy</b> [1] 429/1</p> <p><b>strike</b> [9] 459/3 464/21 481/7 487/3 513/19 544/24 545/7 568/15 580/3</p> <p><b>strung</b> [1] 414/9</p> <p><b>Stuarts</b> [1] 556/4</p> <p><b>stuck</b> [1] 582/8</p> <p><b>stuff</b> [1] 521/10</p> <p><b>subject</b> [4] 408/13 486/16 486/22 517/21</p> <p><b>subluxed</b> [4] 503/20 504/2 504/4 504/7</p> <p><b>suboptimal</b> [1] 541/3</p> <p><b>subsequent</b> [1] 452/23</p> <p><b>subsequently</b> [2] 512/20 529/14</p> <p><b>substance</b> [1] 436/7</p> <p><b>substantial</b> [5] 450/14 450/18 450/24 474/13 588/21</p> <p><b>success</b> [1] 561/9</p> <p><b>such</b> [6] 466/6 487/20 491/14 506/10 541/5 572/14</p> <p><b>sued</b> [3] 471/7 471/20 482/20</p> <p><b>suffer</b> [1] 588/3</p> <p><b>suffering</b> [1] 459/25</p> <p><b>Suite</b> [1] 399/15</p> <p><b>sulfur</b> [1] 495/6</p> <p><b>sum</b> [1] 436/7</p> <p><b>summarize</b> [1] 454/2</p> <p><b>sun</b> [1] 586/12</p> <p><b>Super</b> [1] 421/3</p> <p><b>suppose</b> [1] 579/22</p> <p><b>supposed</b> [7] 438/15 438/15 442/5 548/7 550/7 550/11 550/12</p> <p><b>SUPREME</b> [2] 399/1 399/12</p> <p><b>sure</b> [28] 410/19 424/12 439/18 439/19 440/8 466/4 475/19 480/17 481/19 484/20</p>
---	---	--

**S**  
**sure...** [18] 485/13 491/12 492/17 495/12 498/20 499/24 506/11 513/2 520/5 523/10 523/21 527/8 527/10 527/11 531/9 537/22 568/25 578/18  
**surface** [2] 430/18 442/1  
**surgeon** [21] 451/17 453/17 458/1 478/3 486/1 486/11 497/4 501/22 507/17 515/3 548/8 550/17 551/15 551/19 554/10 554/11 561/6 563/18 565/10 579/15 580/14  
**surgeons** [2] 469/18 579/16  
**surgeries** [3] 520/4 520/12 530/2  
**surgery** [94] 407/24 410/6 411/1 411/8 411/10 411/17 412/5 412/21 412/24 429/10 430/2 430/7 430/23 432/21 440/11 440/13 443/22 444/10 445/2 446/8 446/11 446/22 447/1 453/13 453/20 455/8 455/10 455/11 456/7 456/19 456/21 462/18 462/23 463/1 464/11 464/13 464/18 464/24 465/1 465/17 467/11 467/24 468/2 468/23 469/20 469/24 476/25 477/4 482/14 486/12 495/2 495/20 495/21 503/19 508/18 510/8 513/23 514/5 515/19 522/22 523/5 523/12 528/10 530/4 531/12 531/21 534/12 536/23 539/6 539/6 540/21 541/6 543/12 544/18 552/21 558/17 559/14 564/4 564/10 565/22 575/13 576/7 576/23 577/19 577/22 578/1 578/3 578/8 578/20 581/15 581/17 581/18 587/17 588/9  
**surgical** [17] 412/12 431/8 461/8 467/4 467/8 467/12 467/14 469/19 482/17 486/8 489/19 495/16 507/7 524/23 529/14 541/1 560/1  
**surgically** [1] 587/14  
**sustain** [2] 486/25 580/3  
**sustained** [16] 410/21 459/3 464/21 468/8 469/14 478/5 511/22 513/18 537/6 538/8 547/9 568/15 580/11 581/3 582/3 584/7  
**swear** [1] 406/4  
**swelling** [1] 496/17  
**sworn** [1] 406/9  
**symptoms** [2] 494/14 494/19  
**systems** [1] 496/6

**T**  
**table** [4] 440/25 543/7 555/17 556/16  
**tactics** [1] 497/15  
**take** [56] 412/15 418/19 425/19 427/2 430/13 430/14 430/25 430/25 431/6 432/4 433/6 437/21 439/9 440/12 440/18 448/7 448/10 448/11 448/11 448/13 448/20 449/5 449/15 449/19 449/22 449/22 449/24 451/25 452/7 453/22 454/12 457/14 460/10 461/18 463/20 466/9 466/15 481/20 492/21 501/15 501/17 511/4 520/22 520/24 534/2 543/5 545/11 550/15 552/21 553/3 553/10 553/17 553/21 559/12 571/22 573/2  
**taken** [13] 437/3 437/23 441/14 441/18 442/21 445/2 445/20 461/21 521/12 528/17 536/5 536/8 574/5  
**takes** [6] 412/13 430/24 442/12 445/18 452/11 500/19  
**taking** [17] 409/18 416/22 437/11 439/18 447/9 447/11 447/13 447/20 448/3 448/16 451/23 451/24 457/8 465/23 465/24 551/3 551/5  
**talk** [7] 417/10 472/20 509/6 509/19 510/8 515/10 515/13  
**talked** [12] 438/14 445/4 450/10 459/8 472/24 512/19 514/21 537/12 538/10 550/22 551/1 554/15  
**talking** [22] 418/1 420/25 424/25 435/5 460/14 500/22 506/22 508/24 509/14 522/7 530/14 530/16 530/18 542/6 542/7 546/14

549/20 576/16 577/24 579/2 580/23 581/14  
