IN THE COURT OF COMMON PLEAS

STARK COUNTY, OHIO

DIANE FAIR, et al.,

Plaintiffs,

JUDGE BOGGINS
CASE NO. 99 CV 00636

ROBERT C. ERICKSON, M.D., et al.,

Defendants.

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Videotape deposition of ROBERT MARK FUMICH, M.D., taken as if upon direct examination before Sandra L. Mazzola, a Registered Professional Reporter and Notary Public within and for the State of Ohio, at the offices of Robert Mark Fumich, M.D., 26900 Cedar Road, Suite 221, Beachwood, Ohio, at 11:20 a.m. on Monday, May 2, 1999, pursuant to notice and/or stipulations of counsel, on behalf of the Defendants in this cause.

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On behalf of the Plaintiffs;

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On behalf of the Defendants.

ALSO PRESENT:

Scott Mo ison Videota Operator

VIDEOTAPE OPERATOR: We are on the record.

ROBERT MARK FUMICH, M.D., of lawful age, called by the Defendants for the purpose of direct examination, as provided by the Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

DIRECT EXAMINATION OF ROBERT MARK FUMICH, M.D.

BY MR. SPISAK:

Q. Good morning, doctor. Would you introduce yourself to the ladies and gentlemen of the jury.

A. I'm Robert Mark Fumich.

Q. And what is your business or profession?

A. I'm an orthopedic surgeon.

Q. And what is your business address?

A. 26900 Cedar Road in Beachwood.

And is that a -- okay, doctor, I'd like to get into generally some background as far as your training and education is concerned.

And incidentally, the Beachwood address that you have, that's in the Greater Cleveland area, is it?

Yes.

Q. All right. Just for any of our folks on the jur who may or may not be familiar with some of the areas in and around Cleveland.

Doctor, can you tell us where you received your undergraduate or college education?

A. Case Western Reserve.

Q. And in what year?

A. 1971.

And what as your d ree?

A. B.A.

Q. In what area?

A. I majored in chemistry.

Q. Okay. And following college then what did you do?

A. I went to Ohio State Medical School. I graduated there in 1974.

Q. Okay. And following your completion of your M.D. degree, what did you do by way of training and education?

A. Took an internship and residency in orthopedic surgery in the Mt. Sinai Medical Center in Cleveland.

Q. How many years was that?

A. A total of four. I graduated there in June of '78.

And --

A. I then took a year's fellowship in reconstructiv knee surgery and sports medicine in Williamstown, Massachusetts, and I then took a six-month fellowship in total joint replacement with Charles Townley in Port Huron, Michigan.

I then started practicing in Cleveland in 1980 and I've been practice in Cl ever since.

Q. All right. Can you describe for us generally the nature *of* your private practice?

A. I have a general orthopedic practice taking care of most orthopedic problems. I have a specialty interest in knees and in arthroscopy and in sports medicine and articular cartilage repair.

Q. All right. Doctor, what hospitals are you affiliated with?

The Hillcrest Hospital of the Cleveland Clinic Health Systems and Mt. Sinai of the PHS Health System.

Q. Okay. Doctor, do you do any teaching?

A. I have taught. I've been primary care sports medicine fellowship at Case, and I have had a primary instructor at the office in the past. Presently I do have the

medical students and residents on occasion that rotate through the office.

Q. Okay. The teaching that you have done, I trust, has been primarily either medical students or residents who are involved with advanced training?

A. Correct.

Q. All right. And doctor, have you written or published any articles in your area of specialty

A. Yes, I have.

Q. Can you give us just a general idea of the kind of things you've written or the numbers --

A. I've done some basic investigative articles on use of methomecanoloid cement in joint replacement and in the use of a synovial sheath in anterior cruciate ligament reconstructions. I've had several articles in the sports literature with regard to specific injuries, various fractures and such.

Q. All right. And these are written in some of the journals that go out to the general orthopedic population?

A. Yes.

Q. All right. And doctor, you belong to some professional organizations, do you?

A. Yes, I do.

American Academy of Team Physicians. I'm a member of the American Orthopedic Society for Sports Medicine, a member of the Interarticular -- excuse me, the Articular Cartilage Repair Society, International Society of the Knee, International Arthroscopy Association, and the local organizations.

Q. All right. And doctor, you are Board-certified in orthopedic surgery, are you?

A. Yes, I am.

Q. All right. Generally what does that mean?

A. After you graduate from medical school, you can practice medicine, but if you have a special interest, you can take a subspecialty training in that area of interest. You have to apply to a residency program, an accredited residency program. You take an examination each year. If you pass the examination, you pass to the next

level of training.

Upon completion of that residency training, you then, in my case, you practiced for a year, were judged by your peers and then sat for a two-day oral and written examination. If you passed that, then you were Board-certified in the specialty of orthopedic surgery.

Q. And you completed all those requirements?

A. Yes.

Q. And when did you complete those requirements?

A. In 1981.

Q. All right. Doctor, 1 trust that you spend in excess of 50 percent of your time, your professional time, in the active practice of medicine and/or teaching?

A. Yes.

Q. All right. Doctor, tell us what a Morton's neuroma is, please.

A. A Morton's neuroma is a growth of nerve tissue, an aberrant growth of nerve tissue at the base of the common and interdigital nerves to the third and fourth toe. In the webbed space between third and fourth toe you have a nerve that comes to the webbed space and then splits into to a Y with this nerve going down the outside aspect of

the third toe and the inside aspect of the fourt. toe. And where the crotch *of* that Y is where you have an aberrant increase of nerve growth cells.

Q. All right. Now, doctor, is that something, for example, that can be visualized by an orthopedic surgeon intraoperatively or during the surgery?

A. Yes.

Q. All right. And is that also something that can be visualized so-called pathologically or under microscopic investigation?

A. Yes.

Q. All right. And when a Morton's neuroma is removed or excised, what is the purpose of doing that?

A. Well, the Morton's neuroma causes symptoms, and you remove the neuroma and that relieves the symptoms as a result of this pressure on this nerve.

Q. Okay. And could this neuroma also, or is it sometimes also referred to as a tumor type of thing?

A. Yes.

Q. All right. Now, doctor, at my request did you review certain materials relative to Dr. Erickson's care and treatment *of* Mrs. Fair?

A. Yes.
Q. And also, doctor, at my request did you examine, did you personally examine Mrs. Fair with respect to her present condition?
A. Yes.
Q. I'll get into the examination in a few moments, but let me -- let me, first of all, review with you the materials that you've reviewed. You reviewed, I trust, Dr. Erickson's office records for his care and treatment of Mrs. Fair?
A. Yes.
Q. And there were some records from Dr. Supan as well, is that correct?
MR. YOUNG: Note an objection to the form of the question.
A. Yes.
Q. All right. And doctor, did you also review the Massillon Community Hospital records for the excision of the Morton's neuroma surgery on or about August 22, '95?
MR. YOUNG: Objection.
A. Yes.
Q. Okay. And did that include a pathology report, by the way?

A. Yes.

Q. Okay. And what is the purpose of a pathology report in that context?

A. To determine what the material is that you removed.

All right And do ou as an rthopedi surgeon rely on th e reports?

Yes.

Q. And why is that?

A. You rely on them for, you know, various reasons. Sometimes you remove tissue for diagnostic purposes, sometimes you remove tissue for treatment purposes, and you want to know what you removed.

