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    SUPREME COURT OF THE STATE OF NEW YORK
    COUNTY OF WESTCHESTER
    ANNMARIE FLANNERY and DAVID FLANNERY
                            Plaintiffs
        - against - INDEX NO.
        11230/06
    JOHN MARZANO, D.P.M. & WESTCHESTER
    PODIATRIC MEDICINE, P.C.
        Defendants.
    ***TESTIMONY OF EDWIN WOLF, D.P.M.***
    111 Dr. Martin Luther King, Jr. Blvd.
        White Plains, New York 10601
        July 21, 2010
    B E F O R E:
        HON. MARY H. SMITH,
        Justice of the Supreme Court.
    A P P E A R A N C E S:
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    BY: MARK McANDREW, ESQ.
        CYNTHIA M. HILLS,
        Senior Court Reporter.
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THE COURT: All right, good morning, everyone. Please be seated. And we have a jury now. You have your expert?

MR. MC ANDREW: We do, Judge.
THE COURT: Let's just get started. MR. MC ANDREW: Excellent. MR. OGINSKI: Judge, did you receive my e-mail yesterday?

THE COURT: I have not looked at my e-mails. What does it have to do with?

MR. OGINSKI: I provided case law about why we need separate itemized verdict on the questions as well as one of the questions we talked about yesterday the error of judgment.

THE COURT: Error of judgment, I have done some reading on. I am aware of the provision in PJI for separate verdicts. I will tell you, in the last several years I have done them pretty much like this. If you really -- I don't think you have to do it exactly like that.

MR. OGINSKI: The case law indicates that for every claimed departure there should be a separate jury question. And otherwise because if it goes up on appeal the Appellate Court will not know which particular theory they did or did
not rely on.
THE COURT: And concomitantly, and I will
fill in the rest of the sentence.
You know, if you demand it, I will do it.
But, $I$ don't think it is mandatory, one. Number two, I think it is risky. But if that's what you want.

MR. OGINSKI: Yes, Judge. MR. MC ANDREW: Judge, if I may. It would seem that the cases that were cited by counsel really talk about very different distinguishable facts in that there are multiple -THE COURT: About what? MR. MC ANDREW: About the multiple verdict sheet questions. That there are multiple parties involved, multiple defendants, different departures. Really this case boils down to did the doctor perform the surgery correctly. That's one question. That's our position. As to the medical judgment it seems very clear that Dr. Marzano's position was that, in fact, he recommended to this patient -MR. OGINSKI: I'm sorry, we have the expert in the courtroom. Is there any chance you could ask him to leave.

MR. MC ANDREW: I think we can do this afterwards.

THE COURT: Let's not go over the same arguments. That's time wasted.

Let's go.
COURT OFFICER: Jury entering.
(Jury entering courtroom.)
THE COURT: Good morning, everybody. Sit down, please.

Today we are going to move over to the Defense case. And I believe Mr. McAndrew has a witness, an expert witness.

MR. MC ANDREW: Correct, your Honor. At this time we call Doctor Edwin Wolf to the stand.

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

THE WITNESS: Yes, I do.
EDWIN WOLF, having been first duly sworn, was examined and testified as follows:

THE COURT: Be seated, sir, and give us your full name.

THE WITNESS: Good morning, my name is

Edwin Wolf. W-O-L-F. E-D-W-I-N. THE COURT: And your professional address, sir?

THE WITNESS: One West $85^{\text {th }}$ Street, New York, New York 10024. THE COURT: Your witness, please. MR. MC ANDREW: May I proceed, your Honor? THE COURT: Yes.

DIRECT EXAMINATION
CONDUCTED BY MR. MC ANDREW:
Q Good morning, Doctor Wolf.
A Good morning.
Q Are you a podiatrist licensed to practice in the State of New York?

A Yes, I am.
Q Can you tell us about your education and training in the field of podiatry and podiatric training, please?

A Certainly. After receiving a Bachelor's Degree from the City University of New York, Queens College, $I$ received a doctorate in podiatric medicine degree from the New York College of Podiatric Medicine. I then pursued a course of study in San Francisco in a residency program sponsored jointly by the University of California Medical School and the

California College of Podiatric Medicine.
While I was there I also concomitantly pursued a course of study in education which ultimately lead to a Master's in Surgical Education awarded by the California College of Podiatric Medicine which was finally awarded, I believe, in 1981, after successfully submitting and defending a thesis.

Q And, Doctor, at some point did you become board certified?

A Yes, certainly. I became board certified by both of the boards, the American Board of Podiatric Orthopedics and Primary Podiatric Medicine, I believe, in 1978, and then the American Board of Podiatric Surgery in 1981. I have maintained my board status, of course, as being certified, but I have also maintained a close relationship with both of those boards. Having actually been an oral examiner for the American Board of Podiatric Surgery since about 1984, every year since that year.

For several years I actually sat on the exam committee, helped author the exam for several years, and actually chaired one of the subsections of that exam committee for a number of years as well.

Q So is it fair to say that you administered
the tests to prospective podiatrists trying to become board certified?

A I have and I continue to do so every year on an annual basis. The oral examination is given the weekend after Father's Day in Chicago, and that's where I was this year, as I have been every year, since 1984 or; 85.

Q And your work with the committee, did you help to draft the examination, the written portion of the examination?

A As I said, for a good number of years I was on the exam committee and actually chaired one of the subsections, yes, sir.

Q Doctor, at some point after your training, did you enter into private practice?

A Well, immediately after my training I took a full-time teaching position, which I did for several years. And then I cut back on my responsibilities teaching full-time and started a private practice and maintained academic positions throughout. But I do have a private practice where $I$ continue to see patients on a regular basis at the address that I gave you before on $85^{\text {th }}$ and Central Park West, New York City.

Q Doctor, are you affiliated with any medical
centers?
A Affiliated with several different hospitals. Currently I'm the Chief of Podiatry Service of the Department of Orthopedic Surgery at New York Downtown Hospital. I also have privileges at Beth Israel Hospital, and also at several surgery centers in New York City.

Q And, Doctor, currently do you maintain any positions with regard to teaching podiatrists?

A Yes. I'm also the Director of Podiatric Medical Education and I'm actually salaried by New York Downtown Hospital at 20 hours a week to administer the residency program, teach residents and oversee the 36 -month residency program sponsored by that institution, yes, sir.

Q And, Doctor, have you published in the field of podiatry or podiatric medicine at all?

A I have published several articles over the years and I have contributed to texts and journals, yes, sir.

Q Are you affiliated with any memberships or associations in your field?

A Lots of them. Certainly I'm a member of the New York State Podiatric Medical Association, American Podiatric Medical Association, I'm a fellow of the

American College of Foot and Angle Surgeons, past president of the New York division of such. And, yes, a myriad of other organizations having to do with my profession.

Q And, Doctor, are you being compensated for your time away from your practice for coming here to testify here in Court today?

A Absolutely. We agreed on a rate of $\$ 3,500$ for the day, as well as being reimbursed for time that I spent reviewing and discussing with you at a rate of $\$ 350$ per hour.

Q Doctor, is it fair to say that you have testified in the past in Court?

A I have, yes, many times. This year, this is the second time in 2010 that I have appeared in Court with this type of activity. And usually it is about three or four times a year over the past good number of years, yes, sir.

Q In addition to testifying have you reviewed cases over the years as well, maybe you did not necessarily testify, but you do review a number of cases per year?

A Absolutely I have and continue to do so, that's correct.

Q Doctor, do you only testify for plaintiffs
or only testified for defendants or something else?
A No, I certainly review cases for both Defendants and Plaintiffs. The majority of my appearances in Court clearly have been for Defendants and not for Plaintiffs, absolutely.

Q And, Doctor, you and I worked together before, have you reviewed cases for me?

A There have been several cases over years, over the years that I reviewed for you. But this is the first opportunity that $I$ was willing to appear in Court on your behalf, that's correct.

Q And, Doctor, I'm going to ask you -- and, by the way, did you bring a foot model or anything with you today?

A I did. As you requested I did bring a right foot model, plastic model of the usual anatomical presentation of the foot.

Q You don't ordinarily walk around with that in your pocket, do you?

A You get in a lot of trouble that way, Mr. McAndrew, but, yes, at your request I did bring this one.

Q That's a right foot, correct?
A That is a -- correct, it is a right foot.
Q Right?

A Right, it is a right foot, yes.
Q And, Doctor, what $I$ would like for you to do at this point, and the jurors have heard a lot about bunions. What I would like for you to explain to them, and if you want to step down and use the model, just explain to them briefly and concisely what a bunion is and how it affects the foot?

A Sure, I would be happy to do that. Obviously it is something that students and residents spend significant amount of time and energy, but we will give you a Readers Digest version. May I use that drawing?

Q Of course, that's why it is up there.
THE COURT: I would ask you to go on the other side of the drawing so that the reporter can hear you.

THE WITNESS: I will.
Before we can talk about the abnormal
structure known as bunion, or medical terminology is called hallux valgus, let's take a brief moment to look at the ideal anatomical presentation of the foot specifically having to do with the big toe. The big toe called the hallux.

The hallux contains two bones, two
phalanges, as they are called. The one furthest away from the center of the body is the distal phalanx, and the one right behind that is called the proximal phalanx. Right behind the big toe, the hallux, is the first metatarsal. The joint between the big toe and the foot where the hallux meets the metatarsal is called the first metatarsal phalangeal joint. If we look at the anatomy in the ideal foot, again, this one being made out of plastic, there are certain parameters we like to see. We like to see the first metatarsal being somewhat parallel to the second metatarsal, basically within a certain number of degrees. We like to see the big toe, the hallux, directly above the first metatarsal when we look at it from the top down. We don't expect it to be abducted, or moving towards the middle of the foot, or adducted, moving away from the middle of the foot. We expect to see it in line. There are two other bones that are supposed to sit underneath the first metatarsal these. Two little bones are called sesamoids. The purpose of the sesamoids is to act as somewhat of a fulcrum for certain muscles and
tendons to help bring the toe down against the ground. That's the function.

So when we look at a radiographic appearance, looking at it from top to bottom, also known as anterior to posterior, this is called an AP view. There are certain things we expect to see. We expect to see, once again, the distal phalanx, the proximal phalanx, the first metatarsal, all in line, and in line with the bone right behind the first metatarsal, known as the cuneiform, the joint between the metatarsal and the cuneiform is called a metatarsal cuneiform joint.

And these should be, as I said, somewhat parallel to the second metatarsal, and the second toe next to it, the two sesamoids sitting directly underneath the first metatarsal.

When we look at the ideal anatomical foot, when weightbearing, with an x-ray view called the lateral view, and what happens is in order to take a lateral view an x-ray plate is put behind the foot and the $x$-rays are passed through the foot.

In those areas where the $x$-rays are

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blocked by something that they cannot go through, such as bone, we see something that is white. Areas that there is nothing blocking them we see black, because the x-rays expose the silver on the plate making them black, and in areas where we have different densities of different tissue or bone we see shades of gray.

But when we look at the foot we see that the metatarsals are not parallel to the ground. The normal ideal foot has an angle of inclination, or an angle at which it meets the ground, making it off of the ground coming up off of the foot. So when we look at an $x$-ray projection of what we would expect to see here of a right foot, we would expect to see a first metatarsal, cuneiform, the hallux, or toe right over here, and the sesamoids underneath it. This being the weightbearing surface like this (Indicating.)

THE COURT: Aren't you supposed to be asking him questions?

MR. MC ANDREW: Well, Judge, I asked him to explain what a bunion is. He is giving us the anatomy of the foot.

THE COURT: We don't have lectures.

MR. MC ANDREW: Sorry?
THE COURT: We don't have lectures.
MR. MC ANDREW: I don't think it is at this juncture.

THE COURT: Well, I do. So why don't you ask him some questions and see if we can connect here.

MR. MC ANDREW: Absolutely.
Q Doctor, can you demonstrate for us the anatomy of the foot as seen on that lateral x-ray that you were just talking about, please?

A Okay. Well, that is again on a normal foot. Now, if I may get directly to the issue of the bunion deformity. The abnormality known as hallux valgus.

And so remembering what we have here and what we see on a normal foot, we then see the first metatarsal away from the midline of the foot, the cuneiform looking like that, the big toe being pulled toward the middle of the foot, the sesamoids in an abnormal position over here, the second metatarsal looking somewhat like that, with the second toe over here. So we have got a foot that has a big bump on the outside of the foot.

On a lateral view we don't see much pathology because most of the abnormalities, in bunion
deformity is bringing the toe towards the midline of the foot.

So this, to answer your question, Mr. McAndrew, is the appearance radiographically and the understanding of a bunion deformity.

Q And, Doctor, I think you can probably resume your seat. If you need to demonstrate with the jury again, you can just let us know.

A Okay.
Q Is it fair to say that over the course of your career you have had some experience with patients with bunions?

A Clearly it is quite a common problem that podiatrists deal with and probably one of the more common surgical procedures that we perform.

Q Have you done bunion surgeries in the past?
A Very many, yes, sir.
Q Can you approximate how many?
A Well, if I had to approximate I would say around three or four a week, so say 200 or so a year, times way too many, 35 years. So do the math. Yes, it is called a career, yes, sir.

Q And out of those surgeries do you -- you have done different types of bunionectomies, for instance, Lapidus bunionectomy, have you done those?

A There are lots of different types of bunionectomies that are performed, depending upon criteria. Certainly a percentage of the ones that $I$ have done over the years have been Lapidus procedures as well.

Q Can you approximate in any fashion the Lapidus procedures that you have done?

A If I had to approximate, 5, 10 percent. And, again, what do we say, 500 a year. 1500. So times five or 10 percent. 150, 200, would be a generalization, I guess, of the numbers.

Q Doctor, you mentioned in your last answer that there are a number of different procedures for bunionectomy. Can you tell us about some of those procedures, please?

A Can I go back to my drawings?
Q Of course.
MR. OGINSKI: Your Honor, I object since there is no other issue about other bunion surgery in this case.

THE COURT: Sustained.
MR. MC ANDREW: Judge, I think it should be permitted that the doctor explain his basis of knowledge and types of procedures.

THE COURT: It is not in this case.

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Everybody agreed on the Lapidus procedure.
That's what we have done.
Q Doctor, would you please explain to the jury then the Lapidus procedure itself, please?

A Absolutely, I would be happy to. Well, we are not going to talk about the other types of procedures done specifically. The Lapidus procedure recognizes that there is an increase in the angle between the first and the second metatarsal. That, in fact, there is lots of motion available in this bone. Individuals vary from one to the other in terms of the amount of motion that is available in this bone, depending on the ligamentous structure.