**talks** [4] 458/18 495/4 501/19 510/4  
**tally** [1] 562/15  
**tarsometatarsal** [1] 460/8  
**teach** [3] 469/16 469/19 469/20  
**tear** [2] 429/6 459/16  
**tell** [47] 409/13 412/4 412/23 413/1 413/16 414/17 417/11 417/12 419/18 422/17 423/3 427/8 431/16 431/24 431/25 433/18 435/11 441/20 451/7 452/18 453/24 455/25 458/2 458/21 459/19 460/9 465/4 465/16 467/22 469/5 472/4 473/22 487/24 489/17 492/24 499/1 510/1 521/2 525/7 546/17 553/8 556/12 563/4 567/23 573/17 585/16 586/17  
**telling** [4] 452/20 499/8 499/17 534/3  
**tells** [1] 493/20  
**template** [1] 585/17  
**ten** [8] 412/16 471/23 494/10 494/11 573/14 573/15 573/18 591/3  
**tendon** [3] 428/4 428/15 458/11  
**tendons** [2] 415/16 438/22  
**term** [3] 413/15 520/6 549/5  
**terms** [1] 407/5  
**test** [1] 420/9  
**testified** [33] 406/10 471/14 479/22 479/25 480/8 480/23 481/16 482/21 499/4 499/14 514/14 517/16 517/19 518/2 518/22 531/17 531/20 537/10 537/11 538/10 538/19 539/2 539/15 540/2 544/6 545/19 547/19 553/10 556/1 556/9 565/23 566/10 589/10  
**testifies** [2] 547/25 548/8  
**testify** [11] 478/1 478/3 478/7 479/4 481/23 482/4 482/8 486/18 486/22 486/23 563/2  
**testifying** [1] 545/3  
**testimony** [47] 399/8 407/5 411/12 435/6 435/18 436/2 436/6 439/22 446/15 447/2 448/14 451/3 452/25 473/2 473/9 473/12 473/17 476/15 477/20 478/8 484/20 497/1 499/11 499/21 508/2 514/9 521/4 522/16 528/8 529/21 529/25 536/15 537/1 538/13 540/14 545/17 551/2 551/23 555/8 556/12 556/13 556/18 557/8 560/16 576/19 578/3 579/1  
**tests** [1] 504/9  
**than** [29] 410/7 416/11 421/14 423/4 424/2 430/9 433/25 437/4 437/10 439/4 439/5 484/10 484/14 485/21 485/23 490/1 492/5 498/15 518/18 532/19 532/19 532/21 536/1 546/18 570/23 571/12 572/15 573/20 587/18  
**thank** [36] 406/1 406/13 407/12 420/25 433/3 457/25 466/5 469/13 470/8 472/10 474/20 474/21 476/2 476/5 490/7 491/4 497/6 497/17 520/25 521/7 521/8 529/9 529/24 537/7 539/24 560/8 561/5 561/13 569/7 574/11 584/22 584/23 588/24 589/15 589/17 591/1  
**Thanks** [2] 566/14 584/2  
**that** [982]  
**that's** [142] 407/3 408/12 415/24 416/6 417/8 419/1 421/10 421/14 423/19 425/14 426/13 427/6 429/7 431/1 434/9 437/19 438/5 440/1 440/1 442/3 442/5 442/7 442/17 442/24 442/24 442/25 448/8 451/23 451/25 453/12 455/4 455/7 458/6 458/11 459/13 460/17 466/17 467/17 469/23 472/16 478/1 478/13 479/13 481/14 482/12 489/24 490/18 491/23 491/25 493/15 496/11 496/18 496/23 497/3 500/10 500/22 503/3 503/14 505/5 505/21 505/24 506/9 506/23 507/16 508/23 510/12 512/16 512/21 513/9 513/14 515/2 515/23 516/12 516/17 516/20 519/3 519/10 521/20 522/24

523/19 524/9 530/5 531/10 533/19 534/10 534/14 535/9 535/12 535/17 536/8 536/22 537/17 538/14 538/23 539/15 539/16 540/11 540/15 541/16 542/4 542/6 542/7 542/19 542/21 544/9 544/10 544/23 546/20 549/9 550/1 551/2 552/23 552/25 554/20 554/23 556/22 557/8 558/3 558/15 561/10 561/17 561/21 564/1 564/18 564/19 565/12 565/19 565/25 566/5 568/12 568/23 569/6 569/7 570/10 571/22 576/4 576/6 582/1 582/25 583/1 583/10 589/14  
**the planter** [1] 456/4  
**their** [10] 444/1 489/13 490/23 490/24 490/24 490/25 495/17 504/20 557/19 579/19  
**them** [24] 418/21 419/19 421/16 440/4 444/25 445/16 457/7 460/24 469/12 469/19 469/20 469/20 469/21 475/18 479/9 483/25 484/16 510/9 510/9 511/11 524/14 538/23 568/10 568/10  
**themselves** [2] 485/4 575/19  
**then** [56] 412/8 412/13 412/15 415/6 415/15 415/24 419/6 424/7 425/12 428/17 428/19 429/12 429/24 435/21 437/2 440/21 442/16 444/5 444/13 444/17 446/1 448/4 448/6 451/15 452/22 458/18 493/3 494/22 495/4 495/8 495/13 496/5 496/14 496/20 496/25 504/19 505/10 507/6 514/24 517/10 519/6 519/15 530/25 532/11 535/4 535/6 538/16 539/22 542/18 542/22 566/15 566/23 570/6 571/19 578/25 580/24  
**therapy** [1] 582/7  
**there** [139] 416/14 417/18 423/17 424/4 424/11 424/14 425/5 425/6 425/6 425/23 427/14 427/20 427/23 432/3 432/19 433/10 433/13 435/14 435/15 436/9 439/22 439/23 440/25 441/20 442/25 444/13 444/17 445/14 446/6 446/16 446/20 