Q. What did the pathology report for wh Dr. Erickson removed on August 22 of ab 95 show?

A. A Morton's neuroma.

Q. All right. Well, I'll ask you a little more about that later as well, doctor.

Did you also review the depositi ons of Mrs. Fair as well as Dr. Erickson?

A. Yes.

Q. All right. And recently then you also reviewed some records of Drs. Makley, Klonk and Smith, is that correct?

A. Yes.

Fair at

A. April 29th.

Q. All right. And who was present at the time of that examination?

accompanied his clie Mrs. Fair, to tha

examination?

A. Yes.

a Morton

neur ma,

to

remove it?

MR. YO G: Note an objection to the form of the question.

A. Yes, it's appropriate.

Q. And in your opinion, doctor, d Fair have Morton's neuroma in the period July, August of 1995 in her right foot?

A. Yes.

Q. And in your opinion, doctor, was it appropriate to have removed the Morton's neuroma in Mrs. Fair's foot in August of '95?

A. Yes.

Q. Okay. Doctor, based upon your review of the materials, I want you to tell this jury, the ladies and gentlemen on this jury, if you have an opinion within a reasonable medical probability as to whether Dr. Erickson complied with the reasonable standard of care in performing the excision of the Morton's neuroma surgery on Mrs. Fair in August of 1995.

First, do you have an opinion?

A. Yes.

Q. And what is that opinion?

A. That he complied with the standard of care.

Q. And why do you so believe?

The record reflects that when he examined her, that he felt that she did have a Morton's neuroma. There's a sketch right here that says pain, and then right here you see a dot and a dot, and you see these double lines. They're hard to see. But there's a double line at that webbed space indicative of the interdigital

nerve. And then down here he says lipoma and neuroma.

So he suspected that she had a Morton's neuroma at this area. And the pathology slide bore that out.

Q. All right. Doctor, is something called reflex sympathetic dystrophy something that can happen after surgery such as this?

A. It can happen after extremity surgery, yes.

Q. All right. And if that were to happen, would that necessarily indicate substandard care in the performance of the surgery?

A. No. That would be a complication.

Q. All right. And what about recurrent neuroma, is that something that can also happen after surgery such as this?

A. Yes.

Q. All right. And does a recurrent neuroma or the materialization, if you will, of a recurrent neuroma indicate substandard care?

No. That would be a complication.

All right. Are those things that can and do happen under the best of circumstances?

Yes.

All right. Doctor, you've already told us that

you believe that Dr. Erickson complied with the standard of care in performing that surgery on August 22. Do you also have an opinion as to whether or not the surgery as such was appropriately done?

MR. YOUNG: Note an objection to the question.

Q. In other words, was the technique of the surgery appropriately done?

A. Yes.

Q. All right. Now, you conducted your examination on April 29, and can you tell us, please, what examination you performed.

A. I did an examination of her right foot.

Q. Okay. And you did -- you did provide us with a report regarding that, did you not?

A. Yes.

Q. All right. You talk about, for example, doctor, that there is a soft, doughy swelling over the dorsal medial aspect of the foot. What is that?

MR. YOUNG: Note an objection.

She had a soft tissue mass on the arch side of her foot on the top of the foot.

Okay. Is that the so-called mass that has been talked about here?

A. Yes.
Q. All right.
MR. YOUNG: Note an objection. Move to strike.
Q. Why don't you continue? What else -- what else did you find as far as your examination was concerned?
A. She had a three and a half -- a three-inch by one and a half inch soft, doughy swelling over the dorsal medial aspect of the foot at the first metatarsal area, which was felt to be consistent with a lipoma.
Q. Okay.
A. The circumference of the left foot measured nine and a half inches in diameter, the circumstance of the right measured ten inches in circumference.
Q. All right. Let me interrupt you and ask you what, if any, significance there is to that.
A. It means the -- the right foot was wider in circumference as a result of this, the growth of this mass.
Q. Okay. Go ahead.
A. She had a one-inch dorsal incision, that's -- dorsal is on the top of the foot between -- the

webbed space of the third and fourth toe. She had bilateral pronated flatfeet, right worse than the left, pronated flatfeet. That means she's flat-footed, she has lost the arch.

Q. Now, what causes that, doctor?

A. That can be -- occur developmentally or over time. She had prominent metatarsal heads to both feet with loss of both longitudinal and transverse arch.

Q. Tell us what you mean by that.

A. The arch -- the arch that most people know is flat is what we call the longitudinal arch on the side of the foot that goes this way, but the sides going in this direction, if you look at the food head on, there is another arch at the base of the metatarsals which goes like this. So that there is a curve this way as well. So she had loss of both the transverse and the longitudinal arch.

She had full motion to the ankle without pain or discomfort. Pulses were normal.

Q. Doctor, excuse me. That longitudinal and transverse loss that we talked about, is that related to the flat-footedness as well?

A. Yes.

Q. All right. Go ahead. I'm sorry for interrupting you. Full range of ankle motion without pain or discomfort?

A. Correct.

Q. What's the significance of that?

A. She had what appeared to be normal ankle mechanics.

Q. Okay.

A. Pulses were normal. Sensation appeared to be normal except at the webbed space at the area of the Morton's neuroma surgery. And that's because with Morton's neuroma surgery, you remove the nerve to the toe.

She had some torsion of the tibia, right worse than left. Torsion is a twisting of the tibial bone, the long bone, which may be a reason for some of the flat-footedness or the right being a little worse than the left.

Q. Doctor, any idea what causes that torsion of the tibia?

A. Oh, that's developmental.

Q. Okay. Does that have anything to do with the surgery of August 1995?

A. No.

Q. Now, was her foot sensitive -- reported as being

sensitive to cold, by the way?

A. Yes.

Q. And what significance does that have to you, if any?

A. She indicated the entire foot was sensitive to cold, and I couldn't correlate any significance to that.

Q. Is there any relationship between a foot being -- and we're talking about the right foot here, I trust?

A. Correct.

Q. Yes. Any correlation between that and excision of Morton's neuroma surgery?

A. No. I could understand select toes being cold as a result of a surgical incision, but not the entire foot.

Q. All right. Doctor, how would -- does that essentially complete your examination and your initial findings then on examination?

A. Yes.

Q. All right. What conclusions did you reach as far as Mrs. Fair's present condition?

A. That she had the numbness in the webbed space which is as a result of the surgery and is what the surgery does, and she had pain over the

metatarsal heads which were prominent and what we call a metatarsalgia.

Q. All right. Let me ask you about that, that numbness. Is there any pain associated with numbness? That may sound like a silly question, but --

A. No. There is no pain associated with numbness.

Q. All right. That's just a loss of some feeling in that area, is that right?

A. Loss of sensation in that webbed space.

Q. All right. And you say that's what the Morton's neuroma surgery is supposed to accomplish, right?

MR. YOUNG: Objection.

A. Yes.

Q. Okay. Now, you used the term, metatarsalgia?

A. Yes.

Q. Tell our ladies and gentlemen of the jury what that is.

A. Like I said, there's this transverse arch where the metatarsals are C-shaped, and as a result of that, each one gets a certain amount of pressure on weight-bearing. But when that transverse arch is collapsed down, then there is an abnormal weight distribution on the heads of the metatarsal and this causes pain at the heads of

the metatarsal, which are just slightly behind the webbed spaces.

Q. All right. When you say just slightly behind the webbed spaces, you mean the webbed spaces of the toes?

A. Yes.

Q. So just behind that area where the foot and the toes kind of come together?

A. Correct.

MR. YOUNG: Objection.

