Deposition of Gerald V. Yu, D.P.M.

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HENDERSON CIRCUIT COURT
- - - -
SHEILA ANN PARKEST,)
Plaintiff,)
vs.) Case No.
PETER J. DOLL, D.P.M.,) 95-CI-00079
Defendant.)
- - - -
Deposition of GERARD V. YU, D.P.M., a witness herein, called by the Plaintiff as if upon cross-examination, and taken before Lynn A. Regovich, Notary Public within and for the State of Ohio, pursuant to agreement of counsel, and pursuant to the further stipulations of counsel herein contained, on Friday, the 5th day of January, 1996, at 2:00 p.m., at the offices of Gerard V. Yu, D.P.M., 26250 Euclid Avenue, City of Euclid, County of Cuyahoga and the State of Ohio.
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APPEARANCES:

On Behalf of the Plaintiff:
PRISCILLA DIAMOND, ESQ.

On Behalf of the Defendant:
Stites & Harbison, by:
MARY BOAZ, ESQ.

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PROCEEDINGS
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GERARD V. YU, D.P.M., of lawful age, having been first duly sworn, as hereinafter certified, was examined and testified as follows:
- - - -
CROSS-EXAMINATION
BY MS. DIAMOND:
Q Would you state your name, please?
A Gerard Vincent Yu.
Q And it's Dr. Yu and you're a podiatrist, aren't you?
A Yes, ma'am.
Q Dr. Yu, I have before me your CV, and it's very interesting. I see that you were trained at Doctors Hospital in Tucker, Georgia; is that correct?
A Yes, it is.
Q And who did you work under there?
A Oh, a whole relatively large department of attendings. Mostly podiatrists and some D.O.s and M.D.s.
Q Are you familiar with Dr. Stanley Kalish?

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A Yes.
Q Did you work with him or under him?
A Yes, he was one of my attending physicians.
Q Okay. And what do you think about Dr. Kalish?
A Well, Dr. Kalish is a professional colleague and a friend.
Q Okay. Have you discussed this case with Dr. Kalish?
A No.
Q Have you discussed this case with anyone?
A Meaning?
Q Anyone other than the attorney who represents Dr. Doll?
A No.
Q Have you discussed it with Dr. Doll?
A No. Dr. Doll and I have had no conversation.
Q Do you know Dr. Doll?
A Yes.
Q How do you know Dr. Doll?
A Through his publications.
Q Okay.

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A On a professional basis only.
Q All right. Have you ever attended any meetings or seminars with him?
A Not that I'm aware of. I'm sure he's been in seminars and meetings where I've lectured. Virtually all the meetings I go to I'm lecturing, so.
Q All right. You do not recall having socialized with him?
A No, ma'am.
Q Or anything of that nature? And I understand that you also trained in Philadelphia; is that correct?
A I did my podiatric medical studies at the Pennsylvania College of Podiatric Medicine.
Q All right. And you were trained in part by Dr. Weissman; is that correct?
A Dr. Weissman was one of my instructors.
Q Yes. And so he taught you; is that correct?
A Yes, he did.
Q Okay. For how long?
A I think one course.

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Q Okay.
A And he may have also been a clinician for part of the time.
Q Meaning?
A He was in the clinic setting as an attending physician.
Q And supervising your work?
A To some degree, yes.
Q Okay. Do you have any sort of a personal relationship with Dr. Weissman?
A No.
Q All right. And how do you feel about Dr. Weissman professionally?
A I acknowledge him as a colleague.
Q Okay. And do you think he's well qualified?
A In what area?
Q The area of podiatry.
A I really can't comment on his qualifications now as a practitioner. I've really had no contact with him or known much about his style of practice for the last – since I graduated.
Q Okay. And how did you regard him while you were in school?

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A We got along very well.
Q Okay. And do you regard him as a competent and qualified podiatrist?
A I did at that time.
Q Okay. And you've no reason to change that opinion?
A I know he practices differently now than he used to and he changed some of his methods of practice.
Q How do you know that if you've had no contact with him?
A Because I've been in contact with some of the instructors up in that area over the years and I've kept a pretty good relationship with people that have graduated from there and students who come from there.
Q And when you say he's changed his methods of practice, what specifically do you mean?
A The biggest one I heard about probably maybe ten years ago was he moved into the realm of minimal incision surgery.
Q Minimal incision surgery?

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A Yes, ma'am.
Q And do you do minimal incision surgery?
A Very limited.
Q But you do some?
A Yes.
Q Is that a new thing?
A No. Not now.
Q Not ten years later?
A I'm not sure it was that new then. I think it was definitely new to him I think.
Q You have lectured quite a bit for drug companies, haven't you?
A I'm not sure I understand what you mean by "Drug companies."
Q Well, you list in your professional activities "Speakers bureaus," and they're all for pharmaceutical companies, right? Or medical – it looks like they're all for pharmaceutical companies or medical equipment companies. Is that true?
A They're definitely all companies that are somehow involved in the medical field.
Q Okay. Well, you list them, you say you are a member of the Bristol-Myers Squibb

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Company speakers bureau, is that a correct way to put it?
A Yes.
Q And that's a drug company, correct?
A Yes, ma'am.
Q And Pfizer Laboratories?
A Yes, ma'am.
Q And that's a drug company?
A Yes.
Q And you list Pfizer Laboratories I think twice. Glaxo Pharmaceuticals, it's a drug company?
A Yes.
Q Wright Medical Technology. What kind of company is that?
A They're a prosthesis and implant company.
Q Okay. And Biolectron. What kind of company is that?
A A medical equipment company specializing in electrical bone stimulators and internal fixation devices.
Q And SmithKline Beecham Pharmaceuticals is a drug company, isn't it?
A Yes.

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Q And the Upjohn Company is also a drug company?
A Yes.
Q So when you speak for them, they pay you, don't they?
A Not necessarily pay me, no.
Q Or they provide you with some sort of remuneration on honorarium or something in the way of compensation?
A Or they give it to the – they make a donation to the organization, an educational grant or something. Sometimes they pay me or give me an honorarium directly for my involvement in the meeting.
Q And when you speak on part of their speakers bureau, that is what I'm talking about now, they either pay you or they provide you with an honorarium or something, is that what I'm understanding?
A Yes.
Q Okay. And some sort of remuneration; is that correct?
A Yes.
Q Okay. And what are you speaking about

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when you speak for them? Are you speaking about their products, their drugs or their medical device, implant device or whatever it is?
A No. I've never given a presentation that highlights or specifically is geared toward a company's particular product.
Q All right. So when you're part of their speakers bureau and are remunerated in some way or compensated in some way by them, you're speaking on just any old topic?
A Could be. Yes, ma'am.
Q Okay. Are those the lecturing experiences that you have listed in your – in your resume, CV?
A Most of them are there, yes.
Q Okay. And so those are speaking engagements that you have taken as a result of your being on these various companies speakers bureaus?
A No.
Q Are they in addition to or, you know, some of them are part of that?
A Some of them – there's only one type

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of presentation that's directly tied in with any of the companies and that would be the lecture series that Bristol-Myers Squibb provides across the country.
Q But you lectured in your speaking experiences that you've listed here in detail in your CV, you've lectured extensively on the use of antibiotics, correct?
A Well, I'm not trying to be difficult but I'm sure I've given lots of lectures on antibiotics. I've never tallied them all.
Q In fact, a great number of these are about the use of antibiotics, correct?
A Meaning the different presentations I've done?
Q Yes, sir.
A I've never tallied it up. I really don't know.
Q Well, we can count them at some point, but are these antibiotics that are produced by the companies who you list here as being speakers bureaus of which you are affiliated?

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A Not necessarily.
Q Well, are they in part?
A Not necessarily.
Q Well, whether they necessarily are or not, I want to know if they are at all.
A Well, I explained it to you earlier. I said there's one company there that has a series of lectures that I give when requested that deal specifically with their line of products. They are the only company that I do that with.
Q All right.
A The other companies – let me finish. The other companies I may be in their speakers bureaus but I do not call and/or solicit anyone to sponsor me for presentation. If an organization in this country requests me to speak at the meeting, I simply tell them what the arrangements are that I require, what my requirements are as a speaker, and if they get a corporate sponsor, that's fine, if not, then they're responsible for whatever my charges are.
Q Okay. If they get a corporate

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sponsor, are you – do you then consider yourself a part of that corporation speakers bureau and list them on your resume the way you did there?
A Usually if I have listed it there they have indicated to me that I am listed in their corporate speakers bureau that they give to I guess people that work for them. Let's say field representative, district managers, educational people in their company.
Q Okay. And what do you require in order to speak?
A It varies. Sometimes it's nothing, sometimes it could be a thousand dollars or more.
Q Okay. Do you know about how many times a week or a month on an average you speak someplace?
A I would say it averages between 15 and 30 per year.
Q 15 and 30 per year. And about what do you make in remuneration for speaking 15 to 30 times a year?
A I really couldn't tell you that. It

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varies from year to year. It varies quite a bit actually.
Q Average? Any average?
A It could be as low as 10,000 a year to as much as 30.
Q Okay. Do you believe that anything you have listed here under your lecturing experience or under your publications bears any direct relationship to any issue in this case?
MS. BOAZ: Do you need to review your CV?
THE WITNESS: No. Probably not.
A No.
Q All right. So while you have lectured considerably and written about some things, none of the things about which you have lectured or written directly concern any issue in this case; is that correct?
A Not that I can think of at this moment, that's correct.
Q So it is correct. Okay. If for any reason this or any – you believe that that answer is not correct and you think of

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something that is before the end of this deposition, will you tell me about it?
A Certainly.
Q Okay. Of course this deposition is the only opportunity I have to talk to you and I would expect that your answers here will be complete and I would certainly expect that you will be bound by them, so if you do think of something, will you let me know?
A I will at least let my attorney know and hopefully she'll communicate that with you.
Q Before the end of this session, correct?
A Yes.
Q Thank you. Now, I normally start out by telling people that I represent Sheila Parkest and that's what I'm telling you, and that I'm going to be asking questions and if you don't understand the questions, I would request that you let me know that you do not understand them, will you do that?
A Certainly.
Q Okay. That you need to answer

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questions yes or no because the court reporter can't get down an accurate "uh-huh" or "huh-uh," and I didn't start out that way with you, Dr. Yu, because it was my understanding that you are very experienced in this area of giving depositions; is that true?
A People have characterized me as that way, yes.
Q How many times have you given a deposition of any type?
A I think probably at least 50.
Q And how many times have you given depositions in podiatry malpractice cases?
A All of my depositions that I can think of to date have in some way related to podiatry, whether it's an injury at a store by somebody where I never treated them. They're all in essence tied into foot and ankle problems, or leg problems.
Q Sir, the question was not was it related to podiatry, but to a podiatry malpractice case.
A Probably 90 percent.
Q Okay. And how frequently have you

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testified in court in podiatry malpractice cases?
A I believe I can only estimate, probably five or six times. It could be more.
Q Do you have a list of the cases, the podiatry malpractice cases which comprise you say maybe 90 percent of the depositions that you have given in which you have testified and the court cases in which you have testified at trial –
A No.
Q – that you can provide me?
A No.
Q Can you get that information and provide it to Ms. Boaz?
A No.
Q Why not?
A Because once I've completed the case, I either return all the records or I destroy them. I keep no records other than what I need to keep for tax purposes only, and only until my accountant tells me I no longer need to keep those materials for tax purposes.
Q All right. Doctor, I'm going to ask

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you to start telling me the cases that you have testified in, because I'm entitled to that information, and if I can't get it directly from you, or if you can give it to Miss Boaz she can give it to me, I'm going to ask that a Court order you to produce that information. So I would like you to do your very best to give it to me or Miss Boaz and tell us now what it is you can tell us about that subject.
MS. BOAZ: Well, he has said he may not be able to give you all the information is what he just testified. You can ask him –
MS. DIAMOND: I think I'm entitled to that information, Doctor, and so I'm going to ask that you provide it to me now as best you can, to Miss Boaz, and I'm going to ask the Court to order that you provide it.
A You may do that.
Q All right. What can you tell me now about the, for example, cases that you have testified in this year?
A None.

