THE SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF ORANGE.
--x

CATHY JO and JOHN EWANCIW,

Plaintiffs,

-against-Index No. 5391

_______________,

Defendant.

--x
April 17, 2007
Surrogate Court Building
Goshen, New York

(TESTIMONY OF EXPERT: DR. DAVID J. WIDOM)

Robert J. Cummings, Jr. RPR
Senior Court Reporter

MR. LEFFLER: Thank you, your Honor, we call Doctor David Widom.

D-A-V-I-D J. W-I-D-O-M, M.D., stating his office address as 10316 Northwest 15th street, Plantation, Florida, 33322, was duly sworn and testified as follows:

THE COURT: You may proceed.

MR. LEFFLER: Thank you, your Honor.

DIRECT EXAMINATION BY MR. LEFFLER:

Q Good morning, Doctor Widom?

A Good morning.

Q Doctor Widom, are you a podiatrist?

A Yes.

Q Can you tell us where you attended podiatry school?

A I attended the Pennsylvania College of Podiatric Medicine. And I believe the name has been changed to the Temple School of Podiatric Medicine.

Q Can you tell us your years of attendance there?

A 1974 to 1978.

Q During your course of study in podiatry school, did you learn about the anatomy of the leg and foot?

A Yes.

Q Following your graduation from podiatry school, did you enter into any post doctoral training?

A Yes, I did.
Q Can you explain what that was?

A I did a one year preceptorship. Back then the good residency training programs were limited in number. And I took this preceptorship program, which was accredited through the New York College of Podiatric Medicine. And I trained with a number of different doctors in the south Westchester, New York area.

Q Did you attain licensure in podiatry?

A Yes.

Q In which locations?

A In the State of New York and the state of Florida.

Q And are you current actively licensed in both?

A I have an inactive status in the State of New York, and active license in the state of Florida.

Q Are you presently actively practicing podiatry?

A No.

Q When did you stop?

A I treat a handful of patients, but I essentially retired the last Friday in August of 2005, I believe that would be August 26th, 2005.

Q Can you explain your practice history prior to retirement?

A Well, let's see, I did the preceptorship from '78 to '79 in Westchester County, and then I moved down to Florida. And I had an office in Sunrise, Florida, which is a western suburb of Fort Lauderdale. Do you want me to give you the address?

Q No, no, no, explain generally what you did.

A Oh. I did --well, let's see, I do all types of surgery of the foot. I did wound care, skin grafts, all kinds of things on the leg. The law in Florida is a little bit different than the one in New York. We could treat higher up the leg. Other than that, it's exactly the same.

Q Did you have hospital affiliations?

A Yes, I did.

Q Can you tell us which hospitals and what you did with them?

A I was on staff at Mount Sinai Medical Center. As a matter of fact, my ex-partner and I were given an office in one of their office buildings on the campus. And both of us were training first orthopedic residents -

MR. MILLIGRAM: Objection, both of us? The question is only about this doctor, move to strike.

THE COURT: It shall be stricken. Talk about you.

THE WITNESS: Okay.

A I was involved in a training program at Mount Sinai Medical Center, which is a university affiliated teaching hospital. And at the beginning, I was training doctors who were orthopedic residents, who were interested in learning how to do foot surgery.

We started a --I started a residency training program in podiatry in 1992. And from, well, actually, it was '90, but from '92 to '94, I was the head of the residency program and the Director of Podiatric Medical Education at Mount Sinai on Miami Beach. I think I failed to mention where I was.

Q Any other hospitals that you were affiliated with?

A Yes, I also had the office up in Sunrise. Miami Beach is that Dade County, that's further south, about 25, 30 miles. I had another office in Sunrise, north of Miami Beach, again, a suburb of Fort Lauderdale, maybe 8 miles west of Fort Lauderdale proper.

Q The hospital affiliations?

A Okay. At that office, at that time back in 1980 in the earlier years I predominantly worked at one hospital, which was Florida Medical Center, since managed care had not come around yet, so, you really only needed one hospital because if you were going to admit a patient, or do surgery

on a patient, you didn't have to go where the plan told you to go. They had, back then, traditional indemnity insurance, and I could take them to the one hospital.

Should I continue with the others?

Q Just name the hospitals that you were affiliated with?

A Okay. When managed care came into the picture I got on staff at other hospitals as well because there were several different corporations who pretty much owned the hospitals in the entire county. So I worked at University Hospital in Tamarac, Florida; I worked at Coral Springs Medical Center in Coral Springs, Florida; I also worked at the rehabilitation hospital, Saint John's Rehab Hospital, and there is another rehab hospital that I worked at Healthsouth, which were in Sunrise. These were all close to the Sunrise office. Down in Miami Beach we stayed slowly at Mount Sinai.

Q Doctor, have you had affiliations with professional organizations?

A Yes.

Q Tell us which ones?

A Well, I have been a member of the Florida

Podiatric Medical Association; the National; the American Podiatric Association; and the Broward County Podiatric Association.

Q And have you received any awards from them?

A Yes. I received an award for 25 years of continuous membership in good standing from the National Organization. And then I received the honorable status of life membership from both the Florida Podiatric Medical Association and the American Podiatric Association.

Q Are you Board certified?

A Yes, I am.

Q Which board?

A The American Board of Podiatric Surgery.

Q And do you continue to be Board certified?

