IN THE SUPERIOR COURT OF THE DISTRICT OF COLUMBIA
Civil Division

Peter W. Poe,)
)
Plaintiff,) Civil Action No.:
) 00-0000000
vs.)
) VIDEOTAPE DEPOSITION
John H. Doe,) OF
D.P.M., et al.,) KEVIN M. SMITH, D.P.M.
)
Defendants.)
)
----------)

THE DEPOSITION OF KEVIN M. SMITH, D.P.M., taken before Sandra K. Glick, Certified Shorthand Reporter and Notary Public of the State of Iowa, commencing at 12:55 p.m., May 3, 2005, at Suite 101, 218 6th Avenue, Des Moines, Iowa.

A P P E A R A N C E S

Plaintiff by: JEFFREY A. SHANE
Attorney at Law
SHULMAN ROGERS GANDAL
PORDY & ECKER, P.A.
Third Floor
11921 Rockville Pike
Rockville, MD 20852-2743
(301) 230-5209

Defendants by: RICHARD W. BOONE, SR.
Attorney at Law

BOONE & ASSOCIATES, P.C.
Suite D
10195 Main Street
Fairfax, VA 22031-3415

Videographer: David Seuferer

Reported by: Sandra K. Glick, C.S.R.

I N D E X

(Plaintiff's Exhibit 1 was marked for identification by the reporter.)

THE VIDEOGRAPHER: Today's date is May 3rd, 2005. We are in Des Moines, Iowa, at the Quick Copy Center, 218 6th Avenue. The time is approximately 12:55 p.m.

This is the deposition of Kevin M. Smith before the Superior Court of the District of Columbia, Civil Division, in the matter of Peter W. Poe versus John H. Doe D.P.M., et al., Law Number 03-0009580. The deposition is taken by the plaintiff.

The court reporter is Sandra Glick representing Huney-Vaughn Court Reporters, Suite 307, 604 Locust Street. My name is David Seuferer, the videographer, representing Video Specialties.

Will counsel introduce themselves beginning on my left.

MR. SHANE: Yes. Jeff Shane on behalf of plaintiff Peter Poe.

MR. BOONE: Richard W. Boone, Sr., on behalf of defendant John H. Doe, D.P.M, and Dr. Doe's professional

corporation.

THE VIDEOGRAPHER: Will the court reporter administer the oath to the witness.

KEVIN MICHAEL SMITH, D.P.M.,

called as a witness, having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. SHANE:

Q. Good afternoon, Doctor.

A. Good afternoon.

Q. Would you please state your full name, spell your last name, please.

A. Kevin Michael Smith. S-m-i-t-h.

Q. Thank you. And your current business address, Dr. Smith?

A. 3200 Grand Avenue, Des Moines, Iowa.

Q. Okay. And can you please tell the Court, what is the nature of your practice at

that business address?

A. I am an associate dean for clinical affairs, as well as associate professor of podiatric medicine at Des Moines University, and I also maintain a clinical practice at that location.

Q. Okay. Now, Doctor, would you,

beginning with your professional school, tell the Court and jury please about your training in podiatric medicine?

A. Received my degree in podiatric medicine from Des Moines University, which was formerly known as the University of Osteopathic Medicine and Health Sciences. Following completion of my four-year degree in 1995, I completed a surgical residency at Passaic Beth Israel Hospital, and then was in private practice in New Jersey prior to coming to Iowa.

Q. And following your formal education and your residency program, did you take any further training or courses related to your field of practice?

A. There are a few courses that I have taken. I took an endoscopic plantar fasciotomy course, as well as an ankle arthroscopy course,

and -- I don't know what version of CV you have. Last summer I completed a two-day external fixation course.

Q. Okay. Now, you said you came back here. When did you come back here to Des Moines?

A. In 1998.

Q. Okay. And what -- what are the current positions which you hold as an educator in podiatric medicine and surgery?

A. Associate professor of podiatric medicine, as well as associate dean for clinical affairs.

Q. And have you held other positions teaching students or residents in podiatric medicine and surgery?

A. Yes. I was a residency director at Des Moines General Hospital, which is now closed and is actually called Mercy Capitol Hospital, and I was also a residency director at Broadlawns Medical Center, and that's a three-year surgical program.

Q. Okay. And have you published any papers or articles in your field of practice?

A. Yes.

Q. Have you taken the board certification exams in your specialty area?

A. Yes, I have.

Q. And did you successfully pass them?

A. Yes.

Q. And you are a member of any professional organizations related to your field

of practice?

A. A member of the American College of Foot and Ankle Surgeons, as well as the state and national society, the Iowa Podiatric Medical Association and the American Podiatric Medical Association.

Q. Okay. And, Doctor, you have been asked to comment upon the care rendered by Dr. Doe. Are you familiar with the standard of care required of a board-certified specialist in podiatric medicine and surgery such as Dr. Doe?

A. Yes.

Q. Okay. Is that a standard that just applies to where he practices?

A. The standard of care is a national standard for podiatric medicine in the nation.

Q. Okay. Subject to any questions which

Mr. Boone may have for you, I would now offer you to the Court to testify as an expert in podiatric medicine and surgery.

MR. BOONE: I have no questions.

Q. Doctor, let me ask if you would identify what has been marked as Plaintiff's 1 for this deposition.

A. That is a copy of my CV or curriculum vitae.

Q. Relatively current and up to date?

A. Yeah. The only thing missing would be that external fixation course that I attended last summer.

Q. Okay. Thank you, Doctor.

Now, have you had the opportunity to review some materials related to Dr. Doe's care of Peter Poe?

A. Yes.

Q. Okay. Can you tell us please what you've had the opportunity to look at?

A. I've had the opportunity to look at Dr. Doe's medical records, as well as records from Sports Therapy, a Dr. Green, a Begun Physical Therapy, a Dr. Sauer, Dr. Klien with a "K," Dr. Kratz, Chesapeake Orthopaedics

Associates -- Associates, and some -- what appears to be some psychologist -- some medical records from some psychologist, as well as multiple depositions from plaintiff and defense experts and treating physicians.

Q. Okay. Did you also have the opportunity more recently to look at some

records from Johns Hopkins?

A. Yes.

Q. Now, Doctor, I'm going to ask you if you have formulated some opinions in this case, and would you only offer those opinions which you can offer to a reasonable degree of medical certainty in your field of podiatry or a reasonable degree of podiatric medical certainty? Would that be -- can you do that?