Q. All right. Other than, doctor, the numbness and the metatarsalgia, what other conclusions did you reach, if any?

A. That her present symptomatology that -- for which she is complaining appeared to be consistent with those conditions.

Q. All right. Does the numbness and the metatarsalgia that you've essentially explained to us pretty much summarize the total findings that you had here?

MR. YOUNG: Again, note an objection to the form the question.

A. Yes.

Q. Okay. Doctor, what in your opinion of Mrs. Fair's present condition, if anything, is

related to the surgery of August 1995?
A. Well, the only thing that I see related to the surgery is the numbness in the webbed space.
Q. And the so-called metatarsalgia is related to what?
A. Her flatfeet.
Q. All right. And does she have this in both feet?
A. She has flat-footedness to both feet and prominence of the metatarsals. The right is more pronounced. The right is symptomatic. The left one presently does not appear to be symptomatic.
Q. Okay. Now, do you believe that that metatarsal head symptomology that she's having is in any way related to the August 1995 surgery?
A. It's not related.
Q. Why not?
A. It's a different condition and in a different anatomical area.
Q. Doctor, do you have an opinion as to whether or not Mrs. Fair's present condition would significantly affect her life-style?
A. Metatarsalgia can cause some pain and discomfort with ambulation and walking or putting pressure on the foot. But for the most part, people are able to do what they want to do and what they

have to do. They may have to compensate.

Q. Okay. What about the numbness? Does that numbness affect Mrs. Fair's ability to carry on her life-style?

A. I've never seen the residual numbness from a Morton's neuroma, I've never seen that be a cause for alteration of life-style.

Q. Okay. Doctor, you indicated to us that you did review, among other things, Dr. Makley's records, correct?

A. Yes.

Q. All right. And you recall that that, at least a portion of that record related to a January 24th of 1997 office visit?

A. Yes.

Q. Okay. And Dr. Makley says, among other things, Squeezing the toes did not cause her any specific problems and she has normal neurologic examination except for some decreased sensation where the neuroma area was removed.

Do you recall that?

MR. YOUNG: Note an objection. Move to strike.

A. Yes.

And would that finding by Dr. Makley be

consistent with your findings just within the last few days?

MR. YOUNG: Objection.

A. Yes.

Q. Okay. And Dr. Makley also concludes that his impression is metatarsalgia. Do you recall that?

MR. YOUNG: Note an objection. Move to strike.

A. Yes.

Q. Aqd is that consistent with the findings that you had just recently as well?

A. Yes.

Q. All right.

MR. YOUNG: Again, note an objection and motion to strike.

Q. Dr. Makley suggests the possibility of some shoe inserts, do you recall that?

A. I believe so.

MR. YOUNG: Please, again note an objection to the form of these questions.

Q. And is that consistent or at least sort of compatible with your thoughts on it, that perhaps that could have --

A. I thought that orthotics would be of benefit, yes.

MR. YOUNG: Objection. Move to strike.

Q. All right. Doctor, you also reviewed Dr. Smith's report, which is dated on or about May 3 of 1996. Do you recall that?

A. Yes.

Q. Okay. And among other findings, Dr. Smith mentions that overall motor function of the forefoot is normal. Sensation over the dorsal aspect of the forefoot is normal. And she weight bears without difficulty.

Do you recall that?

MR. YOUNG: Note an objection.

A. Yes.

MR. YOUNG: Objection to the form of the question. Move to strike.

Q. And also, doctor, do you recall his finding that compression in this area does not produce the usual symptom of interdigital neuroma. The third and fourth toes function well. She just describes a very different feeling over that area but nothing can really be confirmed on physical examination.

Do you recall that?

A. Yes.

MR. YOUNG: Note an objection to counsel reading the record of the doctor into the record.

Q. All right. And also, doctor, do you recall that he found there are no symptoms at this point in time that are compatible with a Morton's neuroma. She wears shoes without particular difficulty?

MR. YOUNG: Objection. Move to strike.

A. Yes.

Q. All right. Are those findings essentially consistent with your findings, doctor?

MR. YOUNG: Objection.

A. Yes. I believe it also indicated that I believe he had diagnosis a consistent with metatarsalgia also.

Q. All right.

MR. YOUNG: Move to strike.

Q. And that's consistent with your findings?

A. Yes.

MR. YOUNG: Note an objection.

Q. Incidentally, doctor, there have been a couple of references here to this business of compressing the area or squeezing the area, and both

Dr. Makley and Smith indicate that that did not produce any symptoms. What is the significance of that?

MR. YOUNG: Note an objection to the question of counsel.

A. The -- you squeeze the -- you compress the webbed space to see if there's a symptomatology from a Morton's neuroma. That's part of a physical exam often performed when you suspect a Morton's neuroma.

Q. And if you squeeze that and it doesn't produce symptomatology, what does that mean?

A. It means more likely than not that you don't have the neuroma. Now, in her case the neuroma had already been resected, so they were checking to see if there was any residual neuroma.

Q. All right. Doctor, one final point as far as Dr. Smith's report, do you recall that he indicated, quote, We both agreed that she had been almost constantly focused on this problem for more than a year. I have encouraged her to shift her focus to ordinary activities of daily living and to try her best to avoid preoccupation with this problem.

Do you recall that?

MR. YOUNG: Note an objection. Move to strike.

A. Yes.

Q. Doctor, do you, from your review of the materials, as well as from your examination of Mrs. Fair, do you have an opinion as to whether or not you believe that Mrs. Fair at any time suffered from a reflex sympathetic dystrophy?

A. Do I have an opinion?

Q. Yes. I'm sorry. Do you have an opinion?

A. Yes.

Q. And what is that opinion?

A. The -- she had some postoperative pain for which Dr. Erickson treated her. I saw no findings of reflex sympathetic dystrophy on my examination on April 29. I didn't see that in Dr. Makley or Dr. Smith's reports.

She may have had a very mild form of the condition, but not full-blown sympathetic dystrophy.

Q. And what is sympathetic dystrophy, if you can give us just kind of a very general idea?

A. People can get unexplained pain after surgical procedures such that you can't break the pain cycle. But you get a cold or blue, swollen

extremity. You get x-rays and you'll see bony changes with demineralization of the bones.

And when this occurs, they can get stiff joints and they require a series of sympathetic nerve blocks.

Q. Now, there's some -- well, before I get into that, your opinion as to whether she has that at this point in time or not is what?

A. I don't -- I do not believe she has that at this point in time.

Q. All right. And there's some testimony, or there may well be some testimony, in this case that something like a reflex -- or that reflex sympathetic dystrophy is something that can come back or, you know, in other words, after surgery, there's -- there's a risk that it would reoccur. Do you have an opinion on that as far as Mrs. Fair is concerned?

A. Yes.

Q. And what is that?

A. I don't believe that she's suffering from it presently. I don't believe that it will recur.

Q. All right. And if it -- if it were even hypothetically to reoccur, is there any way to say how or when or how long it would last, if it

did reoccur?

A. No.

Q. Okay. And would any attempt to do that be speculative at best?

A. Yes.

MR. SPISAK: All right, doctor. Thank you. I have nothing further for you at this point.

MR. YOUNG: Let's go off the record for just a minute.

VIDEOTAPE OPERATOR: We're off the record.

- - - -

(Thereupon, a discussion was had off the record.)

- - - -

VIDEOTAPE OPERATOR: We're back on the record.

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CROSS-EXAMINATION OF ROBERT MARK FUMICH, M.D.