So using the other specimens that you have here, this one of course is held together with wire. The bone does not move as much as it might in this one that has elastic holding it together.

Well, the human body does not have either metal or elastic. People have different degrees of ligamentous laxity and different structure which is one of the determinants in helping us determine what sort of procedure to perform.

The Lapidus procedure is done by fusing this joint right here, the metatarsal cuneiform joint.

That gives more stability to the foot. Now, when the metatarsal cuneiform joint is fused in such a way to correct the bunion, what is done in an attempt to bring this first metatarsal back in line to where it should be ideally anatomically, a wedge of bone is removed and the cartilaginous surface between the two bones is removed, and these two sections -- excuse me, these two sections are removed in such a way that when this is moved back down over here, it would cause the metatarsal to swing back towards the first -- the second metatarsal and stay in that position.

Additionally when this procedure is performed it is important to make the cut in such a way that the metatarsal maintains its position against the ground. If we were to take bone out in such a way that it was parallel to the long axis of the first metatarsal, the amount of bone that is removed would shorten the metatarsal that amount. And in shortening it it would lift it up off of the ground that exact amount of bone that is removed.

And so when performing this procedure what is done is the cut is made in such a way that it is cut on two plains, one on the transverse plain, this one right here, so that -- this one right here -- in such a way that when this segment of bone is removed,
it swings the bone back towards the second metatarsal, and cut in such a way that it maintains the position of the first metatarsal against the ground. That it brings it down against the ground. Otherwise it lifts it up off of the ground. And lifting it up off of the ground can cause the body to bear weight specifically transferring weight onto the opposite side of the foot.

So when a cartilaginous surface is moved off the metatarsal and the cuts are made to plantarflex the first metatarsal, bring it down and to adduct, bring it towards the second metatarsal and a position is achieved as seen on the OR table, the two bony segments are held together and kept that way using some sort of fixation device; screw, plate, pin, whatever the surgeon chooses, in order to accomplish fusion at that point. That's the basis.

Now, again, once the bone is moved over this way some work is done at the first metatarsal, the phalangeal joint specifically to realign the soft tissue structures and allow the toe to stay in that position and bring it back where it belongs.

Q Doctor, why is a Lapidus procedure done verses any other procedure?

A Well, again, there are numerous procedures
that are textbooks of different types of different procedures that we perform. The major indication for Lapidus procedure is usually what is called a hypermobile foot where we find that the first metatarsal is not only in this abnormal position away from the midline of the foot, but it is not bearing weight the way that we would like it to and it is not stable, it is hypermobile. It has more mobility.

That hypermobility does not allow the first metatarsal to bear weight during gait when it should, so weight is transferred onto adjacent metatarsals, like the second, causing a lession or a callous under the second. When the thick skin on the bottom of the foot or of the hand is exposed to frequent intermittent pressure, as would happen when one bears weight excessively, the foot, or uses a hammer on the hand, the body tries to protect itself by building up hard skin known as callous. After a while the callous itself builds up so hard that it becomes painful because the skin loses elasticity and it feels like pebbles on the bottom of the foot. And that's a whole nother issue.

Hypermobile first is one of the direct indications to consider a Lapidus procedure for the purpose of stabilizing the first metatarsal, that
whole segment, which is called the first ray.
Q Excellent. Doctor, if you could retake your seat.

A Thank you.
Q At some point, Doctor, we contacted you, I believe it was November of 2007 to take a look at this case for us?

A Correct.
Q And we sent you some materials?
A You did, you sent me a significant amount of material to review.

Q Do you remember what materials it was that I sent you?

A Well, I believe that you had sent me certainly the records of Dr. Marzano relating to his care and treatment of Mrs. Flannery, the hospital records from the surgical procedure done at St. John's Hospital, Dr. Roberts' records from the Hospital of Special Surgery, some examinations or depositions, as you call them, of Mrs. Flannery and Dr. Marzano, and certainly some x-rays having to do with the care and treatment of Miss Flannery's foot.

Q Do you remember I also sent you the deposition of Mr. Flannery?

A Correct, I remember.

Q And the Hospital for Special Surgery records?

A Yes, I think that came in the original package, yes, sir.

Q I did send you the patient's primary care doctor's records, Doctor Caragine?

A I believe you did but I don't recall specifically.

Q Do you recollect another deposition transcript of Dr. Roberts, the subsequent treating surgeon? Do you remember that transcript as well?

A Do I remember that coming at a later date, yes.

Q And also, Doctor, more recently each day of Court -- did I e-mail to you a transcripts of the day's proceedings?

A Yes, you did, and you asked that I review those as well, and I have.

Q And you have reviewed all of the Court testimony of all of the witnesses so far?

A Well, I have reviewed everything you sent me. If that's complete then, yes, I have.

Q So that would include Dr. Marzano, the Plaintiffs, Dr. Joseph, and of course you already reviewed Dr. Roberts transcript as well?

A I did.
Q And, Doctor, is it fair to say that you were familiar with the standard of podiatric medicine and surgery as it existed back in 2000 and 2004 ?

A I believe I am, yes, sir.
Q And, Doctor, based upon your review of the records that are here in evidence and the trial testimony in this case, do you have an opinion within a reasonable degree of medical certainty whether the care and treatment provided to Mrs. Flannery by Dr. Marzano was within the standard of care?

A I certainly do have an opinion.
Q What is that opinion?
A My opinion is that it was within the standard of care with the care and treatment provided.

Q And, Doctor, do you have an opinion within a reasonable degree of medical certainty whether there was any negligent act or omission by Dr. Marzano that in any way contributed to the patient's injuries?

A I do have an opinion.
Q What is that opinion?
A That there was nothing that Dr. Marzano did or did not do that caused injury, specific injury to Mrs. Flannery.

Q And, Doctor, as mentioned, you have had the
opportunity to review the in-Court trial testimony of Dr. Joseph, correct?

A I did.
Q Okay. I'm going to ask you some questions about what the doctor had to say.

First Dr. Joseph at some point suggested that Dr. Marzano took too much bone during the March $25^{\text {th }}, 2005$ surgery. Do you agree with that?

A I disagree with that.
Q Can you tell the jury why you disagree with that?

A I specifically disagree with that because the amount of bone that is taken out is not a prescribed amount, it is not quarter of an inch, half inch, 2 inches, 10 percent, 30 percent. The amount is enough to assure that the correction is achieved. The correction being achieved means that the first metatarsal has been moved back into its position both on transverse plain: ie, closer to the second metatarsal as shown on the AP view that we reviewed there, as well as assuring that the cut is made in such a way that the bone maintains its weightbearing position on the ground. That, in fact, it does bear weight and so it is plantarflexed an appropriate amount.

The postoperative x-rays that I reviewed showed both on the AP and on the lateral that both of those goals had been achieved through the surgical procedure performed by Dr. Marzano.

Q Okay. And, Doctor, Doctor Joseph also indicated in her testimony that Dr. Marzano should not have removed the bone in one cut, that he should have feathered it in multiple cuts. Do you agree with that?

A I disagree with that. I mean, there are various techniques that people use in doing any sort of a -- certainly surgical procedure and other things. I mean, one needs to, for example, cut a board to fit into a certain place. Some people will cut it and place it right away, and some people will cut it long and bring it to the cite and make it shorter and shorter.

The bottom line is the bottom line. If it fits the way that it is supposed to fit, that's what one wants. If the technique used takes the bone out in one cut and it abducts and plantarflexes the way that it should, the desired result has been achieved. It can be done by feathering as well. That's certainly an acceptable technique. But certainly there is nothing wrong with doing it with one single
solitary cut.
Q Okay. And, Doctor, Doctor Joseph mentioned in her testimony that Doctor Marzano shortened the first metatarsal by 1 centimeter. Do you agree with that?

A I absolutely disagree with that statement, for a number of reasons. The operative report and the testimony all show that no bone was taken off of the metatarsal. The metatarsal was never shortened. All of the cartilaginous surface, which is not visible on x-ray, was removed from the first metatarsal. But all of the bone that was removed was removed from the cuneiform. That is shown on the x-ray.

Now, I can understand why if one were to measure only on the anterior/posterior view one might measure the lengths of the bone differently. But clearly there was no bone removed from the first metatarsal and so it could not have been shortened too much. It was not shortened at all.

Q Now, you said you could understand how you could have that impression on the AP view only. Can you explain what you mean by that?

A Sure.
Q And if you wanted to step down and if you want the x-rays or anything, just let us know.

A Let me see if $I$ can do that from here. First of all, once again, when we look at an x-ray we see spaces between the bones, and there are no spaces in our bodies anywhere. What we see is the area where there is cartilage. Cartilage does not stop x-rays from going through it. It is what is called radiolucent, so it leaves a black image on -- excuse me, a white image -- excuse me, black image on the plate.

The more cartilage you have the wider what we call the joint space on $x$-ray. The bone of course appears white, and that we are able to see. So the length of the bone is the same.

However, if we were to take the -- a shadow of this either by x-ray or just the sun, and project it against the screen, it would, if it were perpendicular to this pen, we would see an image that is exactly the length of this pen.

If I were to tilt it this way and have the source, the light source or the x-ray source come at this pen, the image that would be left on the $x$-ray or on the screen would be much smaller, it would be a dot. So it would appear much smaller.

Well, the length of the pen or the length of the metatarsal is still the same. But because the
position of it had changed purposefully by virtue of the surgical procedure that was done, the image appears different radiographically in terms of its length and its size. So since no bone was taken off, as documented by the op report, as testified to in Court, the length of the metatarsal could not and did not change. And if we look and measure the lateral x-ray we can see that, in fact, the length of the metatarsal is the same, even though it is in a different position.

Q And can you explain why it looks different on an AP view as opposed to the lateral, why it might appear shorter?

A Once again if we have two light sources checking this pen, one is coming across this way and the other is coming across this way. The exact length of the pen would still be seen. If I change the position of the pen and the light sources stay the same, the one that was this way, the AP, would make it look like a dot. But the one coming from this way would still show the entire length of the pen or the metatarsal.

And so in more appropriate terms, if this were the metatarsal, and the cartilaginous surface, which we can't see, was taken off, and the position
was changed from here. Well, I'll do it so that the jury can see it, from here, to down here. Well, the image that is projected down this way becomes less. But the length of the metatarsal, from the image projected this way, would still be the same, even though it is occupying a different position in space or in the foot.

Q I see. And, Doctor, Doctor Joseph mentioned that the positioning or the placement of that first metatarsal in the plantar, which means the going-down position, was inappropriate. Do you agree with that statement of Doctor Joseph?

A I disagree with that. Again, the plantar, means the bottom, that's the medical terminology, the bottom of the foot, the plantar aspect. And so the purpose of the procedure, the way in which a procedure should be performed is to plantarflex the metatarsal. Now, how much to plantarflex it, well, that is the art of the surgical procedure.

The flippant answer that we give residents is too much but not too much.

If it were plantarflexed too much, then it would bear too much weight. If, in fact -- if I can use that drawing for a moment.

Q Of course, Doctor. Yes.

A In performing this operation, if the cut were made, as an example like this, when this section over here were put over there, the bone would be pointed down, or plantarflexed too much, and so the bottom of this bone would bear more weight than we would like it to bear.

When that happens the body responds by building up a callous, or as even Doctor Joseph told you in certain cases, severe cases, you get ulceration as all of the blood is squeezed out of the tissues and the tissues necrose and die.

Not only did she not develop a lession underneath the first metatarsal, quite the contrary, the weightbearing was increased underneath the second to the point where the lession exacerbated underneath the second metatarsal. So, no, it was not plantarflexed too much.

Q And, Doctor, then we know from Dr. Roberts' records and his testimony that actually what he did was he took that first metatarsal from down and he dorsiflexed it, or brought it up some. Why would he do that?

MR. OGINSKI: Objection. THE COURT: Grounds?

MR. OGINSKI: Objection as to why

Dr. Roberts would do that particular thing. We have his testimony.

THE COURT: Well, you're saying that it is speculative because you cannot read into someone's mind, is that what you are saying? MR. OGINSKI: That's correct, Judge. THE COURT: Thank you. Yes, it clearly is not a good question. Sustained.

Q Well, Doctor, what would the purpose be subsequently of dorsiflexing a plantarflexed first metatarsal? In other words, bringing that metatarsal up?

A I'm going to sort of agree with Mr. Oginski. I think you better ask Dr. Roberts why he would do that and not me. But he did raise it up. That's clear in his operative report. THE COURT: Do you know what, side bar. (Side bar conference) THE COURT: You are not seriously going to get him to say that Dr. Roberts was negligent. MR. MC ANDREW: Judge, I was not -THE COURT: Well, he started to say that and I'm going to strike it, because that is totally unfair to the Plaintiff. MR. MC ANDREW: He was not going to say

Dr. Roberts was negligent.
THE COURT: He just did.
MR. OGINSKI: He started to.
THE COURT: He just did.
MR. MC ANDREW: I disagree.
THE COURT: Well, read it back. I don't know why he would do that. That's not what is proper. Something of that nature. Right? That's what he said.

MR. MC ANDREW: Well, let's read it back. THE COURT: Read it back.
(Requested testimony repeated.)
MR. MC ANDREW: I don't think he commented upon the characterization of the care of the doctor.

THE COURT: Well, look.
MR. MC ANDREW: Pardon me, Judge.
THE COURT: The tone of his voice was
dismissive of Dr. Roberts. And, two, my understanding of the problem was that her toe is dorsiflexed to some extent. That's her testimony. Right? MR. OGINSKI: Yes. THE COURT: So having the doctor raise it up more, that's what he said, he dorsiflexed the
foot. I don't know why he did that but he did that. So, that's direct problem. Now, I'm going to strike that testimony. Listen, between you and me, no one is alleging that he cut your client's -- cut the actual -- cut anything but the cuniform bone.

MR. MC ANDREW: Okay.
THE COURT: Whereas your doctor went on to this long song and dance about, well, you know, the toe was not cut and the bones were not cut, blah, blah, blah. Most of them were not, except for the cuneiform, and the cuneiform is attached to the big toe. Correct?

MR. MC ANDREW: Well, to the metatarsal.
THE COURT: Well, we are calling that the big toe. I mean, they are all connected, so he kind of mislead the jury, frankly.

MR. MC ANDREW: Well, in all fairness, Judge --

THE COURT: He said the metatarsal was not cut. Who says it was?

MR. MC ANDREW: Well, Judge, Doctor Joseph said the metatarsal was shortened by one centimeter. That's her exact testimony.

THE COURT: That's right. And do you know
why? Because according to her -MR. MC ANDREW: I don't know why she says anything.

THE COURT: Because according to her when you cut that cuneiform bone it kind of shrinks that bone and impacts on the metatarsal. That's why.