A Yes, I re-certified last year through the year

2015. Re-certification comes up every 10 years.

Q Doctor, have you ever testified for me or for my firm before?

A No.

Q And can you tell us whether you have testified in Court before, in a Court proceeding?

A Yes, I have.

Q Approximately how many times?

A Well, I testified I believe it was twice in an actual courtroom. And then I testified --I am not sure, maybe 2, 3, 4 times maybe where I gave testimony in a board room setting that could be played in court, if needed. But it was used to, it was taken to be played in court. They were afraid of bad weather.

Q Doctor, have you testified on behalf of plaintiff or defendant or both?

A I have done both.

Q Doctor, have you ever reviewed any cases for my firm other than this case?
A Yes, I have.

Q How many?

A One.

Q When were you first contacted to review this case, doctor?

A It was the end of November of 2006.

Q Doctor, are you being compensated for your time in court?

A Yes.

Q And how much are you being compensated?

A I am being compensated $5,500.

Q And are you being reimbursed for your travel expenses from Florida?

A Yes.

Q Were you compensated for review of materials that were previously sent to you?

A Yes, I was.

Q How much was that?

A $2,100.

Q Doctor, what materials did you review for this case?

A I reviewed the office notes of Doctor ----------, DPM, as well as his x-rays. I also reviewed the records of the Horton Medical Center. I reviewed records of the doctor who did the medical clearance for Mrs. Ewanciw's surgery -did I get that right? As well as records from two neurologists; one was a Nilay Shah, M.D. and the other was a David Jaeger. I am not sure if I am pronouncing their names right. They were part of a group. I also reviewed a CD that showed -MR.

MILLIGRAM: Objection, your Honor.

THE COURT: Sustained.

MR. LEFFLER: Your Honor, may we approach?

THE COURT: Yes.

(Discussion held off the record at the bench).
BY MR. LEFFLER:

Q Doctor, did you review anything which enabled you
to see Mrs. Ewanciw stand, walk, balance?
A Yes.

Q And were you able to see her feet as well?

A Yes.

Q Doctor, did you review the deposition transcripts?

A Yes.

Q Doctor, based upon your review of those documents, did you reach certain opinions regarding the treatment in this case?

A Yes.

Q Do you hold those opinions to a reasonable degree of podiatric certainty?

A Yes.

Q Have you performed heel spur surgery?

A Yes.

Q Are you familiar with heel spurs?

A Very much so.

Q Doctor, can you estimate the number of times that you have performed heel spur surgery in your career?

A Over an almost 30-year career, I would say several hundred.

Q Is this a procedure you have taught to the residents you spoke about earlier?

A Yes.

Q Doctor, is there one procedure, or are there various procedures to treat heel spur?

A There are several.

Q Can you tell us what those several procedures are?

A There is one called EPF, which means endoscopic plantar fasciotomy - that was the one that was done in this case. There is another approach, which is the one I have been using, called a semi-closed approach, where you make a small incision on the side of the foot also. And then there is the open procedure, where you make a much longer incision on the side of the foot.

Q Doctor, are you familiar with the standards of care for all of those procedures?

A Yes.

Q Doctor, you said that you preferred the semi-closed approach. Can you explain why that is?

MR. MILLIGRAM: Objection, your Honor, relevance. What this doctor prefers in a surgical approach?

THE COURT: Sustained.

Q Doctor, are there any advantages or disadvantages to the three different procedures you discussed?

MR. MILLIGRAM: Objection, your Honor.

THE COURT: Come on up.

(Discussion held off the record at the bench.)
BY MR. LEFFLER:

Q Doctor, can you explain what a heel spur is?

A A heel spur, as we are using it in this venue, in this particular situation, is a projection that comes off of a bone in the foot called the calcaneus, in medical terms. We can refer to it as the heel bone, you know, so everybody understands. And it's a projection that comes off the lower part of the heel, and it's the lower back part of the heel bone, so that if I was to press my thumb into the area on the bottom of the foot, which is a little bit in front of the back of the foot and towards the inside of the foot, if somebody came in with this problem, I would elicit pain.

Q Now, doctor, what you are holding in your hand, can you just explain what that is?

A These are actual bones of a foot that are held together with very strong fishing line.

Q Is that yours?

A Yes.

Q Now, doctor, you explained that to do heel spur surgery, one makes incisions; you recall that?

A Yes they do.

Q Is the location of the incision important?

A Crucial.

Q Explain what you mean by "crucial"?

A The location of the incision has to be made in a specific area so that you are away from the nerves that run not too far from the area of the surgery, that you definitely want to avoid.

Q Doctor, I have some enlargements made of some of the anatomy.
MR. LEFFLER: Your Honor, if the witness may show them? Actually, Judge, now that I am looking at that view box, I think that might be the best thing.

THE COURT: All right.

MR. MILLIGRAM: Your Honor, might I look at them.
(Diagrams marked Plaintiff's 1 through 4 for identification).

MR. MILLIGRAM: Your Honor, to my eye, may we approach at side bar? There appears to be an inconsistency in these diagrams.

(Discussion held off the record at the bench.)
MR. LEFFLER:

Q Doctor, maybe, you know, just putting it into that view box, without the light on --Judge, may I enter in there?

THE COURT: Yes.

Q Now, when you said a moment ago –

MR. MILLIGRAM: Perhaps could the doctor and I go by into that area –

THE COURT: You can go wherever you think you need to see.