BY MR. YOUNG:

Q. Doctor, as you know, my name is Chuck Young, and I represent Diane Fair. We've just had a discovery deposition this morning, have we not?

A. Yes.

Q. Normally we do that a little earlier, but we're cramped for time in this case and I've asked you this morning about your opinions in this case?
A. Yes.
Q. As I understand it, you have a general orthopedic practice here?
A. Yes.
Q. But you generally don't treat Morton's neuroma, is that correct?
A. It's not a large part of my practice, no.
Q. Okay. I think this morning you said that perhaps in the last year you've seen five to ten cases perhaps of it?
A. Yes.
Q. And of those cases, for the most part they were referred to a Dr. Tozzi for treatment?
A. Yes.
Q. And I think you said that perhaps you've surgically actually tried to correct two of those conditions in the last year?
A. Yes.
Q. All right. As I understand it, you have concluded that Dr. Erickson did not deviate from the accepted standard of care in this case, correct?

A. Yes.
Q. A little earlier I asked you the basis for that opinion and you said that the basis for that opinion essentially is the pathology report, correct?
A. Yes.
Q. All right. I asked you whether you could tell from Dr. Erickson's deposition or from the record that the excision of the Morton's neuroma was warranted and you could not, is that accurate?
A. I'm not sure I said that. I said that the notes reflected that he thought she had a Morton's neuroma, and I indicated that if the discussion he had with the patient was such that he felt it should be excised and she agreed, then it should be excised.
Q. All right. But the discussion that he had with the patient is not indicated in the record, is it?
A. No, it's not.
Q. All right. And he has very little information available to him in terms of what was said at that appointment, isn't that accurate?
A. That's correct.
Q. What is the primary complaint that a patient

presents to a doctor with when they have Morton's neuroma?

A. They'll complain of a burning and pain in the foot.

Q. All right. And is it the pain that causes them to come to see the physician?

A. Yes.

Q. All right. And you've described for me the fact that when most of the people come to see you, there's been adequate pain or sufficient pain to cause them to come to see the doctor, correct?

A. Yes.

Q. And that's the pain that may in fact cause some functional problem for them and may present some difficulty for them in walking, correct?

A. Yes.

Q. It may be burning pain?

A. Yes.

Q. It may be very painful when they wear a certain type of shoe?

A. Correct.

Q. But essentially, it's pain that brings that person in to see the doctor when they have a Morton's neuroma, correct?

A. Yes.

Q. As I understand it, Morton's neuroma is a condition that produces only pain; it doesn't produce other medical problems, correct?
A. No.
Q. Well, we talked this morning about the fact that the only problem arising from Morton's neuroma is pain, is that accurate?
A. Yes.
Q. All right.
A. In some form, yes.
Q. All right. In one form or another, a patient has pain if they have a Morton's neuroma and that's the primary problem presented by the condition, correct?
A. Correct.
Q. And when a doctor treats the condition, it's in an attempt to get control of that pain for the patient, correct?
A. Correct.
Q. And the doctor may do a number of things to diagnose the condition, and once the condition is diagnosed, there are a number of ways in which it can be treated, correct?
A. Correct.
Q. Now, when you have a patient who comes to you

with forefoot pain or pain out toward the end of the foot, you do a differential diagnosis, don't you?

A. Yes.

Q. And you want to be able to determine the cause of that pain before you draw any conclusions as to what should be done to alleviate it, correct?

A. Yes.

Q. When you do that differential diagnosis, one of the things that you consider is a stress fracture?

A. It's a condition of the forefoot so it's considered, yes.

Q. And it causes the same type of pain, the metatarsalgia, as Morton's neuroma?

A. It doesn't cause the same type of pain, but the patient's description of the pain can be vague enough that it's something that you would consider.

Q. All right. And as I understand it, when a person comes to you with forefoot pain and you're doing a differential diagnosis, one of the things that you do is perform an x-ray?

A. If I think they have a stress fracture or I'm inconclusive about my diagnosis, yes.

Q. All right. And sometimes the initial x-ray, if we're talking about short-term pain, won't show a stress fracture, correct?
A. Correct.
Q. And you'll get a follow-up x-ray?
A. Yes.
Q. Why is that? Why do you do a follow-up x-ray?
A. A stress fracture may not show up on the first x-ray.
Q. And why would it show up on a later x-ray?
A. Because a stress fracture is similar to taking a coat hanger and bending it once or twice with the coat hanger still intact but it still having a little crack around it. It isn't until there is some bone formation around the area of stress that you know that there was a stress fracture.
Q. And this morning when you said that the first x-ray may not show that stress fracture, you said that you would wait perhaps six weeks and get a repeat x-ray of the condition?
A. Yes.
Q. In addition to that, in the differential diagnosis you talked about the fact there may be pathogenic or malignant tumor, conditions like that, that can cause forefoot pain?

A. Yes.
Q. Foreign bodies?
A. Yes.
Q. Ganglion cysts?
A. Yes.
Q. And essentially, before you draw the conclusion that you have a Morton's neuroma, you want to eliminate those other causes as the possible cause of the forefoot pain, correct?
A. Yes.
Q. I think you said that Morton's neuroma is a diagnosis of exclusion?
A. Yes.
Q. What do you mean by that?
A. It's a -- a stress fracture -- the conditions in this particular set of differential diagnoses are somewhat easy to determine. If you're looking for a foreign body, the patient will give a history of having some break in the skin at some point, so that you would be looking for a foreign body such as a needle situation.

If there was a suspicion for a malignancy, you would see some swelling between the webbed space or something to put you in that direction. A stress fracture you an eliminate with an x-ray

diagnosis and bone scan.

But some of the conditions, including a Morton's neuroma, can be clear-cut on an examination such that it points you in that direction right away.

Q. All right. Now, this morning you said that when you have a diagnosis of Morton's neuroma and the person has had pain for some period of time, that surgery is the recommended treatment for the condition, correct?

A. Yes.

Q. And the purpose for that treatment is to alleviate the pain, correct?

A. Yes.

Q. And this morning we talked about the fact that, you know, we have acute, meaning short-term pain, and we have chronic meaning long-term pain, and I asked you how long does a patient have to have pain before you would consider surgery.

Do you remember that question?

A. Yes.

Q. And you said, well, in your practice people either come to you with acute, meaning short-term, it just occurred, or it's been there for many months generally?

A. Yes.
Q. All right. And if pain has been there and it's been significant pain for a period of many months, at that point you can conclude that surgery would be performed, correct?
A. Yes.
Q. But if it's short-term, acute pain, meaning the person has had pain for a couple of weeks or less, that you would not consider surgery at that time but might consider other alternatives, correct?
A. Yes.
Q. All right. When we talk about other alternatives, we're talking about conservative treatment, isn't that correct?
A. Sometimes conservative treatment, sometimes no treatment. Sometimes observation to gain more confidence in the diagnosis.
Q. Now, as I understand the condition of Morton's neuroma, it occurs more often with women than men?
A. Yes.
Q. And it occurs because of tight or poor footing -- poor-fitting footwear?
A. That's one component, yes.