MR. MC ANDREW: Okay. But that's -- I'm confronting what she said to make it clear.

THE COURT: But nobody is saying that the metatarsal was cut, and that's kind of misleading. Nobody is saying that.

MR. MC ANDREW: I'm not saying that they did, but Doctor Joseph did say --

THE COURT: That's what he said.
MR. MC ANDREW: But Doctor Joseph said it was shortened by one centimeter and I had to clarify that to the jury.

THE COURT: You have to do it but that is not an argument here.

MR. MC ANDREW: Thank you.
THE COURT: But $I$ am saying $I$ think he is being -- I'm going to tell the jury and say that the metatarsal itself was cut. Nobody is --

MR. MC ANDREW: Judge, I don't think
that's necessary.
MR. OGINSKI: It is necessary.
MR. MC ANDREW: It is their interpretation of the evidence. I don't think it is necessary. They have heard what they heard. The doctor merely reiterated.

THE COURT: Why did he testify?
MR. MC ANDREW: Because she said it was shortened by one centimeter. It had to be clarified necessarily.

MR. OGINSKI: But you addressed it -- she said the metatarsal was removed. That's not what she said.

MR. MC ANDREW: He did not say that, she said metatarsal.

MR. OGINSKI: Your question --
MR. MC ANDREW: No, I did not. I specifically phrased it that it was shortened by one centimeter. That's what she said. I took it right out of the transcript of Doctor Joseph's deposition from Friday. I parroted it. I did not make anything up.

THE COURT: All of these bones are connected.

MR. MC ANDREW: Excuse me, I apologize. I
don't mean it that way. What I mean is I took that exact phraseology from Doctor Joseph's testimony to ask him about it, and that's all I did. I don't think there is any instruction warranted on that.

As far as what Dr. Roberts did or did not do, if you want to give an instruction on that or strike that question and answer, okay. I mean, I don't agree but I can understand that.

THE COURT: I'm going to say something. MR. MC ANDREW: I don't agree but I can understand it.

THE COURT: You have the objection, let's go.
(Proceedings resume in open Court.)
THE COURT: I just want to clarify
something because $I$ think it got a little
confusing here. So far in this case, in
Plaintiff's case, which is now done, there is no issue on the following grounds: One, there is no issue that Dr. Roberts, the subsequent doctor, was negligent of anything, all right. There is no issue.

And, two, of course you have to consider both expert's testimony, which is why I want to
clear this up. There is no issue that the Defendant actually cut into a metatarsal. I believe, and your memory will recall it, it had to do with another bone, which was the cuneiform bone.

So, in case you got mislead, I'm not saying that the doctor mislead you or anything, just in case you did. That's what we are concentrating on, all right. Thank you. MR. MC ANDREW: May I proceed, your Honor? THE COURT: Yes.

DIRECT EXAMINATION
CONTINUED BY MR. MC ANDREW:
Q Doctor Wolf, in Doctor Joseph's testimony she indicated it was improper for Doctor Marzano not to take into account the Plaintiff's long second and third metatarsal in advance of surgery, do you agree with that, preoperatively?

A Do I agree with what, sir?
Q That it was improper. Doctor Joseph
indicated in her testimony that Doctor Marzano did not take into account the long second metatarsal in the patient's foot preoperatively. Do you agree with that statement by Doctor Joseph?

A I disagree with that statement.

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Specifically that's one of the reasons to perform a Lapidus procedure as opposed to other procedures. Because in performing a Lapidus one is able to move the first metatarsal in two plains. Not only towards the second metatarsal to straighten it out, but to drop it down a bit and stabilize it in such a way that it accommodates for the weightbearing of the second metatarsal. The length of the metatarsal is only important because it determines how much bone -excuse me, how much weight that bone is bearing. I can show you that on this drawing, if I may. Can I?

Q Please do.
A As I showed you, if too much bone is taken out of the first ray anywhere, then it bears less weight. If anatomically because of what we were born with or for whatever other reason a bone is longer, then when that bone becomes longer, it assumes a position.
If we imagine the second metatarsal
beforehand being like this, we would expect that first and second are bearing weight and bearing weight equally.

If, however, either the second is too long or the first is hypermobile and not bearing weight, then weight is going to be borne on the second. If
the second is too long, not only is it longer, but it assumes a position lower down and increases the weightbearing.

So the purpose of doing a Lapidus was to compensate for the fact that the hypermobile first was causing a functional lengthening -- long second because it was not bearing weight appropriately. So the first was plantarflexed at the time of surgery, as it should have been.

Q Well, Doctor, Doctor Joseph showed us an x-ray, I believe it was the AP view, and she indicated that on that view the second metatarsal was longer. Can you explain that?

A Well, once again, that's why you take more than one view. Because certain views, one is able to evaluate things that we can't on the other. We have to take both views into account. The length of the second metatarsal is difficult to evaluate in lateral view because frequently it is hidden by the first. So what we do is we evaluate the parabola, or the shape of the first metatarsal -- the first metatarsal and the second metatarsal on an AP view by measuring in a certain prescribed fashion. And from that we are able to deduce the relative length, okay.

Q Can you explain to the jury what -- how you
do that? Or can you demonstrate for them how do you that?

A I absolutely can. What we do, and the best way to do it is from an x-ray. But looking at it even from this right here.

Q We have a shadow box and an x-ray if you like.

A Well, we will do that too. But let me do it here first and then we will do it on the $x$-ray if you like. What we do is we bisect the first metatarsal, and we bisect the second metatarsal, and the point at which they cross is considered the apex. We then take a compass, or anything, and run it from the axis here and swing it across and see where it comes in contact with the second metatarsal.

On any anatomical view of a foot, we will always look at it in this direction, and see that the second on this view is longer than the first, when we look at it on an AP view, regardless if it is my model or different model. However, when you put the foot on the ground, because of the angle of declination of the metatarsal, they are supposed to be bearing weight at the same time. And during the gait cycle when we walk, the bones are constructed in such a way that when we walk the weight is shifted across the foot in
such a way that it goes across the parabola.
So looking at the x-rays the first
metatarsal was not short, the second was not long. They were the appropriate length. However, because of the first ray being hypermobile and because of the first bone being swung out further than it should, it was not bearing weight in the way that it was supposed to bear weight. And because of that weight was born on the second. And so when Mrs. Flannery first saw Doctor Marzano at that point she had a lession underneath the second metatarsal.

Q I see. Doctor, would it be instructive for the jury to show that on the shadow box?

A I would be happy to do it. MR. MC ANDREW: Judge, for the record, this is the March 10th, 2005 preoperative AP, anterior/posterior view of the patient's right foot.

THE COURT: Do you have an evidence number on that, counsel?

MR. MC ANDREW: I believe it is Number 2 in evidence. We marked the x-rays Number 2 if $I$ am not mistaken.

Q Doctor, would you step down here. I think the Judge would want you on this side. Is that right?

A So we can see here that, in fact, the --
Q Can everyone see that?
A That the lines bisecting the first and bisecting the second have been made to the point where they do intersect. That is considered the apex from which we measure.

Of course if we look, just eyeball what this looks like, the second has a, what appears to be a protrusion further out. As it would on any model. But if we were to take this as a compass and make the apex, where my finger is right here, and go from the first metatarsal to the second metatarsal, it is difficult to see because it is a dark film. But they in fact lineup the way that they should lineup.

The first metatarsal is neither long nor short. The second metatarsal is neither long nor short. It is appropriate anatomically. The problem was that the first was not bearing the weight that it should have been bearing because of its hypermobility and positioning.

Q Thank you, Doctor. Doctor, Doctor Marzano's records contain a consent form that highlights that there is a potential for additional or further surgery postoperatively. And Doctor Marzano came in and testified that if a
complication should arise it may be necessary to undertake an osteotomy of the second and third metatarsals, down the road.

Do you agree with that approach?
A The approach of putting that on the consent form or the approach of doing an osteotomy? What are you asking?

Q Both of those, Doctor.
A Well, certainly it is appropriate to let a patient know that potential for complications always exist and document in the form of the consent form.

Additionally, yes, shortening the second or third if, in fact, they are bearing too much weight postoperatively is an option in terms of correcting a problem that may occur.

Sometimes we just need to shorten the second, sometimes we need to shorten the second and third. I would imagine there are times when you have to do the second, third and fourth. And of course there are other ways in which the issues could be dealt with as well. So, those are appropriate methods of dealing with a problem if postoperatively, for whatever reason, the second and/or the third and/or the fourth are bearing more weight than they should be.

Q And, Doctor, it was the Plaintiff's expert, Doctor Joseph's testimony, that if intraoperatively, back on March $25^{\text {th }}$, 2005, if Doctor Marzano did not shorten the second and third intraoperatively that he should have done a done a bone graft. Do you agree with that?

A Bone graft where?
Q I presume of the first metatarsal?
A Well, again, we deal with things being relevant. One too short or one too long. Well, the options that you outlined are appropriate.

If, in fact, there was a problem, one could either shorten the second or lengthen the first. Well, you can't lengthen it by using Crazy Glue, you have to put some sort of graft there to incorporate the space that would be left because you always want bone-to-bone contact. So using a bone graft would be appropriate if the position were not correct, shortening the second might be an appropriate way of dealing with it.

But the x-rays that I saw postoperatively
show that the position postoperatively was appropriate, and so I don't agree that that should have been done during the course of the procedure.

Q Doctor, why is it that shortening of the
second and third metatarsal should not be done during a Lapidus procedure?

A It is not part and parcel of the procedure. The Lapidus procedure was originally designed by Lapidus in such a way that you can reposition the first to make it more stable by fusing it in an appropriate position.

There is no reason to go to normal health bones and joints and operate on those to try and stabilize the foot. It can all be done through the one area that one is working on in the Lapidus procedure. It is not indicated to perform operations on normal healthy second and third metatarsals under usual circumstances during a performance of a Lapidus bunionectomy.

Q And, Doctor, the Plaintiff's expert indicated that not taking intraoperative $x$-rays or x-rays immediately following the surgery was improper. Do you agree with that?

A Certainly there is nothing wrong with taking $x$-rays intraoperatively. It is a routine event. Especially now with the use of technology. MR. OGINSKI: Objection as to what is going on now. This is back five years, Judge. THE WITNESS: Even back five years ago
with -- the technology was available. That is something that certainly could have been done. But x-rays give us the ability to see things that otherwise we would not be able to see. If someone is presumed to have a problem with a bone fracture, malposition, or whatever, an x-ray is taken so that you can see what that bone looks like. But when one is doing surgical procedure where the bone is exposed and one can actually see what the bone looks like and where it is, whether the fusion is accomplished, where your screws are, and you're actually able to visualize it, $x$-rays are somewhat redundant, there is nothing wrong with them. Don't get me wrong, but it is not absolutely necessary that it must be done during the surgical procedure.

Q Doctor, before testifying did you have a chance to look at the photographs that have been admitted here into evidence?

A I did.
Q Can you describe what was seen on those photographs?

A Yes. I quite frankly see that -- I was
surprised --

THE COURT: What exhibit are they?
THE WITNESS: This is Plaintiff's
Exhibit 2C. Plaintiff's exhibit --
THE COURT: They are 10A, B, C.
THE WITNESS: Okay. And this one as well
is 10D.
THE COURT: 10A, B, C, D. Four
photographs.
In reading the material that you have been sending me over the last couple days where it said that the toe was up at 90 degrees, I was rather surprised. I did not remember seeing that on the x-rays. 90 degrees of course is perpendicular to the first metatarsal shaft.

Certainly the big toe is raised up off of the ground here. I would -- if I had to estimate, 10 to 20 degrees. Certainly not 90 degrees. Which, of course, can be caused by scarring or fibrosis or other known complications of a surgical procedure.

Q And those scarring, fibrosis, adhesions from the surgery, is that something that you can predict?

A Certainly not. I mean, two different patients can have incisions made and I have different types of scars. Actually the same patient can have
more than one incision made. Scarring is something that is somewhat of an unpredictable event. We do things to try to prevent scaring and adhesions from occurring, but in spite of that it can occur. And we know that it did occur in Mrs. Flannery as evidenced by the very least the subsequent records which show that there was scarring and fibrosis intraoperatively in that area during the second operation performed by Dr. Roberts.

Q And, Doctor, the Plaintiff's expert stated that the complications that occurred to this patient were not a known risk to the surgery. Do you agree with that?

A I disagree. MR. OGINSKI: Objection. Objection, that is not what she said. THE COURT: Read it back, please. (Requested testimony repeated.) THE COURT: I don't recall her saying that.

MR. MC ANDREW: I have page 450 to page 451 of the transcript, your Honor. THE COURT: Show it to Plaintiff's counsel. MR. MC ANDREW: I'll withdraw the question
for purposes of saving time. I think I can rephrase to it make everyone happy.

THE COURT: Okay.
Q Doctor, what happened to this patient postoperatively, do you agree that that is a known complication or risk of the procedure that Doctor Marzano performed on the patient?

A Yes, I do.
Q What is your opinion on that?
A My opinion is that one of the risks of a bunionectomy, including certainly this bunionectomy, was that scarring and adhesions and fibrosis causing the toe to lift up off of the ground. That in spite of the efforts to get -- the ability of the foot to bear weight perfectly, weight can be born imperfectly. The mechanics of the foot can cause types of discomforts underneath the second or third metatarsals that of course Mrs. Flannery did suffer from.

Q Doctor, do you agree that in every surgery there is no guarantee of an outcome?

A That's the general rule, yes.
Q And, Doctor, do you agree that in every surgery a surgeon must exercise his discretion and his judgment?

A Once again certainly surgeons should

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exercise good discretion and judgment in the performance of an operation of course.

Q Based upon what you have reviewed the evidence and the testimony, Doctor Marzano exercise his best judgment and discretion in caring for this patient?

MR. OGINSKI: Objection.
THE COURT: Read it back.
(Requested testimony repeated.)
THE COURT: Sustained.
MR. MC ANDREW: Those are all of the questions that I have for now. Thank you, Doctor.

THE WITNESS: Thank you.
THE COURT: Let's take a break.
Fifteen minutes.
(Recess taken.)
COURT OFFICER: Jury entering.
(Jury entering courtroom.)
THE COURT: You may sit down. I remind
you, Doctor, that you're still under oath.
Understood and agreed?
THE WITNESS: Yes, ma'am.
THE COURT: I believe now that we will
hear from the Plaintiff's counsel, Mr. Oginski,
with regard to cross.
MR. OGINSKI: Thank you, your Honor.