447/2 447/3 447/22 448/9 448/14 449/24 451/3 451/13 451/18 459/12 460/3 463/5 463/5 471/3 471/8 471/23 473/2 473/9 473/17 475/14 475/24 475/24 476/21 482/2 483/7 483/11 485/1 485/1 488/13 490/25 493/8 494/12 495/5 496/5 496/14 496/17 497/8 497/9 497/10 498/10 498/18 499/20 502/7 504/10 505/14 508/7 509/12 510/1 510/10 512/9 512/18 512/20 515/10 515/20 517/10 517/13 518/22 518/24 523/16 527/16 527/16 528/3 529/10 529/13 530/10 530/12 531/5 532/8 532/11 532/12 535/6 535/21 536/4 537/3 538/1 539/3 540/5 541/2 541/14 542/1 545/2 545/3 547/22 547/23 554/10 556/9 559/20 562/24 562/25 563/11 563/12 565/8 566/16 566/20 567/16 567/18 570/16 570/19 571/3 574/17 575/16 579/4 579/16 579/22 581/4 585/21 587/15 588/6  
**therefore** [3] 433/25 489/5 503/7  
**thereof** [1] 520/9  
**these** [34] 414/6 415/7 419/18 425/3 425/8 426/6 427/21 428/3 432/22 432/22 445/13 449/25 453/9 461/10 469/16 477/1 492/18 494/14 497/16 507/3 527/5 530/23 540/20 540/23 541/10 550/1 551/16 561/7 564/20 578/15 581/8 583/13 583/16 583/22  
**they** [56] 419/24 420/7 423/12 426/22 428/3 428/5 429/25 438/15 438/15 440/3 440/4 441/1 444/1 444/1 444/2 449/24 457/20 466/13 466/16 466/16 468/5 469/18 469/19 471/24 475/12 475/17 475/19 475/25 477/2 479/9 481/8 482/9 482/22 483/3 483/13 487/18 487/19 489/14 491/14 491/14 491/22 495/19 496/8 504/13 516/5 517/19 533/12 548/15 548/16 550/7 550/14 578/20

<p><b>T</b></p> <p><b>they...</b> [4] 579/15 583/23 585/12 586/6</p> <p><b>thick</b> [3] 417/8 421/15 421/24</p> <p><b>thickened</b> [1] 423/18</p> <p><b>thickening</b> [3] 417/1 456/2 456/2</p> <p><b>thing</b> [22] 421/21 438/1 443/20 443/24 462/12 478/2 494/22 495/13 495/25 497/20 501/21 502/4 505/10 506/9 507/17 509/21 510/19 523/8 523/19 524/9 536/16 540/16</p> <p><b>things</b> [17] 437/25 438/19 443/25 447/9 468/18 475/13 475/14 475/24 487/19 491/14 519/4 541/10 549/19 565/16 568/8 580/23 586/22</p> <p><b>think</b> [56] 406/14 411/23 414/4 418/1 420/23 425/2 425/11 425/14 429/13 429/13 429/13 432/14 439/7 440/22 441/10 445/20 461/17 469/1 469/22 472/23 475/6 477/1 477/2 477/8 477/25 478/1 478/6 478/9 481/11 481/14 481/21 483/1 484/15 489/24 491/22 492/15 492/22 497/14 508/18 512/24 513/6 524/1 526/2 527/2 539/20 541/19 549/19 564/1 564/19 565/24 573/19 581/9 583/10 585/20 586/15 589/7</p> <p><b>third</b> [61] 417/20 418/4 422/5 428/18 429/19 434/3 435/7 436/9 436/22 436/25 442/2 444/24 450/20 451/1 451/5 455/22 456/12 456/16 456/19 457/5 457/7 457/12 458/16 459/11 460/6 460/19 460/23 461/9 462/10 463/7 463/21 463/25 464/4 464/13 464/17 464/23 465/21 466/1 466/10 474/17 488/14 510/14 514/24 524/1 536/6 536/7 536/17 537/14 538/4 539/7 540/24 542/11 542/19 544/15 545/1 558/8 561/2 570/19 570/24 587/19 588/8</p> <p><b>this</b> [263]</p> <p><b>those</b> [51] 409/13 410/3 422/17 425/10 425/15 426/3 426/20 438/1 438/13 438/13 441/3 450/13 450/17 450/23 459/7 459/13 469/4 469/10 475/7 476/25 480/24 481/1 482/4 482/9 482/20 483/6 487/20 488/11 504/10 507/19 508/16 510/22 516/5 516/5 520/13 527/19 539/7 540/25 542/12 543/22 547/20 560/22 561/3 562/9 563/3 568/8 576/8 579/8 584/21 588/19 588/20</p> <p><b>though</b> [2] 477/2 566/19</p> <p><b>thought</b> [7] 483/11 504/23 507/1 530/20 538/20 544/21 554/2</p> <p><b>threatening</b> [2] 520/7 520/14</p> <p><b>three</b> [8] 412/8 412/16 417/18 467/7 483/7 495/14 589/1 589/24</p> <p><b>three-hour</b> [1] 412/16</p> <p><b>throat</b> [1] 406/20</p> <p><b>throbbing</b> [1] 494/8</p> <p><b>through</b> [18] 437/12 437/16 449/21 456/13 460/8 475/17 496/15 497/18 501/16 504/16 515/9 526/7 541/23 541/24 555/13 577/7 578/13 579/1</p> <p><b>throughout</b> [1] 507/23</p> <p><b>throw</b> [1] 417/14</p> <p><b>thumb</b> [1] 439/11</p> <p><b>tighten</b> [1] 458/12</p> <p><b>time</b> [30] 406/2 407/13 414/22 416/9 434/9 447/15 448/21 472/1 472/12 481/20 482/4 485/7 486/8 486/11 487/15 489/17 501/17 511/4 512/2 517/22 520/22 522/24 526/16 