MR. MILLIGRAM: Thank you. Which number is this for the record, please?

THE WITNESS: Number 4.

MR. MILLIGRAM: This is the one that's objected to.

MR. LEFFLER: We said 2 was objected to.

MR. MILLIGRAM: No, 4.

THE COURT: Why don't you use the other one? That was the one that was okay.

MR. MILLIGRAM: Pardon me, Judge. Yes, your Honor, those two are the ones that I do not object to.

MR. LEFFLER: Judge, I think that would be subject of cross, but that is my objection to that issue.

THE COURT: If you don't need it.

BY MR. LEFFLER:

Q Doctor, can you explain to us using any of these?

A These two?

Q Yes, sure. What you said you are trying to avoid when you said the incision location was crucial?

A See if we can use this one.

MR. MILLIGRAM: If you would tell us the exhibit number, with your Honor's permission.

THE WITNESS: Exhibit number 1.

MR. MILLIGRAM: Great. Thank you.

THE WITNESS: We need a little piece of cellophane tape.

MR. LEFFLER: I will tell you what, I have another solution possibly.

THE WITNESS: I can just hold it.

MR. LEFFLER: No. Clip it onto that.

THE WITNESS: I got it.

Q Okay, doctor, can you explain what is crucial about the location of the incision, about things you wanted to avoid?

A The incision is going to be made here. This is the big toe. That's the inside portion of the foot. The incision for a heel spur surgery of this type is going to be back over here (indicating).

This has removed the skin, the fat, and the fascia that is in this procedure. So we are down to first layer of muscles, and the medial plantar nerve, which is this nerve over here (indicating), and the lateral plantar nerve, which is this nerve over here (indicating). You can see when they first start, they are right next to each other. Then one branches out this way (indicating), the lateral plantar. And the medial plantar branches out this way (indicating).

Q Doctor, is that the top of the foot or the bottom?

A This is the foot turned upside down, it's the right, so it's this way (indicating).

Q And what about the location of the incision is crucial with regard to the location of those nerves you just pointed out?

A The incision is made on the side of the foot against the heel bone and below the bump from the ankle. And it needs to be made at a level where you would not come into contact with either the medial plantar or the lateral plantar nerve, back here, where they enter the foot.

Q Now, doctor, that lateral plantar nerve, what does it do?

A The lateral plantar nerve is responsible for the majority of the muscles, the small little muscles that are in the foot. There are actually four layers of foot muscles. And it's responsible for the muscles being able to work. It also gives sensory sensation to most of the bottom of the foot and to the bottom part of the toes -not the big toe. So it would be the sensation would be from here (indicating) back to about here (indicating).

Q Is that true both for the top and the bottom?

A Only on the bottom and a little bit on the side of the foot out over here (indicating).

Q Does the nerve come onto the top at all?

A No.

Q Now, doctor, if there is numbness to that nerve, if that nerve is injured, how would it manifest itself?

A The patient would experience numbness, primarily they would initially feel numbness on the bottom part of their foot, from this part would be okay (indicating.)and this part (indicating) I am going to draw like a rectangle, would be numb.

Q Would that have any functional affects?

A Yes. It would make it difficult for a patient to balance and to stand for long periods and to walk. Also they lose the feeling of when you are standing, you know where you are, so that if you are in the shower and your eyes are closed from soapy water, you know where your foot is -on the bottom of the shower. You would lose that. You really wouldn't know where it is.

Q Are the toes affected if a lateral plantar nerve is injured?

A Yes.

Q How so? Explain that, if you would.

A Over time the muscles that the lateral plantar nerve makes work, that stops when the lateral plantar nerve is cut. And what happens over time is that the muscles on the top part of the foot, they normally balance out each other -the toes stay straight. And what happens is when the lateral plantar nerve is cut, the muscles on the top part of the foot gain a mechanical advantage and they pull the toes usually in a claw-like fashion. The toes from not the big one, but the four smaller ones.

Q Okay. How does a nerve become numb?

MR. MILLIGRAM: Objection to form, your Honor.

THE COURT: He may answer it, if you can.

A Sure. By some type of injury, or if it's cut.

Q Doctor, are you familiar with the other nerves of the foot; are you familiar with the sural nerve?

A Yes.

Q Explain what the sural nerve is and what it does?

A Well, this one won't help us. Let's see if we have it on here.

Q Does one of the others help?

A No, but I can describe it.

Q Okay, to the best that you can.

MR. MILLIGRAM: Are we done by the diagrams?

All right.

A The sural nerve is a nerve that -I am not going to bore you with anatomy -but the sural nerve is a nerve that goes under the ankle on the outside portion of the foot. And it is responsible for sensation or feeling in that part of the foot just below the ankle and a little bit

further on the side of the foot. It then joins up with another nerve, but a branch of it continues so that the small toe on the outside of the small toe, the feeling on the small toe is also the sural nerve that sends a branch to that portion of the foot.

Q Does the sural nerve, if injured, affect the patient's ability to balance?

A No, I would think not.

Q And if the sural nerve is injured cause the four toes to curl down?

A No, definitely not.

Q Doctor, are you familiar with the tibial nerve or tibialis nerve?

A Yes.

Q And are you familiar with the peroneal nerve?

A Yes.

MR. LEFFLER: Judge, Exhibit 3, if I can try to get it on there.