A. Yes.

Q. Will you let me know if you can't?

A. Yes.

Q. Okay. Doctor, have you formed an opinion, again with that reasonable degree of medical certainty, as to whether or not the care which Dr. Doe gave to Peter Poe met with the appropriate standard of practice?

A. Yes.

MR. BOONE: Objection to form.

Q. And what is that opinion?

A. The -- the opinion that I have come to was that Dr. Doe did not meet the standard of care in the treatment provided to Mr. Poe.

Q. And again to that reasonable degree of

certainty, have you formed an opinion as to whether the failure to meet the standard of care which you have identified caused injury or harm to Mr. Poe?

A. Yes.

Q. And what is that opinion?

A. To a reasonable degree of medical certainty my opinion is that the deviation from standard of care caused the current complaint of Mr. Poe.

Q. Okay. Can you explain to the Court and the jury the basis for your opinion?

A. The basis for my opinion is that the medical records that I reviewed, Mr. Doe -- or Dr. Doe failed to exhaust conservative treatment measures prior to initiating the surgical care.

Q. Okay. And can you explain what is

conservative treatment? What was Mr. Poe's problem? What did he see Dr. Doe for?

A. His initial complaint was complaining of pain in both -- pain and numbness in both feet.

Q. Okay. And did Dr. Doe

ultimately reach a conclusion as to what the -- or at least an opinion as to what the cause of Mr. Poe's symptoms were?

A. Yes. Intermetatarsal neuroma on both feet.

Q. Okay. Does that have another more common name?

A. Morton's neuroma would be another name for it, although Morton's neuroma only describes one specific location for an enlarged nerve or painful inflamed nerve.

Q. Okay. What's an intermetatarsal nerve?

A. Intermetatarsal nerve is between the bones and the foot that lead to all the toes. There are what we call intermetatarsal nerves or common digital nerves that will actually then branch off and send nerves into each toe on both feet.

Q. Okay. And -- and what happens? What makes it a problem?

A. What makes it a problem is that -- there are quite a few different theories as to how it can occur. Sometimes it can be what's called acute trauma from an injury or repet -- repetitive trauma that can actually cause

inflammation of the nerve and enlargement of the nerve and scarring of the nerve, and then when that nerve becomes large, it's impinged between the bones and the ligaments in that area, and that's what creates the symptoms of pain and burning.

Q. Okay. And you said he failed to exhaust conservative treatment?

A. Yes.

Q. What -- what is the prime treatment? How does one treat intermetatarsal neuroma?

A. General answer would be conservative treatment, rendering conservative treatment, and there are multiple different forms of conservative treatment, and once those are exhausted, then initiating surgical treatment.

Q. Okay. How does one initiate conservative treatment? What -- what's the

appropriate way to do that?

A. The appropriate way to initiate conservative treatment is first when you -- when the patient first presents to your office and you examine the patient and record a history, is finding out what things that patient has done already to potentially alleviate their symptoms.

Q. Okay. Was that done by Dr. Doe in this case?

A. I don't specifically remember it being documented in the notes, but I do remember that it was present in Dr. Doe's deposition and Dr. -- or Mr. Poe's deposition where that was discussed.

Q. Okay. What next? Is there an order or is there a way you approach this problem?

A. The -- the general order is to attempt noninvasive conservative therapies first. Noninvasive tends to equate to nonpainful. For example, medications. Usually oral medications such as anti-inflammatories are attempted as a conservative treatment modality say prior to receiving an injection. Most patients will, at least definitely in my practice or in every physician's practice, would rather have a pill

than a shot.

Q. Okay. So one is pills.

A. Uh-huh.

Q. What else?

A. Other methods would be shoe gear modifications; changing to wider shoes. Decreasing physical activity, and that can

either be on the patient's behalf or a recommendation from the physician. Physical therapy modalities. Some physicians will actually conduct physical therapy modalities in their office. Some physicians will consult a physical therapist. Inserts or orthotics. Strapping or taping the foot, which is usually done before orthotics or inserts. Oral cortisone or prednisone. Cortisone injections and alcohol injections. Would be a -- that would be a pretty complete list of conservative treatment modalities.

Q. Okay. And what success would one anticipate in successfully alleviating the symptoms with I think you've listed about nine different possibilities in terms of avoiding, if possible, surgical intervention?

MR. BOONE: Objection to the

form.

A. Employing the conservative treatment modalities that -- that I've listed, one would expect to receive relief or have a patient receive relief of symptoms greater than 80 percent of the time.

Q. Okay. Now what is your understanding

of what Dr. Doe did for Mr. Poe?

A. After reviewing the medical records, there was an orthotic; that the patient was casted for an insert or orthotic, and that was dispensed. And the patient had steroid injections on both feet.

Q. Anything else?

A. As far as treatment rendered by Dr. Doe, I think that's what was in the medical record.

Q. Okay. And did Dr. Doe take -- did Mr. Poe ultimately come to surgery by Dr. Doe?

A. Excuse me? Can you repeat the question?

Q. Yeah. Did Mr. Poe ultimately come to surgery by Dr. Doe?

A. Yes.

Q. Okay. And what is your understanding of the outcome of that surgery?

A. It's my understanding that since the surgery Mr. Poe has continued to have pain. From the most recent records that I've reviewed, he has been diagnosed with complex regional pain syndrome and had a spinal cord

stimulator inserted.

Q. Okay. Would you -- can you explain for the benefit of the -- the Court and the jury what is complex regional pain syndrome; what's a spinal cord stimulator?

MR. BOONE: I'm going to object to any opinions from the doctor about complex regional pain syndrome. In his deposition he indicated that he had not himself made such diagnosis or reached such an opinion; that he was merely repeating what other physicians had said.

Q. Okay. And let --

MR. BOONE: And unless he's got his own opinion independently derived, I don't think he's qualified to say so.

Q. Well, let me ask you, Doctor --

MR. BOONE: And we are surprised

by that if you're changing his testimony at this point in time.

Q. Let me ask you this, Doctor.

Are you familiar with the entity called complex regional pain syndrome as an entity?

MR. BOONE: Please note my

continuing objection to this series of questions.

A. Yes.

Q. Okay. And without -- was there any basis in the records which you have reviewed, not independently but from other sources, of a finding that -- that other physicians have diagnosed Mr. Poe with complex regional pain syndrome?