Q. All right. And in conservative treatment when you have a patient who's had pain for a short period of time, it's an accepted practice to recommend a change of footwear, is it not?
A. Yes.
Q. In addition to that, you can have injections of corticosteroids to treat the inflammation?
A. Some people do that. That's not something I do, but that is a method of treatment. It's not a definitive treatment, but it is method of treatment.
Q. When you say that's not something you do, do you treat every case that comes into your office surgically or refer the person for surgery?
A. When I'm convinced that it's a Morton's neuroma, then I will treat them surgically. There's very little else to do for Morton's neuroma that is curative for the condition.
Q. When you say if you're convinced that you're dealing with a case of Morton's neuroma you'll do surgery, what does it take to convince you that you have a surgical case of Morton's neuroma?
A. Pain in the webbed space of the third and fourth toe, and they may or may not have a palpable click or pain on squeezing in that area. And if

they're having pain at the webbed space and they're not having pain over the metatarsal and not have any wounds over the plantar or dorsal aspect of the foot any toe deformity or anything like that, then that is the most common condition associated with that kind of pain.

Q. And does the period of time that the person has had the pain play any part in your consideration of how to treat it?

A. It plays a part in that if they complain of pain over a 48-hour or a two-week period, I may not be thinking of a Morton's neuroma. It would take me more time to observe or look for consistency in the patient's symptoms to be confident in my diagnosis.

Q. All right. Now, as I understand it, it's your testimony that Morton's neuroma surgery is elective surgery, correct?

A. Yes.

Q. It's surgery that's undertaken to correct a painful condition?

A. Yes.

Q. And a physician who diagnosis Morton's neuroma should make available to the patient the availability of the surgery versus the amount of

pain that they're feeling, correct?

A. It's a decision the patient has to make in

Q. All right. And you draw the balance between the pain that they're experiencing and the surgery

A.

Q. And the standard of care requires that a surgeon explain to the patient the options that are ayailable to the patient, correct?

A. Yes.

Q. And explain how the surgery will be performed, correct?

A. Yes.

Q. And explain the complications that can arise from that surgery?

A. Yes.

Q. And the standard of care requires an explanation of those things in such a way that the patient can make a decision on whether to undergo'the surgery or continue to experience pain, correct?

A. Those are the things that physicians do, yes.

Q. All right. Now, you're aware of the fact that Diane Fair returned to see Dr. Erickson after the surgery, are you not?

A. Yes.
Q. And you are aware of the fact that when she went back to see him on the first visit after the surgery she was surprised to find the incision had been placed between her toes, was she not?
A. Yes.
MR. SPISAK: Objection. She said she was surprised?
A. She said she -- she said she was surprised.
Q. And Dr. Erickson's deposition confirms that she was surprised, does it not?
A. That she said she was surprised, yes.
Q. Dr. Erickson says that?
A. Yes.
Q. All right. Now, Dr. Erickson and Diane Fair explained that she was under the impression that he was going to excise the lipoma, did they not?
MR. SPISAK: Again, that she said that, Mr. Young?
MR. YOUNG: That she said that and that Dr. Erickson confirmed it.
MR. SPISAK: That she said that?
MR. YOUNG: That's correct.
A. That she said that and he confirmed that she said that, yes.

Q. All right. And you have seen in Dr. Erickson's note of July 17, 1995 handwritten across that diagram, Excision lipoma, have you not?
A. I don't -- I saw lipoma and neuroma. I don't remember the word, excision. If you say it's there, I'm sure it's there.
Q. Well, take a look at the note. You just held it up for the jury. Hold it up again, if you would. Do you have the diagram of Dr. Erickson's notes on July 17?
A. Yes, yes.
Q. I want you to hold it up. You pointed to two dots at the top of that diagram and said they represent what?
A. These are the -- I just pointed to the two dots and the second line around the webbed space which indicates the interdigital nerve. So this is the neuroma. This is the mass.
Q. Where there is a circle and the word, pain?
A. Yes.
Q. Okay.
A. This says, Mass. Says, Excision lipoma of the foot.
Q. And you would agree that that mass on the top of the foot is a lipoma, wouldn't you?

A. That's my best guess.
Q. All right.
A. Nobody's taken a piece of tissue to define it.
Q. Dr. Erickson attempted to aspirate it and was unable to draw fluid?
A. One of the doctors attempted to aspirate. I believe it was Dr. Erickson, but I'm not sure.
Q. Take a look at his note of July 17. Does that indicate --
A. It says aspirate. No blood.
Q. So Dr. Erickson did that, correct?
A. He did an aspiration, yes.
Q. Of the lipoma?
A. It doesn't say specifically the lipoma, but I would believe it more likely than not is the lipoma.
Q. And his deposition confirmed that, did it not?
A. I believe -- I don't think so. I don't think he referred to it as lipoma.
Q. Do you recall that any --
A. He may have referred to it as a mass and not a lipoma.
Q. All right. But he made reference to the fact that he aspirated it?
A. Or attempted to aspirate, yes.

Q. What does it mean when it is aspirated?
A. You put a needle inside and try to draw fluid.
Q. And he was unable to draw fluid?
A. Correct.
Q. And that's consistent with a lipoma, is it not?
A. Yes.
Q. All right. Now, if you hold up for the jury that diagram, you've indicated that there is an area where Dr. Erickson wrote, Mass and neuroma?
A. Right here, yes.
Q. A., correct?
A. Yes.
Q. And you are assuming that that was written on July 17, 1995?
A. Yes.
Q. All right. And across there is excision lipoma of what?
A. Of the foot.
Q. Of the foot or of right foot?
A. Of the foot.
Q. Okay. Now, do you know when those words were written there?
A. I believe everything was done July 17, 1995. It doesn't have any other dates on it.
Q. All right. Do you believe that it was his

intention on July 17, 1995, to excise the lipoma and not the neuroma as indicated by that note?

MR. SPISAK: Objection. That's very misleading according to the evidence as you know it and what was written by Dr. Erickson.

A. Excuse me. Read back the question, please.

Q. Withdraw the question and ask it this way, doctor.

Do you have any knowledge concerning what Dr. Erickson's intention was on July 17, 1995 based on that page on that diagram?

A. I don't know what his intents were based on this diagram. I see the conditions that he was assessing on the diagram, and I know the condition that he intended to treat based on the operative permit.

Q. All right. The operative permit shows a Morton's neuroma, correct?

A. Yes.

Q. But there is nothing on his note of July 17, 1995 that indicates that he was going to perform surgery for Morton's neuroma, is there?

A. There is nothing that says, Excise Morton's neuroma, no.

Q. All right. Now, I want you to take a look at the history pages that Dr. Erickson had Diane Fair fill out when she presented at his office on July 17, 1995. Do you have those?
A. The surgery worksheet.
Q. Why don't we do this. I have a chart arranged by page number and I can refer you to certain pages. And the first page, it's previously been marked for identification purposes as Plaintiff's Exhibit 1, and we have page 1 --
A. Right foot, yes.
Q. -- on ortho clinic and that is Dr. Erickson's clinic, is it not?
A. Yes.
Q. And we have the patient's name, Diane Fair?
A. Yes.
Q. Problem No. 1, right foot, correct?
A. Correct.
Q. Now, if we go to page No. 2, we see a standard history form that would be filled out by a patient approaching a doctor for the first time, correct?
A. Yes. Well, it's insurance information, yes.
Q. All right. Page 3 begins a history form which she has filled out?