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Q Have you given depositions in anything this year besides this case?
A No.
Q What about in 1995, either testified or given depositions?
A Yes.
Q All right. Will you tell us what cases you testified in either by deposition or at trial?
A I don't have any of the names of the cases at hand. I can only tell you right now the one that comes to mind was a trial that was held in Albany, New York last year is the only one I can tell you specifically. I don't know the names.
Q Who are the parties to that?
A I do not know names.
Q Who was the lawyers involved in that case?
A I do not know.
MS. DIAMOND: Mary, I'm going to move that he be ordered to produce a complete list of all cases in which he has testified. Certainly if you can get together with him after this

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deposition and produce that information to me, I won't have to make that motion and we can avoid that hassle. So I just want you –

MS. BOAZ: We'll get whatever we can.

MS. DIAMOND: I just want you to be aware that that's going to occur, because I think that clearly and unequivocally I'm entitled to it.

Q Doctor, you have spoken a number of times for these various drug companies on the subjects that you've listed here and at various meetings and so forth. Do you believe that one of the reasons that you're called upon to do that is because you're an interesting speaker?

A Yes.

Q Is it also because sometimes you take a unique perspective to certain things?

A I don't know. That's never been given to me as a reason, but I think people find me to be a very interesting speaker and a very audience captivating speaker.

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Q And do you take sometimes a very unique perspective?

A I'm sure people think I do. I think sometimes my perspectives are different.

Q Perhaps different than other podiatrists?

A Oh, I'm sure.

MS. DIAMOND: Let's go off the record for a moment.

(Discussion had off the record.)

Q You think that you do take a little bit different perspective than many other podiatrists; is that correct?

A I'm not so sure it's my perspective. I think it's my delivery and my – maybe it's partly perspective, my way of trying to help my colleagues look at things and formulate ideas about treating patients with foot and ankle conditions.

Q Let's take it this way. On a continuum, there's the very conservative end and then there's the very non-conservative or more unique or unusual end of the practice of podiatry. Would you place yourself at that end, of the

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more unusual, less conservative end?

A No, actually I wouldn't. Actually, people who know me well will tell you that I'm actually a very conservative practitioner. I think people get the impression from the topics I present that I see some very as you described on a continuum far out conditions, complex and interesting, challenging cases, but my actual approach to foot and ankle medicine and surgery is actually conservative.

Q Well, then would you – I guess perhaps the correct word is "different." While you may see yourself as conservative, your approach sometimes is different than others?

(Interruption in proceedings.)

(Question read.)

A I'm sure it is.

Q Doctor, can you tell me everything that has been provided to you in this case to review?

A Sure. I can also show it to you if you'd like.

Q Yes.

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A This is basically the material that has been – this is all the material that has been provided to me to review to date, and the condition you see it here is how it was. It was bound and sent to me with the exception of correspondence. That is not here.

Q All right. Do you have the correspondence?

A Here with us?

Q Yes.

A No, I do not.

Q Do you have it in your office?

A No, I do not.

Q What did you do with it?

A I maintain my legal files and correspondence at home, my home office.

MS. BOAZ: We're not going to produce our correspondence.

Q When were you first contacted about this case?

A I can only tell you sometime in 1995. I don't even know the month.

Q All right. Who contacted you? How did you hear about it?

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A Well, it was one of the – one of two mechanisms. It was either OUM contacted me or had somebody in their claims office contact me first, or Mary Boaz may have contacted me first, and to be honest I don't know.
Q OUM is Dr. Doll's insurance company?
A I believe so.
Q You think they may have contacted you first?
A I'm saying I don't remember and frequently they're the first ones to contact me.
MS. BOAZ: He said he doesn't know if it was OUM or us.
A Or PICA, I'll put PICA in there.
Q Who's PICA?
A Another insurance carrier.
Q Do the insurance carriers pretty routinely contact you to review cases for them?
A I would say one-third, one-half the time they'll call and somebody from the office who has been assigned to the case will contact me, even before an attorney

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has contacted me.
Q Okay.
A Sometimes it's a doctor and other times it's the attorney.
Q Okay. Have you been contacted by Dr. Doll?
A No, I don't think so.
Q Have you talked to him about this case?
A I don't believe I have. I don't recall any conversations with him.
Q Have you talked to any other podiatrists about this case?
A No.
Q Have you talked to any other doctor of medicine about this case, any doctor of medicine?
A No. I have created a case scenario and asked some of my colleagues if they've ever seen some of the conditions that are talked about in here. Not for purposes of discussing this case, but just to see if they ever had.
Q Well, but it was this case that you were talking about, right?
A No, not really because I have other

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cases that are – involve this case, and actually the reason it came up, this is just another case in the same realm, I actually have a patient who I'm dealing with with a very similar entity which is actually how the conversation got started. For example, my partners in my practice.
Q All right. Who have you provided any scenarios from this case or from a similar case to?
A Well, primarily my partner, one of my partners.
Q Okay. And what particular part of this case did you reference to him?
A The nerve disorder.
Q Tell me what it was you discussed with him.
A Simply asked if he had seen anybody in his own or what would he do if he had somebody that had a nerve entrapment, involving a nerve, this particular nerve in the bottom of the foot and the big toe.
Q And what did you all discuss about what you would do? What did he say, what did you

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say?
A I don't really remember. It was just general conversation. If I had to, I'd take the nerve out maybe. As you know, I try conservative care first, it was basically that type of – the gist of the conversation. And that was probably about it. It was probably no more than a two-minute discussion.
Q You have two copies of Dr. Donley's deposition here. Is there any particular reason?
A I think I might have – I received one first and then counsel wasn't sure if I had received – had that one originally.
Q Is this the second set of depositions that you have received?
A I don't know.
MS. BOAZ: What do you mean the second set of depositions?
Q I mean, did you receive another set of depositions of these same depositions from the defense attorney in the case?
A No.
MS. BOAZ: Of all of these

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depositions you mean?
MS. DIAMOND: Yeah. Any or
all of them.
A Everything I received is here in
front of you.
Q Okay.
A So if there's two depositions, then
those were the two exactly as I received
them.
Q Okay. Is this something that you have
written on this?
A I'm sure it is.
Q Is this something that relates to this
case?
A I don't know. I have to look at it.
Q Will you read it to me?
A Well, what I can read, two years –
two years baptist medical center. I don't
know what the second thing is. Maybe it's
vitamins or – I don't know. I think that
says Vietnam. I don't know what the
second word is though. And psych
orderly. That must relate to this case I
think.
Q You have tabs that you've placed here.

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Have you placed them or has someone else
placed them?
A I placed them.
Q Okay. We'll talk about that in a
minute. Have you reviewed these x-rays?
A Yes, ma'am.
Q And do you know how many x-rays you've
received?
A No.
Q Have you –
MS. DIAMOND: Let me just
ask, counsel, did he receive the same
complete set of x-rays that your other
expert Dr. Nava received?
MS. BOAZ: He should have.
Q Okay. Doctor, have you done any
research or found any books or articles that
you think bear any relevance to the issues
in this case?
A In my initial review of the case I
looked quickly through some references I had
on my own library shelf just to confirm
radiographic interpretation of some of the
issues in the case. Did I read the articles
and – no, I did not.

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Q What books did you refer to to
confirm radiographic interpretations?
A I looked in Dr. Weissman's book on
radiology. I looked in the comprehensive
textbook of foot surgery, I looked in a
book that was authored by I believe Josh
Gerber.
Q I didn't –
A Joshua Gerber. I don't know the name
of the book. I looked at a couple
orthopedic texts, Campbell's I think, may
have been Josh's book also. That's all I
can recall.
Q Have you researched any articles to
support any opinion that you plan to give in
this case?
A No.
Q Okay. Do you plan to do that?
A If requested by counsel.
Q But you have not at this point and have
nothing to tell me about; is that correct?
A No, I've done no literature reference
or literature reviews on these issues.
Q Of course I'm going to object to his
testifying from any article that he hasn't

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told us about now or regarding any article
he isn't telling us about now.
MS. BOAZ: Have you gone
through the articles, Doctor, that – have
you told her all the articles?
THE WITNESS: The ones that
I can think of, yes.
Q Were you provided any articles by
defense counsel?
A No.
Q Or by the insurance company?
A No. I have not – I know--
Q Or Dr. Doll?
A I don't think so. Not that I can think
of.
Q All right. Has Dr. Doll provided you
anything?
A No. As I mentioned, Dr. Doll and I, I
don't think we ever even talked about this
case.
Q Okay.
A I don't want you to think I'm trying
to be evasive to your questions. I have a
lot of malpractice cases so I don't know
who I talked to. I try not to talk to

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anybody because I don't believe expert witnesses should be talking to defending physicians and I make it a general rule not to but I can't control that if somebody picks up the telephone. But I have no recall of him ever calling me to discuss this matter at all.
Q Okay. We were on the subject of articles. Let's move on for a moment to something else.
Dr. Yu, what happens if – what is likely to happen to a bone, first metatarsal in the foot if it is put in a position that is too low, too depressed?
A Repeat your question to make sure I understand it correctly.
Q If through surgery the first metatarsal, the metatarsus primus I believe is the way you podiatrists refer to it, is placed in a position and if it is lowered or depressed too much what happens? What happens to the bone itself?
A What do you – what are you using as a reference for too much?
Q More than the bone is comfortable

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with. Does the bone show signs of stress under such a circumstance?
A It may.
Q And what are those signs of stress?
A The – a bone which has too much stress in terms of being overloaded could develop a stress fracture.
Q Are there others?
A Could manifest some x-ray changes at another joint level because of an impingement or jamming.
Q What might you find on the bone itself?
A I don't think I understand your question.
Q Okay. Let me see if I can ask it differently.
A Okay.
Q Have you reviewed all of the x-rays that were provided to you?
A Yes, ma'am.
Q Okay. Both pre and post-operatively?
A Yes.
Q Have you reviewed all of the x-rays both before – well, you have reviewed the x-rays of Dr. Donley as well as the x-rays

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of Dr. Doll?
A Yes, I presume some of them are from Dr. Donley's. I never really checked them from that perspective.
Q Okay. Did you notice anything significant with regard to the first metatarsal after this surgery and prior to Dr. Donley's surgery?
A Notice anything significant?
Q With regard to the bone itself.
A The bone was cut and transpositioned.
Q Okay. And what else?
A That's basically it.
Q Did you look for cystic changes on that bone?
A Not specifically, no.
Q What would cystic changes indicate?
A Could indicate nothing, and it could indicate that there's some bone process taking place such as a slow union or slow healing, arthritic changes in the joint nearby, a reaction to a pin or screw that's in the area, avascular necrosis.
Q Are cystic –
A Infection.

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Q Are cystic changes sometimes seen on a first metatarsal, a bone, when it is bearing too much weight?
A I've never – I've never heard that really or read about that as being a manifestation of excessive weight bearing.
Q Okay. If there's too much pressure on the bone as a result of being lowered, will it sometimes show cystic changes?
A That's not something I'm used to seeing, no.
Q Okay. Under what circumstances do you see cystic changes after surgery?
A In the ones I just described.
Q Explain them to me. Under what circumstances are you used to seeing cystic changes?
A Well, I'm not used to seeing a lot of cystic changes at all in the first metatarsal bone after surgery other than if they're – a patient has some bone healing complication related to the surgery.
Q Would cystic changes be very painful?
A Cystic changes from any etiology could be painful and they could be totally

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asymptomatic.
Q Okay.
A Cystic changes are a very common observation in general on foot x-rays, or I should say they're not uncommon, especially in older patients.
Q And if a bone is depressed, a metatarsal, a first metatarsal is depressed to a point where there's excessive pressure on it, would it be fair to say that that bone might begin to show osteoporotic type changes, cystic type changes?
A I would say absolutely not.
Q You think that doesn't ever happen?
A You said commonly, or you implied commonly and I said no. Does it ever happen? It could happen, but I can honestly say I've never seen it in my time being in practice where the bone has become cystic because of excessive weight bearing to it.
Q Okay. Have you ever seen a bone, a first metatarsal become cystic under any circumstances?