## CROSS-EXAMINATION

CONDUCTED BY MR. OGINSKI:
Q Good morning, Doctor.
A Good morning, sir.
Q Your goal in coming into Court here and testify and giving your opinion is to be as objective as possible, correct.

A I try to, yes, sir.
Q And the purpose of being objective is so that you can give your opinion about the information and records that you reviewed regardless of who hired you, correct?

A I try to, yes, sir.
Q Your purpose as an expert giving testimony today is designed to give a fair opinion about the interpretation of those records regardless of who it may help and regardless of who it may hurt, correct?

A I will try to, yes, sir.
Q Anything less would be unfair, true?
A Agreed.
Q And, Doctor, coming in here and giving your opinion, you would agree, for lack of a better analogy, that if there is a foul ball, you're going to
call a foul ball, correct?
A Yes, sir.
Q And, now, when you evaluate a particular case, you're relying on the records that are provided to you, correct?

A To some degree, yes, sir.
Q You are also relying on the deposition testimony that has gone on in a particular case, true?

A To some degree, yes, sir.
Q And, Doctor, and you also rely on $x$-rays as part of your evaluation, correct?

A Also to some degree, yes, sir.
Q And, Doctor, if the records are inaccurate then the opinions upon which you may be basing that opinion may be faulty, true?

A Possibly.
Q If the deposition testimony is inaccurate or incorrect and you base that opinion on the deposition testimony, would you agree that your opinion may be faulty?

A Not necessarily. But in general I would have to agree with that.

Q And, Doctor, if you are missing information and you come to an opinion about the treatment that's rendered in a particular case, you may be basing your
opinion on incomplete information, correct?
A Certainly the more information $I$ have to evaluate the better off $I$ would be, yes, sir.

Q And that if you had rendered an opinion without having all of the necessary information that you need to come to an answer, come to an opinion, then your opinion may not be entirely accurate, fair?

A That might be correct, yes, sir.
Q Now, when you were first contacted, I believe it was November of 2007.

A Correct.
Q Somebody from, on behalf of Doctor Marzano, an attorney, contacted you, correct?

A Correct.
Q And they said, Doctor Wolf, would you be interested in reviewing this case, in substance?

A Something to that effect, correct.
Q Now, it was not simply that you got a package in the mail with records and a cover letter saying, Doctor, please evaluate it and let us know what you think?

A Pretty much that's what it was. I mean, there was a phone call before that asking me if $I$ had any specific --

Q Well, hang on, Doctor. I'm going to go
through.
A My apologies.
Q I want to know, did a phone call precipitate the sending of the records, or did somebody just send you the records unasked and unsolicited?

A I really don't recall specifically, but chances are there was a phone call beforehand.

Q And tell us who it was that you spoke to during that first encounter with the attorney?

A As I say, I really don't recall if there was a phone call back in 2007. I do remember receiving a package from Mr. Levine.

Q I'm going to ask you about that.
A Sorry.
Q As a result of whatever communication you had with the attorney, you knew that that attorney was calling you on behalf of a podiatrist who was being sued, correct?

A Was calling me because he represented a podiatrist who was being sued. Not exactly on behalf of. Because as a said I was asked to be objective in my evaluation of the material.

Q And it would be correct to say that you asked, Who are you representing, the injured patient or the doctor, correct?

A Among other questions, yes.
Q Right. But just to understand as a baseline who do you represent, Plaintiff or Defendant, fair?

A Of course.
Q Okay. Now, at some point you were sent some records to review, correct?

A Yes, sir.
Q And together with those records there was a cover letter, correct?

A Correct.
Q Do you have the cover letter with you?
A I do not.
Q Where is that cover letter?
A Sitting on my desk. And I specifically asked if $I$ should bring material with me, and Mr. McAndrew said, No, don't bring anything, everything you need is in Court.

Q In that cover letter the attorney indicated what type of case it was, correct?

A No, I recall seeing it just yesterday, the cover letter.

Q Hang on, I'm going to ask you, Doctor. Would it be too much trouble to have somebody from your office fax that cover letter here to the Court?

A Probably because it is probably in the trunk
of my car which is parked somewhere near my office and the keys are in my pocket.

Q You just told us that that letter was sitting on your desk?

A My apologies, it is somewhere between here and my office. As I think about it, it is probably in my car.

Q Did that letter give you information about the substance of the claims in this case?

A It did not.
Q Did that letter indicate the substance of the defense claims in this case?

A It did not.
Q Was it a one-page or two-page letter?
A It was a half-page letter.
Q Who wrote that letter?
A A gentlemen by the name of Jason Levine is his name.

Q And he was the attorney representing Doctor Marzano at the time, correct?

A I don't know. He was an attorney who worked for the firm that was representing, I guess, Doctor Marzano, yes, sir.

Q And what specific records were provided to you during that first set of materials -- I'm going to
rephrase the question.
When you got that first package of materials were you given in that packet the Plaintiff's deposition testimony?

A I believe I was.
Q Were you given Doctor Marzano's medical records?

A I believe I was.
Q Were you given Doctor Marzano's deposition testimony?

A I don't recall.
Q And in that cover letter did it itemize and list what records were included?

A It did not.
Q You know, Doctor, that if you were to bring in any particular writings that you had in your possession I would be able to look at it and then ask you questions about that, correct?

A I'm sure you could.
Q You know that to be the case, right?
A I do, which is why I asked Mr. McAndrew what he wanted me to bring with me today.

Q And Mr. McAndrew told you don't bring that letter, correct?

A Absolutely told me to bring nothing
whatsoever other than the right foot model. Quote, Everything else you need is in Court.

Q In addition to Doctor Marzano's records were you also provided with copies of Doctor Marzano's x-rays?

A At some point I was. I don't remember if it came with the original packet or later on.

Q I'm only asking this first packet of material.

A I don't recall specifically.
Q Did it indicate in that letter, that cover letter, whether those x-rays came with that first packet of material?

A I don't recall specifically.
Q Did you receive Dr. Roberts' records with that first packet of material?

A I believe so, but once again I don't recall exactly if it came with the first packet of material.

Q Did you receive Dr. Roberts' video deposition transcript during that first packet of material?

A Absolutely not.
Q Did you receive Dr. Roberts x-rays of Annmarie Flannery with that first set of materials?

A Probably not, but $I$ don't recall
specifically.
Q Now, Doctor, when you received these
materials to review, how big were they?
A I would say it was a looseleaf binder of two and a half, 3-inch variety that was pretty full.

Q You said two or 3 inches?
A Something like that, yes, sir.
Q Where are those records?
A They are with the cover letter. That's all together.

Q And which is where, in your office?
A Unavailable. It is probably in the trunk of my car as I think about it.

Q Your car?
A I reviewed it in my office. It is probably in the trunk of my car.

Q Your car here or in the office in Manhattan?
A There.
Q Now, when you go through and review these records, Doctor, am I correct that in addition to this particular case that you review other cases as well, you have told us that?

A Absolutely.
Q And give us an idea of how many cases you review on any given year?

A Well, it varies from year to year.
Q Approximately?
A Certainly more than five and certainly less than 12. So, certainly less than one a month.

Q And, Doctor, in order to keep track of everything that is going on in the various cases that you review, would it be fair to say that you will make notes about whatever it is that you are reviewing?

A Usually I do not. I try not to.
Q You know, when you are going through these records in this case that you received, is it not correct that you make notes on the side, in the margins, for things that you find to be significant?

A It is not correct. I did not.
Q Do you ever make notes on a separate piece of paper so that you can always remember what you had read?

A I certainly did not in this case. I don't remember if $I$ have on other cases or not. But in this case I did not.

Q You know, don't you, Doctor, that if you make notes in that record or anything that is sent to you or on a separate piece of paper, that I have the ability to look at those notes and question you about them, correct?

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A If you tell me so, I believe that, sure.
Q Doctor, this is not the first time you're here in Court. You know that to be true, don't you?

A Of course.
Q So you know that any notations that you make in any record that you review for this case, that $I$ have the ability to ask you questions about that, correct?

A You certainly have that right, absolutely.
Q Without you bringing those records here into Court I have no way to actually verify or confirm that you made no notations, correct?

A You will just have to believe me but that's specifically why I asked Mr. McAndrew what he wanted me to bring.

Q But that is true, correct, Doctor?
A That's absolutely true.
Q You know in the three to four cases in which you have testified for a year over, I believe you said, 35 years you have been testifying?

A Well, I have not been testifying for 35 years. But, yes, the very many cases I have reviewed.

Q Have you testified in over a hundred cases in the course of your career?

A Probably not, but it would not surprise me
if it approached that. I really have not done the math.

Q You know that if you bring your records into Court the attorney has an absolutely right to look at those records and to question you about that, correct?

A I do, which is specifically, again, why I asked Mr. McAndrew what he wanted me to bring.

Q And did Mr. McAndrew say, and tell you, that if you bring those records here into Court I have an opportunity to now question you about those records?

A No, he specifically said, No, don't bring anything with you but that foot. Quote, Everything else you need will be there in Court for you. Okay.

Q Now, when you finished reviewing that first set of records --

A Yes.
Q -- did you find that there was information that you needed in order to come to opinions about whether the treatment was appropriate that you did not have with that first set of materials?

A Well, after the first set of materials I came to a preliminary decision but reserved my final decision as further information became available, correct.

Q I'm only asking you, Doctor, when you

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received the first packet of material you were missing information that you as a podiatrist evaluating a case from a medical/legal standpoint wanted to know, correct?

A At that point I had enough to come to some conclusions. My final conclusions I did not come to at the very first time I had those records, correct.

Q Now, by the way, when you reviewed those materials did you review them all in one sitting, or did you come back to them every once in a while when you had some time?

A Probably did it all in one sitting.
Q How long did that take you?
A Several hours. Two, three, four.
Q How many?
A Somewhere between two and four.
Q Do you have your bill that you sent to the attorney's office for the time that you spent reviewing?

A No. And, once again, Mr. Oginski, I have nothing with me here at all other than what you see on my body, my person, and the right foot right there.

Q Where is the bill, Doctor?
A Once again, if anywhere it would be with
that file. It is not here with me.

Q You said you charged \$350 an hour, correct?
A That's correct.
Q For your time to review. That's
approximately $\$ 1,400$ if you spent four hours reviewing just for the first part?

A Probably correct.
Q And in your review in preparation for coming here today did you see the bill that you sent to the attorney for the initial review?

A I don't recall seeing it, no.
Q By the way, Doctor, after you reviewed those first set of records did you make a report about your opinions and thoughts concerning the records that you looked at?

A I did not and I was not asked to.
Q I'm only asking you if you did.
A I did not.
Q You know, don't you, Doctor, that if you generate a report for the attorney that I have every right to look at that report and then ask you questions about that report, correct?

A I did not generate a report. Yes, I do know that.

Q And, Doctor, after completing your review in the first set of records did you contact an attorney
on behalf -- who represented Doctor Marzano to talk about your thoughts and your opinions?

A I certainly did.
Q Did you have that conversation by telephone?
A I believe the first conversation was by telephone, yes.

Q That was with Mr. Levine?
A I don't recall specifically, but I think it was, yes, sir.

Q When did that conversation take place?
A Some time probably in early 2008.
Q And do you have a notation, Doctor, about what you discussed?

A I do not.
Q Do you have any report or notes about your conversation with that attorney?

A I do not.
Q And, again, you know if you had made notes $I$ would be able to see them, correct?

A You absolutely have the right and the ability to see them, yes.

Q And, Doctor, did Doctor Marzano's attorney tell you specifically, do not render a written report after your review?

A I think he did, but I don't recall
specifically.
Q And during that conversation with the attorney did you ask for any additional records so that you could finalize your opinions?

A I don't recall. But $I$ certainly --
Q Hang on then, $I$ will rephrase it.
A Thank you.
Q Do you have any notation, any record of anything that you asked the attorney for in order to allow you to generate a final opinion about this case?

A No, I do not.
Q Now, you told us that you received additional records at some point afterwards, correct?

A Correct.
Q When was the next time, the very next time that you received any record for this case after the beginning of January of 2008?

A Yes, I can't tell you specifically what I did receive when. I do remember what was in the original packet, as I told you. I did tell you that all of the material that $I$ have reviewed over the course of time. I do remember that at a later date specifically Doctor -- a transcript of Dr. Roberts' deposition came. I can't tell you specifically when that was.

Q When the second set of information came to you, was there a cover letter?

A I don't recall.
Q They did not just send you a packet of records without knowing what it was about, right?

A I don't recall. I mean, it is quite possible there was a cover letter, but I cannot visualize it nor would I recall what was in it if there was one.

Q Where is that cover letter?
A Probably with all of the other materials that we have been talking about here.

Q In that cover letter, Doctor, did the attorney indicate whatever claims were being made in this case?

A Once again, I don't recall.
Q Did the attorney indicate what defenses where being claimed in this case?

A I have no recollection if there was a letter, so $I$ certainly could not tell you what, if anything, was included in that letter.

Q By the way, Doctor, in the first set of records that you received did you see copies of these photographs?

A I did not.

Q In the second set of records did you see copies of these photographs?

A I did not.
Q Did you receive the Hospital for Special Surgery records?

A In its entirety, I don't believe I did, no.
Q You did review, you did see Dr. Roberts' records, correct?

A I saw Dr. Roberts records including his operative report from the Hospital for Special Surgery, yes, sir.

Q Now, when you got the second set of material, whatever those records were, how much time had elapsed from when you had last reviewed the first set of materials? Was it a week, a month, a year, or something else?

A Well, once again, Mr. Oginski, I can't tell you specifically when the second wave did come through, so I can't tell you how much time elapsed.

Q Can you approximate for me, Doctor?
A Well, again, I first received this in November of 2007. And I probably received that more than a year ago. I would be guessing, Mr. Oginski. I'm not going to do that. I can tell you what $I$ have seen up-to-date, but $I$ can't tell you.

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Q Hang on. So, now, when you received the second set of materials after having a period of time between when you first reviewed the case and now when you received these other materials, did you have to reread that entire stack of records initially to refresh your memory about what you had read?

A Not in its entirety, no.
Q Did you have notes to look at, to refresh your memory about what you thought was significant regarding what you read, Doctor?

A I did not.
Q Did you make any notations about this second batch of materials that you reviewed?

A I did not.
Q By the way, did you review the surveillance video of Annmarie Flannery taken in this case?

A I did not review that.
Q Did you know that Annmarie Flannery was videotaped secretly by someone on behalf of the defense?

A I do know that there was a videotape taken by a surveillance individual of Mrs. Flannery, yes, sir.

Q And, Doctor, in coming to court and giving your opinions about the treatment rendered, would it

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be important for you to know what problems Annmarie Flannery has today as far as your testimony about this particular case?