A. Yes.
Q. I want you to look at item 4 under personal history. What is the question and what's the answer there?
A. Foot swollen, had bruising.
Q. All right. And that is a complaint that arises from the lipoma which she had or the mass on the top of the foot, correct?
MR. SPISAK: Objection.
A. It doesn't say that. But I believe that to be the case.
Q. It is consistent with that, correct?
A. Yes.
Q. All right. And if we continue back to page 5, we have under general data a question, Regular physical activity, and Diane Fair has indicated what?
A. Walking.
Q. Now, under B., present illness, reason here today, what has she indicated?
A. Foot swollen.
Q. And item 2 is, Is this problem new, with a question mark, correct?
A. Yes.
Q. Does that indicate to you the primary complaint

or the reason that brought Diane Fair in to see Dr. Erickson that day?

MR. SPISAK: Objection. It indicates what's written there.

A. Well, if you're -- if you assume that the swelling and bruising is to the lipoma area and nowhere else on the foot, yes.

Q. All right. In other words, she went in to see him because of a mass on the foot, not because of any uncontrolled pain in the webbed space area, would you agree?

A. She hasn't put down that on this history.

Q. All right. Let me take you back to that page that you were showing for the jury, page 8. Now, when she appeared for this appointment, July 17, 1995 would have been stamped for the record in that office, correct?

A. Yes.

Q. And under S., what does that stand for in a physician's office?

A. Subjective.

Q. Okay. And that subjective means what under these circumstances?

A. Patient's complaints.

Q. All right. And written there by his office staff

is what language?
A. Review right foot. Approximately one month ago patient woke up and dorsal aspect of foot was swollen and black and blue. Patient's had complaints of swelling ever since. Swelling is worse today than before, feels bruised.
Q. Now, that is the recording of the patient's complaint as related to the physician or the assistant there taking that information, correct?
A. Yes.
Q. Has this patient, Diane Fair, indicated anything about pain in the forefoot or in the webbed space?
A. No, there is no mention of pain in the forefoot or webbed space.
Q. In your experience as an orthopedic surgeon here in Beachwood, would it be unusual for a person to have significant, long-term plain -- pain and not related it to the patient -- and not relate it to the doctor if they're complaining about a mass?
A. If they're complaining --
Q. Yes. Wouldn't it be unusual --
A. You switched on me there. I missed that. Please say that again.
Q. Sure. Wouldn't it be unusual for her to come in

complaining about an area that feels bruised if she's had significant, long-term pain in the front of her foot?

A. Would it be unusual for -- you know, we're assuming that the swell -- you know, you want to go on the accuracy of the notes, and if you're going to go on the accuracy of the notes, the one problem that we have is that the notes don't reflect -- it says dorsal aspect of foot swollen, black and blue, and it doesn't say specifically it was over the lipoma. Now I'm making that assumption and you're making that assumption.

The record and the notes are not the most detailed notes I've seen in a physician's chart.

Q. If a person has a lipoma, it generally does not cause pain or discomfort, does it?

A. No.

Q. A lipoma is a soft tissue tumor, correct?

A. Yes.

Q. And it's benign?

A. Yes.

Q. It's not malignant, it's not cancerous by definition?

A. Correct.

Q. And it's not harmful to a patient unless it

invades other soft tissue areas, correct?
A. Correct.
Q. But if it's exposed and if it's subject to irritation, it can become sore or bruised feeling, would you agree?
A. That and other areas of the foot, yes.
Q. All right. And the mass that you found when you examined Diane Fair was on the top of her right foot, correct?
A. Yes, correct.
Q. And it was in an area where it could easily be rubbed by shoes?
A. Yes.
Q. And you would expect it to be so, would you not?
A. Yes.
Q. And would you expect it to become sore?
A. I would expect that it could be, yes.
Q. All right. And these complaints are consistent with that soreness arising from the mass on the top of her foot, are they not?
A. Yes.
Q. But there is nothing here about any complaint of pain or burning pain or long-term pain or difficulty walking, is there?
A. That's not written there, no.

Q. All right. In fact, this chart indicates that one of the hobbies that Diane Fair had was walking, correct?
A. It says she walked. I don't know if it was a hobby, but she says she was a walk -- she walked, correct.
Q. Regular physical activity was walking, correct?
A. Yes.
Q. But there is no complaint about any difficulty walking or any pain arising from walking, correct?
A. No, that's not written there.
Q. All right. Now, Morton's neuroma is a condition which is painful and certain things can aggravate the pain, correct?
A. Yes.
Q. Weight-bearing?
A. Yes.
Q. Walking?
A. Yes.
Q. And the pain is decreased in general by resting or removing your shoes, is it not?
A. Yes.
Q. And there is no such complaint like that in Dr. Erickson's chart, is there?

A. No.
Q. Now, as I understand your testimony, the only thing in this chart that indicates that there was a Morton's neuroma is the reference to pain in that area of the metatarsal heads and his conclusion that there was a Morton's neuroma, correct?
A. There's the diagram, his conclusion and then the pathology report.
Q. All right. Now, and his conclusion has no support in his chart, would you agree, other than the reference to the pain?
A. Just the diagram, correct.
Q. All right. And earlier today I pointed out to you that when I asked him on deposition what he meant by pain, he answered, The area was tender when I examined her foot.

Now, is that what you mean by pain with a Morton's -- Morton's neuroma?
A. Yes.
Q. Tender when he examines the foot?
A. Yes.
Q. All right. Now, he learned that on examination and not by history, and he did not inquire as to when the pain was present, he learned nothing

about the nature of the pain, just that the spot was tender and he did not recall if he learned that she had ever had the pain before.

Now, would you agree that that doesn't provide you with much of a basis then on the record to confirm a diagnosis of Morton's neuroma?

MR. SPISAK: Note my objection. Go ahead.

A. His responses to those questions?

Q. His responses to those questions.

A. His responses to those questions are not conclusive of a Morton's neuroma.

Q. All right. Well, his responses to those questions were indicative of what he found on July 17, 1995, and he said he found that the spot was tender.

MR. SPISAK: Objection.

Q. Now, that's consistent with Morton's neuroma, correct?

A. Yes.

Q. But not diagnostic?

A. No.

Q. It's not definitive?

A. No.

Q. It doesn't enable anyone to conclude that she had a Morton's neuroma, that and nothing more?
A. That and nothing more, no.
Q. All right. Now, your testimony, as I understand it, is based on the fact that the pathology report in this case confirms that there was a Morton's neuroma, correct?
A. Correct.
Q. All right. And the pathology report lists as a diagnosis Morton's neuroma?
A. Correct.
Q. Now, earlier today I asked you whether in your opinion the existence of a Morton's neuroma meant that there was always pain and you testified that it did, correct? If you have a Morton's neuroma, you have pain?

MR. SPISAK: I'm going to object to this kind of referencing back to testimony. That's improper and it's an improper way to proceed. And you have been doing it. I've been allowing you leeway on it, but I it certainly isn't appropriate.

MR. YOUNG: Well, I made the accommodation of taking a discovery deposition immediately before. You can

allow me some latitude.

MR. SPISAK: Not if it's improper, I can't.

A Please read the question back.

- - - -

(Thereupon, the requested portion of the record was read by the Notary.)

- - - -

A I don't know the entire context of that, but that -- that's probably consistent with what I said.

Q Well, let me not ask it in that way because I don't want to be unfair to you, doctor. Let me ask you what your opinion is.

We have here a pathology report and a pathology report is based on a microscopic examination of tissue that came after surgery, correct?

A Microscopic and macroscopic.

Q All right. In other words, you take the tissue out from between the toes, you submit it to the pathologists and they come up with a diagnosis?

A Yes.