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A Yes.
Q What are the circumstances under which you have seen first metatarsal become cystic?
A In the list I gave earlier where patients have arthritic changes, may have had a previous surgery and a complication from that, may be having a reaction to the pin, may be developing an avascular necrosis of the bone, may be developing a bone tumor or as part of the normal aging process.
Q Have you ever seen such changes in a bone be reversed?
A You mean spontaneously reverse themselves?
Q No, reversed by some action.
A Sure.
Q Under what circumstances would that – can you reverse such a process?
A I've seen it reversed as a result of just time. I've seen it reversed with surgery if it's a big enough cyst that could be treated surgically.
Q What kind of surgery?

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A Well, usually a surgery to remove the cyst and replace it with other bone.
Q Other kinds of surgery ever help such changes to reverse themselves?
A Not that I can think of.
Q Okay. Do you have a record of the time that you have spent on this case?
A Not a separate record, no. The only record I would keep is in the course of my Daytimer calendar. If I am spending time consulting with somebody on the telephone, I may keep a log if I remember to do it of the date or enter it in my daily ledger of activities that I spent 20 minutes talking to you or some other attorney relative to a –
Q How do you bill?
A I bill according to my fee schedule.
Q What is your fee schedule?
A I don't know what the fee schedule says.
Q Well, I mean, what are you billing for the review that you have done and the time you have spent on this?
A I'd have to look at the fee schedule.

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And if I exceed the number of hours for the initial review, well then I'll know.
Q I'm lost. You'll have to explain that to me better. I don't understand.
A Okay. I'll be happy to but I need to have a copy of my fee schedule to do that.
Q Can your secretary bring it down?
A Sure. Or she may have one.
MS. BOAZ: I may have a copy.
A Actually, I understand you were provided with a copy of it. No?
Q No.
MS. BOAZ: I think it was too late. We got it late. We called – somebody called your office. Did you get a call about his fees for the deposition?
MS. DIAMOND: Yes.
MS. BOAZ: Okay.
THE WITNESS: So can we go off the record for a moment?
MS. DIAMOND: Sure.
(Discussion had off the record.)
BY MS. DIAMOND:
Q Have you prepared a report in this

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case?
A No, ma'am.
Q Okay. Have you spent pre-deposition
consultation time?
A Yes, ma'am.
Q Okay. So you charge $250 an hour for a
case review with a minimum of three hours,
$150 an hour to prepare a report, but you
have consulted prior to the deposition,
haven't you?
A Yes.
Q You have spent additional time. Do you
have a record of how much time you spent?
A In my Daytimer as I mentioned, yes,
for some of it.
Q Okay. But you don't have any record
here with you today?
A No. Definitely not.
Q Okay.
MS. DIAMOND: Can you
produce that?
A Can I produce my calendar?
Q No. I just wanted – I don't want
your calendar. I just want to know how
much time you spent on our case so far.

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A If you want an estimate, I'd be happy
to give you an estimate right now.
Q Okay.
MS. BOAZ: That's fine.
A The initial review was a minimum of
three hours, that's probably been exceeded
because after the initial review there was
some supplemental materials that were sent
which probably took one or two hours.
There was maybe an hour at the most of
total telephone legal consultation time to
date, and the maximum would be one hour
for pre-deposition consultation conference
prior to today. And perhaps about 30
minutes of browsing through the – 30
minutes to an hour going through the texts
that we talked about earlier.
Q Have you tabbed what you consider to be
significant in the medical records, or what
is the reason that you have tabbed what you
have tabbed?
A Usually what I tab is pertinent items
at the time of first review so I can refer
back to them when I speak with counsel, or
I tab things that I think will need to be

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used in the course of the deposition so we
don't waste time trying to track something
down. That's usually it.
Q Okay. You, according to the attorney
in this case, have formed an opinion, and I
want you to tell me about your opinion in
this case. Will you tell me what it is?
A Yes. To do that what I would like to
do is ask counsel if I can simply refer to
what I've gone over with you before.
MS. BOAZ: To the
disclosure?
Q Have you prepared –
THE WITNESS: Right.
MS. BOAZ: The supplemental
disclosure that we provided to you is what
he prepared.
MS. DIAMOND: Is this what
you're talking about?
MS. BOAZ: Yes.
THE WITNESS: That looks
like it.
MS. BOAZ: Yeah.
Q Okay. Doctor, what role in assessing
whether or not there is elevated metatarsal,

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first metatarsal, does measurements play in
that determination?
A You're talking about clinical
measurements or x-ray measurements?
Q X-ray measurements or clinical
measurements. Tell me about that. What
role do measurements play?
A In the diagnosis of an elevated
metatarsal?
Q Metatarsal. First metatarsal.
A The most important thing is the
clinical diagnosis and assessment. And
x-rays would be used to supplement or to
further – could be used to further
document and substantiate the clinical
findings.
Q My question was with regard to
measurements.
A That's what I answered.
Q What do you measure clinically or on
x-ray and how do you do it?
A No, I think your question was how do I
measure –
Q No.
THE WITNESS: Could you

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(1) repeat the question for us that she asked
(2) originally, please.
(3) (Question read.)
(4) Q What role do measurements play in that
(5) determination?
(6) A That's the answer I gave you.
(7) Q You haven't mentioned what you would
(8) measure or how you would measure it.
(9) That's what I'd like you to do.
(10) A Now you're asking me rather than
(11) answering the question of what role do
(12) measurements play, now you're asking me to
(13) define –
(14) Q You haven't told me at all what role
(15) measurements play yet, but I'll ask the
(16) question differently if it would be
(17) helpful to you.
(18) A Sure.
(19) Q What if anything would you measure and
(20) how would you measure it?
(21) A If you're defining measure as
(22) determining a number for relationship, I
(23) measure nothing. For the condition of
(24) metatarsus primus elevatus.
(25) Q You would measure nothing?

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(1) A Nothing.
(2) Q So you do not –
(3) A I –
(4) Q – think –
(5) A Let me finish my answer.
(6) Q Sure.
(7) A I have in 12 years can think of no
(8) cases in which I have treated either
(9) metatarsus primus elevatus or any
(10) metatarsus elevatus. Actually measured a
(11) number as part of my evaluation and
(12) assessment of the patient until
(13) determining what treatment I would provide
(14) or the treatment that I provided.
(15) Q So do you just sort of eyeball it and
(16) decide whether or not it's elevated?
(17) A I use my eyeballs to look at it and I
(18) use my hands and I use the x-rays to get
(19) an idea of the relationship of the bone.
(20) Q How do you use the x-rays?
(21) A How I use the x-rays to determine
(22) length and position and condition of the
(23) bone.
(24) Q And you don't think it's necessary to
(25) determine, for example, if you have an

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(1) elevated first metatarsal how elevated it
(2) is?
(3) A No, ma'am.
(4) Q How do you decide then if you're going
(5) to lower it, how much you're going to lower
(6) it?
(7) A By clinical judgment in surgery.
(8) Q So it's just again sort of eyeballing
(9) it and doing so much?
(10) A You don't just eyeball it. I go by
(11) feel of one bone to all the other bones in
(12) the foot you think are important in
(13) determining the position of the bone
(14) you're operating on.
(15) Q So you would never measure angle of
(16) declination?
(17) A No, I didn't say I would never
(18) measure angle of declination. I have not
(19) in my professional career can I think of
(20) in treating a patient actually determined
(21) the measurement of the first metatarsal
(22) declination for purposes of making my
(23) diagnosis or establishing what I'm going
(24) to do or how I'm going to do what I'm
(25) going to do in surgery.

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(1) Q Under what circumstances would you
(2) measure angle of declination of the first
(3) metatarsal?
(4) A Primarily when I'm in a teaching
(5) situation for people to understand
(6) relationships of that first metatarsal
(7) declination to a global picture.
(8) Q And why would you teach them that if
(9) you don't want them ever to use it?
(10) MS. BOAZ: I don't know
(11) that he testified –
(12) A I never said –
(13) MS. BOAZ: – to that.
(14) A I never said I don't want them to use
(15) it.
(16) Q Well, you don't use it, do you?
(17) A The actual measurement, of course
(18) not, because I don't usually measure it
(19) for purposes of treating a patient. But
(20) do I use metatarsal declination?
(21) Q Yeah.
(22) A As a factor in treating patients?
(23) Q Yes.
(24) A Oh, yes.
(25) Q For what purposes?

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A So I know what the condition is.
Q Okay.
A And I can see that in fact what I think I am feeling and seeing and observing clinically is in fact correlated with what I see on x-ray.
Q So you use it sort of as a confirmation?
A You could say that, yes.
Q Okay. Have you ever performed the same combinations of surgery that Dr. Doll performed, in this case lowering or depressing the first metatarsal and at the same time doing a sesamoidectomy beneath it?
A Yes.
Q How many times?
A Many.
Q Do you have evidence of that here and can you produce it?
A Well, I would not produce for you any patient records.
Q I'm going to ask that you produce any patient records and you may black out the names, redact the names of any record of any time that you have performed both of

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those simultaneously.
A Well, I'll tell you I won't do it because there's no easy way for me to do it.
Q Well, can you think of anyone you've performed it on?
A I can think of many patients that I've taken out the fibular sesamoid and cut the first metatarsal bone and repositioned it with part of that aimed at lowering first metatarsal. Absolutely. Now, to help you understand it and make this a little more realistic an issue, if you want to know about it in terms of as it refers to this case, which I presume is what you're trying to arrive at, I would ask that you address the questions from that perspective and I'll try to answer them for you.
Q Well, if you would like to relate what we are now discussing to this case in particular, go ahead, I'll be glad to listen to you.
A I don't want to do that unless there's something I can answer for you.
Q Does it relate to this case? Does

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the subject matter relate to this case?
A I really – to be honest with you, I think it's a matter of what your personal opinion is about it. If you want to ask me, is up down position of the first metatarsal important in the first ray, it's important in anybody doing any surgery on the first metatarsal. For example, let's take a simple condition, hallux valgus deformity.
Q We're not dealing with the hallux valgus deformity in this case, are we?
A Well, do you want to change the line of questioning?
MS. BOAZ: Just answer the question.
Q I just wanted to ask –
MS. BOAZ: Just answer.
Q – the question before we go on.
A No.
Q Let's talk about what we are dealing with in this case.
A Okay.
Q What do you think we're dealing with in this case?

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MS. BOAZ: Well, don't answer this question, Doctor.
Q Of course –
MS. BOAZ: No. You ask him a question and he'll answer it.
THE WITNESS: I can answer it for her.
MS. BOAZ: No. No. Don't answer that question.
Q Well, what do you think Dr. Doll was dealing with?
MS. BOAZ: Do you mean what condition –
MS. DIAMOND: Yes.
MS. BOAZ: – the patient had?
Q What condition do you think Dr. Doll had to deal with?
A Based on my review of the records, Dr. Doll was dealing with a patient who had a nerve irritation or some type of nerve problem in relationship to a fibular sesamoid, which is part of the problem, and a condition that he diagnosed as metatarsus primus elevatus.

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Q All right. Let's talk about it in connection with what you believe Dr. Doll was dealing with. All right. Do you believe that there was a metatarsus primus elevatus?
A Based on his review of the records and x-rays, yes.
Q All right. Based on what now?
A Based on my review of the medical records and the x-rays, yes.
Q All right. Based on what Dr. Doll said in his medical records?
A Well, based upon his medical records of the patient.
Q All right. And based upon the x-rays?
A Yes.
Q Okay. Was there any x-ray that you believe prior to Dr. Doll's surgery demonstrated metatarsus primus elevatus?
An elevated first metatarsal or first ray as you podiatrists like to say?
A Either way. Yes.
Q Okay. And how did you determine that the first metatarsal was elevated in any x-ray if you didn't measure any angle?