THE WITNESS: I think I got it now.

MR. LEFFLER: Let me see what I can do.

THE COURT: Counsel?

MR. MILLIGRAM: Not on this one, Judge, I am okay for now. If I need to.

Q If you could explain, if you would, the tibial nerve and if peroneal nerve?

A Okay. The tibial nerve you can see over here -

MR. MILLIGRAM: You know, Judge, maybe I better. I can't see where the doctor is pointing. If you would just give me one second please, doctor.

THE WITNESS: Sure.

A In this picture we can see the tibial nerve. I am not going to start with the pelvis and work our way down, it's not apropos, so the tibial nerve you can see starts over here (indicating) and this is below the knee joint and it runs down the back of the leg and over here (indicating). It comes down the inside portion of the foot and it goes under the ankle bone. Just like the other nerve we talked about, the sural nerve went under the ankle bone, but on the outside portion of the foot. So the sural nerve is going under the ankle bone on the inside part of the foot, the side here the big toe is.

Q The sural or the tibial?

A I am sorry, the tibial. Thank you.

Q Does the tibial run into or become another nerve?

A Yes. The tibial, as it gets down closer to the foot, the name changes and we refer to it as the posterior tibial nerve. That nerve then goes under the ankle, and as it enters into the foot, it branches into the medial plantar nerve and the lateral plantar nerve. The medial plantar nerve also gives off branches to the inside part of the heel bone, again, the side where the big toe is.

Q Is the peroneal nerve related at all to the plantar nerves?

A Well, the peroneal nerve --actually on this diagram, the peroneal nerve comes down the front of the leg. And when it gets down by the ankle, it will split into two, again, deep peroneal, would go deep down into the foot. And the superficial peroneal, which also splits on the top of the foot.

Q Doctor, if there were a test of nerve function of the peroneal nerve, such as an EMG, and if the lateral plantar nerve were injured, would the peroneal nerve show as being injured?

A No.

MR. MILLIGRAM: Objection, your Honor, unless the doctor shows he performs EMG's or interprets their results.

THE COURT: I am sorry, what was that question again?

(Court Reporter reads back last question).

THE COURT: You may answer.

A No.

Q Doctor, for the record, are you familiar with EMG's?

A I am familiar with them as to pretty much how they are done. If I need an EMG, I will send it out to a neurologist to do a consult for me. And they will give me the results as to what the test was. I pretty much know how it's done. They are needle electrodes, or sometimes they just put them. If anybody ever has had an EMG done, it's not a lot of fun, it's almost like going for root canal. They do it one of two ways; they either put a surface electrode on the muscle, or they stick a needle in -that's the bad one. And they check to see if the muscle has con tractability, that it's being innervated by a nerve.

Q Doctor, if an EMG were done of Mrs. Ewanciw's peroneal nerve, would you expect it to be normal or abnormal?

A Normal.

MR. MILLIGRAM: Again objection, your Honor.

THE COURT: Overruled.

A Normal.

Q And why would you expect it to be normal?

A The surgery she had done was done in an area where it wasn't near that nerve.

MR. LEFFLER: I think that's all we will need for that poster at this point.

THE WITNESS: Do you want me to just leave it here?

MR. LEFFLER: Sure.

THE COURT: Are you going to go into a new material now? Maybe we should take a break.

MR. LEFFLER: Sure.

THE COURT: We will break until 2:00 for lunch. (Jury exits courtroom. Lunch recess. Whereupon, the following proceedings transpired outside the presence of the jury.)

MR. MILLIGRAM: I would ask for a recess after the doctor's direct, could I ask they be left now so I could go through them, so we could get him finished today.

MR. LEFFLER: He's got them in his car.

THE COURT: If he could bring them in. Let him use the lunch hour to go over them, that's fine.

MR. MILLIGRAM: If he could bring them 1:15 or so, that would be fine.

THE COURT: If you want to bring them up now and then you can go.

THE WITNESS: I can go get them.

MR. MILLIGRAM: Thank you.

(Whereupon, the following proceedings transpired outside the presence of the jury.)

MR. MILLIGRAM: Your Honor, while Doctor Widom was on the stand earlier, he was on direct examination, Mr. Leffler asked him about results of an EMG study. At this point, your Honor, I think that they have waived the right to have any objections to the EMG. Their doctor said it wouldn't show anything regarding the nerves of the foot. Now it's an issue for what the experts are going to say about it, they have waived any objection to admissibility based on the questioning of the doctor.

MR. LEFFLER: Your Honor, I tried very carefully to word the question in a hypothetical, that if there were an EMG study done -

THE COURT: If this is the raw data, it comes in, the reality is it's going to come in. That's why I permitted it because that's what you have indicated representing to the Court it's raw data. If it is, it's coming in.

MR. MILLIGRAM: That's what Doctor Jaeger said to me, in addition --at a side bar, I would rather not put this on the record yet.

(Discussion held off the record at the bench.) (Doctor Widom resumes witness stand. Whereupon, the jury entered the courtroom.)

THE COURT: Good afternoon. Please be seated. You may continue.

MR. LEFFLER: Thank you, your Honor.

By MR. LEFFLER:

Q Doctor, did you review the operative report of Doctor ______ regarding his surgery of Mrs. Ewanciw?

A Yes.

Q And did you review his discussion of his surgery in his deposition?

A Yes.