MR. BOONE: Same objection. Plus it's also hearsay in the context in which the question has been asked.

MR. SHANE: Well, we can respond to it in Court, but I believe the doctor can rely on information that's not necessarily in evidence.

Q. But go ahead, Doctor.

MR. BOONE: He can rely upon the

information, Counsel, but he can't simply parrot another expert's opinions.

Q. Okay. Go ahead, Doctor.

A. There was another reference to that entity in another deposition.

Q. Okay. And was it present in any medical records you reviewed?

A. Yes, it was also in that same physician's medical records.

Q. Okay. And what do you understand the most current treatment has been for Mr. Poe?

A. The most current treatment that I've seen in review of the records that were sent to me were an insertion of a spinal cord stimulator.

Q. Okay.

MR. BOONE: Objection to any questions to this witness about spinal cord stimulator. There's been no proffer to us that he was going to comment in any way on that aspect of Mr. Poe's case.

Q. The records you reviewed are relatively current records provided to you. From what institution?

MR. BOONE: Please note my continuing objection to any questions about the spinal stimulator for the -- on the basis stated.

A. They were from Johns Hopkins neurosurgery department.

Q. Okay. Now, can you explain to the

Court and the jury why you feel that Dr. Doe's treatments that you have mentioned did not meet the standard of care and what would have been required of him to meet the standard of care?

A. Dr. Doe did not exhaust conservative treatment measures prior to performing surgery on Mr. Poe.

Q. Okay. What -- what should he have done? What would have met the standard of care?

A. What would have met the standard of care is that although the patient did have inserts or orthotics, initially the patient, according to Dr. Doe's records, has stated that he did receive some relief initially from the insert. The standard of care would have dictated continuing with that treatment modality and continue with the use of the

insert.

Patient did have corticosteroid injections or cortisone injections. Patient did have relief after that first injection. And also additional conservative treatment measures should have also been employed prior to initiating surgical treatment.

Q. Okay. Is it your opinion that with that again reasonable degree of medical certainty that had those conservative methods been employed, Mr. Poe would not have required surgery?

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

A. With a reasonable degree -- degree of medical certainty there is a greater than 80 percent chance that the patient would have had relief of symptoms with conservative treatment.

MR. BOONE: Move to strike as not responsive to the question asked.

Q. Is it your opinion, Doctor, that the -- what -- what is the effectiveness of surgery? What -- how -- how effective is surgery in most individual's hands when performed for this entity?

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

A. Define -- I mean, you asked me what -- what is -- what is it and how effective it is. So are you asking me both --

Q. Yes, please.

A. -- questions?

Q. Go ahead.

MR. BOONE: Object to the form of the question again.

A. The surgery for intermetatarsal neuroma which was done in this case is to excise the -- the neuroma or the scarred nerve. How effective it is is it's based on literature, approximately 80 percent effective in relieving the patient's symptoms.

Q. Okay. For those patients who are not successfully treated by surgery, what's -- what happens to them?

A. They continue to have pain or undergo additional treatments, depending on what may be causing their symptoms after the first surgery.

Q. Okay. Where in -- in the practice of reasonable podiatric medical and surgical practice does surgery fall in the order of the

things which you have named or listed as -- as treatments?

A. Surgery would fall after conservative treatment.

Q. Okay. And you said that the -- the probability that Mr. Poe would have come to this surgical intervention if all of the

appropriate -- what you have expressed as the appropriate conservative modalities were used was what percent of probability of success?

MR. BOONE: Objection to the form of the question. You are also trying very hard to lead him.

Q. I just want to be sure that -- that it is understood what the probability of success is for nonsurgical conservative management.

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

A. The probability of relieving a patient's symptoms with conservative treatment measures would be 80 percent or higher.

Q. Now you mentioned alcohol injections.

A. Yes.

Q. What are alcohol injections? What do they do?

A. Alcohol injections are a series of three to seven injections of dehydrated alcohol, 4 percent by volume, into the area of the neuroma. Actually just proximal or just behind the -- the neuroma or the enlarged scarred nerve, and alcohol injections -- alcohol actually has an affinity for nerve tissue, and

it's designed to desiccate or shrivel up the nerve.

Q. Okay. And what -- what's the -- what's the result? What happens with them?

A. The result would be that if you shriveled up the nerve, that you would alleviate the patient's symptoms.

Q. Is the -- is the success -- success of that treatment at all dependent upon the size of the neuroma?

A. No.

Q. Why is that?

A. Because you're not injecting the alcohol into the neuroma or at the neuroma. You are injecting it proximal to the neuroma. So for example if I use my hand, distal would be the -- the end of the finger or the end of the toe. Proximal would be farther back toward my

wrist or ankle. So you're injecting it on the proximal side or the -- prior to the development of the neuroma or enlarged scarred nerve.

Q. Okay. Now, when you talk about these, are all of the procedures which you believe should be performed prior to surgical intervention, were all these available in the

standard of care at the time that Dr. Doe was caring for Mr. Poe?

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

A. Yes, they were all available at the time that Mr. Poe sought treatment from Dr. Doe.

Q. Okay. And were they the standard of care?

A. Yes, they were.

MR. BOONE: Objection to the form of the question. Move to strike the response.

Q. How much experience have you had over the course of your practice in the management of patients with -- with interdigital neuroma?

A. I've treated conservatively and surgically patients with intermetatarsal neuroma.

Q. Okay. Do you teach the management of these type of patients to the residents and students in your educational program?

A. Yes, I do.

Q. And how -- how many residents do you have in your program?

A. There are three.

Q. Per year?

A. Three total. We take one resident per year. So we have a total of three residents in the three-year program.

Q. Okay. And do these residents to your knowledge go to various places throughout the country?

A. Yes.

MR. SHANE: All right. Thank you, Doctor.

CROSS-EXAMINATION

BY MR. BOONE:

Q. When did Mr. Poe first come to see Dr. Doe?

A. July 31st of 2000.

Q. And what, if any, understanding do you have of his presenting complaints on that occasion?

A. From the medical records that I reviewed, his presenting complaint was pain and numbness in both feet.

Q. And what, if any, understanding do you have about the duration of those symptoms prior to his presentation for care from Dr. Doe?

A. From the information that was provided to me, this had been going on for a couple to a few months, so two to three months prior to that presentation.