543/11 544/3 559/2 559/24 562/7 564/3 573/3</p> <p><b>times</b> [13] 471/17 471/22 472/22 479/17 479/19 480/3 480/8 480/23 481/18 486/4 560/2 562/5 573/18</p> <p><b>timing</b> [2] 509/25 536/23</p> <p><b>tip</b> [4] 502/12 502/14 535/9 572/5</p>	<p><b>tissue</b> [2] 516/16 517/16</p> <p><b>today</b> [9] 452/20 471/18 472/2 487/16 511/25 562/1 562/3 562/13 562/18</p> <p><b>today's</b> [1] 562/15</p> <p><b>toe</b> [84] 414/13 414/13 414/14 414/20 414/22 415/7 415/14 415/16 415/21 416/12 416/20 422/25 423/1 423/24 424/2 424/7 428/13 428/14 428/20 428/22 428/25 429/6 431/19 431/23 434/4 435/13 435/16 438/20 439/14 442/4 442/5 442/8 442/10 442/13 442/15 442/22 443/19 443/23 443/24 444/1 444/3 444/6 454/23 454/24 455/2 458/9 458/10 458/14 458/16 459/10 459/22 459/22 460/1 460/3 462/9 463/13 466/12 502/13 503/19 505/11 516/23 517/4 517/7 517/16 518/4 528/25 529/4 529/6 529/6 529/7 533/1 533/2 533/3 533/4 568/25 577/13 577/16 577/21 577/24 581/12 581/22 582/6 582/19 586/24</p> <p><b>toes</b> [8] 415/8 416/17 435/7 459/9 466/11 552/23 575/19 577/10</p> <p><b>together</b> [7] 414/8 418/21 421/17 429/2 448/12 500/19 509/20</p> <p><b>told</b> [29] 428/15 436/21 441/19 446/20 450/11 455/7 455/18 456/17 465/11 465/24 466/20 467/4 469/23 476/16 479/16 481/17 492/22 498/14 499/5 532/13 536/15 542/9 544/5 551/22 557/7 572/4 586/8 586/11 588/18</p> <p><b>ton</b> [1] 481/2</p> <p><b>too</b> [33] 409/18 417/7 419/2 424/18 429/3 429/5 429/8 429/25 430/1 435/14 446/6 446/8 458/24 460/3 460/7 466/14 490/4 511/22 519/20 530/6 546/21 565/24 565/25 566/12 568/5 568/22 568/23 569/2 575/23 575/24 576/21 576/22 587/16</p> <p><b>took</b> [7] 412/13 445/22 446/8 458/19 473/24 485/5 552/25</p> <p><b>top</b> [8] 429/23 442/23 455/2 458/11 458/13 463/10 463/14 533/17</p> <p><b>tops</b> [1] 573/14</p> <p><b>total</b> [2] 451/22 467/7</p> <p><b>totally</b> [4] 546/15 546/19 563/25 564/13</p> <p><b>touch</b> [6] 435/19 436/25 532/2 566/21 566/23 567/17</p> <p><b>touching</b> [2] 454/23 455/4</p> <p><b>toward</b> [3] 428/21 459/9 505/19</p> <p><b>towards</b> [4] 423/1 428/14 466/12 524/19</p> <p><b>train</b> [1] 491/14</p> <p><b>trained</b> [3] 487/19 487/19 488/21</p> <p><b>training</b> [6] 412/9 469/10 469/17 489/14 491/10 548/3</p> <p><b>transcript</b> [3] 478/21 575/10 591/12</p> <p><b>transfer</b> [1] 576/1</p> <p><b>treat</b> [4] 430/21 467/12 469/9 469/12</p> <p><b>treated</b> [2] 422/9 453/10</p> <p><b>treating</b> [2] 452/23 487/4</p> <p><b>treatment</b> [6] 409/10 412/2 422/16 582/5 582/7 582/9</p> <p><b>treatments</b> [1] 528/13</p> <p><b>treats</b> [1] 432/7</p> <p><b>trial</b> [7] 479/25 482/5 482/8 490/11 490/20 514/9 518/2</p> <p><b>tried</b> [3] 441/24 454/8 457/16</p> <p><b>trouble</b> [2] 420/22 520/1</p> <p><b>true</b> [16] 426/17 459/2 488/4 488/5 534/13 544/25 548/12 555/20 555/25 556/16 559/23 567/25 568/4 568/8 568/10 591/11</p> <p><b>truth</b> [3] 406/5 406/6 406/6</p> <p><b>try</b> [11] 416/20 460/22 463/17 463/19 465/1 465/4 507/2 510/9 521/25 552/15 580/5</p> <p><b>trying</b> [12] 406/21 421/7 460/25 462/25 463/2 463/4 466/7 466/16 469/1 490/19</p>	<p>504/1 538/17</p> <p><b>tube</b> [1] 555/7</p> <p><b>Tuesday</b> [1] 589/21</p> <p><b>tumor</b> [1] 468/25</p> <p><b>tumors</b> [1] 469/2</p> <p><b>turn</b> [6] 427/16 439/9 510/25 522/8 524/16 526/17</p> <p><b>turned</b> [1] 428/14</p> <p><b>turning</b> [1] 523/2</p> <p><b>Twenty</b> [3] 413/3 413/6 573/7</p> <p><b>Twenty-two</b> [2] 413/3 413/6</p> <p><b>twice</b> [4] 412/18 472/23 479/20 480/7</p> <p><b>two</b> [40] 412/9 412/12 413/3 413/6 413/21 417/3 419/12 419/13 421/8 421/9 431/10 433/23 438/1 438/13 438/19 467/20 467/21 471/23 479/19 480/8 482/20 483/7 497/2 507/11 509/4 509/20 509/23 519/15 531/5 531/6 535/7 535/8 535/8 542/12 543/22 549/19 562/5 566/22 589/1 589/4</p> <p><b>type</b> [7] 414/11 446/11 462/18 465/1 465/17 491/17 585/18</p> <p><b>types</b> [1] 