Q Based upon that, do you have opinions with regard to the method by which he performed the surgery?

A Yes.

Q Doctor, in your opinion was Doctor ______’s surgery performed by him within a good and accepted practice and standards for that surgery?

A No.

Q And can you explain to us why?

A Regardless of which approach is used, and I explained three before, it is crucial that the initial incision be made right over the heel spur, and right in front of the heel spur, and right below it. And when I say "right in front of" and "below", I am talking 5 millimeters, which is a quarter of an inch.

So, the way that Doctor _________ does his heel spur surgery, is that he makes a quarter of an inch incision. And it should have been made below the heel spur and in front of it. Does that makes sense?

Q And how does one one determine that location specifically?

A Now, there are two ways to do that. The way I have been doing it and teaching it for many many years, is to use a device called a "C" arm fluoroscopic unit. And really all that is is it's a thing that's shaped like a big "C" and it comes over the operative field. Before it does, it's draped sterilely with sterile plastic, and I am able to step on a pedal and get an instant on x-ray. So that with the foot on the table, where it's turned so that I have the side of the heel where I want to make my incision 90 degrees to the table. If this is the foot (indicating), I am going to have the patient have their knee flexed a little. I am going to rotate the hip so I have the foot this way (indicating) on the big toe side. The heel would be facing me. And then I will bring this machine in. I will take two thin syringe needles, cross them, step on the pedal for this fluoroscopic unit, which again is nothing more than an instant on x-ray machine, I will look at a 27-inch monitor, or t.v. And I am going to want to make the incision right over the heel spur and about a quarter of an inch beyond it and below it. And I can visualize the bone with this unit.

The other way that you can do this is to do a non-weight bearing x-ray, a side x-ray of the heel. And then you can take measurements from the x-ray and measure on the patient. So, those are the two ways.

Q Did he do either of those ways?

A No.

Q Now, doctor, was his location of the incision in the proper place?

A No.

Q Doctor, in your opinion was that a departure from good and accepted podiatric practice?

A Yes.

Q Doctor, why is it necessary to place the incision as you have described?

A If you place the incision the way I described, you are not going to encounter the lateral plantar nerve and/or the medial plantar nerve.

Q In this case was that departure that you described, a substantial factor in causing Mrs. Ewanciw's injuries?

A Yes.

MR. MILLIGRAM: Objection to form, your Honor.

THE COURT: Overruled.

A Yes.

Q And why so?

A She ended up having the lateral plantar nerve cut, and most probably some of the branches of the medial plantar nerve.

Q Now, doctor, was that directly as a result of the location of the incision?

MR. MILLIGRAM: Objection, your Honor.

A That was one of the reasons.

THE COURT: Rephrase.

Q Doctor, was the location of the incision a substantial factor in causing that cut of the lateral plantar nerve?

MR. MILLIGRAM: Objection, your Honor, asked and answered.

THE COURT: Sustained.
Q Doctor, were there any other aspects of the surgery which in your opinion constituted a departure from good and accepted practice?

MR. MILLIGRAM: Objection to form, your Honor.

THE COURT: Overruled.

A Yes.

Q Explain that, please.

A There is one other step that's crucial in doing this kind of work. When the medial plantar fascia -that's the fascia that the heel spur is attached to, and it attaches to the bone in that area -when you use your cutting instrument, it must be placed hard up against the bone.

Q Why?

A If it's not placed hard up against the bone, you can easily encounter the lateral plantar nerve and/or the medial plantar nerve, especially when the incision was too low.

Q Doctor, in this case based upon the operative report and his testimony about the surgery, did he place the instrument hard up against bone?

A There is nothing indicated in either his testimony or in his operative report to indicate that.

Q Doctor, in your opinion was that departure a substantial factor in causing injury to Mrs. Ewanciw?

MR. MILLIGRAM: Objection, your Honor.

THE COURT: Overruled.

A Yes, that's the second crucial part of this procedure.

Q And what about it made it a substantial factor in causing the injury?

A I am sorry, I don't quite understand.

Q What about the instrument not being hard against bone made that a substantial factor in causing injury?

A In all medical probability his cutting instrument cut the lateral plantar nerve, and possibly part of the medial plantar nerve.

Q Doctor, you said that you viewed Mrs. Ewanciw's foot, correct? Not in person?

A On the DVD, yes, on television.

Q And, doctor, did you read about Mrs. Ewanciw's complaints?

A Yes.

Q What, in your opinion, is her injury based upon what you viewed about her and her complaints?

MR. MILLIGRAM: Objection, your Honor.

THE COURT: Overruled.

A In my opinion the complaints that she has is complaints that one would have if the lateral plantar nerve and/or a branch of the medial plantar nerve were cut during the surgery.

Q Doctor, you reviewed Doctor Shah's report?

A Yes, I did.

Q I would like to possibly have you assist us in understanding some of the terms in there. With regard to gait, first of all, what is "gait"?

THE COURT: I think I have your copy.

MR. MILLIGRAM: You do, Judge.

THE COURT: You may continue.

Q What is "gait"?

A Gait is just a medical term for walking.

Q When it says, "Her gait was mildly antalgic and lumbering"; what does that mean?

A Antalgic and lumbering means that she has difficulty walking, and that she's not walking with the regular rhythm that a person without an injury would walk. It's not a normal gait. And she -

Q I am sorry.

A I have one more. And she's struggling to walk.