Q. And what, if any, test did Dr. Doe perform -- I'm sorry, strike that question.

What, if any, possible sources of the discomfort being experienced by Mr. Poe should Dr. Doe have considered on the occasion of Mr. Doe's first visit?

MR. SHANE: Object to form. Go ahead, Doctor.

A. Sources would be any repetitive type of trauma that may be occurring. Foot type that the patient may have that may contribute to developing this condition.

Q. By that I mean were there any other types of pathology which might have -- other than a neuroma which might have produced the same symptomology in Mr. Poe's feet?

A. Yes.

Q. And what were those?

A. What were those or what are they?

Q. What are they generally?

A. Compressed nerve more proximally, such as a tarsal tunnel, would be one possibility. There are other forms of neuropathy, such as diabetic neuropathy can occur with patients with diabetes that can cause burning in the balls of both feet.

Q. Anything else?

A. There's a -- there are possible nerve tumors that can occur that would reproduce burning and numbness in -- in both feet, although it would be extremely rare to have that in both -- to have nerve tumors in both feet. Compressed nerve at the level of the back.

Q. All right, sir. And of course there were the neuromas; is that correct?

A. There's also neuromas that can also cause those symptoms.

Q. What testing did Dr. Doe perform as you understand it in an effort to determine the source of Mr. Poe's discomfort?

A. There was ultrasound examination that was performed.

Q. All right. And were there any tests that Dr. Doe himself performed on the

occasion of the first visit that might have been suspicious for the presence of interdigital neuromas?

A. During the physical examination there was a -- what's called a Mulder's sign, or some people call it a Mulder's click.

Q. All right. And have you had occasion to see the results of the ultrasound that was performed on Mr. Poe's feet?

A. Yes, I have.

Q. And what, if anything, did that ultrasound reveal to you as you understand it?

A. It revealed that there was enlarged intermetatarsal nerves, and I can't give you the exact diameter, but they were I think approximately a centimeter in -- in diameter.

Q. All right. Would it refresh your recollection if I suggested to you that on the

right foot there was one mass that was .76 millimeters in diameter and that there was another one -- .76 centimeters in diameter, and that there was another one that was 1.08 centimeters in diameter?

A. Yeah. I knew they were enlarged.

Q. All right. What is the normal size of

the interdigital nerve in the inner space between the toes?

A. Approximately 2 to 3 millimeters.

Q. So these things were somewhere between four to six times as large as you would expect the structures in there and the nerve tissue to be; is that correct?

A. I wouldn't say four to six times.

Q. Well, isn't 1.08 -- well, five and a half times as large as the normal nerve?

A. Yeah, but then .7 divided by .3 would only be a little over two and a half times.

Q. But they were a lot larger than the normal nerve; is that correct?

MR. SHANE: Objection.

A. They were larger than the normal nerve, yes.

Q. And on the left foot we know that --

would it refresh your recollection, rather, to -- if I suggested that the mass was .97 centimeters in diameter?

A. Yes.

Q. All right. Now, we know from the results of the subsequent surgery that was actually done on Mr. Poe's feet exactly

what those lumps that were seen on sonography were composed of, don't we?

A. Yes.

Q. And what, if any, understanding do you have of the nature of the tissue that was removed from Mr. Poe's right foot?

A. There was inflammatory nerve tissue that was removed. I would have to -- to exactly give you what the pathologist's description of it was, I'd have to refer to the microscopic portion of the pathology report.

Q. If I suggested to you that it was fibroadipose tissue with prominent vessels with intimal thickening, a focal organizing thrombus and prominent nerve fibers consistent with a neurofibroma, would that refresh your recollection?

A. Yes.

Q. All right. A neurofibroma strictly speaking is not a Morton's neuroma, is it?

A. Not specifically.

Q. All right, sir. And on the left foot, would it refresh your recollection if I told you that the tissue was perineural fibrosis consistent with neuroma?

A. Yes.

Q. And perineural fibrosis means that there was fibrotic tissue or scarring in the nerve; is that correct?

A. Yes.

Q. And the intimal thickening on the right foot means that there was a sheath of tissue surrounding the nerve; is that correct?

A. Yes.

Q. All right. Now based upon -- what is your understanding -- strike that question.

What is your understanding of what Dr. Doe concluded was wrong with Mr. Poe as the result of that son -- sonographic testing?

A. From the -- the medical records he -- from the results of the sonograph he concluded that the patient had interdigital neuromas.

Q. Do you agree that that was the correct diagnosis based upon the information that was available to him?

A. Yes.

Q. All right. Now, what exactly is a neuroma? Would you tell us again, please?

A. Neuroma is an enlarged intermetatarsal

nerve that will usually become scarred, or another term for scarring would be fi -- fibrotic. There's inflammation involved. In the literature there are numerous definitions of neuroma, and one of them, some people have described it as a tumor. It's not actually a tumor, but there's also fibrosis that occurs of the nerve.

Q. All right. And when you try to treat the neuroma conservatively, would you agree with me that what you're attempting to do is alleviate the symptomology of that structure that's there in the foot?

MR. SHANE: Object to form. Go ahead.

A. No, I wouldn't agree with you on that.

Q. Well, what conservative treatments are you aware of, other than the alcohol, I want to

deal with that separately, if you will, that will do anything actually to eliminate or remove the neuroma?

A. The conservative treatments -- it would depend on how you define neuroma. If the nerve is not scarred and it's just inflamed, then the conservative treatments would alleviate the

symptoms by alleviating the inflammation. If there is scarring, then the conservative treatments, with the exception of the alcohol injections, would not decrease the size of the enlarged nerve but just aid in alleviating the inflammation.

Q. Would you agree with -- I'm sorry, Doctor, strike that question.

Did I understand you to say that perhaps one of the first things one might consider doing when confronted with a situation like Mr. Poe's was the use of some sort of oral medications to reduce the inflammation and/or the swelling of these structures?

A. Yes.

Q. All right. Do you have an opinion that you're able to state within a reasonable degree of podiatric medical certainty as to what the

probability was that any NSAID type or anti-inflammatory medication was going to have any kind of a beneficial effect upon neuroma-type structures of the size of those that were contained in Mr. Poe's feet?

A. Anti-inflammatories would -- would be less than 50 percent.

Q. All right. Now, and you also indicated that there was a step that you could take that involved the use of something called orthotics or perhaps some strapping or some padding; is that correct?