Q All right. And it was your opinion -- or it is your opinion that if microscopically you have a neuroma formation --

A. Yes.
Q. -- by definition you have to have pain?
A. If you have a Morton's neuroma, yes, you will have pain or you're in -- I don't believe there are asymptomatic Morton's neuromas.
Q. All right. In other words, if this pathologist says Morton's neuroma based on his microscopic examination of that slide, that means Diane Fair had pain?
A. Yes.
Q. Do you have any opinion as to how long she had had pain before July 17, 1995?
A. I have no idea.
Q. All right. But you believe that she had pain on July 17, 1995, correct?
A. I believe she had pain at some point if he is removing a Morton's neuroma, yes.
Q. All right. And you base your opinion there on the pathology diagnosis?
A. Yes.
Q. Now, I asked you this morning whether you can make a pathological diagnosis or whether it's a clinical diagnosis requiring actually the presence of the pain. Do you remember that?
MR. SPISAK: Objection.

A. Yes.
Q. Okay. And it's your testimony that you can do it pathologically as well as clinically?
A. Yes.
Q. And I asked you this morning whether you had any orthopedic texts that you rely on in terms of dealing with areas of orthopedic surgery that you may not see often in your practice, correct?
A. Yes.
MR. SPISAK: Objection.
Q. And you made reference to the fact that you have Campbell's Orthopedic -- excuse me -- Campbell's Operative Orthopedics here in the office?
A. In the other office, yes.
Q. All right. And you make reference to it periodically if there's some question that you have in mind as to how to deal with something, correct?
A. Yes.
MR. YOUNG: Now, I'm going to have this marked, if I may.
MR. SPISAK: Are we still on the record? Note my objection to this entire procedure. I want to note my objection to this entire procedure. This is improper,

clearly improper cross-examination and want to alert Mr. Young to my objectio go into it --

MR. YOUNG: We will go into it. It's the mistake, but be that as it may, I want --

MR. SPISAK: So that he doesn't make it clearly on the record that I have an objection to this.

MR. YOUNG: Mark that 2, if you would.

(Thereupon, Plaintiff's Exhibit 2 was mark'd for purposes of identification.)

Q. Doctor, let me show you what's been marked for identification purposes as Plaintiff's Exhibit 2. Now, this is a copy of certain pages from the Eighth Edition, Volume 4, of Campbell's Operative Orthopedics. It's taken pertaining to Morton's neuroma. And I've made copies because it's easier than having you scramble across your desk here in this crowded room to get into that area. But I want you to look at a page. After we

answer these questions, I'll hand it to you here. This morning you said essentially that there are no texts or writings that are totally authoritative, did you not?

A. Yes.

Q. That essentially that all opinions in a textbook can be called into question or discussed and are subject to further study, is that fair?

A. Yes.

Q. But you testified that a text like Campbell's Operative Orthopedics has stood the test of time, correct?

A. For the most part, yes.

Q. It's been out for a period of ten years or so and anything in there is subject to comment and subject to being changed, correct?

A. Yes.

Q. So it's as reliable as any other medical text or authority in publication, would you agree?

MR. SPISAK: Note my objection.

A. It may be.

MR. SPISAK: Continuing objection, so I don't keep interrupting, to this entire line.

Q. Familiarize yourself with this, but I'm going to

draw your attention to page 2783 and to the area that I have underlined in red there.

MR. SPISAK: What did you underline in red?

MR. YOUNG: Page 2783.

MR. SPISAK: Okay.

A. Is the Eighth Edition the most recent edition?

Q. It is. At least it's the most recent edition available in the Allen Medical Library.

MR. SPISAK: Having been published when?

Q. What is the Allen Medical Library, doctor?

A. It's a -- it's the medical library for -- well, it's open to the public, but it's the medical library for Case.

Q. And it's available to physicians in training at Case Western Reserve and to their professors as well?

A. Yes.

Q. I want you to take a look at the section here under signs and symptoms. The first paragraph reads, The primary symptom -- at page 2783. Do you have it?

A. Yes, yes.

Q. It begins, The primary symptom of interdigital

neuroma is pain.

Interdigital neuroma is another name for Morton's neuroma, isn't it?

A. Yes.

Q. Most often located in the region of the metatarsal heads, usually the third and fourth.

Would you agree with that statement?

A. Yes.

Q. And frequently described as burning, aching or cramping. Correct?

A. That's what you're reading, yes.

Q. Do you agree with it?

A. Burning and aching. Cramping I've never seen.

Q. Aching and cramping you've never seen?

A. I have never seen cramping.

Q. Okay. The duration of pain varies from a few weeks to many years. Would you agree with that?

A. Yes.

Q. It is increased on walking and relieved by rest, removing the shoe or massaging the forefoot. Would you agree with that?

A. Yes.

Q. And it goes on to talk about examination, findings and so forth. And I want to direct your attention to the last sentence on this page. It

talks about how a physician should examine the area to confirm the diagnosis of Morton's neuroma. And would you read the last sentence that has been underlined?

A. The use of sensory action potential to objectively confirm the diagnosis has yielded variable results.

Q. Now, what does that mean, doctor?

MR. SPISAK: Continuing objection.

A. There is a nerve test that can be done which may or may not give you some information. They say it gives variable results. They don't have confidence in it.

Q. Do you agree with that?

A. Yes.

Q. All right. And the next section?

A. And the pathologic findings are occasionally found in asymptomatic interdigital nerves.

Q. So that the diagnosis of Morton's toe is still a clinical one, correct?

A. Yes.

Q. Now, it's the opinion of the editors of Campbell's Operative Orthopedics that a pathological diagnosis is not definitive, do you agree?

MR. SPISAK: Oh, object to that.
A. Say that again.
Q. Yes. They're saying that you can't pathologically diagnose Morton's neuroma, are they not?
MR. SPISAK: Whoa, objection.
A. No.
Q. No? You disagree with that?
A. I disagree with what you just said.
Q. Well, what does this mean to you?
A. The pathologic findings are occasionally found in asymptomatic interdigital nerves.
Q. Now, what does asymptomatic mean?
A. Non -- non-symptoms.
Q. Pain-free, right?
A. Yes.
Q. Okay.
MR. SPISAK: Do you want to know what occasionally means?
A. But it says --
MR. YOUNG: Move to strike.
A. It says, The pathological findings are occasionally found in asymptomatic interdigital nerves. Now --
Q. So that --

MR. SPISAK: Well, wait a minute.
A. Wait a minute.
Q. Go ahead. Go ahead.
MR. SPISAK: You're not letting him finish his answer.
A. This -- it doesn't say the pathologic findings are occasionally found in asymptomatic Morton's neuromas. It says in asymptomatic interdigital nerves.
Q. All right. And by definition then not all pathologic findings of neuroma indicate Morton's neuroma with pain, would you agree?
MR. SPISAK: Objection.
A. Say this again.
Q. Just because you have the pathologic findings, that doesn't mean you have pain?
A. Pathologic findings in and of the neuroma or in and of the interdigital nerves?
Q. The interdigital nerves.
A. If it's in the interdigital nerves, that does not necessarily mean that he has a neuroma. He could have a pre -- he could be working his way towards a neuroma and he may well be asymptomatic.
Q. All right. Now, it is possible that Diane Fair was asymptomatic on July 17, 1995, and that she

could still have those findings on the path --

MR. SPISAK: Objection.

Q. -- on the pathology report, is it not?

MR. SPISAK: Objection as to possibility.

A. The pathology report said Morton's neuroma, not interdigital nerves. And I looked at the slides with a pathologist to make sure.