412/14</p> <p><b>typical</b> [1] 437/4</p> <p><b>typically</b> [1] 486/10</p> <p><b>U</b></p> <p><b>ulcer</b> [1] 417/6</p> <p><b>ultimately</b> [3] 498/3 509/7 510/11</p> <p><b>Um</b> [1] 480/10</p> <p><b>Um-hum</b> [1] 480/10</p> <p><b>unclear</b> [1] 421/2</p> <p><b>unclear</b> [2] 537/5 542/22</p> <p><b>under</b> [30] 409/22 416/11 424/4 424/9 424/17 428/4 431/18 432/5 433/10 447/4 450/25 451/14 455/12 456/9 456/12 456/15 457/12 458/5 458/6 458/16 474/17 485/25 512/11 512/12 512/15 521/3 521/22 574/8 579/9 586/12</p> <p><b>undergo</b> [1] 462/18</p> <p><b>underneath</b> [2] 428/6 464/4</p> <p><b>understand</b> [17] 407/10 415/2 421/2 463/2 487/18 488/9 513/2 514/1 522/2 523/3 525/11 542/7 547/6 547/18 559/6 566/25 585/4</p> <p><b>understanding</b> [5] 453/15 470/1 478/10 492/4 493/2</p> <p><b>understood</b> [6] 521/22 521/24 544/10 559/5 574/8 574/10</p> <p><b>undertaken</b> [3] 554/17 560/19 562/20</p> <p><b>unite</b> [1] 559/18</p> <p><b>University</b> [1] 469/6</p> <p><b>unless</b> [3] 436/23 517/23 563/12</p> <p><b>unrelated</b> [2] 546/15 563/25</p> <p><b>unsightly</b> [1] 493/20</p> <p><b>unstable</b> [11] 419/5 419/6 419/11 444/2 444/4 498/22 499/6 499/16 500/13 501/12 571/24</p> <p><b>until</b> [7] 409/6 435/20 436/10 437/1 441/3 441/14 542/23</p> <p><b>up</b> [86] 406/12 409/6 414/9 414/25 418/25 421/16 423/13 423/24 425/12 425/18 429/6 431/4 435/17 438/14 438/21 438/21 442/4 442/13 442/13 442/13 442/14 442/15 442/23 442/24 443/20 451/4 451/8 451/11 452/1 454/16 454/23 455/2 455/3 456/8 458/9 458/10 459/10 459/10 460/1 463/9 463/13 463/17 466/12 466/15 466/18 482/12 488/12 502/2 502/10 502/13 502/16 502/18 502/19 502/24 505/4 505/5 516/17 516/23 517/4 517/7 517/17 518/4 521/10 521/11 545/2 551/19 552/6 553/25 554/1 562/15 566/16 568/5 568/25 569/2 569/20 570/23 571/5 571/25 572/2 572/5 573/3</p>
--	---	--

**U**  
**up...** [5] 576/21 577/14 577/22 581/12 581/22  
**upgoing** [1] 582/6  
**upon** [12] 462/21 464/2 464/7 464/12 465/11 465/14 485/9 498/9 534/4 535/15 553/22 571/10  
**upward** [2] 577/10 582/19  
**us** [64] 406/22 406/25 409/13 412/4 412/23 413/1 413/7 413/11 413/17 414/17 417/11 417/12 422/17 427/8 428/6 431/24 431/25 432/23 435/11 436/21 437/22 441/19 441/20 450/11 451/7 452/18 452/20 453/24 454/2 455/7 455/18 455/25 456/18 458/2 458/21 459/19 460/9 465/11 465/16 466/20 467/4 467/22 468/18 469/5 469/23 471/17 472/4 473/22 475/10 476/16 479/16 481/17 498/14 518/5 522/22 532/13 536/15 542/9 551/22 557/7 572/4 585/16 586/8 586/17  
**use** [10] 407/5 413/19 497/15 506/3 521/18 525/14 547/20 567/5 567/7 585/25  
**used** [8] 413/15 426/3 428/5 501/12 525/8 555/4 555/9 567/11  
**using** [3] 454/24 475/22 528/10  
**usual** [1] 562/19  
**usually** [4] 434/5 513/23 514/4 525/20

**V**  
**vague** [2] 511/22 549/4  
**valgus** [2] 498/6 498/19  
**valid** [1] 564/19  
**variability** [1] 566/17  
**varied** [1] 562/19  
**variety** [2] 496/7 514/2  
**various** [2] 425/4 509/4  
**vasculature** [1] 496/17  
**verge** [1] 476/12  
**versa** [1] 490/22  
**Verses** [1] 533/22  
**versus** [2] 463/6 467/25  
**very** [21] 418/16 418/16 418/23 419/18 420/17 420/25 427/24 444/2 447/19 449/18 456/19 461/19 474/20 488/13 508/3 521/7 536/16 540/9 559/20 564/6 589/15  
**vice** [1] 490/22  
**vice-versa** [1] 490/22  
**video** [2] 517/20 518/2  
**videotape** [1] 477/22  
**view** [7] 427/10 427/12 432/23 463/11 533/10 557/6 569/19  
**visible** [1] 442/18  
**visit** [12] 454/14 461/11 462/4 462/13 462/13 475/15 475/16 475/16 492/14 506/3 507/25 522/15  
**visited** [1] 486/3  
**visits** [2] 531/5 531/6  
**voice** [1] 406/12  
**VOUTE** [1] 399/17

**W**  
**W-A-L-T-O-N** [1] 556/3  
**wait** [2] 465/6 552/8  
**walk** [4] 417/9 439/13 460/17 497/3  
**walking** [5] 424/19 433/15 475/23 502/1 502/8  
**Walton** [3] 556/2 556/3 556/3  
**want** [57] 413/19 413/23 415/2 419/6 420/3 422/22 422/24 423/1 423/13 423/21 423/23 424/12 424/21 425/17 425/21 430/3 430/6 433/4 433/6 439/20 440/4 443/21 461/17 468/4 473/9 474/22 481/19 483/10 496/15 507/9 511/6 511/11 518/6 519/14 519/16

519/19 521/2 522/14 528/8 536/14 537/9 537/25 538/9 539/1 540/1 540/16 545/25 546/1 556/19 560/25 568/16 576/12 576/20 580/17 580/19 581/7 585/15  