A. Correct.

Q. Would you agree with me, Doctor, that what you're doing with the strapping and the padding and the orthotics is trying to rebalance the biomechanical forces in the feet to relieve the stress upon those neuromas?

A. I wouldn't necessarily agree with that.

Q. Then what do you think that you're doing? How would you describe the function of orthotics in the -- or strapping and padding in the treatment of interdigital neuroma?

A. It can rebalance the forces that may be causing the neuroma, but other things that can

be done to an orthotic are things such as a metatarsal pad that would actually just take pressure off of the area that's causing pain in the location of the neuroma. So balancing and taking pressure off of I would describe as two different things.

Q. But at any rate, what you're trying to

do is take the force away from the neuroma which would then lessen the resulting inflammation and pain? Can you --

A. Yes.

Q. You could agree with that part of it?

A. Yes.

Q. All right. Do you have an opinion that you're able to state with a reasonable degree of podiatric medical certainty as what the probability was that Mr. Poe would have obtained complete relief from these three neuroma structures, like structures in his feet through the continued use of an orthotic?

A. It would have been less than 50 percent.

Q. All right. Now, you talked about the possible use of corticosteroids, either orally or by injection, as being another step in the

treatment regimen; is that correct?

A. Correct.

Q. And what do corticosteroids do for the neuromas in the feet of a patient such as Mr. Poe?

A. They have the similar effect as oral anti-inflammatory medications, to -- to decrease

inflammation and swelling around the nerve.

Q. And do you have an opinion that you're able to state within a reasonable degree of podiatric medical certainty as to whether or not a reasonable course of corticosteroid medication would have eliminated the problems that Mr. Poe was experiencing with these three structures in his feet?

A. What would you define as -- what would be the definition of reasonable course?

Q. Whatever definition you choose to give it. Whatever it is you think that Mr. -- Dr. Doe should have done for Mr. Poe in this case.

A. I think that the chance of cortisone injections would be less than 50 percent.

Q. All right. So up to this point do I correctly understand you, Doctor, that even

though you believe that Mr. -- Dr. Doe should have exhausted his conservative treatment options, except for the alcohol we haven't talked about yet, that none of the things we are talking about had as much as a 50 percent chance of giving Mr. Poe the relief that he sought?

A. Yes, I would agree with that.
Q. All right. Now, let's talk about the alcohol injections, Doctor. Were you trained in 1995 on the use of alcohol injections specifically for the treatment of interdigital neuromas?
A. I was trained on injecting cyanocobalamin which has alcohol in it, and it's the same procedure.
Q. All right. But you weren't trained to use alcohol per se, at least not the 4 percent anhydrous alcohol that's currently used; is that correct?
A. There's no such thing as 4 percent anhydrous.
Q. I thought that's what it was called. I apologize. Well, whatever the preparation is that you referred to that's 4 percent of

something by volume, you weren't trained to use that specifically, is that a fair statement?

A. Not in 1995, no.

Q. All right. When did the use of that kind of medication come into vogue?

A. In 1998 training -- it started to become in vogue and training started to occur

with regards to our students and our residents in using that method of conservative treatment.

Q. All right. When was Dr. Doe trained in the treatment of interdigital neuromas? You've read his deposition so you may have that information.

A. He received his training in 1990.

Q. Now --

A. Or his residency training or postgraduate training in 1990.

Q. So he -- it's fair to say then that he would not have been trained in the use of that medication when he was a resident; is that correct?

A. Correct.

Q. All right. Is it your belief, Doctor, that in the year 2000, specifically in the months of July through say early December, that

the use of a series of alcohol injections prior to attempting surgical removal was the standard of care?

A. Yes.

Q. Well, how was Dr. Doe supposed to know that?

A. How was he supposed to know it was

standard of care?

Q. That's right. What textbooks could he have consulted that would have suggested to him that this was a really good way to treat neuromas before you do surgery or what journal articles from journals that podiatrists commonly use and respect could he have read that would have told him that this procedure was a really good way to treat interdigital neuromas before you did surgery? What information was available in the podiatric community from which a reasonable and prudent podiatrist such as Dr. Doe could have ascertained that the standard of care required him to try a course of this alcohol injection therapy before he did any surgery?

A. That infor --

MR. SHANE: Object to form. Go

ahead.

A. Sorry. That information would have been available in Journal of Foot & Ankle Surgery, as well as podiatric medical conferences and -- and lectures.

Q. Well, are you certain from your own knowledge and experience that the podiatric

medical conferences in the mid-Atlantic region where Dr. Doe happens to hang out were teaching alcohol injection therapy in the time frame of the year 2000?

MR. SHANE: Objection. That doesn't set the standard for what they were doing in his local community, but go ahead, Doctor.

A. Yes, they were being -- there were medical lectures or podiatric medical lectures on alcohol injections in the mid-Atlantic states.

Q. Tell me a couple of them that you personally know about.

A. There would have been at the New York Podiatric Conference.

Q. All right. And where else?

A. As far as a couple of them, I, I --

I only know of, if you're asking me specifically, that one.

Q. All right. And how else might Dr. Doe have known about this if he had not had the great good fortune of attending that conference in New York -- New York?

MR. SHANE: Objection to

characterization. Go ahead, Doctor.

A. Well, other than the Journal of Foot & Ankle Surgery as I already mentioned.

Q. And what, if any, recollection do you have of the date of the publication of the first of these articles in the Journal of Foot & Ankle Surgery about the use of alcohol injection therapy?

A. It's the fall of 1999.

Q. And who was the principal author of that article?

A. Dr. Gary Dockery.

Q. All right. And isn't it a fact that that was the first article in a juried journal for many, many years which had specifically addressed the use of alcohol injection therapy for the treatment of interdigital neuromas?

A. Yes.

Q. Have there been any since?

A. No.

Q. All right. So is it your statement, Doctor, that a single article in the Journal of Foot & Ankle Surgery was sufficient to establish the standard of care that a reasonable and prudent podiatrist in the United States of

America should have been adhering to in the treatment of interdigital neuromas in the latter half of the year 2000?

A. Yes.

Q. All right. And how common is it in your profession to have a single article set the standard of care for a treatment modality for use by all of your colleagues nationwide?