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A By visualizing the bone in relation to all the other bones that are on the x-ray.
Q Okay. Did you measure any angle of declination?
A No.
Q And you did say that if it was – if you were doing this, you would use a measurement of the angle of declination to confirm your opinion; is that correct?
A I may, yes.
Q But you did not in this case?
A I used all of the material that was given to me.
Q No. Did you measure angle of declination on whatever x-ray you believe showed a metatarsus primus elevatus?
A I think I stated earlier, no.
Q Okay. Did you think it was not necessary?
A Wasn't necessary for me to do so.
Q Okay. Do you know what a normal declination number would be, a normal degree of declination for metatarsus – first metatarsal, first ray?
A First of all, there's no one number.

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Q Is there a range?
A Well, secondly, you can argue there is a range, but it would not be widely accepted in a profession that if you fell outside of the range that you could not have a normal foot. I know it's probably hard to understand that, but I'll give you a range. An accepted range would be 15 to 25 degrees, perhaps up to 30.
Q But if –
A Let me finish.
Q Sure. Go ahead.
A If you ask a podiatrist, all podiatrists practicing in the country to give you a number, the closest number to the average as we accept as a metatarsus declination, it would be 20 degrees plus or minus one or two degrees because this is what I understand and at the time I was teaching was being taught and I think to some degree still is. Now, you'll have patients that will fall outside of that range that I gave you, but actually have – would be considered as having a normal foot, even though they fall outside of that

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range. So consequently I don't know that using the number or the range by itself would have a lot of meaning. For this condition most people would correlate it with a clinical symptomatology and clinical findings maybe even more so than a lot of other things we do measure on x-ray where angles seem to be more important.
Q All right. Let me see if I can paraphrase what you said so I can be sure that I understand at least some of what you said.
A Okay.
Q What you have said is that a normal range might be 15 to 30, but that if you were looking for a normal – real normal number, it would be 20 plus or minus one; is that correct?
A One or two degrees, yes, ma'am.
MS. BOAZ: I think he said an average number.
A Average number.
Q Is that an average number for a normal degree of declination of the first ray?

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A I think that would be the number if you polled all podiatrists. Give me a number of the closest to the normal first metatarsal declination. It would be 20 degrees plus or minus one or two degrees.
Q If I understand also what you said, you can be outside of that range and still have a perfectly normal foot?
A Yes. Maybe a better way to say that would be a normal functioning foot that doesn't necessitate any treatment or require any conservative or surgical care.
Q Okay. Do you know what the angle of declination was for Sheila Parkest before Dr. Doll operated on her foot?
A No, I don't.
Q Would you be surprised to learn that it measures 21 degrees?
A Not really, because I know there was something in his deposition dealing with this whole issue.
Q Okay. So she would have what would be considered by most podiatrists a perfectly normal degree of declination before he operated on her; is that

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correct?
MS. BOAZ: If she had 21 degrees? I don't think there's any testimony in the record that she had 21 degrees.
MS. DIAMOND: If she had 21 degrees.
Q Okay. If she had 21 degrees she would have had a perfectly normal degree of declination at the time Dr. Doll operated on her, before he operated on her?
A The only way I can answer your question is to say if you ask all the podiatrists the question, I have a patient with a metatarsal declination of 21 degrees, would that be normal. I think the answer you're going to get is it could be.
Q Okay.
A I think that's what the vast majority of podiatrists would tell you, yes, it certainly could be.
Q But would they also think that it might not be?
A I think a good practicing physician is

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going to say, immediately going to have a flag raised in their mind, say it may or may not be, depends on what the rest of the patient's foot is, or what kind of problems they have had, have they had any work done before, what kind of symptoms do they have.
Q On what basis do you believe that Dr. Doll determined that Sheila Parkest had an elevated first metatarsal?
A My understanding from reviewing of records is both clinical and radiographic.
Q Based on x-rays, he talked about a shadow on an x-ray, didn't he, in his deposition? Do you remember that?
A I remember something to that effect, but I don't remember the specific -- his specific testimony about it.
Q Let me ask you this. Do you follow the shadow method of reading x-rays in determining whether or not there's a raised metatarsal?
A I never understood exactly the shadow theory. I look at the x-rays and whatever I can see and draw lines on is what I draw. Maybe that is the shadow thing or not, but

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I'm not sure what the shadow thing is.
Q When you say draw lines, what lines are you drawing? Tell me about how you would look at an x-ray to determine if there was an elevated metatarsal.
A Okay. Now, are you asking me about with drawing lines or just by looking at the x-ray?
Q Well, you said you would do it by drawing lines.
A What I'm saying is if I was drawing lines on the x-ray, I would just draw my lines based upon the lines I would see. I don't know if those are shadows.
Q Can you explain what lines you would draw?
A Sure.
Q Would you do that for me now?
A Sure. If I were to draw lines to assess first metatarsal position on an x-ray, I would draw lines that involve the first metatarsal, I would draw lines that involve the second metatarsal, I would draw lines that involve the talus and the calcaneus and probably a line that would

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represent the bottom of the foot.
Q And then what would you do with those lines?
A I would probably just look at them.
Q What would you be looking for?
A Where various lines would intersect.
Q And where they intersected would be of what significance to you?
A Depending on the patient's symptoms and my physical exam, it would mean a lot or it could mean really nothing. Really all depends on what my clinical findings are and what the complaint is.
Q Okay. You evaluated this case based upon in part those x-rays, correct?
A Yes, I reviewed the x-rays as part of the case.
Q All right. What did you see significant, if anything, in those x-rays at any time? What if – what about any of those x-rays do you think makes any kind of difference in this case, either to Dr. Doll's actions or to anything else that bears any importance to this case?
MS. BOAZ: Now –

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MS. DIAMOND: What I –
MS. BOAZ: – that's a little broad, Penny. You can't just ask him what's significant on 15 x-rays.
MS. DIAMOND: If he's going to testify in this case, I'm entitled to know what he's going to testify about. He needs to tell me.
Q So what I'm asking you now is what in these x-rays are going to be worth your talking about at trial?
MS. BOAZ: With regard to what?
MS. DIAMOND: With regard to the issues in this case. Whether or not Dr. Doll's work was appropriate.
A Well, I don't know because I don't know what really I'm going to be asked. I'm going to answer whatever is asked of me at trial.
Q No you're not, sir. The way the rules read –
MS. BOAZ: Yes, he is.
MS. DIAMOND: No.
MS. BOAZ: He's going to be

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asked questions and he's going to answer them, and that's what he's going to do today.
Q The way the rules go, I'm entitled to know what your opinions are. Your – the lawyers in this case have provided me with a very sketchy, very sketchy summary of your opinions and I'm entitled to ask you here now, tell me what your opinions are, and you need to tell me what they are or I'm going to object to your saying them at any other time.
So do you have any opinions, and now I'm trying to help you out by being more precise. Tell me, do you have any opinions about any of these x-rays? Did you believe any of these x-rays were significant? If so, tell me which ones and what was significant about them.
MS. BOAZ: Just a minute, Doctor. You have got to ask – you have got to be more specific than that. Significant as to what?
Q Do you believe any of these x-rays demonstrated anything that justified either

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of – any of the surgery performed by Dr. Doll? Let's try that.
A You mean the x-rays as they stand by themselves?
Q Did any of the x-rays in any way verify any of his opinions expressed in his notes, or justify anything that he did? Did they verify or justify anything that he did?
A Okay. I'll use the word verify and ignore the word justify. I will say that he has a lateral – one lateral x-ray taken before surgery –
Q Before his surgery?
A – that would be consistent with his observation of a metatarsus primus elevatus.
Q Can you show us that x-ray and tell us why it's consistent?
A Sure. I think this one's his.
MS. BOAZ: It's 9-8-93.
A I think there's two.
MS. BOAZ: I think those smaller ones were also. That may be it.
Yeah. Those are his?
A This would be the x-ray.
Q All right.

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A This is a pre-operative x-ray I believe
dated 9-8-93. You probably have to turn it
upside down to read the date.
Q What do you see on that x-ray that
indicates to you that you have an elevated
first metatarsal?
A The relationship of the first
metatarsal here to the second metatarsal.
Q And what is that relationship that you
see?
A It's above the level of the second
metatarsal very clearly when one looks at
the dorsal cortex.
Q Now, if you weren't putting a lot of
weight on the area under the first
metatarsal because it was painful, wouldn't
that cause that effect?
A Say that again.
Q If the person who was standing there
having their x-ray taken was un-weighting
the inside of the foot, wouldn't it give
the same effect, and if because it was
painful they were not putting a lot of
weight on that foot, wouldn't you get the
same effect?

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A You could, but the rest of the foot
wouldn't have this alignment on x-ray.
Q Are you saying that you think you can
tell whether or not somebody is putting
weight equally on all parts of their foot by
looking at an x-ray?
A As a general rule you can tell
whether someone is standing with their
foot in a weight bearing attitude. You
may not be able to know that if the foot
has such significant deformity that the
x-ray would be markedly distorted because
the foot is distorted and they could still
be putting all their weight on the foot.
Q You can put all your weight on
different parts of the foot, too, can't
you? You can un-weight a toe or a side of
the foot or a heel?
A Sure. But you cannot un-weight just
the first metatarsal and leave everything
else in what would indicate a weight
bearing attitude for an x-ray.
Q If you lean on the outside of the foot,
wouldn't you do just that?
A No, you wouldn't. You would create

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what you see here, possibly, but the rest of
the x-ray would be different.
Q So you think you can tell from looking
at that?
A No, I know that you can tell from
looking at this x-ray that this is not a
patient who's taking their foot and as you
have suggested unloaded and un-weighted
the area beneath the first metatarsal
because of pain.
Q Well, you know, don't you think that
people if they have a painful say big toe
would try to keep the weight off of that
part of the foot without even realizing
they were doing it?
A Not if you're taking – well, maybe I'm
presumming we're talking about the same
thing here. I'm presumming as I've learned
in the records that this was an instructed
weight bearing lateral x-ray under the
doctor's supervision, and this x-ray would
be very consistent with that. Could a
patient unconsciously unload the first
metatarsal given the instruction that we're
taking an x-ray, I need your weight on it

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and I'm setting up the x-ray beam? I guess
they could if for a split second I didn't
see them when the x-ray was taken, but you'd
be able to see a change in the position of
the foot, because you and I could not stand
there and in any way simply unload our first
metatarsal bone and just have the first
metatarsal bone change position. In other
words, and have everything else stay in
position. It can't happen.
Q Doctor, so you think you can tell by
looking at this x-ray whether or not the
weight was equally distributed in the foot
as it should have been?
A No. What I said was I can – my
belief is that this is a weight bearing
x-ray as taken under Dr. Doll's
supervision. Whether all parts of the
foot bore equal weight, I would doubt
that.
Q If –
A Not given her condition.
Q When you're measuring angle of
declination, what are the important parts
that you measure?

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A You mean the important angles that you determine if you do it?
Q Yes.
A Well, I think there's actually multiple ones. I don't think there's just one. There's one – most common one that people use, but I don't think it's of any greater importance than the other ones.
Q Why is that?
A Because it's just one part of the picture. There are three or four different ways to actually assess first metatarsal position as we're talking about it in a condition of metatarsus primus elevatus.
Q And what are they?
A Well, one is you could just measure the angle of declination with respect to the ground. Two is you could measure the angle of declination of the first metatarsal with respect to the talus.
Q Okay.
A Three, you could measure the angle declination of the first metatarsal with respect to the calcaneus.