Q Now, doctor, Doctor Shah's report also notes in his physical exam that, "Mrs. Ewanciw has decreased sensation to pin, temp and vibration at the left lateral plantaris"; what does that mean to you?

A In all medical probability, and in my opinion, he's referring to the lateral plantar nerve.

Q And what does -MR.

MILLIGRAM: Objection to those, calls for now speculation to what Doctor Shah meant.

THE COURT: Sustained.
MR. MILLIGRAM: Move to strike, your Honor.

THE COURT: It shall be stricken. The jury shall disregard the answer.

Q Doctor, can you explain what decreased sensation to pin means?

A You don't feel when you are being stuck with a pin or a needle.

Q And can you explain what decreased sensation to temp means?

A You don't feel hot or cold.

Q Now, is not feeling a needle consistent with a cut lateral plantar nerve?

MR. MILLIGRAM: Objection to form, your Honor.

THE COURT: Overruled.

A Yes.

Q And is not feeling hot or cold a finding that you would expect with a cut lateral plantar nerve?

A Yes.

Q And, doctor, what does decreased sensation to vibration mean?

A Vibration is a test that we use -it's a tuning fork that we use. And we would put it on a bony area and we would ask the patient to close their eyes and you would be testing for damage to a nerve. And you would say tell me when the vibration stops. And a patient who has a damaged nerve

will say that the vibration has stopped. And I am looking at the tuning fork vibrating.

Q And, doctor, is that finding, decreased sensation to vibration, something you would expect with a cut lateral plantar nerve?

A Yes.

MR. MILLIGRAM: Same objection, your Honor.

THE COURT: Rephrase.

Q Doctor, if a lateral plantar nerve were cut, would you expect there to be decreased vibration?

A Yes.

Q Now, his report, Doctor Shah's report, goes on to speak about a motor impairment; what does motor impairment mean?

A That has to do with the use of muscles.

Q And it states that the motor impairment involves toe flexion; what is toe flexion?

A Bending and raising of the toes. Mostly bending.

Q And what is extension?

A Extension is when you are going, bringing the toes up.

Q And it also notes an impairment related to foot inversion, what is that?

A If you are looking at a foot this way (indicating) inversion means this direction. Inversion would mean towards the midline of the body. Eversion would mean towards the outside of the body.

Q And are the findings that he reports consistent with injury to the lateral plantar nerve?

MR. MILLIGRAM: Objection, your Honor.

THE COURT: Overruled.

A Yes.

Q Doctor, the evidence demonstrates that the surgery took place in July of 2003, about 3 and 1/2 years ago; in your opinion will Mrs. Ewanciw re-gain the nerve function?

A No. Never.

Q Why not?

A Because, first of all, surgically it cannot be re-attached. And, secondly, they do not grow back.

Q Are her injuries permanent in your opinion?

MR. MILLIGRAM: Objection to form, your Honor.

THE COURT: Overruled.

A Yes.

MR. LEFFLER: Thank you. I have nothing further, your Honor.

MR. MILLIGRAM: Can we have another couple of minutes going through those notes?

THE COURT: We will take a short recess. (Jury exits courtroom. Recess taken.)

(Whereupon, the jury entered the courtroom.)

THE COURT: You may inquire.

MR. MILLIGRAM: Thank you, your Honor.

CROSS EXAMINATION

BY MR. MILLIGRAM:

Q All set?

A I think so.

Q It's Doctor Widom; did I pronounce your name correctly?

A Yes.

Q Doctor, my name is Steven milligram. I represent Doctor __________. I know you have told us you have been in court before, so you probably heard what I am going to say to you. Most of my questions will call for a yes or no. Will you promise me that you will do your best to answer them yes or no, if you can?

A Yes.

Q And if you can't answer me yes or no, you will tell me?

A I will tell you if I need to explain.

Q Good enough.

Now, let's start with the beginning, doctor, the surgery that DR. __________ performed, an endoscopic plantar fasciotomy; is that the procedure?

A Yes.

Q And that's the procedure using a scope connected to a t.v. camera that gives him a visualization of the area where he's performing surgery?

A Somewhat, yes.

Q And "plantar" refers to the plantar ligament that runs on the bottom of the foot?

A No.

Q Well, actually, we can talk about the anatomy in a second, but the plantar fasciotomy involves making an incision or a cut in the plantar tissue?

A Well, the cut is made on the side and -Q And the plantar fascia itself is cut?

A Yes.

Q Good. Now, the anatomy of the foot, at the very bottom --by the way, the bottom of the foot is called the plantar surface, correct?

A Yes.

Q Top of the foot is called the dorsal surface or dorsum, correct?

A Yes.

Q And the nerves that innervate the plantar surface of the foot are different than the nerves has innervate the dorsal surface of the foot, correct?

A Yes.

Q Now, we have the skin, correct?

A Yeah.

Q And underneath the skin, the first layer below that is called the fat, correct?

A Are we going from top to bottom?

Q We are going from the bottom of the foot north?

A Okay. Yes, more fat in different areas.

Q Of course.

A It would be more fat in the heel.

Q We are just talking about layers, doctor, we are not talking about what's in what area, just the layers.

A Well, it's hard --if you are going under the metatarsal heads, there is virtually no fat. If you are talking about the heels -

Q But there is fat under the metatarsals heads, doctor -

A It's debatable.