**wanted** [6] 423/22 518/21 527/11 537/22 544/12 558/1  
**wants** [2] 489/11 511/17  
**was** [166] 406/10 407/18 408/16 409/11 409/14 409/15 409/15 412/3 412/10 420/20 422/24 424/1 424/3 430/2 434/13 434/18 434/20 434/21 434/22 436/16 436/17 436/18 436/22 439/4 439/5 439/7 439/16 439/23 442/16 442/19 443/13 444/16 446/6 446/20 446/21 447/3 448/16 448/17 450/3 450/5 450/14 452/14 456/7 456/8 456/8 461/8 462/25 463/2 463/3 463/10 463/16 463/23 468/21 474/6 474/7 474/12 475/20 475/21 475/22 475/22 475/23 479/2 481/21 481/25 482/2 483/6 483/10 483/16 483/21 484/22 485/7 485/18 485/21 485/23 488/20 490/18 494/17 494/20 494/24 498/6 498/15 498/21 499/11 499/11 499/21 499/22 502/25 504/2 504/15 505/14 505/17 506/22 508/21 509/5 510/21 512/5 512/18 512/20 517/3 517/11 517/13 521/18 522/14 522/15 524/23 528/7 530/5 531/13 532/14 532/18 532/21 534/4 535/21 535/22 536/24 537/10 538/6 538/12 540/5 541/2 542/1 542/17 542/23 544/2 544/3 544/5 544/5 545/3 545/11 546/8 547/3 547/23 547/25 548/2 548/9 548/18 551/23 552/16 554/8 554/9 554/10 554/13 555/9 555/9 556/20 556/20 557/9 560/22 563/11 565/10 565/24 565/25 565/11 581/4 581/12 582/3 582/4 583/14 586/21 586/25 587/18 587/18 587/20 588/10 588/20 589/6  
**way** [26] 410/22 415/22 418/18 433/14 436/15 443/2 443/5 450/9 463/22 502/21 504/8 508/23 517/12 525/1 528/15 534/5 548/4 550/8 552/6 558/3 561/11 580/6 582/13 582/15 582/16 586/22  
**ways** [1] 483/7  
**we** [136] 406/17 406/18 407/9 408/3 408/3 412/4 413/15 413/21 413/23 414/3 414/5 414/13 416/2 416/3 417/10 417/16 418/1 419/5 420/24 420/24 422/1 424/25 425/7 425/11 425/12 427/5 427/9 433/19 435/5 435/18 435/21 436/6 437/24 438/1 438/14 441/18 443/22 444/7 444/22 445/3 446/15 450/10 455/1 456/20 456/23 461/2 461/17 461/25 462/3 462/3 462/12 466/16 472/22 472/24 472/25 476/12 483/1 483/15 484/15 487/22 488/2 488/7 488/18 491/1 496/2 497/9 501/2 503/12 505/17 508/1 508/1 508/6 508/10 508/13 508/23 509/12 509/14 510/9 512/19 512/19 513/15 514/13 515/8 515/10 515/17 515/17 516/21 517/22 518/12 518/18 519/15 520/23 520/24 521/9 521/11 521/20 522/7 526/6 526/7 526/9 526/22 529/9 529/14 530/5 530/14 530/16 530/18 530/20 531/12 537/21 543/14 544/11 546/21 549/10 552/7 554/15 559/15 565/7 565/24 567/20 569/20 573/2 574/7 574/15 574/25 577/24 579/18 580/22 586/3 586/5 589/19 589/20 589/24 590/2 590/3 590/5  
**wear** [2] 459/16 493/22  
**wearing** [3] 475/22 507/11 509/24  
**web** [1] 414/21  
**wedge** [5] 447/16 546/8 546/9 546/10 581/24  
**week** [6] 412/25 469/20 475/15 573/18 589/25 590/4  
**weekend** [1] 591/2

**weeks** [1] 522/21  
**weigh** [1] 558/18  
**weight** [27] 423/5 423/23 424/16 433/10 436/9 444/5 449/13 449/13 451/13 456/12 460/24 495/23 503/1 503/7 514/24 558/1 568/2 568/6 568/18 568/23 569/3 569/4 569/5 572/24 575/23 575/24 575/25  
**weightbearing** [12] 430/18 432/4 433/14 435/14 441/22 454/19 507/12 509/25 557/13 557/16 557/16 557/18  
**welcome** [2] 461/24 560/9  
**well** [75] 406/14 409/14 409/25 416/1 422/19 426/18 426/24 430/11 430/23 436/15 438/22 441/7 445/1 449/16 451/18 452/5 459/19 462/10 463/8 470/17 470/18 475/9 475/12 476/17 478/13 478/16 478/18 482/10 483/3 483/9 486/8 488/24 492/11 492/20 492/22 499/15 502/24 507/8 509/2 514/23 515/17 518/25 526/2 526/12 526/14 529/6 530/25 532/1 532/21 535/19 537/5 538/7 539/21 542/13 543/5 548/12 555/24 556/22 557/5 563/8 563/16 564/19 565/5 565/12 569/3 571/4 571/15 572/25 573/11 574/24 575/13 575/21 576/6 579/22 582/18  
**went** [8] 412/6 462/23 466/20 467/4 467/6 467/21 483/15 497/18  
**were** [67] 436/13 441/19 