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Q What is the most common method of doing it?
A I would say it's split.
Q Between what and what?
A Between measuring the angle – I didn't really finish all the other ways.
Q Go ahead.
A I'm going to give you an answer that I didn't explain yet. The other way is to measure the angle of declination of the first metatarsal to the second metatarsal, based on looking at the cortex of the bone. I would say that what's done in clinical practice when people are assessing this condition is look at three probably equally. One is relationship of the first metatarsal to the second metatarsal. One is relationship of the first metatarsal to the ground. And one is relationship of the first metatarsal to the talus.
Q And what do you think is the most commonly used method when you're measuring angle of declination?
A I think most people if you're measuring the angle of declination, that's separate than assessing metatarsus primus elevatus. Measuring the angle of declination, the most common way to do that, there's really only one way, is measure the angle with respect to the ground. To identify your first metatarsal declination.
Q And that's what we were talking about when we were talking about a range of 15 to 30 and the average accepted as normal being 20 plus or minus one or two, right?
A I didn't say that was normal. I said if you polled all podiatrists and asked them to give you a number, that's the number people have had drilled in their heads in studying, in learning in school and studying all the angular measurements in the foot, that's what people would think is 20 degrees.
Q And when Dr. Donley returned Sheila Parkest's metatarsal to about where it was when it started out before Dr. Doll operated on it, do you know what the angle of declination was after he returned it?

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A No, I don't.
Q Okay. Do you believe that he acted improperly in returning it?
A I have not reviewed the case to look at it from that perspective at all. I understand what he did and why he did it.
Q What did he do and why did he do it?
A He re-cut the bone and repositioned it.
Q And why did he do it?
A His records indicate that he thought it was positioned or was carrying excessive pressure or was excessively plantar flexed.
Q It was too low?
A Too low, same thing.
Q Excessive pressure or excessive plantar flexed. And if it was too low following surgery in which it was placed low, then we would have to conclude, wouldn't we, that the surgery was how it got too low, and it got this carrying excessive pressure, it was Dr. Doll's surgery that caused that, right?
A Well, I would presume that as a result of the surgery that's the position it would end up in, yes.

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Q All right. Do you believe that Dr. Doll properly was – let me scratch that question. Is that all right with you?
A Sure.
Q Let me ask it differently. Based on your review of the records, do you believe that the position Dr. Doll placed the first metatarsal in was appropriate, or do you believe it was too high or too low?
A Oh, I think where he positioned it was appropriate.
Q Okay. Then how do you explain that Dr. Donley raised it because he thought it was too low causing excessive pressure?
A Just when it healed it turned out it was too low and she apparently had – or appears to have symptoms.
Q So you say it was was too low when it healed?
A I don't know if it was too low. What I'm saying is I believe that what Dr. Doll did at the time of surgery was cut the bone in position where he felt was appropriate.
Q Did you feel it was appropriate?

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A I have no way to have any feeling about it.
Q Did you look at the x-rays?
A Yes. You can't assess that based on the x-rays, as I mentioned from the very beginning. This is a clinical decision just as the diagnosis is made based upon the clinical findings in conjunction with the patient's complaints or symptoms. The decision in surgery of where to position it has nothing to do with the x-ray. We talked about this extensively at the beginning and that's why I don't recommend and never have condoned nor have I ever measured angles to use that as a determining factor in surgery as to where to move the bone.
Q So he just sort of decides on his own while he's in surgery how low he's going to place it?
A I hope so. He's the surgeon and the surgeon's responsibility is to cut the bone, reposition it, and based upon everything the surgeon knows of that patient's foot of his examination before in treating the patient and whatever he has gleaned from the x-rays

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is to reposition that bone where he feels will be the most functional and best place for that patient.
Q So do I understand then that you have no opinion at all as to whether or not he placed it appropriately, that you can only say that he's the surgeon and it's his judgment to do it wherever he feels like doing it?
A I'm not really sure I understand what you're asking me.
MS. BOAZ: That's not quite what he said.
Q All right. Well, let me dissect that section into two parts. Is it your position then, do I understand, that you have no opinion with regard to whether or not Dr. Doll placed it appropriately in as much as you consider it simply his decision as to where to place it, that anyplace he would have placed it would have been appropriate?
MS. BOAZ: Do you understand that?
THE WITNESS: No, not

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really.
A I don't really understand what you're asking me.
Q That's what I want you to tell me when you don't understand it because I'll ask it again.
Do you have any opinion of your own based on your review of the records and the x-rays about whether or not Dr. Doll placed this bone appropriately, or whether or not it was too low?
A No. I think I answered that earlier. I think based on whatever I've read in the records and looked at, at that time x-rays before and after surgery, I think it looked like it was appropriately positioned.
Q Where you say it looked like it was appropriately positioned, what do you mean by that?
A I mean when I look at the x-rays and read the records, they seem to correlate.
Q Explain that in more detail. What correlates with what?
A Dr. Doll is treating a patient and diagnoses metatarsus primus elevatus.

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Q Do you agree that –
A Wait a minute.
Q – that there was metatarsus primus elevatus?
MS. BOAZ: Let the Doctor finish his answer. Were you finished?
THE WITNESS: No. I started the first of probably ten sentences.
A Once he made that appropriate diagnosis, he had x-rays and felt the x-rays confirmed his clinical impression. He then recommended or discussed surgical correction of this to the patient and she underwent the surgery. As a result of the surgery or in the course of the surgery he cut the bone and repositioned it. Intentionally moving it to its new location. Based upon what I've read in the records and in particular with regard to the surgery, the operative report, his before and after x-rays coincide very accurately and very well exactly what he described and correlate very nicely for the diagnosis he made. I think it was

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entirely appropriate.
Q Okay. I think I understand what you're saying.
A Okay.
Q Are you through now?
A Yes.
Q Now, let me ask you some questions about what you're saying. You have said that you read his notes, his office notes with his diagnosis, correct?
A Yes.
Q And that you have looked at the before x-rays and you have looked at the after x-rays and you have looked at the operative note where it describes what he did. So far am I with you?
A Yes.
Q Okay. And you believe that the x-rays afterwards correlate with what he said he did; is that correct?
A Oh, yeah. They definitely do.
Q All right. Do you believe that what he said he did was appropriate?
A Yes.
Q What if he had said that he lowered

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it two millimeters less than he said he lowered it, and the x-rays confirmed? In other words, what if he had said something different and the x-rays confirmed something different by two millimeters, would you then also think that was appropriate?
A Yes.
Q And if he had said in the operative note that he had lowered it actually two millimeters more than he actually said in the operative note and the x-rays confirmed those extra two millimeters, would you also then think that was appropriate?
A I might start to question at that point that it would have been an excessive amount of movement for everything he's described there.
Q So within some sort of range you think anything he does is okay?
A No, I didn't say that at all.
Q How much do you think that you can lower this bone without causing a problem in general for people?
A It depends on how severe the clinical

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impression is of this malalignment.
Q How severe in your opinion was Sheila Parkest's malalignment?
A You're talking about pre-operatively?
Q Yes, sir.
A I don't think it would be considered excessive by any means. I think it's clearly a metatarsus primus elevatus clinically and radiographically.
Q By how much was it elevated based on your review of the x-ray we just held up?
A I didn't measure it.
Q Would you look at it and tell me? Can you tell me in millimeters if you can't tell me in degrees?
A I can tell you based on the lateral x-rays that the dorsal cortex of the first metatarsal is several millimeters above the dorsal cortex in the second. That you can measure perhaps two or three.
Q Okay.
A The first metatarsal head is way in excess of several millimeters. It may be the top of the metatarsal head to the top of the second metatarsal could be – it's

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probably getting close to a sonometer.
Q But in fact he did something different
to the metatarsal head, didn't he? He
didn't just lower it?
A No, he didn't.
Q What did he do?
A He also remodeled it.
Q Right. Right. So let's just talk
about the metatarsal bone itself.
A The metatarsal –
Q Not the head, the rest of the
metatarsal.
A Ignore the head?
Q No, just for the purposes of this
question, sir. We're not going to ignore
the head forever.
A Okay.
Q For the purposes of this question, you
think two or three millimeters is what this
metatarsal was too high and that's based
upon this x-ray?
A Maybe I'm just totally lost now. Did
you ask me just to ignore the metatarsal
head?
Q No. I did, yes.

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A Then you're asking me the question
about the position of the first metatarsal
head by more than two millimeters?
Q No. No. You said two different
things before. You said the metatarsal
itself was a couple of millimeters too
high based upon this x-ray that we have
been talking about?
A The whole metatarsal bone.
Q This whole metatarsal bone, but the
metatarsal head was higher than that, right?
A Right.
Q Okay. But he did some things besides
lower the metatarsal head and I'm just now
talking about the metatarsal itself, all
right?
A Okay.
Q Because you made that distinction?
A Yes.
Q All right. The metatarsal was lowered
I think you said a couple centimeters,
right? I mean a couple of millimeters. Big
difference there.
A Yes. I didn't actually measure, but
I recall from his description of the

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deposition plus I looked at the post-op
x-ray it was probably a couple
millimeters.
Q Do you know how much he lowered it?
A I don't remember exactly the number.
If he said a number in the op report, I
don't recall if he did that.
Q So as far as you're concerned,
whatever it was he lowered it, it was
okay; is that right? Without knowing a
number, you think whatever he did was all
right, that's what you're telling me?
A Yeah. I think based – when I look at
the x-rays –
Q And so are you comparing this x-ray
to another x-ray in saying that? You're
comparing the x-ray of 9-3-93 to another
x-ray in saying what he did is okay?
A No. What I mean, I'm specifically
saying when I looked at the x-rays before
and after surgery, all the x-rays, I looked
at two or three x-ray views. I looked at
all the x-rays and I could see the bone was
repositioned in a downward position to
correct for metatarsus primus elevatus, and

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I looked at the x-ray because I didn't – I
don't think I had the x-rays initially when
I reviewed the materials, and when I looked
at the x-rays, I thought it was well
positioned. I didn't think it was
excessive. It didn't strike me as being
excessive. The fixation looked good.
Everything looked good and it seemed to
correlate with what he described in his
records.
Q Am I correct then in understanding
that you have no opinion whatsoever with
regard to whether Dr. Donley was correct
or incorrect in raising that same bone
back to about where it was?
A Could you repeat that?
Q Yes. Would you please read that
question back?
MS. BOAZ: I think that's
assuming a fact that you haven't – you
haven't asked him if he – where he thinks
Dr. Donley put the bone. I don't think
you've asked him that and that's included
in the question.
Q Let me ask you this. Where do you

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think Dr. Donley put the bone? Have you looked at that?
A I've looked at it, but I did not measure in any way to see if it's back to where it started out.
Q But you haven't measured any of these, you've just been eyeballing them, right?
A Eyeballing them is a loose term.
Q You've been looking at the x-rays. You haven't measured anything because you don't believe in measuring, right?
A I don't believe in measuring to obtain numbers.
Q Okay. So you haven't measured anything?
A Yes. To determine a number or angle or specific millimeter, no, absolutely not.
Q And so you didn't measure what Dr. Donley did either, right?
A That's correct.
Q You looked at it, or didn't you?
A Yeah, I studied the x-ray.
Q Okay.
A I studied all the x-rays.
Q Okay. So you studied it. Do you

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think he put it back about where it was to start with, based on studying it?
A No, I don't think he did at all.
Q You don't think he put it back about where it was?
A Well, about. Plus or minus a millimeter. It's certainly not back from where she started at the very beginning.
Q Is it back about 20 or 21 degrees? I guess you wouldn't know that because you didn't measure it, right?
A Which –
MS. BOAZ: Which question do you want him to answer?
A Which question are you asking me?
Q You didn't measure it, correct?
A That's correct.
Q Why do you think it's not about back where it was? How does it differ from where it was before Dr. Doll cut it and moved it?
A How is it –
Q How does the position that Dr. Donley put it in differ from the position that it was in before Dr. Doll operated?