MR. LEFFLER: Judge, can he finish his answer?

THE COURT: Give him time to answer.

A It's debatable, yes, if you are talking about the heel, yes, there is fat, because we hit the ground on the outside part of our heel during the walking cycle.

Q Doctor, isn't there a fat layer underneath the tarsals also? Some, right?
A Yeah, a little.

Q Okay, so instead of telling me how much is where, the first layer is the skin, correct?

A Yes.

Q And the second layer of once you go through the layers of the skin is the fat, correct?

A Okay.

Q Thank you.

A You are welcome.

Q As you are heading north from the fat, you encounter a white fibrous tissue called the plantar fascia, correct?

A Yes.

Q And that tissue connects, in essence, the bone at the heel to the bones at the toes, correct?

A It spreads out and fans out.

Q And connects to the bones on the toes?

A Yes, eventually.

Q Okay. As you move further north up the body, the next layer you hit is the muscle, correct?

A Yes.

Q Now, in the area of the heel, I am going to mess up this name something fierce, doctor, you bear with me, okay?

A Take your time.

Q The flexor digitorum brevis. Did I get that right?

A Yes.

Q That's a muscle that's essentially in the center of the foot running length-wise along the foot, correct?

A Yes.

Q Okay. And the various nerves we have been talking about lie northward of that muscle, correct?

A Does that mean on top of?

Q Heading up the body, yes, north?

A Yes.

Q Would you prefer to call it more proximally? Would you prefer to call it some other word, doctor?

A I think you should do it so that the jury understands.

Q That's why I am using north and south, doctor. If they can't understand, we will clear it up.

A That's fine.

Q Let me ask you this way: In medicine, doctor, "distal" means further from the heart, correct?

A Well, it depends –

Q When you measure?

A --which anatomy you are talking about. Like if you said the distal foot, you would be talking about the toes, most likely.

Q I am talking about the word "distal", not parts of the anatomy, if you are talking -

A You can use north and south if you want; that would be fine.

Q Thank you. As we move upward up through the layers of the foot then, after the muscles come the nerves, correct?

A On the bottom, yes.

Q Yes. And then come additional deeper muscle layers, correct?

A There is four muscle layers altogether, going from north to south.

Q And then comes bone, correct?

A Yes. Well, let's back up for a second.

Q I am sorry.

A Not in the area of the heel.

Q In the area in front of the heel there is muscle, nerve, muscle connective tissue, and bone, correct?

A In front of the heel, yes.

Q Okay. Now, doctor, what year did endoscopic plantar fasciotomies first become developed?

A They started doing them around 1991, the early '90's.

Q That was Doctor Barrett in Arizona, I believe, who devised the procedure?

A Yeah, he was one of the first, I would say yes.

Q And at the time that you completed your training, this procedure wasn't known, is that correct?

A That is correct.

Q Doctor, have you received training in the performance of endoscopic plantar fasciotomies? That's a yes or no.

A I looked into it and -

Q That's a yes or no, doctor.

A And the answer is no.

Q And, doctor, would it be fair to say that you have not performed endoscopic plantar fasciotomies, is that correct?

A That is correct.

Q So you have never done the surgical procedure that Doctor __________ performed on this patient, is that correct?

A Yes.

Q Okay. So, you have no personal knowledge as to how the type of procedure should be done, isn't that correct?

A No, that's not correct.

Q So even though you have got no training and no experience at doing it, you maintain you know how the surgery should be done?

A There is basic –

Q That's a yes or no, doctor.

A Well, it calls for a bit of an explanation.

Q I am sure your attorney can ask you that, but my question was very simple; even though you have got no training in it, even though you have never done the procedure, you know how it should be performed? That's a yes or a no.

A Well, I can't do it yes or no. I know where the basic incision should be made, regardless of which procedure you are using, you want to get the same effect. And you want to make the incision in the same place, whether you are using any one of the three procedures that we do.

MR. MILLIGRAM: Move to strike as not responsive, your Honor.

THE COURT: It shall be stricken and the jury shall disregard the answer.
Q Now, you told us that you saw the records of Doctor Shah, is that correct?

A Yes.

Q Now, you told us that the plaintiff had a mildly antalgic and lumbering gait, correct?

A Yes.

Q And to address that, Doctor Shah indicated, I believe you said, recommended gait training?

MR. LEFFLER: Objection, your Honor. The portion of the report that's been excluded.

MR. MILLIGRAM: I believe the doctor testified that Doctor Shah said gait training.

THE WITNESS: No training.

THE COURT: I don't remember.

MR. MILLIGRAM: I will withdraw the question then, Judge. That's fine.

Q Doctor, are you familiar with something called gait training? Yes or no.

MR. LEFFLER: Objection, your Honor.

THE COURT: Overruled.

A Yes.

Q And that's a procedure where a trained physical therapist, or other specialist in some medical field, can help teach a patient how to walk more appropriately in light of their condition?

A Sometimes, yes.

Q And surely the person that would teach them would know more about how to walk than the patient themselves would, correct?

MR. LEFFLER: Objection.

THE COURT: Overruled.
A Yes.
Q Did you also see the records of Doctor Jaeger?
A Yes.
Q Now, by the way, according to Doctor Shah, the plaintiff was able to tip-toe, heel and tandem, do you recall reading that?

MR. MILLIGRAM: May I approach the witness, your Honor?

THE COURT: You may.