A. A research article with the success rates reported, extremely common.

Q. All right. Did the publication of that article then make it incumbent upon Dr. Doe to go out immediately and get himself trained in the use of this modality?

A. I believe, yes, it requires a physician to add that to their conservative treatment regimen.

Q. Are there any other reasons why the use

of alcohol injection therapy for the treatment of interdigital neuromas has become popular in the United States of America within recent years?

A. Other than what?

MR. SHANE: Objection.

Q. Other than the publication by

Dr. Dockery of this seminal article.

A. Other than the success rates reported by Dr. Dockery?

Q. That's right.

A. That would -- that would be the only reason needed for it to -- to be incorporated into standard of care, would be the success rates reported in literature.

Q. And would the fact that it pays at least as well or better than the performance of surgery to remove the neuromas have any impact upon its popularity in your profession?

MR. SHANE: Objection.

A. No.

Q. And it's your opinion, is it, Doctor, that there was an 80 percent chance of success with the use of this alcohol therapy?

A. Actually according to that literature,

at least 80 percent.

Q. All right. And isn't that the same success rate that you indicated to us you attributed to surgical excision of the neuromas?

A. Yes.

Q. Well, if the success rate is the same, why in your opinion is a physician required to

use one in preference to the other, or at least to use one prior to resorting to the other?

A. Because the alcohol injections are considered a conservative treatment modality, and you avoid other complications that can accompany surgery.

Q. And are there no complications with the use of the alcohol injection therapy?

A. There are complications associated with it.

Q. Okay. Now, do you use this alcohol to inject it into the foot of your patient straight the way it comes out of the bottle, or do you mix it with something else?

A. You mix it.

Q. And what is it that it's mixed with commonly?

A. It is commonly mixed with an anesthetic

called Marcaine or Bupivacaine, which is a long-acting anesthetic. That anesthetic also has a medication called epinephrine in it that constricts the blood vessels and is designed to keep the alcohol and the anesthetic in the area where you injected it for a longer period of time.

Q. And I take it that the use of the anesthetic provides the patient with immediate relief from the pain that he or she was experiencing?

A. Yes.

Q. All right. Now, have you ever had in your own practice patients who have undergone a course of alcohol therapy and then returned to you for surgical excision of their neuromas?

A. Yes.

Q. And have you ever had patients whom you have treated with NSAIDs and gotten an initial success in relief of symptoms who have subsequently had the symptoms return and come to you for surgery?

A. In my own practice, yes.

Q. Have you ever had patients whom you have initially had success in treating with

orthotics who have returned to your practice requesting surgery after their pain returned?

A. Requesting surgery or requiring surgery?

Q. Requiring surgery was what I meant to say. Thank you for the correction.

A. Yes.

Q. And would the same also be true with corticosteroid injections and pills?

A. Yes.

Q. In fact, doesn't the literature document a fairly high recurrence of the symptoms of the neuromas in patients who have initial success with the conservative treatment modalities?

A. Excluding alcohol, yes.

Q. Okay. And you be -- you're stating now for the ladies and gentlemen of the jury that it was below the standard of care for Dr. Doe not to have used alcohol injections that because by the end of the year 2000 they had become the standard of care for the treatment of interdigital neuromas?

A. As a conservative treatment measure, yes.

Q. All right. Now what does the literature say about the success of alcohol injection therapy on fibroneuromas?

A. It is a treatment -- as far as the literature, there isn't anything specifically out there on one entity other than intermetatarsal neuroma. It is used for nerve

pain and neurological pain to decrease the sensation or to desiccate or dehydrate the nerve.

Q. Well, if there is no literature that tells you about the efficacy of these treatment -- of this alcohol treatment in cases of neurofibromas, how can you say that the failure to use it -- that it was required to be used in this particular case?

MR. SHANE: Object. Object to form.

Q. I hope you understand that question because I'm not sure that I did. Let me withdraw the question, all right.

What, if any, scientific basis are you aware of for saying that the use of alcohol injection therapy is efficacious in the treatment of neurofibromas?

A. There's no scientific basis for treatment of a neuro -- the entity of neurofibroma.

Q. Are you telling the ladies and gentlemen of the jury that Dr. Doe was obligated to use the alcohol on these neurofibromas even though concededly at the time

he didn't know they were neurofibromas?

MR. SHANE: Object to form.

A. I think some of the confusion that -- that I am having is how you define. I don't consider intermetatarsal neuromas to be neurofibromas.

Q. Well, isn't it a fact that ultimately the diagnosis of a neuroma is made by the pathologist, the definitive diagnosis is made by the pathologist, and up to that point the diagnosis is simply presumptive based upon the best evidence in the surgeon's possession?

A. You said ultimate physical diagnosis?

Q. I'm sorry. Ultimately the positive diagnosis of neuroma is made by a pathologist?

A. Correct.

Q. All right. And up until the time the pathologist can examine the tissue, the surgeon

is just making an educated guess?

MR. SHANE: Objection.

A. I wouldn't say it's a -- a guess. From the clinical information that a physician has from the examination, as well as the history, a physician will make an initial diagnosis to -- to work off of.

Q. Well, perhaps I'm confused then. Would you explain to us again how it was in Mr. Poe's case that the alcohol was going to permanently alleviate Mr. Poe's pain that he was experiencing as the result of the neurofibromas in his right foot?

A. Because based on the best available evidence, as we've discussed, for example Dr. Dockery's article on intermetatarsal neuromas, that study was conducted on 100 patients that had the same clinical findings as Mr. Poe.

Q. And how many of those patients of Dr. Dockery's had neurofibromas?

A. We don't know how many of them had neurofibromas because there wasn't any pathology reports that were included in that article, but they had intermetatarsal neuromas.

Q. And what success rate did Dr. Dockery attribute to his treatment in his article?

A. 82 percent of his patients had either 60 to 100 percent complete relief, and there was another 7 percent that had improved symptoms.

Q. Over what period of time?

A. The study was conducted over a period

of ten years. So the study was actually started in 1986 through 1996. And the follow-up was, average was 13 months postsurgical.

Q. And this was --

A. Or postconservative treatment.

Q. And this was published in the Journal of Foot & Ankle Surgery?

A. Yes.

Q. What is the Journal of Foot & Ankle Surgery?

A. It's a peer-reviewed -- a peer-reviewed journal that is run by the American College of Foot and Ankle Surgeons.

Q. And is it distributed to all of the members of the American College of Foot and Ankle Surgeons?

A. Yes.

Q. Do you get it if you aren't a member of

the American College of Foot and Ankle Surgeons?