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A I couldn't tell you unless I were to study the x-ray now.
Q Well, please look at it.
A I could look at it if you like me to.
Q Sure, I would like you to. Because you said it was not the same and I want to know in what way it was not the same. Now, there's going to be certain differences, aren't there, as a result of there having been two surgeries on that bone, right?
A I think that was sort of what I was trying to tell you earlier.
Q Is that correct?
A Yes.
Q It can never be exactly the way it was to start with because it's been cut on twice, correct?
A That's correct.
Q And every time you cut on it, you lose some bone, right?
A Yes.
Q Just like when you're sawing on a piece of wood, every time you make a cut there's going to be sawdust on the ground, right?

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And you're losing something, correct?
A That would be correct.
Q And it's the same thing in cutting on a bone, every time you cut on it you lose something, right?
A Sure.
Q Okay. So that bone can never be exactly the way it was before, right?
A That's correct.
Q Okay. All right. Doctor, have you had an opportunity while we have been chatting to look at those x-rays and you also referred to the records. Can you tell us what you referred to and what you noted?
A I just briefly reviewed Dr. Doll's operative report and then I was looking at Dr. Doll's post-op x-ray of 9-24-93.
Q Which one?
A Lateral x-ray. And then I was looking at an x-ray which is dated 3-6-95, which is by Dr. Donley, and this is also a lateral x-ray. And you had asked me to –
Q Have you reviewed any pre-op x-ray of doctor – before Dr. Doll's surgery?

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A No. Not just now.
Q Okay. But you think you have it well enough fixed in your memory that you can tell us?
A Well, now I can answer the question.
Q All right.
A And hopefully not be confusing. If I remember, your question was asking me is not the first metatarsal bone after Dr. Donley's surgery back to the same position as it was before Dr. Doll's surgery, given the fact that it's never going to be exactly the same because some bone is removed?
Q Yes, sir.
A Okay.
Q And you feel you can answer that question without reviewing a pre Dr. Doll surgery x-ray; is that correct?
A Well, only because Dr. Doll's pre-op x-ray is fresh in my mind.
MS. BOAZ: We've just looked at that x-ray.
A When I studied the x-rays, I was asked to study the case in relationship to Dr.

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Doll's care and treatment of Sheila Parkest.
So now we're sort of engaging in a little different side line which is the care and treatment by Dr. Donley.
Q Well, it's not really, Doctor, because what he did is correct what Dr. Doll did. He felt that what Dr. Doll did was causing her problems and he corrected it?
A Yes.
Q So it's a part of this discussion?
A Yes, I would agree – I agree with that. But the emphasis was a little bit greater on the other materials. So I was hesitating in the answer. My answer would be that he has moved – or the bone – I can't even tell you if he moved it here. I can only tell you how the bone healed because I don't even know if I have the whole series of x-rays that Dr. Donley took, but I presume I have what's pertinent to the case.
Q Well, I will tell you that it's my understanding that the lawyers who represent Dr. Doll subpoenaed all of those

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x-rays from the hospital and the clinic and provided them to you from what they have told me.
MS. BOAZ: This is all we – we did subpoena x-rays. These are the x-rays we got. We provided them to you and we've provided them also to Miss Parkest's counsel.
A That's fine. That's great. So what I can tell you is that the bone has healed with the first metatarsal in line with what looks like it was the top of the metatarsal after Dr. Doll finished the surgery.
Q I'm sorry. I don't understand that answer because –
A I didn't think you would.
Q Because the question that I asked was, and let me ask it again.
A Okay.
Q Isn't it true that Dr. Donley returned the first metatarsal to substantially the same position it was in before Dr. Doll's surgery, given of course that it can never be exactly the same

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because of the surgeries?
A No, I'm going to disagree with you, but I'll tell you the best way to answer your question is just to make a little diagram for you.
Q Why don't you think he did that? He said he did that and do you disagree with that?
A No. In order for me to explain what's on x-ray and understand –
Q Go ahead and draw me a picture and tell me why you disagree with his statement and our understanding of what he did?
A It can be seen on x-ray, but it would be hard for people who don't look at x-rays a lot to really understand. This would be a representation of the first metatarsal.
Q When?
A At the time of surgery by Dr. Doll.
Q Before surgery by Dr. –
A No, during surgery.
Q After surgery by Dr. Doll?
A During surgery.
Q During surgery. After he cut it?

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A Yes, during surgery, after he cut it. After he moved the bone down, he remodeled the top of this ledge right here, and he says that in the operative report, that's why I was hesitating.
Q That's the exostosis that he was talking about?
A No, he remodeled that other exostosis I think before. When he shifts the bone down, I can just refer to the operative report if it'll make it easier.
Q Well, I'm looking at your diagram and I would like you to go ahead and explain the diagram. If you think it would be easier to refer to the operative report, go ahead.
A Not really, but the exostosis that he was referring to is here in the metatarsal. We know he took that away. That's in the operative report. What he also did is remodeled this bone back here, and you can see it on his x-rays very clearly. So after he shifted the bone down and pinned it, it says he burred away, remodeled the dorsal lip on this metatarsal, and I see that on x-ray.

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Now –
Q So that's another thing that he did that can never ever go back to the way it was before, correct?
A Well, sometimes bone re-grows and fills in, but it's probably not going to make any difference. It's not –
Q But it can never be the same as it was before because when you say he remodeled, he's sanded some of it?
A Right. It's never going to be exactly the way it was before surgery. Now, when the bone healed, it clearly is lower than the rest of the bone. And Dr. Donley's x-ray indicates that the bone was cut and moved back up and the x-ray shows it as being equal in line with the top of the other bone. That's how it healed. But the reality of it is since this bone was remodeled, that – how do I say this? The top of the bone is lower than the original top was.
Q Because it can never be the same, correct?
A That's correct. We've established

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that.
Q But the bottom of the bone has been raised, right?
A The bottom of the bone has been raised but not back up to where it was originally because originally the top of the bone was up here somewhere and he remodeled it. Now, when the bone was shifted back up from where it healed, it is probably somewhere in between where – the best thing we could say in between where Dr. Doll had it and where it originally was in the very beginning.
Q So you don't think there was any possible way that Dr. Donley could get it back the way it was, exactly?
A In terms of up, down position?
Q Yes.
A Oh, sure he could. He could just push it up higher, in which case the after x-ray would show that the original bone after it re-contoured from let's say Dr. Doll's surgery, now when Dr. Donley's done, if he pushed it up higher than that ledge then it would look something like this. What would

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happen is we have a lip up here.
Q You would have a problem if you had a lip up there?
A No. This would fill back in with bone back here, or you'd have to remodel it this way.
Q You'd have to take off more bone to make it meet is what you're saying?
A You'd have to take off more bone if you wanted the top to be –
Q Even?
A – even.
Q And you would want the top even, wouldn't you?
A I don't usually remodel it.
Q You don't worry about it if it's a little jagged up there?
A No. As long as it's not going to interfere with the function. Jagged isn't – there's a ledge. I don't worry about it, but back to the original question you were asking was.
Q Let's have this diagram marked as Plaintiff's Exhibit A and attached to this deposition. Would you put your initials

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on it, Dr. Yu?
A Sure.
MS. BOAZ: Do you want him
to finish answering the question?
Q Sure. And keep the paper if you need
it.
A This?
Q Yeah. If you need to show anything
else.
A That's all right.
So I mean, yes, Dr. Donley has
moved the – re-cut the bone, probably at
about the same place it was cut
originally, and he clearly moved it back
up. Where it heals is somewhere in
between where the bone originally started
and where Dr. Doll had moved it.
Q Closer to where it was originally or
closer to where Dr. Doll moved it?
A I don't think there's any way to really
know it because we're talking about being
the total amount that the x-ray shows it was
ever moved down looks like it couldn't have
been more than – between one and two
millimeters. So we're talking about

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fractions of less than two millimeters, no
matter how you start out the conversation.
Q But those are significant millimeters,
aren't they? Or are they insignificant?
A I think whatever – I think whenever
you move a bone it's significant. I don't
know if the millimeters itself is what
makes the significance. It seems to be
always more significant when there's a
problem afterwards, then that little bit
seems to be a little bit more
significant. That's pretty common in
medicine.
Q Is it justified to cut a bone and move
it for only a millimeter or two?
A Sure.
Q Why?
A Because that may be all that's needed
to achieve correction.
Q And what does moving it that millimeter
or two potentially do?
A Well, it hopefully corrects some sort
of clinical problem.
Q Okay. In your opinion was there –
and have you – was there a problem that

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Dr. Donley corrected?
A Again, based on the records, appears
that she was having increased pressure
under the first metatarsal.
Q Did you see signs of that on x-ray?
A No.
Q Did you look for it?
A Well, let me complete my other answer.
No in the sense that I don't think there's
– other than what I've talked about before,
that there's specific things that you can
actually see on the x-ray that tell you on
the first metatarsal that the bone has too
much weight to it. When you talked about a
cyst before, their presence or absence does
not mean anything to me in terms of
excessive weight merely because people who
have the most pressure under their first
metatarsal of all the people we treat don't
have any cysts.
Q So if there was too much pressure and
Dr. Donley was correct in moving it
higher, there was too much pressure
because of where Dr. Doll moved it, right?
A Well, there's too much pressure because

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of where the bone healed, yes, or was
carrying more than was comfortable for her.
That presumes that as a result of his
procedure, that she is now walking and
doesn't complain of any pressure underneath
that area anymore.
Q After someone has two surgeries on a
bone and in the course of those surgeries
there is an exostosis, and that is a
removal, isn't it, of parts of the head of
the bone, and there is also – exostosis
is a removal of that bone, isn't it?
A An exostosis is part of – is the
bone spur.
Q It's a removal of the bone spur?
A Exostosectomy would be a correct term
for removal of the bone spur.
Q What did he do?
A He removed and remodeled the two
areas. One is the top of the first
metatarsal, which he indicated was
prominent, and also remodeled the first
metatarsal bone after he cut it and
repositioned it.
Q All right. So he really did three

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things to take – that affected that bone permanently and can never be changed, didn't he?
A Well, I mean, it's a hard question to answer because you could just keep going on. You could say every pin he put in permanently changed the bone to some degree. Any time you cut a bone, fixate a bone, remodel the bone, the bone is changed.
Q When you say "Remodel a bone," because he did remodel the top part of her metatarsal, where he cut it, didn't he, and near where he cut it?
A Yes, he did.
Q Can you explain in lay language what he does? When I said before that he has sanded it and removed some of it, is that a good – is that a good description or can you give us a better one?
A There are a number of different ways to do it, but in essence you could either use a little like sharp chisel, or you can use an instrument that would bite away at pieces of the bone, and you could take special drills

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or burrs that sort of smooth it and give it a fine, smooth finish.
Q What did he do?
A I'd have to read it to tell you exactly how he –
Q Would you do that?
A Sure.
(Dr. Yu Exhibit A marked for identification purposes.)
A Well, he doesn't describe exactly how he did it. He simply says the first metatarsal was then burred to a smooth contour. So he may have used just a burr only.
Q So he either clipped it off, or pinched it off, or cut it off, and then sanded it, or you don't exactly know because his records don't say?
A Or he could have just used the burr for the whole thing.
Q Okay.
A Usually it's just – many times orthopedic surgeons or podiatric surgeons don't say exactly how they do it. They simply indicate that the bone exostosis or

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lip was removed and re-contoured.
Q I'm talking now about the part you referred to, the top of the bone that was remodeled.
A Okay.
Q That's separate from the head of the bone on which he performed the exostosis, isn't it?
A Well, there's two separate areas, yes.
Q Now, how was the exostosis performed?
A I don't know that he says that either, per se. I'm not even sure you can make a distinction between which is which. He indicates in the beginning of the operative report he says the exostosis and mediolateral aspects of the dorsal first metatarsal head were free from any ligamentous attachment in the dorsal exostosis. Okay. Burred to a normal contour. So apparently he used a burr there also.
Q Okay. So again, he took off parts of the bone in two separate places, right?
A Yes.