Q. All right. Doctor, would you agree with me that --

MR. SPISAK: Objection. And move to strike that entire line as it relates to the text and so on and so forth. I think I made my position very clear on that.

Q. Doctor, would you agree with me that the lipoma and any possible Morton's neuroma that existed on July -- in July of 1995 for Diane Fair were not related?

A. They're not related to each other, no.

Q. All right. In other words, the neuroma didn't cause the lipoma; the lipoma didn't cause the neuroma?

A. Correct.

Q. When you read Dr. Erickson's deposition, were you aware of the fact that he testified he was under

the impression that the lipoma was caused by the neuroma?

MR. SPISAK: Objection. That's a mischaracterization.

I don't remember that specific comment, and I don't remember that specific thing if he said it?

Q. All right. But in your opinion one is not related to the other and didn't cause the other, correct?

A. Correct.

Q. In reading Dr. Erickson's deposition, did you note that he told Diane Fair and her husband that one was related to the other?

MR. SPISAK: Objection. Are you talking about after the fact now?

Q. His postsurgical discussions with Diane Fair and her husband.

A. You know, I just said that they aren't related. They aren't related pathologically. He could have made a reference to the fact that they're related in that they both become symptomatic with tight shoe wear. I don't know where or what the scope of the relationship is.

Pathologically, anatomically they're not

related.

Q. Causally they're not related?

A. No, but symptomatologically they could be if he's talking about footwear will cause symptoms in both of them. I mean where the relationship is, I don't know what he was thinking of when he indicated that.

Q. All right.

A. But from an anatomic and pathologic situation, I don't see them related.

Q. And as an orthopedic surgeon you know that any removal of a Morton's neuroma would not remove the lipoma?

A. Correct.

Q. All right. Did you read Dr. Erickson's postoperative notes pertaining to Diane Fair?

A. Yes.

Q. And you know that he treated her for some period of time for the ongoing pain following surgery?

A. Yes, for four months.

Q. All right. And you're aware of the fact that he was of the opinion that the cause of the pain was either a reflex sympathetic dystrophy or a recurrent neuroma, correct?

A. Yes.

Q. All right. And he was of the opinion that either one of those was a complication from the surgery that he performed, but that it was one of those two conditions, correct?
A. Yes.
Q. All right. And that's consistent with Dr. Treister's opinion in this case, is it not?
A. Yes.
Q. You've read Dr. Treister's report?
A. Yes.
Q. You know his opinion concerning causation you know his opinion concerning the ongoing pain that she's been experiencing?
A. I've read it. I'm familiar with it. I can't quote it verbatim.
Q. All right. He gives the opinion that she is going to permanently have pain as a result of this condition. Do you disagree with that?
A. Based on my examination on Thursday, April 29, yes.
Q. You disagree?
A. I don't see any reflex sympathetic dystrophy or any recurrent neuroma that I felt was present on my examination.
Q. All right. Dr. Treister agrees --

A. That doesn't mean that she may not have had some symptomatology of reflex sympathetic dystrophy at that point in time, but I did not see that on my examination.

Q. Dr. Treister agrees that there is no evidence of reflex sympathetic dystrophy at this time, but he believes that there is a recurrent neuroma, correct?

A. I believe he said that.

Q. You've read his report?

A. Yes.

Q. And he believes that that condition is permanent unless surgically repaired. Would you agree with that if there is a recurrent neuroma?

A. If there is a recurrent neuroma, yes.

Q. In other words, the pain of a recurrent neuroma isn't going to go away unless it's surgically repaired, correct?

A. Yes.

Q. And if there is surgery on a recurrent neuroma, could that possibly trigger reflex sympathetic dystrophy, a recurrence of the condition?

A. Is it possible? Anything is possible.

MR. YOUNG: Okay. Thank you. I have nothing further.

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REDIRECT EXAMINATION OF ROBERT MARK FUMICH, M.D.

BY MR. SPISAK:

Q. Doctor, just one or two follow-up questions.

Doctor, would it be fair to say that when a patient presents to you or to any physician with whatever history or complaints, so forth, the patient doesn't come in and present you with a diagnosis as such?

MR. YOUNG: Again, note an objection to the form of the leading question.

A. A patient rarely comes in with a diagnosis on their -- from their lips.

Q. In other words, for example, a patient might come in, I trust, and kind of complain of things in general, correct?

A. Yes.

Q. All right. And would it also be fair to say that the examination portion of that first visit is an important aspect of what a physician does?

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

A. Yes.

Q. All right. And from your experience have you found things on examination, for example, that

the patient didn't necessarily complain to you about?

MR. YOUNG: Objection to the form of the leading question.

A. We find significant asymptomatic conditions in medicine all the time.

Q. And tell me what you mean by that.

A. As an orthopedist you're a little more localized in your examinations based on complaints. But if a patient comes in with foot pain, a physician may notice arthritis in the hip or the knee. If he comes in with knee pain, they may have an arthritic hip.

What I'm saying is there are unrecognized by the patient symptomatic and unrecognized asymptomatic conditions that are picked up on physical examination by physicians all the time, much more prominent in the internal medicine field than in the orthopedic field, but, you know, this occurs somewhat routinely.

Q. All right. So would it be fair to say that the fact that a patient doesn't per se complain about something doesn't mean that the patient doesn't have it?

MR. YOUNG: Note an objection to the

form of the question.

A. That's correct.

MR. SPISAK: All right. I have nothing further. Thank you, doctor.

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RECROSS-EXAMINATION OF ROBERT MARK FUMICH, M.D.

BY MR. YOUNG:

Q. Doctor, if a patient came in to you complaining about soreness arising from a lipoma on the foot and you were to find a tender condition between the toes that they didn't know they had and they'd never had pain before, you wouldn't recommend surgery for Morton's neuroma, would you?

MR. SPISAK: Note my objection.

A. If they told me they were asymptomatic and they told me they had no pain and that was the line of questioning and those were the answers she was giving me, then I would not operate on her.

MR. YOUNG: All right. Thank you.

MR. SPISAK: Thank you, doctor. I have nothing further.

VIDEOTAPE OPERATOR: Doctor, you do have the right to review the transcript of this deposition and to review the videotape

or you may waive such rights.

A. I'll waive.

VIDEOTAPE OPERATOR: Counsel, will you waive filing?

MR. SPISAK: I assume we can, Chuck?

MR. YOUNG: I'm sorry?

MR. SPISAK: We can waive filing?

MR. YOUNG: Yes.

(Signature waived.)

C E R T I F I C A T E

The State of Ohio,) SS:
County of Cuyahoga.)

I, Sandra L. Mazzola, a Notary Public withir and for the State of Ohio, authorized to administer oaths and to take and certify depositions, do hereby certify that the above-named ROBERT MARK FUMICH, M.D. was by me, before the giving of his deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above-set forth was reduced to writing by me by means of stenotypy, and was later transcribed into typewriting under my direction; that this is a true record of the testimony given by the witness, and the reading and signing of the deposition was expressly waived by the witness and by stipulation of counsel; that said deposition was taken at the aforementioned time, date and place, pursuant to notice or stipulation of counsel; and that I am not a relative or employee or attorney of any of the parties, or a relative or employee of such attorney, or financially interested in this action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland, Ohio, this 5th day of May A.D. 19 99 .

Sandra L. Mazzola

Sandra L. Mazzola, Notary Public, State of Ohio
14237 Detroit Avenue, Cleveland, Ohio 44107
My commission expires January 26, 2002

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