A Well, to some degree, but not necessarily, no.

Q Would it matter to you, Doctor, if
Annmarie Flannery told you that she could not walk? You would want to be able to see evidence of that, to some extent, correct?

A Well, evidence does not necessarily mean a videotape.

Q I'm sorry, I'm going to rephrase the question.

Would it be important to you, Doctor, to know whether Annmarie Flannery walks with a limp?

A Not necessarily at this point, no.
Q Would it be important for you to know what complaints Annmarie Flannery has with regard to her current condition?

A Her current condition, not necessarily, no.
Q Would it be important for you to know what problems she experiences on a day-to-day basis to determine from your point of view whether those complaints are related to anything that may or may not have been done wrong?

A I'm sorry, could you repeat that?
Q Sure. Would it be important for you to know as a witness coming in here to tell us your opinion, Doctor, what problems Annmarie Flannery has today and how those complaints affect her on a day-to-day basis?

A Not necessarily.
Q Would it be important for you to know the problems she has today to determine whether they are in any way related to the treatment that she is claiming was done improperly in this case?

A Not necessarily.
Q You're saying that in some instances it would help, correct?

A No. I mean, you asked me specifically about this case and, what I'm saying --

Q That's all right, Doctor, I'll ask a different question.

A Okay.
Q Now, did you review Dr. Roberts' video testimony?

A See the actual video?
Q Yes.
A I read the transcript of it, I did not see the actual videotape.

Q And you had read Annmarie Flannery's
deposition transcript?
A I did.
Q And, Doctor, in addition to reading the first -- I'm sorry, the first set of materials and the second, did you at some point later get another batch of materials to review?

A I don't believe I got a batch. They might have been --

Q Or whatever it was?
A Once again, I don't remember exactly what came when. All $I$ can do is tell you the beginning, what I got in 2007 and what I reviewed up to this very moment. The exact times and dates as to when they came, I can't be any more helpful, Mr. Oginski. I don't remember specifically when they came.

Q When did you first see the x-rays taken by Dr. Roberts from the Hospital for Special Surgery?

A I don't recall.
Q Have you seen those?
A Absolutely.
Q In preparation for coming here, Doctor, did you rereview all of the materials?

A I absolutely did.
Q And during the course of reviewing all of these materials, did you make notes?

A I did not make any notes at any time, Mr. Oginski, regarding any of the material that I reviewed.

Q Now, other than getting the, what is called daily copy of the transcripts from what was going on in this case over the last two weeks, when was the last time you had any contact with an attorney on behalf of Doctor Marzano?

A Last night.
Q No, no, before that, Doctor, before?
A I'm sorry.
Q I'll rephrase it. After you had finished reviewing all of the records that were provided to you?

A Okay.
Q When was that?
A I don't recall. Because I don't recall exactly when $I$ did get them.

Q Was it in 2008?
A Once again, Mr. Oginski, I don't recall. I think you're asking me the last time that $I$ met with an attorney before $I$ got the daily transcripts of the Court testimony. I would say within the last two to three months I probably met with Mr. McAndrew.

Q That was the question that was coming too.

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But I'm asking after you completed your review you had some other communication with the attorney for Doctor Marzano, correct?

A Sure.
Q And you told them the whole purpose of that communication was to tell them what your thoughts and opinions were at that time, correct?

A Absolutely correct.
Q And, Doctor, who did you speak to?
A I believe it was Mr. McAndrew.
Q And during that conversation did you ask Mr. McAndrew whether you should prepare a written report about your final opinions?

A No, I was not asked for one and I did not ask him if I should. None was ever prepared.

Q You know again, Doctor, that if you had I would be able to look at it?

A Absolutely.
Q Did you give Mr. McAndrew any notes that you had created about your review?

A I could not give him any notes since I never took any, Mr. Oginski.

Q How long did your conversation last?
A I think I met with him for an hour or so.
Q Where was that?

A My office.
Q When was that?
A Several months ago.
Q That was the first time that you had met Mr. McAndrew? I'm sorry, in regard to this case?

A I believe I had spoken with him on the telephone. But that was the first time that he and I actually sat face-to-face and reviewed the issues having to do with this case, yes, sir.

Q And how much time did you spend reviewing the second batch of materials?

A There was no second batch of materials. Once again, materials had come in. As I said I had refreshed my recollection from the first materials I received, reviewed the other materials and sat down to meet Mr. McAndrew. In preparation for that meeting I probably spent another hour or two. Probably spent an hour or two with him that date. And, yes, I was reimbursed for all of that time $I$ spent with him.

Q Do you have the bill?
A I do not.
Q Where is the bill. Doctor, I'm not asking facetiously.

A But you are because I told you that I have nothing else with me, Mr. Oginski. I can't produce
something that I told you several times I do not have with me. All I have with me are the clothes and the right foot that $I$ was asked to bring. And, yes, I will yell at Mr. McAndrew for putting me through this later on, but he specifically told me don't bring anything.

Q Doctor, hang on. How do you know Mr. McAndrew?

A I had an opportunity to review a case for him several years ago.

Q I don't want you to go into details.
A I won't.
Q Did Mr. McAndrew provide you with a list of questions that he was going to ask you?

A No, he did not. He did not provide me with a list. We did review.

Q I'm only asking if he provided you with a list?

A He did not.
Q Doctor, the cases that you review, you said you review cases on behalf of doctors who are being sued, correct, podiatrists?

A I do.
Q And you have on occasion reviewed cases on behalf of injured patients?

A I have.
Q You told us that you testify many more times on behalf of the defense, correct?

A Absolutely true.
Q In this year, doctor how many times have you testified on behalf of an injured patient?

A This is my second appearance in Court this year. This is the first time I'm here on behalf of a doctor who is being sued.

Q And last year, Doctor, how many times had you testified on behalf of an injured patient?

A Probably one or two.
Q And the year before, on behalf of an injured patient?

A Once again, probably one or two. But I cannot tell you specifically.

Q Now, Doctor, would it be fair to say that in the cases that you are asked to review on behalf of the podiatrist, that if you feel that the case is not defensible you have no problem telling the attorney that fact, correct?

A Clearly.
Q Now, Doctor, you told us that you have published in the past, correct?

A I have.

Q And do any of your publications concern treatment of Lapidus bunionectomies, specifically that particular bunionectomy?

A I do believe that one of them did deal with bunionectomies. I cannot remember if Lapidus was included in that publication or not.

Q Did that publication deal with the complications and treatment of Lapidus bunionectomy, Doctor?

A I don't recall specifically, but probably not.

Q And, now, you treat patients in your office, correct?

A I do.
Q You observe them when they come into your office?

A I do.
Q You give them medication when you perform surgery on them, correct?

A When appropriate, yes, sir.
Q You recommend medical treatment, right?
A When appropriate, yes, sir.
Q You perform surgery on them?
A When appropriate, yes, I do.
Q And in this case you never treated Annmarie,

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correct?
A Certainly not.
Q Now, Doctor, let's talk about records.
Would you agree that a podiatrist who treats patients, that it is important for you as a treating podiatrist to keep accurate records?

A It is important to keep records. The definition of accurate is one that is debatable or debated. But, yes, it is important to keep records and they have to have some degree of accuracy.

Q Would you agree, Doctor, that it is important to have complete records?

A Once again, the definition of complete is a difficult one for me to deal with. But it is important to have records that of a patient's care and treatment, yes, sir.

Q Would you agree that it is important to have detailed records?

A Again, detail is a difficult adjective to put in here. But it is important to keep records, I absolutely agree with that.

Q Doctor, in the course of your duties as an educational director of the residency program, you teach podiatry residents what is good practice, correct?

A That's one of the things that $I$ do, yes, sure.

Q And as part of your teaching duties you teach these doctors in training how to take accurate records, correct?

A I teach them how to keep records as part of their training, yes.

Q I'm asking about accurate records?
A Well, accurate is a very difficult term to define. What one may --

Q I'll rephrase it then.
A Fine.
Q You teach them to create records that are complete, correct?

A Again, complete is a very difficult term to define.

Q You teach them to create records that are detailed, surely you teach them that?

A Again, there is levels of detail, and I teach them to keep records that are appropriate for the pathology which is being evaluated that are useful records.

Q You would agree, Doctor, that it is good podiatric practice to keep accurate records, correct?

A It is important to keep records. I don't
know what your definition of "accurate" is. That varies from individual to individual. They have to be truthful, there is no question about that, and I would certainly agree with that. But what you mean by "accurate," I think you will have to define that point, Mr. Oginski.

Q If the records are inaccurate, Doctor, that would represent careless recordkeeping, would it not?

A It can, certainly.
Q If the records are incomplete that also would represent careless records, recordkeeping, true?

A Again it depends on what the incompleteness is, but it certainly might.

Q If the records are simply wrong that again would represent careless recordkeeping, true?

A It might, yes.
Q Now, Doctor, in your office, in your own personal practice, if the records are inaccurate, that would be inexcusable to you as a practicing podiatrist, right?

A If they are not untruthful.
Q I'm not talking about truthful.
A Well then please define "accurate" for me.
Q If you did not keep complete records, Doctor, where the significant findings and history and
other relevant information is recorded in your record, you would consider that to be inexcusable recordkeeping for a podiatrist, true?

A I can't answer that question the way that you have asked me, Mr. Oginski.

Q I'll rephrase it.
A Please.
Q If a podiatrist failed to keep accurate records that reflected what treatment he provided, that to you would be inexcusable, true?

A It might or might not. Depends on the situation. Again you keep using the word accurate, Mr. Oginski, and I don't know what you define as accurate.

Q Well, Doctor, if a podiatrist indicates that he performed an Austin bunionectomy when, in fact, he never did, you would consider that to be careless recordkeeping, true?

MR. MC ANDREW: Objection, your Honor.
THE COURT: Overruled.
THE WITNESS: And sloppy, yes, I do agree.
Q Okay. And you personally feel that that would be inexcusable if that occurred in your office, true?

A I don't think inexcusable is appropriate. I
would not be happy to learn that that had occurred. But there are certain things that are excusable.

Q If the residents that you teach, if you learn that those residents are putting information in the notes about the patients that they are treating and they are indicating that the procedure being performed or had been performed was not the procedure that they had actually performed, you would have a problem with that, correct?

A That would not make me happy and I would have a problem with that, yes.

Q In fact, you would take that resident to task most likely, true?

A It depends on the resident. Some of them are bigger than $I$ am, so.

Q Well, you would certainly bring it to their attention to make sure that it did not happen again, correct?

A Of course, we try to correct errors in the records at all times, absolutely.

Q Doctor, the purpose of keeping accurate records has a dual purpose, true?

A The purpose of keeping records has many purposes, that's correct.

Q Let me go through some of them and ask you
if you agree.
A Sure.
Q One of the primary purposes of keeping accurate records is that you want to be able to know what you did and what the patient's problems were at any given date, correct?

A To some degree.
Q So that at any later time down the road when the patient returned you can simply look back to those records to see what problems the patient had, what your exam was, what your findings were and what you did for the patient, true?

A To some degree that is true.
Q And in addition any other health care professional who takes a look at those records would automatically know right away what complaints the patient had and what you had found and done for the patient, true?

A Well, one needs to look at the record as a whole, that's correct.

Q Doctor, if those records are inaccurate then any health care professional who now looks at those records might not get a true understanding of exactly what was done at a given point in time, true?

A Depends on the case. That might be true,
that might not be true, Mr. Oginski.
Q In other words, if all that the health care provider had to look at was simply records, and the records themselves were inaccurate, it might give the person who was looking at those records a view of what was done, but it might be an incorrect view, correct?

A Well, all of the -- if all of the records had the same inaccuracy certainly it would skew the observer's decision making and ability to discern what had occurred, that's correct.

Q Now, you coming into Court as a podiatrist and giving us testimony about what your opinions are, you would agree that it is important for any podiatrist, especially a board certified podiatrist, to know and make a note in the record about which foot they are treating, true?

A Of course.
Q And you as a podiatrist have three options when treating a patient's feet, correct?

A Two. Right and left.
Q And bilateral, both?
A Very good. You're right. That's correct.
Q So we have right, left and treating both feet.

A All right.

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Q That's something that you want to know about, which foot is involved?

A Every so often I do have an amputee. But I don't want to be flippant. But, yes, it is important to know which foot is being taken care of by Mr. Oginski. I have made many mistakes over my years.

Q Hang on, Doctor, I'm not asking about mistakes. I'm asking specifically about this case.

A Okay.
Q I know you have testified before and I know you have treated lots of patients. If you can I just want to focus on this case. Because you know that there are certain issues in this case, right?

A Correct.
Q You know that one of the issues in this case is that it is our claim that too much bone or cartilage was removed from the first metatarsal?

A From the first metatarsal? THE COURT: No. No.

Q Let me rephrase that, that was incorrect. MR. OGINSKI: Sorry, Judge, my apologies. THE COURT: Cuneiform. THE WITNESS: Very good. THE COURT: That's the only bone we are talking about now.

THE WITNESS: Very good.
Q You know that that is one of the issues in this case, correct?

A I do.
Q You also know that one of the issues in this case is that the manner in which the first metatarsal was positioned was improper?

A That's one of the claims, correct.
Q Okay. And you also know that one of the claims in this case is that the patient's second and third metatarsals were not shortened at or about the time of the first Lapidus surgery, correct?

A Yes, I understand that is one of your claims, sir.

Q You also understand that the claim about lack of informed consent is out, that has nothing to do with this case any more, right?

A So I am told, yes, sir.
Q All right. Now, Doctor, the failure to correctly identify which foot was involved would make it impossible for you as a reviewing podiatrist to give an accurate opinion in this case, true?

A If it were consistent throughout all the records and I was mislead, yes, that's absolutely true.

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Q Now, and also the failure to correctly
identify which surgical procedure was performed would also mean that your opinion might be skewed and incorrect?

A If I were consistently given the wrong information and I did not have the correct knowledge of what procedure was done, yes, that would be true.

Q And would you agree that the failure to correctly note whether a patient is weightbearing or not would have some impact on your opinion in this case?

A It depends at what point and it depends for what reason.

Q In other words, Doctor, if the record indicates that the patient was not weightbearing 11 weeks after the surgery then you would want to know why isn't the patient weightbearing at that point, correct?

A I might, or might not, depending on the issue I'm trying to evaluate.

Q And if there was nothing in the records to answer that question about why the patient is not weightbearing, that might alter your opinion about whether the treatment was appropriate in this particular case, true?

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A That depends what I'm trying to evaluate, Mr. Oginski. It depends what issue that relates to.

Q You do recognize, Doctor, that there are certain points within Doctor Marzano's records where he has indicated that the patient's weightbearing -was not weightbearing when, in fact, she was, you're aware of that, right?