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Q And that can – will never change, the fact that he has re-shaped the bone, that he's taken off parts of it will never change, correct?
A Well, I'm not – change, and what do you mean by change?
Q It can never go back to the way it was? Nothing Dr. Donley could do could replace the parts of the bone that he – that Dr. Doll had removed, right?
A Well, Dr. Doll removed what he judged to be pathological bone, abnormal bone. Now, can the abnormal bone come back again like it was in the very beginning? It could. I mean, many patients get a recurrence of the same problem, looks identical five years later, ten years later. I would hope that in her that wouldn't happen, because that was abnormal bone he removed. So I don't believe it would be desirable for her to have that bone come back.
Q But that removal affected the ability of Dr. Donley to exactly replace the bone the way it was originally, didn't it, in

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that he would have what you describe as a lip or a jagged place because of the bone that he had removed, correct?
A I can't answer that for Dr. Donley. I can tell you for me as a surgeon, it wouldn't make any difference. I'm going to move the bone where I need to move it to be in the proper position, whether there's going to be – because there's going to be a lip there would not preclude me from moving the bone to where it should be positioned. The most important thing is I get the bone positioned so I think it is where it will bear a proper share of weight during the course of function. So I don't think any surgeon going in there saying on any bone, I need to move this bone five millimeters but I can't move it up because I'll have a little lip there, unless it's going to negatively impact on function less than it could be to not move it, this is a decision that has to be made by a surgeon. Happens all the time. When you cut the bone or move it, there's going to be a lip, so we don't sit there and say,

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I'm not going to move it because there's going to be a lip. That's a byproduct of doing the surgical procedure. So as long as that lip is either going to be remodeled or as I indicated earlier, isn't going to be a problem with function, it may not need to be remodeled. So it's a byproduct.
Q Okay. Let me see if I understand where you are with regard to Dr. Donley. What Donley did was appropriate, in your opinion, correct?
A Based upon what I have reviewed in the records, what he did was appropriate to correct an overly prominent or overly weight bearing metatarsal segment, and that's what he sort of described as his impression of the problem. That being correct, then that would be an appropriate procedure to move the bone and decrease the amount of pressure to it, yes.
Q Okay. And the way the bone got in that position was by virtue of the surgery performed by Dr. Doll; is that correct?
A Yes, that was the end result of Dr. Doll's surgery.

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Q And you nonetheless maintain that what Dr. Doll did was appropriate to move it in such a position that it caused that kind of pressure?
A Yes.
Q How do you –
A Well –
Q How do you reconcile those two statements?
A Let me complete that. No, it was not – what Dr. Doll did was quite appropriate. For the diagnosis he established, I think he picked an appropriate procedure, he executed appropriately and all the x-rays and records to me show a very reasonable and well done job. It turns out that what Dr. Donley has said is the problem since he's treating her, if in fact that was the problem and I'm not saying it isn't, I presume it is, that means that the bone was bearing too much weight and had too much pressure. So it means that the bone was – ended up being down too low, or whatever it is that contributes to a bearing excessive pressure. Doesn't in any way mean that what

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Dr. Doll did was wrong. I'm sure Dr. Doll positioned it where he thought it would best be to function best in her.
Q So do you believe then that Dr. Doll's decision about where to position it turned out to be incorrect?
A I'd see – I mean, the records would suggest that it was lower, it was too low for her condition.
Q And how does a surgeon – well, let me scratch that question. Is that all right with you if I start over?
A Sure.
Q How does a podiatrist make sure that he doesn't put it – put the bone too low?
A There's no way to guarantee that.
Q Is it sort of hit and miss then?
A In a sense that since you can't have a patient walk and you can't measure that pressure, the hit and miss implies a reckless kind of approach. You just go in and do it and hope. No, that's not what you do at all. You go in there and reposition it based on your experience and your clinical impression that that is the right

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position for it.
Q All right. And you don't believe that it would help to measure the angle beforehand the way you were taught to do in school to determine if it really needs to be lowered at all?
A That's correct.
MS. DIAMOND: If you need to take a break, that's all right with me.
THE WITNESS: Unless everybody else wants to take a break.
MS. DIAMOND: Why don't we take a break for a few minutes.
(Recess held.)
BY MS. DIAMOND:
Q Doctor, I would like you to take each of the tabbed pages and tell me what you thought was important on each of those pages, what it was why you tabbed them. What page are we referring to now?
A Actually, there may be nothing that's important on them. I tabbed them because in my initial review they're usually areas that I need to go back to when I talk to counsel, or when we get to a deposition it usually

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comes up. So I only tabbed this section because this is the start of the original office records of Dr. Doll.
Q Okay.
A I tabbed the next thing, which was his op report, because that would probably be necessary. I tabbed the radiographic reports. I'm not even sure whose surgery they were, I'm not even sure whose they were. And the bone scan report. And I tabbed the – this must be – yeah, Dr. Donley's surgery, his op report. Then there is a consultation that was done by Dr. Saunders. I don't know what this was, maybe a second opinion or third opinion. Second opinion. And then I tabbed a report by Dr. Davis. This was at the Trover Clinic, I think he was the original podiatrist, and the functional capacity evaluation talking about her present condition.
Q All right. Which of those things, if any, do you consider critical or important even to the opinion that you have propounded that everything that Dr. Doll

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did was appropriate? Is that your opinion, incidentally?
A Yes.
Q All right. Are any of those things critical to that or important to it?
A I think they're all very important, very critical to the whole picture of the case. I think – I mean, I probably reviewed in closer detail records particularly written by Dr. Doll or dictated by Dr. Doll, especially the op report and those type of things.
Q Doctor, what facts or factors are essential to the opinion that you have propounded that Dr. Doll's surgery was appropriate? On what do you base that opinion?
A That the surgical procedure he selected and performed was appropriate?
Q The procedures. Yes.
A Because I think the procedure was appropriate for correction of the condition of metatarsus primus elevatus if one can diagnose and substantiate that clinically, and especially if you have radiographic

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confirmation.
Q So the fact that the x-rays seem to you to show elevated metatarsal is a critical factor to you?
A It's not critical. It's a part of the case.
Q And what Dr. Doll says that he found on examination is important to you or not important to you?
A I think what one finds in the physical exam and how that physician correlates that with his – with the subjective symptoms that a patient is giving is important. Very important.
Q Okay. Are there any other facts that you have learned that are very significant to you?
MS. BOAZ: To his opinion –
MS. DIAMOND: Yes.
MS. BOAZ: – that Dr. Doll's procedure was appropriate?
MS. DIAMOND: Procedures. In the plural.
A None that come to mind.
Q Okay. And you believe that they are,

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based upon what Dr. Doll has said about them and on the x-rays; is that correct?
A Yes. As well as the other records are there.
Q So you don't attach any particular significance to the depositions that we have taken and that you have read?
A No, I think they're a part of the case.
Q Do they tell you anything that was important to your opinion?
A Different than what I was able to take from the medical records and x-rays?
Q Yes.
A Not that I can think of right now, no.
Q All right.
A Sometimes they do. I don't recall that being in this case.
Q That's why I'm asking. So it's your opinion that he operated for an elevated metatarsal and not for a forefoot varus?
A Yes.
Q How did you come to that conclusion?
A I never got the impression that the forefoot varus was the main thing he was

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treating here. I always got the impression the problem was confined to the first ray but she had symptomatology in other parts of her foot.
Q Would operating for forefoot varus be unusual?
A There's a lot of different – well, there's a lot of different kinds of forefoot varus. I don't really – haven't given what he says in his records was part of his findings of forefoot varus, if my memory is correct, I haven't really thought much about that.
Q Because you don't believe that's what occurred?
A I think she probably – she may have had varus of part of the forefoot, but I mean, was the whole forefoot up in varus? I mean, I don't know. There's no way to know that from looking at these x-rays, but I'll tell you this, to me these x-rays, you don't use x-rays to make the diagnosis of a forefoot varus, just as you don't use them to make the diagnosis of a metatarsus primus elevatus. But the

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x-rays clearly show to me that there is a metatarsus primus elevatus. Seems to correlate very well with what he has described in the records. The x-rays on the other hand are not impressive to me of being somebody with forefoot varus. Does that answer the question?
Q Yes, sir.
The overall impression that I have gotten from what you have said this afternoon is that x-rays are not particularly important to you as a podiatrist in making a diagnosis; is that correct?
A No, that's not correct. Maybe it came across that way, but that would not be an accurate reflection. To me x-rays are important as part of the workup of a patient, but they are in general secondary to the clinical findings in the physical examination – and the physical examination. So I take them and use them, but I don't put as much stock on the issue of measurements, as you've called them. So in terms of determining actual numbers and

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millimeters, I don't do that.
Q Okay. A measurement like that would be an objective thing, however, that you could compute, correct?
A Sure. You could, yes.
Q And the rest –
A One of many.
Q And the rest of the things that you are talking about on which you put more weight are subjective in that they depend upon the interpretation of the particular person who's looking at it, right?
A Well, you could say that, but if you're going to say that, I would say it's actually true for the interpretation of the x-ray. In one case you draw a line and can tell. If when you draw the line you want to look at it from a different perspective, there's certain guidelines that you want to weigh to do it. If you put ten podiatrists in the room and ask them to measure it, they're not going to come up with the same numbers exactly.
Q Will they be substantially the same?
A They'll be close. Probably have no

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clinical bearing or significance, that's why when somebody talks about one millimeter, or two millimeters, it may or may not have, you know, any significance, or it could be very significant. So we talked earlier about – talking about moving a bone one millimeter or two millimeters, and hey, it may have nothing to do with anything. In other cases or other situations it could be very, very critical.
Q Do you think it was very, very critical to move her bone downward?
A If you want to correct metatarsus primus elevatus, it would be the critical part of the surgery, it would be when you cut that bone, move it downward. Most people that do that surgery aren't very good at getting it down. They don't get it down enough.
Q Absent your examining her foot personally, assuming if, as you say, that's the most important thing to you and measuring angles isn't, you have no way of knowing, do you, whether or not you would

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have personally considered her to be a candidate for surgery for an elevated metatarsal; isn't that correct?
A In this case that's correct, yes.
Q So you must rely on what Dr. Doll has said about his opinion in forming your opinion since you have nothing that is objective that's available to you that you would use to make that decision?
A Well, if I understand your comment or question to me, Dr. Doll's physical examination is very objective. A physical examination, a biomechanical exam, a physical assessment, to me they're objective. There is –
Q What parts, for example, of a –
MS. BOAZ: Were you finished with your answer?
THE WITNESS: No.
Q Go ahead.
MS. BOAZ: Let him finish his answer.
Q Sure. I want you to finish your answer.
A I think we would all agree that there

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is some subjective interpretations as we all understand subjectivity to mean in doing anything. So when he examines this foot, and he has to decide when he touches this foot if this first metatarsal is clinically up or not to determine – to be able to say there's metatarsus primus elevatus. I, well, I mean, the objective – the objective aspect of that is he has got to palpate and touch the foot and determine if the first metatarsal bone is in line with the second, third, fourth or fifth or not. To me is an objective thing to do. How much he determines without any way to actually measure a number when you're examining the foot clinically, is this mild, moderate or severe, well now we're talking there's some subjectivity here. Because no one's going to be able to define for you clinically when you examined this foot you said it was moderate. What did you mean by moderate.
Well, that would imply it's one inch up, it's moderate. If it's two inches up it's severe. There's no such grading scale

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with a lot of things in medicine and that's what you have here. So there is a subjective component to it. But the overall diagnosis I would hope is based upon objective factors that we teach and learn about in terms of physical conditions or disorders.
Q What are those objective factors that you would expect to find related to you for example in a record or by a student who is describing a biomechanical exam that indicated such a problem?
A You mean metatarsus primus elevatus?
Q Yes, sir.
A Well, in a student record I expect a little more detail. The student is going to say, the position of the first metatarsal is above the level of the second, third, fourth and/or fifth. Podiatrist in practice may very well examine the foot and say, there's metatarsus primus elevatus. One is going to be a little more wordy about describing that metatarsus primus elevatus, and some people may argue that's actually the final