A. You don't get it with your dues, but you can subscribe to it.

Q. Now, just so that there can be no concern about this, would you agree with me that even though you believe the surgery was not done correct -- was not necessary, that it was done

correctly?

A. According to the records I reviewed, which consisted of the operative report, yes.

Q. All right. Now, are you also familiar with a journal known as the Journal of the American Podiagraph -- Podiatric Medical Association?

A. Yes.

Q. And is that a learned journal that you find reliable in terms of the information that it contains therein?

MR. SHANE: Objection. Are you talking about a particular article or the journal just generally?

Q. I'm talking about the journal generally at the moment.

A. The journal generally at the moment? I would not consider it as -- the publication's as

high a quality as the Journal of Foot & Ankle Surgery.

Q. But it is generally regarded as reliable by your colleagues, is it not?

MR. SHANE: Objection.

A. By my colleagues? No.

Q. Yeah.

All right. Are you familiar with a Dr. Rodney Tomczak?

A. Yes.

Q. How do you know Dr. Tomczak, or what do you know about him?

A. Those are two different questions.

Q. All right. Well --

MR. SHANE: Objection to form.

Q. Let me withdraw the question then.

At one point in time wasn't Dr. Tomczak an associate professor of podiatric medicine at something called the University of Osteopathic Medicine and Health Sciences College of Podiatric Medicine and Surgery in a place called Des Moines, Iowa?

A. Yes.

Q. Is that the same place that you currently work?

A. Yes.

Q. Is Dr. Tomczak still there by any chance?

A. No, he's not.

Q. All right. Was Dr. Tomczak -- are you familiar with his article on "A comparative analysis of conservative versus surgical

treatment of Morton's neuroma."

A. Is that the one he published with Dr. Hake?

Q. Yes.

A. Yes, I'm familiar with it.

Q. Gaynor, Hake, Spinner and Tomczak. All right.

Do you consider the information contained in that article to be reliable?

A. Based on my general impression of the journal, not as reliable as the Journal of Foot & Ankle Surgery.

Q. All right. Do you agree with the following statement in --

MR. SHANE: Objection. He hasn't recognized it as authoritative. You're just going to read him something?

Q. All right. Then let me ask you the

question again.

Do you consider Dr. Tomczak's article to be authoritative in the field of treatment of Morton's neuroma?

A. I wouldn't consider it authoritative.

Q. Do you consider it reliable?

A. I would look at it and take it into

consideration with the -- the other information that's available on the treatment of intermetatarsal neuromas.

Q. So it's something upon which one of your colleagues might reasonably rely in trying to formulate a treatment pattern for a patient with Morton's neuroma; that article and anything else that he might wish to consider?

A. Yes.

Q. All right. Do you agree with the following statements in Dr. Tomczak's article: "That the summary of treatment success data demonstrates a clear advantage of surgical excision of the neuroma"?

A. No, I don't agree with that statement.

Q. Do you agree that surgery -- with this statement, and I quote.

MR. SHANE: Objection.

Q. "Surgical treatment was successful in 76 percent of the cases reviewed"?

MR. SHANE: Objection. How can he agree with that?

MR. BOONE: Well, he either does or he doesn't.

MR. SHANE: That's a -- that's a

conclusionary statement by the author. That's not an opinion. I don't --

MR. BOONE: Well, I'm asking if he agrees with the authors' conclusions.

A. Those authors' conclusions are in line with other published data regarding success rate of surgical excision of neuroma.

Q. In fact, would you agree with me, Doctor, that those conclusions are in line with all of the published data on the treatment of neuromas, both surgical and conservative?

A. I would have you define in line.

Q. Well, aren't his results consistent with the results reported by virtually every other author who has reported on the subject?

A. They are similar. In line, I wouldn't say that they're exactly the same as every other author, but they are similarly reported success

rates.

Q. Okay. Do you agree with the following statement, and I quote. "From the data presented here, it can be seen that surgical management of Morton's neuroma demonstrates a much higher probability of success when compared to conservative methods"?

A. No, I do not agree with that statement.
Q. Now, are you familiar with a publication known as Trial Magazine?
A. Yes.
Q. What do you understand it to be?
A. I understand it to be a -- oh, I wouldn't call it a journal, but a magazine that trial attorneys consult.
MR. SHANE: I'm going to object. I think this goes far beyond cross-examination of direct examination unless I missed something.
Q. Do you recall that a while back we had occasion to convene by videoconference and I took your deposition?
A. Yes.
Q. My records reflect that that deposition occurred on September the 3rd of 2000. Is that correct?

A. Yes.

Q. And if I'm not mistaken, you were actually in this very room when all of that happened; is that correct?

A. Yes.

Q. Now --

MR. SHANE: I'm going to object.

This is improper use of a deposition. If you are using it to impeach him and have a question pending, ask it and then you can use it for impeachment purposes, but you just can't read from his deposition. He's not a party.

Q. Have you ever advertised in Trial Magazine?

A. Yes.

Q. And isn't it a fact that during the course of the deposition we mentioned a moment ago, you indicated that you were no longer advertising in Trial Magazine?

A. Correct.

Q. In fact, weren't you asked the following question?

MR. SHANE: Objection. There is -- there is nothing pending for impeachment purposes. He's answered your question.

MR. BOONE: Thank you.

Q. Do you recall having been asked the following question and giving the following answer? For the convenience of the Court and counsel, I'm referring to Dr. Smith's deposition at page 10, commencing at line 25.

Question: "Do you know whether

or not this case was referred to you by TASA, T-A-S-A?"

Answer: "I don't think it was, and I also used to have an ad -- used to have an advertisement in a legal journal, but I can't recall which one."

Is that correct?

A. Correct.

Q. In point of fact, at that particular time you actually had an advertisement running in the current issue -- the then current issue of Trial Magazine, is -- is that a true statement?

A. I don't know if it was running or not. I know that I think last summer I signed up for an advertisement for a period, and I -- and I don't know how many months. I thought it was only three months, and I thought I started it in

June. So at the time when I gave you that answer, the advertisement, if I thought I would have started it in June, then September would have been after that three-month window, so the answer that I gave you to my recollection was a truthful answer.