444/7 450/17 450/23 459/7 469/5 471/23 471/24 475/14 475/15 475/17 475/19 475/24 475/24 475/25 476/21 477/1 477/2 480/24 481/1 481/24 482/3 482/9 482/9 482/20 482/22 483/3 483/12 483/13 484/21 485/1 485/2 485/4 485/24 486/6 489/10 492/12 492/18 494/19 494/20 499/6 499/16 507/24 508/1 508/16 512/4 514/7 514/13 517/15 531/5 545/20 547/11 547/19 547/22 554/7 563/1 563/13 579/2 583/5 583/5 583/6 583/7 583/12 583/16 585/5 586/16  
**WESTCHESTER** [2] 399/1 399/6  
**what** [226]  
**whatever** [7] 408/13 424/12 430/24 445/18 468/6 538/11 544/19  
**when** [70] 412/3 412/4 413/15 415/11 416/2 417/7 417/8 418/15 423/25 424/11 424/15 424/18 427/10 428/25 429/3 429/25 430/2 430/16 430/21 431/7 431/20 431/21 431/24 433/1 433/2 435/4 437/2 442/9 443/21 443/25 445/1 445/12 447/10 448/15 448/25 459/16 460/14 463/16 466/24 467/17 475/20 475/23 477/25 484/22 485/10 486/10 487/18 490/22 492/11 500/13 500/16 501/22 504/16 507/21 510/18 513/7 515/19 534/20 540/18 543/7 544/18 548/15 553/15 559/18 567/4 574/24 582/11 582/18 583/5 583/17  
**where** [48] 411/18 412/5 420/8 420/10 420/10 421/25 422/1 422/3 428/21 432/6 440/3 440/11 442/10 442/22 444/5 444/7 447/12 454/22 460/17 466/13 467/10 476/22 480/17 482/8 501/12 511/3 516/15 520/13 521/20 530/3 535/2 535/8 545/20 546/5 552/2 557/18 563/18 565/22 565/22 570/10 570/24 571/11 572/14 576/1 581/12 582/21 583/7 586/21  
**Whereas** [1] 498/12  
**Whereupon** [3] 407/18 408/16 420/20  
**whether** [26] 412/2 423/16 424/24 436/17 439/16 448/20 449/21 450/12 450/13 457/4 460/10 464/10 471/3 471/8 482/1 488/20 488/20 489/13 499/22 504/23 539/5 551/18 559/25 579/15 586/12 587/6  
**which** [41] 409/23 417/4 417/5 417/5 420/24 421/24 423/22 423/23 424/9 426/25 429/1

<p><b>W</b></p> <p><b>which...</b> [30] 430/13 433/22 438/14 454/9 454/15 456/3 457/15 457/17 458/8 458/9 458/13 459/7 459/22 460/6 466/9 468/12 483/8 483/24 488/22 498/11 503/10 505/18 510/14 511/1 511/1 524/20 530/15 540/6 555/21 557/1</p> <p><b>while</b> [4] 434/6 451/16 479/2 494/14</p> <p><b>white</b> [3] 399/9 399/19 421/10</p> <p><b>who</b> [15] 422/9 432/7 444/9 451/17 453/10 467/13 469/10 469/17 471/2 471/7 490/12 495/1 554/10 561/6 564/9</p> <p><b>whole</b> [14] 406/6 409/16 418/19 437/10 448/11 451/13 460/11 460/12 466/9 502/14 502/24 509/10 552/3 572/5</p> <p><b>whose</b> [1] 457/23</p> <p><b>why</b> [12] 414/6 415/1 430/20 435/11 437/7 449/10 451/8 473/22 539/21 546/17 569/6 569/7</p> <p><b>wide</b> [1] 490/21</p> <p><b>width</b> [1] 422/5</p> <p><b>will</b> [44] 406/5 411/3 411/25 415/16 432/20 435/8 438/20 464/10 465/1 465/17 465/19 486/17 486/22 490/12 499/22 500/14 503/1 503/12 505/18 506/18 512/12 514/13 514/17 518/2 519/16 520/24 521/11 522/23 537/17 537/21 538/25 559/10 568/25 573/19 573/24 574/7 574/24 575/7 579/19 580/8 586/10 589/23 589/24 590/3</p> <p><b>wires</b> [1] 414/7</p> <p><b>withdraw</b> [5] 487/25 490/12 513/4 538/25 583/25</p> <p><b>withdrawn</b> [10] 410/4 432/18 440/10 445/11 488/18 490/2 490/14 515/18 520/20 580/12</p> <p><b>withdrew</b> [1] 488/10</p> <p><b>within</b> [12] 410/12 410/16 428/4 439/24 443/8 457/3 464/9 500/10 551/17 576/18 587/5 591/11</p> <p><b>without</b> [9] 419/10 431/17 439/13 494/23 525/2 525/11 525/13 525/14 587/1</p> <p><b>withstand</b> [3] 423/19 429/4 429/5</p> <p><b>witness</b> [10] 411/23 425/8 426/25 464/20 488/13 488/16 489/12 521/3 573/25 589/18</p> <p><b>witnesses</b> [2] 490/22 490/23</p> <p><b>woman</b> [2] 420/19 492/6</p> <p><b>won't</b> [4] 441/8 447/22 569/2 571/19</p> <p><b>word</b> [3] 418/24 419/5 555/5</p> <p><b>worded</b> [1] 528/7</p> <p><b>words</b> [8] 430/22 445/10 471/1 538/11 547/20 582/12 585/13 585/16</p> <p><b>work</b> [2] 447/15 589/21</p> <p><b>worked</b> [2] 441/13 467/20</p> <p><b>working</b> [3] 583/14 583/15 583/17</p> <p><b>worry</b> [1] 589/24</p> <p><b>worse</b> [9] 429/17 454/8 485/21 485/23 494/4 494/12 498/15 507/3 