A I am aware of that.
Q And did you learn that from the records themselves? I'm sorry, I'm going to rephrase that.

Did you learn that information from Doctor Marzano's office record itself?

A From the records themselves, just that one piece, no.

Q Did you learn from Doctor Marzano's record that this patient underwent an Austin bunionectomy?

A I learned from his record that there are certain times when he wrote that an Austin was performed, which at first gave me pause, but realized that that was incorrect.

Q What was it within the note -- I'm sorry. Let's focus on Doctor Marzano's records. Not his operative report, just the records.

A But the op report are in the records.
Q Hang on. I'm going to get to that. As you
are initially reviewing this patient's records and you see that the Austin bunionectomy is the procedure that he performed of -- that that is what he performed, are you asking yourself, What are they talking about here? Is this an Austin bunionectomy that was performed?

A There did come a point, when going through the records sequentially, knowing that a Lapidus was planned and knowing that a Lapidus was done, that I saw Austin, I said, Well, what the hell. What, what is this, and then did realize that it was incorrect.

Q Okay. Did you receive a copy of the claims that we have made, known as a Bill of Particulars?

A I believe I did.
Q And you saw in that document that we were claiming that the Lapidus procedure was not properly done, correct?

A Correct.
Q But judging from the records itself, from Doctor Marzano's records itself, there was no way for you to definitively determine what actual procedure he performed, true?

A Untrue.
Q Putting aside his operative report from St. John's Hospital, Doctor.

A I can't put that aside. It was part of his
record.
Q Hang on. I'm going to get that.
THE COURT: Well, wait. Wait. Wait. You have to follow the question of the witness. If you can't answer the question legitimately, tell him.

THE WITNESS: Yes, your Honor.
THE COURT: We can't decide what you're going to consider and what you're not going to consider. He is the examiner. THE WITNESS: Okay, your Honor, I will try and do that.

MR. OGINSKI: May I proceed, Judge?
THE COURT: Yes.
Q Doctor, when you were going through just
Doctor Marzano's records separate from the operative report, were you able to tell what surgical procedure was done in this case?

A Yes, I was.
Q Are there indications that this patient had an Austin bunionectomy according to Doctor Marzano's office record, correct?

A There are places in the record where it does say Austin bunionectomy, that's correct.

Q And you know at some later point in time he
does refer to a Lapidus procedure, correct?
A Some later points and some earlier points, correct.

Q And you know from the operative report that he actually performed a Lapidus procedure, true?

A Yes, sir.
Q The failure by Doctor Marzano to keep accurate records about which procedure he performed on a repetitive basis, you would not consider that to be good recordkeeping, would you?

A As I said, there is some degree of sloppiness in there, that's correct.

Q That would be a departure from good recordkeeping, would it not? MR. MC ANDREW: Objection, your Honor. THE COURT: Sustained. I don't think there is a cause of action.

Q Doctor, if the patient was walking and there are notes in the doctor's records that says that the patient was not walking, is that something that you would want to know postoperatively?

MR. MC ANDREW: Objection, asked and answered.

MR. OGINSKI: I asked about weightbearing.
THE COURT: I'll allow it.

THE WITNESS: Once again, it depends on what I'm trying to evaluate. It would be helpful or not useful at all.

Q If a patient -- by the way, following a
Lapidus procedure there is a period of healing time, recuperation, correct?

A Correct.
Q At some point after that the cast is removed and now they are told they can begin to weight bear, true?

A That's correct.
Q And in order to begin weightbearing I want to place more weight on that foot to see how it does, correct?

A I'm sorry.
Q I'll rephrase it.
After the cast is off and the patient now begins to put some weight on their foot, that is done for a specific purpose, true?

A I don't understand your question.
Q You want the patient to begin weightbearing after the bone has healed, correct?

A At some point certain.
Q You one of the reasons is to allow the bone to strength then?

A No. One of the reasons is to get them back into their normal life.

Q Okay. And if the patient was not walking in a timely fashion after surgery, you, as a podiatrist, would want to know why?

A It depends on the timing. It depends on many other factors, but certainly that's taken into consideration.

Q And you, as a podiatrist, if the patient was not walking, you would ask the patient, why aren't you walking, what is the problem?

A That's correct.
Q And good practice tells you you make a note of that in the chart to indicate why the patient is not walking at that time, correct?

A If there is some issue that it is important for, of course.

Q You did not see any such notes in this particular case, true?

A Such notes about what, sir?
Q About whether Annmarie Flannery was walking or not walking postoperatively?

A I don't recall specifically.
Q Now, in addition to never having treated Annmarie Flannery, you did not perform any

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    medical/legal examination of her foot as part of this
    litigation process, correct?
    A Absolutely correct, I did not.
Q In fact, you have never seen or touched her feet as far as your evaluation goes, correct?
A I never have, that's correct.
Q Now, you told us that you reviewed Doctor Marzano's records, correct?
A I did.
Q Sorry, I meant to say Dr. Matthew Roberts' records.
A I did review Dr. Roberts' records, yes, sir.
Q You know that Dr. Roberts is a -- you read his notes. I'm sorry, you read his testimony that indicated he graduated from medical school, from the University of Texas?
A That's my understanding.
Q And that he was also the valedictorian of his medical school class?
A Congratulations.
Q You read that, right?
A I did.
Q You read that he had done an orthopedic surgery residency at the Hospital for Special Surgery, correct?
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A I don't remember where his residency was, but I know that he is at the Hospital for Special Surgery now.

Q Now, I want you to assume, Doctor, that Dr. Roberts did his surgical residency at the Hospital for Special Surgery, and that -- are you aware that this was a five-year surgical residency program?

A Orthopedic surgical residencies are, yes, sir.

Q And you're also aware that he did a fellowship, which is an additional postgraduate year of training in foot and angle surgery, you're aware of that?

A Yes, I am.
Q And you are aware that Dr. Roberts is board certified in the field of orthopedic surgery, correct?

A That's correct.
Q Now, after you, Doctor, graduated from podiatry school, you told us that you went to California for some surgical training, correct?

A Two years, yes, sir.
Q I was just going to ask you how long it was. Thank you.

A You're welcome.
Q After completing those two years, did you do

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any additional postgraduate training?
A Over the years I have done significant postgraduate training.

Q No, no, I apologize. I was wrong. My question was not right. As a part of a residency training program, did you do any additional training beyond those two years?

A Two year residency forefoot and ankle only, that's correct.

Q Now, when Doctor -- when you read Dr. Roberts' deposition -- sorry, this pre-trial deposition transcript, that was videotaped, you saw that he had examined Annmarie Flannery in January of 2006, correct?

A I believe so, yes.
Q And based upon his examination he makes certain findings about the condition of her foot at that time, correct?

A He did make certain findings, yes, sir.
Q And one of the findings that he needed was that the metatarsal was in a too far down position. You are aware of that, true?

A I believe he said it was plantarflexed, correct.

Q And not in the position that you would

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normally see that. Is that your understanding of what he said?

A No, I don't remember him saying not in the position that you would normally find it.

Q Let me read to you from his transcript, Doctor, that's in evidence. The video is in evidence.

MR. MC ANDREW: If I may get the transcript, your Honor. Got it, thank you.

Q Before I actually get to the transcript, I am going to read to you from his record, Doctor, for the January $23^{\text {rd, }} 2006$ exam, and that's Plaintiff's 5 in evidence. Under assessment and plan it says, she also has pain in the second and third metatarsal region. You don't dispute that complaint of pain, do you?

A Certainly not.
Q He continues by saying, which is related to that being too long and the first ray is relatively shortened at this point through the tarsometatarsal joint.

Do you take issue with that finding?
A To some degree, yes.
Q You don't agree with it?
A No. Did you not say that?
Q I'll rephrase it, I'm sorry.

You did not exam Annmarie Flannery at any
time?
A Absolutely not.
Q Okay. And you don't dispute or have any issue with Dr. Roberts' credentials as being a qualified orthopedist, being able to make accurate observations, do you?

A I have no opinion on that. THE COURT: Counsel. MR. MC ANDREW: Objection, your Honor. THE COURT: We had a side bar on this subject. MR. OGINSKI: Okay. THE COURT: It is like it never happened. MR. OGINSKI: Okay.

Q Now, doctor --
THE COURT: Move on, please.
Q Doctor, page two, I'm reading from Dr. Roberts' deposition.

THE COURT: Are you going to move on or not?

MR. OGINSKI: Yes, your Honor. This is his observation, nothing else. THE COURT: Let's take a side bar. (Side bar conference.)

THE COURT: What the hell are you doing?
What are you doing?
MR. OGINSKI: This is his observation about the exam.

THE COURT: I covered this. You have a real slick operator there. You don't think he can outwit you on this? Of course he can. He is going to make him negligent and he will do it within the first two questions you ask.

MR. MC ANDREW: I think he is opening the door here, Judge.

THE COURT: He is. You wanted to have a setoff, you're going to get one.

MR. OGINSKI: Here is the observation that the metatarsal was too far down and it healed in that position.

I am going to ask him whether he agrees with that statement or not.

THE COURT: He will say no.
MR. OGINSKI: Fine, then $I$ move on.
MR. MC ANDREW: But, Judge, this was the whole point. You would not let me talk about it.

MR. OGINSKI: It has nothing to do with it.

THE COURT: You're not asking these questions. You're not asking these questions. That's the end of that story. Nothing about Dr. Roberts.
(Proceedings resume in open Court.) BY MR. OGINSKI:

Q Doctor Wolf, when you reviewed Doctor Marzano's deposition testimony for the purposes of evaluating this case, did you believe everything that Doctor Marzano said in his deposition?

A Everything? That's a broad statement. I mean, probably not everything.

Q When you read Annmarie Flannery's deposition testimony in preparation for evaluating this case, did you believe everything in her deposition?

A I am the true New York cynic, Mr. Oginski. I don't believe anything, everything, anybody says.

Q Now, you know, you know, Doctor, that in December of 2005, the last visit that

Annmarie Flannery saw Doctor Marzano, you know that that was the very first time that there is any indication that Doctor Marzano recommended another surgery for her to address her problems, true?

A I don't recall specifically, but that's possible.

Q I want you to assume -- no, I don't want you to assume. I want you to turn to Doctor Marzano's records, please, that are in evidence. Plaintiff's 1 for identification. I'm sorry, Plaintiff's 1 in evidence.

And specifically the visit for December $15^{\text {th }}, 2005$, and it is a two-page note, Doctor. You have seen that note before, true?

A I have.
Q And in that note it indicates for the very first time that Doctor Marzano now proposed a corrective surgery for the second and third metatarsal, true?

A That was what was proposed here for the very first time, correct.

Q Okay. And the patient had made complaints. Let me go back. On the second page under Impression and Assessment, three lines down, it says, Resultant shortening of the first ray has lead to failure of hallux purchase during ambulation.

Do you see that?
A I do.
Q That is something that is known to occur with this Lapidus procedure, true?

A Among the other things that it says here,
yes.
Q And that is something that a podiatrist should tell a patient about during their discussion before surgery, true?

MR. MC ANDREW: Objection, your Honor.
THE COURT: Overruled.
THE WITNESS: I'm sorry, what was that, sir? Repeat that.

Q As a result of performing a Lapidus surgery they can expect to have the first metatarsal or the first ray to be shortened?

A That it may be, yes.
Q May?
A May.
Q Are you saying, Doctor, that when you perform a Lapidus surgery, that first metatarsal will never reduce in size?

A In certain cases when a Lapidus procedure, Lapidus are performed, there is no shortening of the first ray, correct.

Q In this case there is a shortening of the first ray, true?

A Correct.
Q Okay. Now, it also says on the third line from the bottom of that paragraph, shortening of the
first ray has lead to an increase in right second and third metatarsal head, plantar pressures, and resultant plantar hyperkeratosis. Did I read that right?

A You did read it correctly.
Q So here he is indicating that the cause, the first ray has been shortened, the patient now has pressure under the second and third metatarsals?

A Among the other things that you did not read here, yes, he does say that.

Q I'm only talking about this particular sentence, Doctor.

A Okay.
Q That's what that sentence refers to?
A Taken out of context, yes, that is correct.
Q Let's go up, please, to the middle of the top paragraph where it says "x-ray shows."

Do you see that?
A I do.
Q X-ray shows relative shortening of the first metatarsal. Do you see that?

A I do.
Q Okay. And that will occur with a Lapidus surgery, true?

A It can.

Q In this case it did. It did, correct?
A Not necessarily, no.
THE COURT: No, no, no. If you -- there are three answers to these questions. Yes, no, or I don't know. This is what he is looking for.

THE WITNESS: Okay. So if you would be so kind as to...

THE COURT: The question will be repeated. Please ask the question again.

Q In this case, this patient had a shortening of the first metatarsal, true?

A No.
Q Doctor Marzano's note says, X-ray shows relative shortening of the first metatarsal.

Did I not read that correctly, Doctor?
A That you read correctly. It does say
"relative shortening of the first metatarsal."
THE COURT: There is no question before you.

Q Now, you looked at the patient's postoperative x-ray from March $25^{\text {th }}$, 2005, correct?

A I did.
Q And, Doctor, this is the enlargement of that x-ray. Correct?

A May I see it? Yes, this is an x-ray that is --

THE COURT: Yes, it is an x-ray. Next question.

Q Can you see the first metatarsal in that $x-r a y ?$

A I can.

Q And can you determine from this x-ray whether the positioning was proper and the placement was proper regarding the first metatarsal based upon this postoperative $x$-ray?

A On this $x$-ray, no.
Q You also saw the June 1st postoperative x-ray taken three months later or two and a half months later, correct?

A I did.

Q And this is a lateral view, a side view?

A It is.

Q And you were able to visualize the first metatarsal in that $x$-ray, true?

A I did and I am, yes, sir.

Q And the first metatarsal in that $x$-ray, Doctor, in your opinion, is that the appropriate positioning for that metatarsal?

A Yes, it is.

Q That is pointing in a downward fashion, correct?

A Correct.
Q And as a result, the big toe or the first metatarsal is sticking up, correct?

A This x-ray, all of the, in this x-ray, all of the toes are sticking up, correct.

THE COURT: No, the answer is yes or no. Yes?

THE WITNESS: Yes.
Q Thank you.
Now, you know from reading the patient's preoperative records that she had a long second and third metatarsal relative to a short first metatarsal, correct?

A I don't know that, no.
Q You don't know that this patient's records indicate that the second and third metatarsals were long to begin with?

A I'm sorry, I don't know what you are referring to. I don't know where in the record you are referring to, sir.