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conclusion or diagnosis based upon the findings, but it says the same thing.
Q Did Dr. Doll describe any finding that would have told you there was metatarsus primus elevatus?
A I didn't – I didn't look at the records from that perspective.
Q So you –
A I didn't anticipate this so I didn't look at it from that perspective. I think he mentioned that the first metatarsal is prominent, somewhere, I don't know if it's in his deposition or in medical records, that the first metatarsal joint was prominent clinically. To me that's a finding that there's metatarsus primus elevatus.
Q What other findings would be consistent with that for a podiatrist to note if they existed?
A Lesser metatarsalgia or pain underneath the second, third, fourth or fifth metatarsal, or all of them, and I think that there's – that that exists here because if my memory is correct, not only did he

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mention there was some pain in the lateral portion of the foot, but I think the original podiatrist may have mentioned that also.
Q Besides pain in the lateral portion of the foot under the second, third, fourth or fifth bones in the foot, rays, as you guys like to say, doctors of podiatry, what other physical manifestation would there be that a doctor might note in his records?
A You could have problems with the quality or quantity of range of motion in the big toe joint, great toe.
Q What about calluses?
A Yeah, calluses.
Q Where would those calluses be if there was an elevated metatarsal? First metatarsal. I'm sorry. An elevated first metatarsal.
A You could have calluses underneath the second, third, fourth and/or fifth metatarsal.
Q But not under the first?
A If you had it under the first it wouldn't be directly under. You could have

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it on the medial side because people can roll off abnormally when they walk.
Q But it wouldn't be directly under the first?
A Very unlikely.
Q Because it's raised?
A Sure.
Q Okay.
A Actually, you know what, let me back up a minute. That's not really the correct answer. You could get it underneath the big toe if you had what's referred to as a hallux ligamentous along with this metatarsus elevatus.
Q But no one's said she had a hallux condition?
A I don't think so. I just want to make sure I gave you the right answer.
Q Okay. Tell me about a sesamoidectomy. Under what circumstances do you take out the sesamoid?
A Wow, that's a loaded question in the sense that there's a lot of conditions for which you could do it. It's relatively

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common in dealing with bunion surgery correction. It is.
Q She didn't have bunion surgery, did she?
A No. That's not the focus of the surgery, no.
Q Why did he take out her sesamoid?
A I'm not going to finish answering the first question now, but that's okay if you want.
Q Let's focus it more directly on her.
That's all I'm trying to do.
MS. BOAZ: As long as it's clear that –
Q That's what I've said.
A That's fine. Why did he remove the fibular sesamoid? As he indicated in his report, he felt that the sesamoid was directly irritating or causing a problem with one of the nerves that goes to the plantar lateral aspect of her great toe.
Q Where was that nerve relative – in fact, I'd like you to draw me another little – do you have another piece of paper?
Another little drawing.

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A Sure.
Q Can you show me the first metatarsal, the nerve and the sesamoid? Just a little sketch that would show where those are relative to one another.
A You actually have two sesamoids. Both should be about the same size.
Q All right. And what we have here is the –
A Yeah. Let's –
Q We have the metatarsal, that's the bone. We have the sesamoids. And are they beneath the metatarsal?
A Yes, directly.
Q There's two sesamoids?
A Yes.
Q Beneath the first metatarsal, the fibular sesamoid and –
A Tibial sesamoid.
Q Tibial sesamoid. And where is the nerve at issue located relative to those three items?
A Normally?
Q Normally.
A Normally – normally the nerve that's

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been talked about in this case would run somewhere just adjacent to on the lateral side of the fibular sesamoid.
Q And where does Dr. Doll say it was in this case?
A He says that it was directly beneath the sesamoid as drawn there.
Q Is that unusual?
A Yeah, I would say it's unusual. Yes.
Q And is that why he removed it, the sesamoid?
A I believe so, yes.
Q Have you ever removed a sesamoid under similar circumstances?
A Yes.
Q And at the same time lowered the first metatarsal?
A I've removed the fibular sesamoid and at the same time have lowered the first metatarsal.
Q For the reason that there is a nerve –
A That's what I was just going to say. But not for – not because of a nerve condition.

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Q Okay. Is there a basic inconsistency in doing both of those things when there is a nerve that is being irritated in the position that he said this nerve was in?
A Is there an inconsistency?
Q Yes.
A You mean in doing both of those procedures?
Q Under those circumstances where there's a nerve that's being irritated.
A I'm not sure I really understand the question, but let me answer it and tell me if I misunderstood it.
MS. BOAZ: Well, if you don't understand it, don't answer.
A Okay.
Q Let me rephrase the question. Let me ask it to you this way, Doctor. Isn't it true that if you are removing the sesamoid because it is pressing on a nerve beneath it, and then you lower the bone, you replace the thing you have removed with something else to press on it?
A No, I would disagree with that.
Q Why?

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A Because you have another sesamoid bone next to it. So there would never be able to create – you wouldn't be able to get that same kind of pressure against the nerve up in that area. The sesamoid bone is very thick. I don't know what the number is, but it's close to – it's between half and one sonometer in thickness, in average, normal non-hypertrophic sesamoid. If that is pressing against the nerve, and I've seen cases, I have a case right now that I'm taking care of, it can be a real problem. One way to deal with it would be to take out the sesamoid.
Q Are you planning to lower the metatarsal of your patient?
A I thought that would be coming now.
Q Are you planning to raise it, or do nothing with it?
A No, actually I'm probably planning on doing something else to the bone, but I may not do it at the same time.
Q What is it you're planning to do and why wouldn't you do it at the same time?
A I'm planning on exploring the area

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first to see if I can simply either
transpose the nerve, or remove the nerve
in lieu of removing the sesamoid, or
whether I should remove the sesamoid.
Q Why do you think it would be an
advantage to transpose or move the nerve
rather than remove the sesamoid? Is it –
what advantage does the sesamoid provide
that you want to preserve?
A Well, if you have any tendency toward
abnormal balance to function because the toe
has been operated on a couple of times, as
is the situation of the patient I'm thinking
of right now, I would be inclined to try not
to take out the sesamoid bone.
Q Why?
A Because it may cause a significant
imbalance in the rest of the joint muscles
and tendons, such that the toe starts
deviating in an abnormal direction and
creating another deformity.
Q In which direction would it be likely
to deviate if you remove the fibular
sesamoid?
A Inward, away from the second toe.

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Q So in order to maintain the appropriate
balance, you want to maintain both
sesamoids, if you can; is that correct?
A Yeah, if you can. In some cases.
Q You said you were thinking about doing
a separate operation not at the same time,
or to do something to the first metatarsal?
A Correct.
Q What?
A You mean – I thought you just made –
Q What is it you're contemplating doing
to the first metatarsal?
A Well, depending on how the toe ends
up taking is depend how much I need to
move the bone, whether I need it move it
altogether. This patient's already been
operated on three times. I'm in a little
bit different predicament.
Q If you plan to move it at all, which
direction will you move it if at all?
A I don't know that yet.
Q You don't know if you'll move it up,
down or sideways?
A Depends where the toe ends up after I
take out the sesamoid, if I do.

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Q Why do you think it's prudent to wait
and see where the toe ends up?
A In my own case that I'm dealing with
right now because she's had three surgeries.
Q What are the surgeries?
A All bunion surgeries.
Q How does that change the picture or
affect what you're doing?
A Well, in this particular patient she's
got so much scar tissue and she's had so
much surgery done, including already having
her nerve and tendons operated on, that I
don't want to do anything more than I need
to.
Q And have you considered how you would
move the bone? Do you have a metatarsus
primus elevatus situation?
A I don't remember.
Q You don't?
A I can tell you she's not walking with
that part of her foot bearing weight right
now. I don't remember if it's because
it's metatarsus primus elevatus or she's
holding that foot that way.
Q You could hold your foot that way if

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you were in pain, right?
A Sure you could. Sure.
Q What's the affect of multiple
surgeries to say on someone's foot?
What's likely to happen long-term?
A It's really a variable, but I think
most surgeons would agree that the more you
operate in the same area, the more likely
you are to have increased amounts of scar
tissue formation. That would be the main
thing in general.
Q And that happens over a period of
time?
A You mean with each surgery?
Q Yes.
A Well, it usually increases with each
surgery.
Q And so you just – and over time will
you get more scar tissue?
A It will reach a plateau and
stabilize. There will be some point in
time after each surgery where let's call
it fibrosis and scarring will reach a
maximum and sort of level off.
Q What's that period of time usually?

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A I think clinically? Somewhere between three months and a year.
Q And what about arthritis?
A What about it?
Q Do you increase the likelihood of arthritis with each surgery that's been performed?
A Not necessarily. I mean, you could, depending on how the surgery is done.
Q Explain that. I don't understand.
A As long as you're not going inside the joint and moving around so to speak with it and doing all kinds of things with it, it shouldn't. And providing that the alignment of the bones that make up that joint are in good position, it would probably be okay.
Q But if the alignment of the bones are not in good position that make up a joint, then you increase the likelihood of arthritis?
A You could.
Q And what you were changing when you raised and lowered the metatarsal was

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ultimately the alignment of that bone in a joint, correct?
A Sure. I mean, the purpose of the bone surgery was to change the alignment of the bone.
Q All right.
A Whether it would impact the joint negatively, not if it's being moved to a more normal position, it could not. Doesn't mean it couldn't happen.
Q What about pain? If you operate on the same place more than once, do you increase the likelihood that that particular spot will be sensitive and painful from time to time?
A As long as the surgery goes well and there's no complication and once it all heals, probably not. If in the course of surgery patients develop nerve irritation from the surgery, or, let's say, develop a complication where a bone spur develops in the area where the bone was cut, it irritates the overlying soft tissues, well then you could develop increased pain.
Q How do you know whether that's going to

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happen or not?
A You mean whether you're going to have that happen?
Q You don't. It's a risk, isn't it? It's a risk of surgery?
A Yeah, it's a low risk, but it's a risk.
Q It's something that you can't always determine even that it's happened until sometime after the surgery, after the fact of the surgery?
A Sure, that's correct. That could be said of any complication, not just that one.
Q All right. Dr. Yu, I'm entitled to know any opinion that you intend to express at the trial of this action. If I haven't asked a question to elicit any opinion, is there any subject matter about which you intend to give an opinion that you have not told me about?
A No, not that I can think of at this point.
MS. DIAMOND: Thank you. That's all the questions that I have.

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MS. BOAZ: No questions here.
(Dr. Yu Exhibit B marked for identification purposes.)
(Deposition concluded at 5:02 p.m.)

CERTIFICATE

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

I, Lynn A. Regovich, Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness, GERARD V. YU, D.P.M., was by me first duly sworn to testify to the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by the above-referenced witness was by me reduced to stenotype in the presence of said witness; afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony so given by the above-referenced witness.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified, and was completed without adjournment.

I do further certify that I am not a relative, counsel or attorney for either party, or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, this 7th day of January, 1996.

Lynn A. Regovich,
Notary Public/State of Ohio.
My commission expires: 6-14-98.

Look-See Concordance Report

UNIQUE WORDS: 1,517
TOTAL OCCURRENCES: 6,183
NOISE WORDS: 385
TOTAL WORDS IN FILE: 21,060

SINGLE FILE CONCORDANCE

CASE SENSITIVE

NOISE WORD LIST(S): NOISE.NOI

INCLUDES ALL TEXT OCCURRENCES

IGNORES PURE NUMBERS

WORD RANGES @ BOTTOM OF PAGE

MAXIMUM TRACKED OCCURRENCE THRESHOLD: 50

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