517/14</p> <p><b>would</b> [122] 414/23 417/6 423/6 424/25 425/5 425/16 426/17 437/22 438/10 441/13 442/20 442/21 452/7 453/22 453/24 456/19 457/4 457/10 457/11 457/18 457/20 458/25 459/4 460/22 461/9 461/10 463/5 466/2 482/13 484/13 484/15 485/9 485/19 489/6 492/3 492/21 494/17 494/24 497/23 498/11 499/3 500/1 501/15 502/22 503/6 504/2 506/2 506/12 507/2 507/3 507/14 508/3 509/6 509/10 509/25 515/2 515/12 517/12 518/1 518/4 518/9 518/10 518/16 519/1 519/2 519/18 522/9 522/16 522/22 524/16 526/17 528/11 528/16 528/16 531/20 532/2 532/8 540/25 541/5 541/9 541/10 541/21 543/24 544/7 544/21 545/2 545/10 547/3 548/17 550/16 552/4 553/8 553/13 553/25</p>	<p>555/13 555/16 555/19 557/1 557/3 560/17 567/14 568/16 568/20 569/9 569/10 569/23 570/6 570/15 571/14 573/13 579/4 579/14 582/5 582/6 582/21 583/2 583/12 583/21 584/3 584/12 587/1 588/19</p> <p><b>wouldn't</b> [3] 510/7 550/5 571/23</p> <p><b>wound</b> [2] 451/4 451/8</p> <p><b>write</b> [3] 499/9 510/18 539/21</p> <p><b>writes</b> [6] 454/19 455/21 457/16 458/21 459/20 460/5</p> <p><b>written</b> [1] 412/16</p> <p><b>wrong</b> [12] 410/7 497/10 501/1 505/18 518/9 518/10 518/13 518/14 540/16 565/22 567/19 575/22</p> <p><b>wrote</b> [2] 468/20 468/23</p> <p><b>X</b></p> <p><b>x-ray</b> [31] 421/11 425/12 426/13 427/8 427/13 437/22 437/23 437/24 441/18 441/20 442/18 443/10 451/7 455/9 465/3 517/9 533/11 534/5 534/8 535/16 535/22 554/17 555/2 555/7 555/9 555/12 555/23 556/14 556/15 557/2 557/12</p> <p><b>x-rays</b> [39] 409/3 409/19 422/20 424/1 424/23 425/4 425/9 425/25 426/1 426/3 426/21 432/17 432/19 432/22 435/1 439/18 439/23 440/7 440/13 440/18 441/3 441/14 442/22 445/2 445/13 452/21 452/23 456/7 458/19 458/22 472/13 476/16 476/17 485/4 485/10 505/22 543/6 543/7 583/6</p> <p><b>Y</b></p> <p><b>year</b> [4] 409/5 467/6 482/1 503/19</p> <p><b>years</b> [18] 408/24 412/7 412/8 412/9 412/12 412/14 413/3 413/6 467/1 467/2 467/3 467/7 467/20 467/21 471/23 484/22 485/1 494/4</p> <p><b>yes</b> [331]</p> <p><b>yesterday</b> [3] 448/14 497/1 555/10</p> <p><b>yet</b> [4] 411/24 509/12 517/19 526/7</p> <p><b>YORK</b> [5] 399/1 399/9 407/3 410/23 467/6</p> <p><b>you</b> [972]</p> <p><b>you're</b> [58] 410/22 416/10 422/6 423/16 424/6 424/11 431/10 433/1 433/22 437/5 439/10 439/17 440/22 440/22 442/11 447/11 447/16 447/18 447/20 449/11 449/13 452/1 455/16 465/10 482/8 484/3 484/20 499/8 499/17 499/19 507/15 512/22 521/3 528/21 528/24 530/3 535/15 536/4 537/23 539/19 540/17 543/15 546/14 549/19 549/20 551/3 551/5 556/25 557/6 558/11 560/9 561/21 561/25 564/13 570/20 571/2 574/2 585/2</p> <p><b>your</b> [168] 406/1 406/12 406/22 406/25 407/5 407/13 409/9 410/7 410/9 410/12 410/20 411/3 411/12 412/19 412/20 413/9 413/13 415/8 415/9 415/9 415/10 417/9 419/20 421/18 422/6 422/7 423/2 423/7 423/8 425/19 426/3 426/14 426/22 426/24 431/13 431/15 434/1 434/7 434/18 434/20 435/24 436/3 436/19 437/14 439/18 439/23 440/3 440/5 440/7 440/8 440/19 441/4 441/7 441/12 442/4 442/5 442/7 442/18 444/19 447/13 448/23 450/1 451/24 452/19 453/11 453/15 459/1 462/2 462/21 464/2 464/7 464/8 465/10 465/10 465/14 465/16 467/16 467/17 468/7 468/11 469/8 470/1 470/15 470/19 470/24 472/1 472/4 473/6 474/24 475/5 475/8 475/10 476/5 476/15 480/5 481/10 481/20 482/21 482/22 483/14 483/21 484/5 484/17 486/23 487/23 491/5 491/9 491/13 492/5 493/2 497/17 501/2 501/17 503/24 506/14 511/4 515/24 516/21</p>	<p>517/20 517/22 519/6 520/9 520/10 521/4 521/16 521/25 526/12 526/19 526/22 527/5 530/5 530/17 530/22 534/2 536/8 545/19 550/15 551/1 551/17 556/11 556/12 557/8 558/18 561/19 562/18 563/15 564/9 567/3 569/13 571/22 578/17 580/13 580/15 580/16 583/5 583/6 583/13 583/16 584/24 585/10 586/13 587/15 587/22 587/23 588/5 588/6 588/13 591/1</p> <p><b>yourself</b> [3] 482/17 576/25 578/5</p> <p><b>Z</b></p> <p><b>zero</b> [2] 438/10 494/11</p> <p><b>zinc</b> [1] 469/3</p>
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