Q Before Annmarie Flannery had her surgery, she had $x$-rays taken, correct?

A Correct.

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Q And those preoperative x-rays indicate that she had long second and third metatarsals, true?

A I can't answer that question.
Q Those x-rays indicate that as far as the first metatarsal, that she had a long second and third metatarsal relative to the first metatarsal, correct?

A Incorrect.
Q Now, Doctor, you know that before Annmarie had surgery that when she first appeared in Doctor Marzano's office she had a callous under her second metatarsal, correct?

A Correct.
Q That's something significant among the other things for you as a podiatrist to know prior to planning surgical treatment, correct?

A Among other things, yes, it is.
Q And one of the reasons why it is important to know that she had this existing condition is because you want to be able to treat the patient, in addition to the bunion itself, you know that if you remove too much bone the forces of her foot are now going to cascade to the other parts of her foot. True?

A Not necessarily. Not true.
Q You told us earlier, in response to

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Mr. McAndrew, that if you remove too much bone, and you drew it up here, that what will happen is the forces will now shift to the other parts of the foot. True?

A They can if the amount of bone taken is inappropriately taken. That's correct.

Q Now, in order to determine whether or not the amount of bone was properly removed, you have to do a number of things to evaluate that, true?

A I don't know what you are referring to, Mr. Oginski.

Q Well, you told us that if the inappropriate amount of bone was removed, the patient would now experience this cascade where the forces would now move over to the other parts of the foot, correct?

A That's not what $I$ said, sir.
Q My question, Doctor, is in order for you to determine how much bone is taken out, you have to look at a number of things, correct?

A At a number of things, yes, sir.
Q You have to look at the preoperative x-rays, right?

A Correct.
Q You have to look at the postoperative $x$-rays?

A I do.
Q You have to look at any intraoperative x-rays taken during surgery, if any were taken, correct?

A Not necessarily.
Q It would be helpful to see what the positioning was at the time that surgery is going on, would it not?

A It would not because -- do you want to know why or should I give a yes or no?

Q That's fine, Doctor. It would also be important for you to know from pathology how much bone was actually removed and sent off to pathology to be evaluated, correct?

A Not necessarily.
Q In some instances it would be, correct?
A Possibly.
Q And you know, Doctor, that when you remove bone or cartilage from the patient, during the course of surgery, you will then send that specimen -- you call that a specimen, right?

A It is.
Q To pathology so that they can look at it under the microscope, right?

A Not necessarily.

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Q They look at it and give you a visual of it, right?

A That's called a gross evaluation, yes. Many times it is a gross evaluation. Just a gross evaluation is what is asked for.

Q And there are times when the doctor, who is in the pathology department, known as the pathologist, will actually look under the microscope to see what is there, right?

A There are times, yes, sir.
Q And it is the function of a pathologist, who gets that specimen, to record whatever it is that they have received, true?

A They should, yes, sir.
Q And as part of what they receive, they indicate the size, the dimensions of that particular specimen, true?

A Of all of the specimens they receive, correct.

Q And that -- and in order for you to determine how much bone or cartilage was removed, you can turn to the pathology report to see what the dimensions of this specimen was, correct?

A Incorrect.

Q Is there anything in this patient's records
from the Pathology Department of St. John's Hospital that indicate the dimensions of the amount of either bone or cartilage that was removed during this surgical procedure on March $25^{\text {th }}, 2005 ?$

A There is. The pathology report does identify four fragments of bone, and it gives the dimensions of each fragment, but does not say where those fragments come from.

Q Wouldn't that be important for you to know in order to determine whether or not the appropriate amount of bone was removed?

A It is not.
Q Wouldn't it be helpful for you to know that information, Doctor?

A It is not. And I would be happy to tell you why if would you like to know.

Q For the purposes of coming into Court here and telling us your opinions about whether too much bone or cartilage was removed, it would be useful to know precisely how much was actually removed, correct?

A Incorrect.
Q Now, I want you to assume, Doctor, that -let me go back. When you perform a Lapidus surgery, you know at the outset that there is a chance that that first ray is going to be shortened, true?

A Correct.
Q And is it appropriate for you as a podiatrist to know that before, as far as planning purposes, true?

A Correct.
Q And if you fail to recognize that during the course of the planning process, that would be a departure from good and accepted care, true?

A It could be.
Q Would it be?
A Not necessarily, but it could be.

Q And, Doctor, if the podiatrist who is planning this procedure did not address the likelihood or the effect that reducing this first metatarsal would have on the second or third metatarsals, in that instance, you would agree that that would be a departure from good and accepted care, true?

A Not necessarily. It could be, but not necessarily.

Q Now, I want you to assume the following facts. I want you to assume that Annmarie Flannery had a severe bunion on her right foot. I also want you to assume that she had what has been described as an unstable or a hypermobile foot. I also want you to assume that her foot, the right foot, was painful
because of the bunion, and that she had a callous underneath the second metatarsal.

Assuming those facts to be true, if you know at the beginning of planning a Lapidus surgery, you would agree, Doctor, that it would be important for the doctor who is going to do the surgery to plan for the possibility that the pressure will now shift, the weight forces will now shift to the second and third metatarsals?

A I absolutely do agree with that.
Q And the failure to consider that would be a departure from good and accepted care, true?

A If it were not considered, yes, I would agree with that.

Q And, now, if you also know at the outset, using those same facts, assuming those same facts to be true, if you also know that there is a chance that this patient's callous under her second metatarsal is not going to be alleviated as a result of this Lapidus procedure, the podiatrist has an obligation to talk to the patient about options that are available to her at that time, true?

A I'm sorry, no, you lost me there, Mr. Oginski.

Q Okay. I want you to assume that

Annmarie Flannery has this severe bunion, she has got pain, she has a callous under her second toe. You know that performing a Lapidus procedure, that there is a chance and you told us this, that it can affect the second and third metatarsals, correct?

A Correct.
Q And that you have to plan for that. Now, if you know at the outset that there is a chance that this surgery is not going to correct the problem regarding that second callous and possibly affect the third metatarsal, it would be appropriate at that point to talk with the patient about what other surgical options are available to her that might be addressed during the first surgery. True?

A That's the decision as to which procedure or procedures to perform, which is why a Lapidus is chosen over others given the scenario that you're giving me. So, yes, it is important to discuss procedures, absolutely.

Q I am only talking now about the Lapidus procedure. We know what condition she had?

A Correct.
Q We know that she had this problem under her second metatarsal. We know and we have heard that this surgery may not solve the problem under her

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second metatarsal, correct? Second metatarsal,
correct?
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A May not, but it may, correct.
Q And if you know at the very outset that there is a chance that this surgery will not address and fix that particular problem, then it will be incumbent upon the podiatrist to talk to the patient, say, Do you know what, this, we have to do something else during this Lapidus surgery that will address this. Would you agree?

THE COURT: Yes or no?
THE WITNESS: No.
THE COURT: He says no.
Q Now, there has been much discussion in this case about the consent form. You know, don't you, Doctor, that when a patient comes into your office for treatment and you recommend a surgery, when they are at the hospital, the time that they get the hospital consent form is either at the admitting office when they are filling out papers work, true?

A It depends on the hospital, depends on the case, depends on a number of things. But, yes, that's certainly in the immediate preoperative period.

Q So it can come when they are going to be admitted and they are filling out the payment and
insurance information, true?
A It can.
Q And a nurse or somebody at the desk gives them a bunch of papers to sign, correct?

A Usually not.
Q Another option is that it can be done in the holding area right outside of the operating room, true?

A It can.
Q And you know that when the patient is given those papers to sign, they are simply told sign this so that you can go ahead and have the surgery, correct?

MR. MC ANDREW: Objection. THE WITNESS: No, that's not the way that
it usually works.
Q Doctor, when a patient goes to the hospital and they are now waiting to have the surgery done, and if they are outside in the waiting area, the holding area, and an anesthesiologist comes to talk to them, after whatever talk they have, the anesthesiologist gives the paper to the patient and says sign, they can't do the surgery without this, true?

A For the anesthesia consent, correct.
Q And you know that when a patient goes to a
podiatrist and the podiatrist talks to the patient that you are obligated to have a patient sign a consent form, true?

A At some point.
Q And the purpose of having the patient sign a consent form is so that it gives you permission to go ahead and cut into them during the course of this proposed surgery, true?

A I don't know if that's legally why it is done.

THE COURT: Well, your answer is yes or no or you don't know. THE WITNESS: I can't answer that.

Q You know, Doctor, that you can't have surgery unless the patient actually signs that piece of paper, true?

A You can do surgery. It is not appropriate to do surgery.

THE COURT: The answer is yes or no?
THE WITNESS: I can't answer like that.
Q You also know that the majority of patients who are given those forms at the hospital to sign, the hospital consent forms, the majority of them do not read those forms, true?

MR. MC ANDREW: Objection, your Honor.

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THE COURT: If he knows.
Q You know that in your career? THE COURT: Yes, no, I don't know? THE WITNESS: I don't know.

Q You know that when the patient is in the podiatrist's office and the podiatrist talks to them about what they are going to do, you know that it is typically not the actual podiatrist who hands them the form to sign, but rather the receptionist or a nurse?

A Not true at all.
Q You know that the majority of patients, Doctor, don't read the consent form, true?

A No, I don't know that at all.
Q You know that because a lot of patients don't read the consent form it is incumbent upon the doctor to talk to the patient about that, true?

A Nothing to do with the form. I do agree that it is incumbent with the doctor to discuss the surgical procedure with the patient, absolutely.

Q Now, Doctor, as part of the consent form and the risks associated with that, you would agree that one of the risks that, of undergoing surgery is that the patient could die, true?

A Of course.
Q And you know that since that is the most

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severe or horrendous outcome of any type of surgery,
that if you told that risk to every single patient who
you were proposing surgery for, you know that nobody
would ever agree to have surgery, true?
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A No, not true. I mean even in the face of that, certainly --

Q I'll rephrase it. Patients who are undergoing elective surgery, if you told them that there was a risk that they could die, the majority of patients are not going to accept that possible risk, true?

A I can't agree or disagree with that. I don't know what the majority of patients would or would not do, and it depends on the elective surgical procedure that you're talking about.

Q We are talking about surgery to the feet, elective surgery to the feet?

A Correct.
Q If the patient is told that this is a risk of the surgery, you know that most people will not go ahead with the surgery, true?

A It is not a usual and customary risk.
THE COURT: I don't know where we are going with this. I do know that we are going to lunch.

MR. OGINSKI: Judge, I have a few more questions and I am done.

THE COURT: And he has redirect.

MR. MC ANDREW: I'll be short.
MR. OGINSKI: Can I finish up?
THE COURT: Proceed.
Q Doctor, this consent form that we have been talking about does not give the podiatrist a license to do whatever they please during surgery?

A No form does, correct.
Q And the consent form does not give the doctor a license to improperly perform that surgery, true?

A Nothing gives a doctor a license to improperly perform a procedure.

Q And you know, don't you, Doctor, that that particular form, that Doctor Marzano's form was generated in the same way that he generated his other medical records, do you understand that?

A I don't know that specifically, no.
Q I want you to assume that this medical record, that this consent form is a template and that Doctor Marzano fills in certain parts of it. Okay. Assuming that to be true, you know from reviewing Doctor Marzano's records that his overall
recordkeeping is sloppy, true?
A To some degree.
Q And you don't know whether everything that he talked about is contained in this note, true?

A I was not there. I certainly do not know.
Q And you are not rendering any opinion about the information contained here, correct, because you were not there?

A Correct.
MR. OGINSKI: I have nothing further at this time, Judge.

THE COURT: Thank you.
MR. MC ANDREW: Judge, I have about five minutes. Is that okay?

THE COURT: Sure.
REDIRECT EXAMINATION

CONDUCTED BY MR. MC ANDREW:
Q Good afternoon, Doctor.
A Good morning, Mr. McAndrew.
Q Just a few questions to clarify.
A Of course.
Q Mr. Oginski went over with you a fact pattern a few moments ago about a severe bunion, pain, hypermobile ray, et cetera. And he ultimately got to the point that with Lapidus in this case, or in a case

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such as this, that it is incumbent upon the doctor to tell the patient that they have to do something else with the second and third metatarsal. Do you remember the question he asked you?

A I think that's where he was going to, yes, sir.

Q Why didn't you agree with Mr. Oginski? Can you tell the jury?

A Sure, I disagreed with that this morning. The purpose of doing a Lapidus as opposed to many other types of procedure is because the Lapidus gives you the ability to plantarflex the first metatarsal in an attempt to have it bear more weight, to take the pressure off of the second and third, as well as lengthening or stabilizing the first ray so that if you do have a hypermobile first ray and if more weight had been thrown onto the second, for whatever reason, you do have an opportunity, by performance of the Lapidus, that that will go away.

Q So in this case was the second and third shortening on March $25^{\text {th }}$, 2005, was that necessary for this patient?

A Not only it was not necessary, it would have been inappropriate.

Q Thank you, Doctor.

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And then there was some discussion going back a little farther about the pathology report and determining the amount of bone that was removed and you asked Mr. Oginski if you could explain that.

A Sure.
Q At this time we will give you that opportunity.

A Thank you. The pathology report, as I remember, because I did look for it, gives a gross evaluation. By the way, the pathology report, after it says four pieces submitted, it then says no specimen submitted, so the validity of that report is questionable to me. However, it says four pieces submitted. It does not say where they are. One of the pieces certainly was the bump along the medial eminence that is in Doctor Marzano's report that he took off. That is a three-centimeter piece in length. It does not say the width. It does not identify which piece comes from where. So the four pieces are certainly consistent with the surgical procedures that were done, but don't identify which piece came from where. And if you have that report I would be happy to give it to you and tell you.

Q Sure. It is in the St. John's records here. If I may.

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THE COURT: Well, in efforts of moving this case along.

MR. MC ANDREW: I'll find it, Judge.
THE COURT: Either you find it.
MR. MC ANDREW: I did find it. The pressure was on and I found it.

THE COURT: Okay.
Q Do you have that report, doctor?
A I do have it. There is no microscopic evaluation of the bone, nor should there be. This is not cancerous bones. This is just sent to pathology for verification that bone was removed, and basically the description, the gross description says that the specimen was received informally, labeled as bunion right foot first metatarsal, consists of four pieces of white and pink hard bone tissue fragments measuring from 0.5 to 3 centimeters. No specimen submitted.

Made no sense to me, what that means, but let's presume that the four pieces that were sent were from . 5 to 3 centimeters. That certainly is consistent with the types of pieces of bone that should and were removed during a performance of a Lapidus bunionectomy.