MR. BOONE: Madam reporter, would

you mark this as Defense Deposition Exhibit Number 1 for identification, please.

(Defendant's Exhibit 1 was marked for identification by the reporter.)

Q. Doctor, let me show you what's been marked as Defense Deposition Exhibit Number 1 for identification, please. I'm going to refer you to page 104 of that exhibit, the middle column, about right there, and ask you to see if there's any advertisement on that page that you recognize.

A. Yes.

Q. Would you read it, please?

A. "Podiatry and foot and ankle surgery. Board certified. University faculty. Associate dean for clinical affairs. Plaintiff/defense case review and testimony." And then a phone number is listed.

Q. Is that your telephone number?

A. Yes.

MR. BOONE: All right. I have nothing further of the doctor at this time.

MR. SHANE: Okay. I have a few more questions, Doctor.

REDIRECT EXAMINATION

BY MR. SHANE:

Q. Let me ask you something. If you try a course of conservative management of neuromas and that is unsuccessful in I think you said around 20 percent of cases?

A. Yes.

Q. Somewhere in that range. Can you then go to surgery as a -- as a -- what you said was the final resort?

A. Yes.

Q. If you do the surgery and you fail, can you go back now and successfully use conservative measures?

A. You can go back and use conservative measures.

Q. Successfully?

A. Not successfully, no.

Q. Now, you said that -- Mr. Boone asked you about the ultrasound. Those ultrasound measurements that he read to you, do they automatically mean that this is a patient who's got to have surgery?

A. No.

Q. How long was it -- I think you said --

do you know when Dr. Doe actually gave Mr. Poe his orthotics?

A. September, early September or mid September.

Q. Of 2000?

A. Of 2000 I think it was.

Q. And what was the date of the first surgery?

A. I think December 7th of 2000.

Q. Is that a reasonable period of time of conservative management for someone who has three diagnosed interdigital neuromas?

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

A. No.

Q. Mr. Boone talked to you about the -- this article here. What, what -- what percentage of your, your professional time is

spent in reviewing matters like this?

A. Very small percent actually. I'd probably say total time, less than 2 percent, 3 percent.

Q. And why do you -- what -- to what use do you put the information you gather from cases you review?

MR. BOONE: Objection. Beyond the scope of either direct or cross.

MR. SHANE: You brought up the advertising.

Q. Go ahead, Doctor.

MR. BOONE: I didn't bring up what he uses the information that he garners from his review of cases.

Q. Go ahead, Doctor.

A. Some of the cases I've actually removed names from and actually used them in the curriculum --

Q. How --

A. -- in small group discussions that we have with students.

Q. How -- how is that used for teaching purposes?

A. Well, it's useful in teaching purposes

for a couple of reasons. One to -- to teach the students what issues such as standard of care, complications. I give a lecture to the students, and often I'll bring in information that -- from previous cases such as is -- is a complication after surgery a deviation from standard of care or not. You know, so I use it

for teaching purposes to kind of highlight not only conservative treatment versus surgical treatment, but also the general legal process.

Q. Okay. And I assume like most experts there is some payment for your time in this. Do you actually --

MR. BOONE: Objection. Beyond the scope of cross and beyond the scope of direct.

MR. SHANE: I don't think so. I think you brought up the advertising.

Q. What -- what purposes do you use the money garnered from this?

MR. BOONE: I strongly object to that. Same reason. Move to strike any answer he gives.

Q. Go ahead, Doctor.

A. I get I would say reimbursed, or I

actually do receive payment for review of cases. Some of it is personal income and then some of it has been donated to the university in the form of student scholarships.

Q. Okay. Last question, Doctor.

Surgery goes to whom?

A. It goes to associates of the American College of Foot and Ankle Surgeons, which are members who join the organization after they receive board -- board certification. It goes to podiatric medical students, hospitals and libraries subscribe to it.

Q. When someone's a member of that group, is that a fellow of the American College of Foot and Ankle Surgeons?

A. Yes.

Q. Is that FACFAS?

A. Yes.

Q. When Dr. Doe signs his name, how does -- what's his signature block say?

A. FACFAS.

Q. You mentioned something earlier about you learned to do a different kind of injection. What actually was that injection that you

learned? You said methyl -- you said you learned to do an injection.

A. Cyanocobalamin.

Q. Cyanocobalamin. What is that?

A. It's B12.

Q. Okay. And that was something that people used earlier even than Dr. Dockery's

article?

A. Yes. People had used that to inject intermetatarsal neuromas. It was often thought that it was the B12 that was actually giving patients relief. However, cy -- cyanocobalamin actually has dehydrated alcohol in it.

MR. SHANE: Okay, thank you, Doctor. That's all.

MR. BOONE: Nothing further.

THE VIDEOGRAPHER: This deposition is complete. We are off the record at 2:16 p.m.

(Deposition concluded at 2:16 p.m.)

The deposition of Kevin M. Smith, D.P.M., is now complete. When transcribed, the original of the deposition shall be given to Mr. Jeffrey A. Shane. The original exhibits shall be distributed as follows: Original of Plaintiff's Exhibit 1 was retained by Mr. Shane, and original of Defendants' Exhibit 1 was retained by Mr. Richard W. Boone, Sr.

(UNLESS OTHERWISE DIRECTED BY

COUNSEL OR THE PARTIES HERETO, THE STENOGRAPHIC NOTES FOR THE FOREGOING DEPOSITION SHALL BE DESTROYED AFTER A PERIOD OF 3 YEARS FROM THE DATE OF TAKING OF SAID DEPOSITION.)

C E R T I F I C A T E

I, the undersigned, a Certified Shorthand Reporter and Notary Public of the State of Iowa, do hereby certify that I acted as the Certified Shorthand Reporter in the foregoing matter at the time and place indicated herein; that I took in shorthand the proceedings had at said time and place; that said shorthand notes were reduced to typewriting under my supervision and direction, and that the foregoing pages are a full and correct transcript of the shorthand notes so taken; that said deposition was not submitted for review.

I further certify that I am neither attorney nor counsel for, or related to or employed by any of the parties in the foregoing matter, and further that I am not a relative or employee of any attorney or counsel employed by the parties hereto, or financially interested in the action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal this _ _ day of _ _ _ _ _ _ _ _ _, 2005.

_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

CERTIFIED SHORTHAND REPORTER
and NOTARY PUBLIC