Q Does that report delineate the dimensions of each and every piece of bone or does did give the
general spectrum?
A Again, it says four pieces measuring from . 5
to 3 centimeters. It does not say which is from where, nor the exact dimensions of any one piece.

Q And then, Doctor, Mr. Oginski was asking you about using films to determine how much bone was removed, and he talked about pre-op, post-op, and you agreed those were important in making that determination. But then he asked you about intraoperative films and were those important, and you said not necessarily. And it seemed like you wanted to explain, if you would?

A No, but as I said this morning, the films that would be taken intraoperatively are non-weightbearing and the angulation is rather difficult. And when we are looking at an x-ray we are looking at the presentation of a shadow and they can be difficult to evaluate.

The x-rays taken intraoperatively are classically taken not to determine position, because it is very hard to position a patient on the OR table. They are classically done to determine whether the screws you put in are biting correctly, are in the appropriate bones, are too long, or are too short.

That's not an issue here. That's not what

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we are talking about. To use the intraoperative x-ray to determine the appropriate weightbearing position of any bone in relation to the others would not have been appropriate in this case.

Q Thank you, Doctor.
THE COURT: Last question.
MR. MC ANDREW: Just two more, Judge, please.

THE COURT: Because I have been patient and heard on so many cases two more, and then the next hour goes by.

MR. MC ANDREW: I think I can do one question, Judge.

THE COURT: Do one more question. That's it.

MR. MC ANDREW: To abide by your
instruction.
Q With regard to Mr. Oginski's questions about that last visit in December, I think it was the 15th, 2005, the patient had with Doctor Marzano, and he went over with you some findings there, and particularly with regard to the x-rays and relative shortening of the first to the second metatarsal. You wanted to explain that as well. Here is your chance.

A Well, basically he read pieces and missed a

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sentence in between that says, Dorsal soft tissue contracture is contributory to this condition.

Yes, all of the things are identified here, put together form the pieces of a jigsaw puzzle that give you the complete picture. You can't take one piece of the puzzle and say, oh, see, see what you have got here. No, it's the whole thing together. So, the entire thing is correct, that, in fact, relatively what was happening was the second and third were bearing more weight. We know that.

Various options were considered. Several things contributed to it, which I agree.

MR. MC ANDREW: Well thank you very much, Doctor.

THE WITNESS: Thank you.
MR. OGINSKI: I have to follow up to that answer.

THE COURT: You only have one. Choose it carefully.

MR. OGINSKI: Thank you, your Honor.
RECROSS-EXAMINATION
CONDUCTED BY MR. OGINSKI:
Q Where is the information in Doctor Marzano's records that show that this patient had all of these problems leading up to the December $15^{\text {th }}$ information
that is in his records, the pain and the problems that she is complaining of?

A There are indications of problems in terms of thickening, dorsal skin contracture, keeps hallux in dorsiflex position.

I think your Honor would kill me if $I$ went through each of the records now. But certainly that record, at the end here, is a culmination of the events. But there are indications throughout the record of issues that are less than the ideal and perfect situation.

THE COURT: Thank you. THE WITNESS: Thank you, your Honor. (Witness excused.)


I, Cynthia M. Hills, do hereby certify That the within proceedings are a true and accurate Transcript of the original stenographic record's.
Cynthia M. Hills, RPR, CRR

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THE COURT: Okay. We are going to break now. We will reconvene tomorrow at 2 o'clock. Am I correct?

MR. OGINSKI: Yes.
MR. MC ANDREW: Yes.
THE COURT: 2 o'clock for summations. Thank you very much.
(Jury excused.)
THE COURT: You.
THE COURT: You may step down, Doctor.
THE WITNESS: Thank you.
THE COURT: I would like to address with counsel a little more with the verdict SHRAOEFPLT we are not having any more testimony today.

MR. MC ANDREW: That's right, Judge.
THE COURT: Does the defense rest?
THE COURT: Well, can he do that tomorrow morning.

MR. MC ANDREW: Can $I$ do that tomorrow afternoon. I think there might be one thing I wants to do, Judge still. Just reading testimony, that's all.

THE COURT: I want do address the verdict sleet. Did you get a copy of the Plaintiff's

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verdict sheet, Mr. McAndrew, the new one. MR. MC ANDREW: I got it $\backslash$ has $\backslash$ last evening, Judge. And I did print it out but I apparently left it on my desk. So I'm going to try to pull it up on my blackberry, as well some notes I made.

THE COURT: So Plaintiff now submits the following: He wants a more factual verdict sheet, specific verdict sheet which he is entitled to but frankly this is the first time a Plaintiff in my experience has ever posit Ted such a request. Usually it is defense.

The question is this, was the amount of bone or cartilage removed by Defendant during Annmarie Flannery's surgery on March $25^{\text {th }}$, 2005 a departure from good and accepted podiatric care.

Any objection to that?
MR. MC ANDREW: Yes, Judge.
THE COURT: What is it?
MR. MC ANDREW: First of all I don't think there has ever been an allegation or testimony about cartilage being removed. THE COURT: I never heard that except this morning.

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MR. MC ANDREW: Judge unfortunately I
don't have that e-mail in front of me.
THE COURT: Well, that is tough TPHUG
TKPWAOES because I had to operate the same way when you had all of these objections to the deposition. So what is good for the goose is good for the began TKER.

MR. MC ANDREW: If you bear with me, Judge.

THE COURT: I'm not bearing with you, I had to do it myself; you made me do it.

MR. OGINSKI: Judge, Doctor Marzano said during his direct examination that he removed cartilage and did not remove bone. So that's where I got the testimony. The statement that he removed cartilage.

MR. MC ANDREW: That's not a departure that's not what the Plaintiff's expert said.

THE COURT: Do you have your BPs?
MR. OGINSKI: Yes.
THE COURT: Did you allege that in your BPs?

MR. OGINSKI: That too much bone was removed.

THE COURT: What.

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MR. OGINSKI: That too much bone was removed, an inappropriate amount of bone.

MR. MC ANDREW: It said nothing about cartilage is my recollection, Judge. And Doctor Joseph said no such thing.

Additionally I have said this before and I don't wish to be repetitive but I do need to make a record here. That this, the cases cited by counsel cited by counsel indicate that there are different Defendants involved, there are different departures involved. All of these departures revolve around was that procedure done properly. Was too much bone removed was it plantarflexed too much. Those are the issues, your Honor.

THE COURT: Could what.
MR. MC ANDREW: So I think it should be one question not four or two or three. THE COURT: I don't remember any cartilage.

MR. OGINSKI: Okay.
MR. MC ANDREW: That's right.
THE COURT: So I'm taking that out.
The next he thing question two was the Defendant's position of the Annmarie Flannery's

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first metatarsal during surgery on March $25^{\text {th }}$, a departure from good and accepted podiatric care.

Did you prove that.
MR. OGINSKI: Yes.
THE COURT: Where.
MR. OGINSKI: Plaintiff's expert Doctor Joseph said looking at the $x$-rays that the first metatarsal was placed there too many of a plantarflexion, placed too far down. Dr. Roberts said that in his video dope significance and also in the transcript that it was too far down.

THE COURT: Was the Defendant's failure to recommend to Annmarie Flannery that her second and third metatarsals should be shortened at the time of her Lapidus surgery a departure from good and accepted podiatric yacht trick care.

MR. MC ANDREW: Judge that's the same question as number four and additionally.

THE COURT: They are very similar questions.

MR. MC ANDREW: Additionally
recommendation that really goes towards the withdrawn claim of alleged lack of informed

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consent.
THE COURT: Well, it TOUFPS on it I'm not sure if it-

MR. OGINSKI: Eye.
MR. OGINSKI: I'll tell you the reason why
it is important at least $I$ think it is important is because if the jury is presented with the question about whether Doctor Marzano's failure to shorten the second and third metatarsals during the surgery, the obvious question will come back as you can't do surgery unless the doctor TKELS her about it first.

THE COURT: I know about that.
Q So that's why I?
MR. OGINSKI: So that's why I put in that question because otherwise they are going to be confused and say but you are missing that piece.

THE COURT: Well, it should say was
Defendant's failure to.
MR. MC ANDREW: Judge can I interrupt a moment.

THE COURT: Can $I$ say something.
MR. MC ANDREW: Sure.
THE COURT: Gee that would be great.
MR. MC ANDREW: I apologize for

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interrupting, your Honor. I just did not want you to write it twice.

THE COURT: Question four.
MR. MC ANDREW: Judge I did not hear the last part.

THE COURT: Question four. Was TKEFTD's failure to recommend preoperatively a shortening of Annmarie Flannery's second and third metatarsals during her surgery -- wait a minute. Was Defendant's failure to recommend preoperatively and then intraoperatively to SHORTD ten Annmarie Flannery's second and third metatarsals during her surgery a departure. We will do it in one question.

MR. MC ANDREW: That's prefer TPER able to do questions. But I don't think the word recommend should be in there and failure should not be in there. That's a connotation that immediately gives a sense that something was done wrong. Was it a departure for the doctor not to speak to or recommend and then go on and perform the surgery.

THE COURT: Was it a departure.
MR. MC ANDREW: That's what $I$ was going to say and that's why I interrupted you Judge I did

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not mean to do that earlier I apologize. CONDUCTED BY

MR. OGINSKI: But that's our allegation.
THE COURT: Let me explain the problem to you ofth I'm going to do it one more time. You have one question in your verdict sheet. Did Defendant depart from good and accepted standards of podiatric care and surgical practice in the operative procedure he performed an Annmarie Flannery's right foot?

That's one question. Yes or no and a causation.

You have now three questions and three causations. And that's a tougher burden for you.

MR. OGINSKI: I don't think so, Judge because now they are addressing each one individually.

THE COURT: What about your failure to tell me about, in your Request to Charge, about the husband.

MR. OGINSKI: Sorry, Judge.
THE COURT: Isn't the husband a Plaintiff.
MR. OGINSKI: Yes, Judge.
THE COURT: Yes. Good to know.

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MR. OGINSKI: Okay.
THE COURT: So don't you need to put a question in there about his damages, if any.

MR. OGINSKI: Yes, Judge.
THE COURT: Otherwise he loses.
MR. OGINSKI: Right, but that's separate and distinct from the three liability and causation questions.

THE COURT: I'm just concerned because it is very rare that Plaintiff will want those questions in there.

MR. OGINSKI: According to the case law I have no choice but to ask for it because again if it goes up on appeal, the appellate AP division will not be able to decipher and determine what the jury's factual issue was.

THE COURT: And that's-then connect the next sentence to it.

MR. MC ANDREW: Judge those cases, though, that he is referring to.

THE COURT: I never have been reversed on a medical malpractice case.

MR. OGINSKI: I'm not saying anything like that Judge.

MR. MC ANDREW: Judge if I may.

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THE COURT: Just think what that inference means.

MR. MC ANDREW: Judge if I may.
MR. OGINSKI: I can't help but look at the case law that says for every departure that we are claiming we are required or entitled to separate question.

THE COURT: You are entitled butin the Court's discretion.

MR. OGINSKI: That is entirely correct Judge.

THE COURT: That is entirely correct. The Court is not forced to do that.

MR. MC ANDREW: That's right Judge and those cases that are cited by counsel and is he referencing now again they -- it is not one surgery by one Doctor on one date. It is a period of time, it is different departures sometimes by different doctors or nurses or hospitals. This is a very different situation, very distinguishable and I'm objecting to more than one question. I think the originally proposed question that this Court submitted to us the other day, yesterday during the charge conference was the appropriate and proper
question. With all due respect your Honor.
MR. OGINSKI: The PJI calf jot says each
claimed debar tour from accepted medical
practice should be the subject of a separate jury question.

THE COURT: I know what the PJI says.
MR. MC ANDREW: Judge.
THE COURT: 8 million words have been
expended on this case. And everybody says
something at least ten times. I usually get it
the first time. I really do. So, as a result I
get very tired.
MR. MC ANDREW: I'm sorry.
THE COURT: I'll reserve on that and I'll
tell you tomorrow before we do the the --
MR. OGINSKI: WHRAURS deSKEUGS regarding
the error of judgment issue?
THE COURT: I'm not going to give that (what was your decision .)

MR. MC ANDREW: Judge if I may be heard on that again.

THE COURT: No, you're not. Because that would be the 11 time.

MR. MC ANDREW: Well you told us would RAO would you would reserve until this witness

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testified here today. And he specifically testified that there were a number of different choices or procedures that could be done.

THE COURT: But that's not an issue in this case.

MR. MC ANDREW: It is not -THE COURT: Will you let me finish. MR. MC ANDREW: Yes, Judge I will. THE COURT: There is no issue that the Plaintiffs and the doctor decided on the Lapidus surgery. There Lapidus procedure. There is no issue. There is no issue that it was a medically correct procedure. No one has said it was not. So, therefore, he went in he did the procedure and the allegation is that he did the procedure as a departure. It was a departure from podiatric care.

MR. MC ANDREW: By not doing another part of the procedure the second and third shortening of the metatarsal SALS.

THE COURT: If in fact that's another part of the procedure your doctor just lied.

MR. MC ANDREW: I don't know what you mean by that, Judge, but I --

THE COURT: He said it was not part of the
procedure.
MR. MC ANDREW: It was not part of this procedure, correct.

THE COURT: He says it was not necessarily part of the procedure.

MR. MC ANDREW: Could I take my exception.
I don't --
THE COURT: You did not listen carefully
to what he said.
MR. MC ANDREW: That's possible too, Judge. I note my exception.

THE COURT: He made that very clear because is he trying to cover your position that the doctor did not necessarily have to do the metatarsal shortening.

MR. MC ANDREW: I agree with that.
THE COURT: That's your position.
MR. MC ANDREW: I absolutely agree with that.

THE COURT: That's what he said.
MR. MC ANDREW: That's not what I was talking about but okay, Judge.

THE COURT: He is saying that it should be part of the procedure. You're saying that two does not have to be part of the procedure. Your

Doctor covered that.
MR. MC ANDREW: Okay. (KHRO*P KHRO*P all
of this.)
MR. MC ANDREW: That's fine.
MR. OGINSKI: 2 o'clock tomorrow.
THE COURT: Tomorrow at 1:30. We are going to have to discuss this verdict sheet. You are going to have to come to me tomorrow with your husband damages questions.

MR. OGINSKI: Okay.
THE COURT: Because $I$ have not and at this point I'm not going to create them.

MR. OGINSKI: May I e-mail them to you, Judge?

MR. MC ANDREW: Can I have that tonight?
MR. OGINSKI: Absolutely.
MR. MC ANDREW: I assumed you would do that.

THE COURT: Yes, you can e-mail them to me.

MR. OGINSKI: Thank you.
THE COURT: Thank you.

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