Q Is that correct?

A Where did you point again?

Q "Able to tip-toe, heel and tandem"?

A Okay.

Q It says that?

A Yes.

Q Okay. Now, that refers to a way of walking, does it not?

A No.

Q Tip-toe doesn't refer to a patient being able to walk on their tip-toes?

A Well, we don't know -

Q That's a yes or no, doctor.

A I can't give you a yes or no answer.

Q Because you don't know what Doctor Shah referred to?

A There is an extra parameter here that we are leaving out. We don't know if she was holding on or not.

Q Doctor, does it say "She's able to tip-toe, heel and tandem"?

A It says that in the record, yes.

Q And if the patient was impaired in her ability to do so, Doctor Shah would write that, wouldn't she?

MR. LEFFLER: Objection.

Q Wouldn't he, excuse me?

THE COURT: Sustained.

Q Doctor, throwing out what you don't know, when it says in a medical record that a patient is able to tip-toe, it means that they are able to walk on their tip-toes, correct?
A Not necessarily, no.

Q And when Doctor Shah wrote that "she's able to heel walk"; heel walk refers to taking your toes up in the air and walking on your heels, doesn't it, just like I am doing here (indicating)?

A Again, he doesn't put in the record whether she was holding on or not.

Q I am just asking you what it means. Come on, don't fight me, please?

A You have to ask him because -

MR. LEFFLER: Your Honor -

A --sometimes it's done with the patient holding on, and sometimes it's not.

Q Does it say "holding on", doctor?

A It doesn't.

Q Does it say able to do those things?

A Yes, but I don't know if she was holding on or not.

Q And, of course, doctor, since the record doesn't say she was, there is no reason for you to suspect she was, other than to argue with me, isn't that correct?

A I am not arguing with you. I just know what goes on in physical therapy.

Q Doctor, if a patient is described as a doctor being able to heel walk, tip-toe and tandem walk, she's describing the patient's gait, correct?

A Okay.

Q And she's able to walk on her tip-toes, correct?

A Okay.

Q And she's able to walk on her heels?

MR. LEFFLER: Objection, your Honor, asked and answered.

THE COURT: Sustained.

Q Now, you told us that her flexion, extension, and foot inversion were 4 out of 5, correct? I am sorry, maybe you didn't say it that way. Did Doctor Shah describe her toe flexion and extension as 4 out of 5?

A I see it.

Q Is that what it says?
A Excuse me.

Q Sure. Doctor, does it say toe flexion, extension 4 out of 5?

A Yes, 4 over 5.

Q And normal is 5 over 5?

A Yes.

Q And the weakness that Doctor Shah said he found was an inversion, that is turning the foot in?

A Yes.

Q It didn't say eversion, correct?

A Correct.

Q Doctor, did you see the complete records of the Crystal Run doctors?

A Yes.

Q The whole file?

A Doctor Jaeger you are talking about?

Q No, I am talking about the records of her doctors at Crystal Run?

A No. What I saw is what I gave you.

Q Okay. So, doctor, you were not given the complete information of all her physical examinations done by her doctors at Crystal Run, is that correct?

A Like, I can answer the question what I gave you is what I reviewed.

Q Okay. Doctor, were you given a note of August 11, 2004 by of an examination that was done and follow-up by Doctor Ancelevitch? May I approach the witness again, your Honor?

A I don't think so.

Q Doctor, would you take a look, there is a note there that says neuropsychiatric, is that correct? I have highlighted it.

A Yes, let me just see it for a second.

Q Sure, there is the first page?

A Can you give me a moment?

Q Take a second. Take two.

A Thank you. Whose record is this again?

Q Crystal Run Healthcare?

A Which doctor was that?

Q Last page. Doctor Ancilevitch. And I may be mispronouncing her name?

A I never saw this.

Q Doctor, does it indicate in that record that under neuropsychiatric part of the assessment, "no numbness, weakness", where I highlighted the language; does it say that?

A Under review of systems it does.

Q It says "no numbness and no weakness" that's dated on the bottom, August 11, 2004?

A Yes.

Q May I have that?

MR. MILLIGRAM: I am sorry, Judge, being so klutzy with these. There is so many pages, I am trying to filter through them.

THE COURT: That's okay.

Q Doctor, from time to time you said that you have ordered EMG's?

A No, I don't order EMG's.

Q I am sorry, have you requested other doctors to do EMG's?

A No, I would send the patient to a neurologist and let them determine if EMG's are needed or not.

Q Fair enough. And would you receive a report from that doctor concerning the EMG information?

A Yes.

Q Doctor, I believe you have seen this report from Crystal Run Healthcare, it's Exhibit E in evidence. May I use my copy, Judge?

THE COURT: You may.

Q Have you seen that before today, doctor?

A Yes, I have.

Q Okay. And, doctor, to your knowledge in that report there is a graph with a bunch of letters and numbers, is that correct?

A Are you talking about the first page or the second page?

Q Continuing onto the second page.

A This page I never saw before.

Q In any event, doctor, that information refers to the actual conduction or the velocity of the transmission that the EMG obtained on those particular nerve groups of muscles, correct?

MR. LEFFLER: Objection, your Honor, no foundation.

MR. MILLIGRAM: If he knows.

THE COURT: If you can tell us that.

A Can you repeat the question?

MR. MILLIGRAM: May I approach the witness, your Honor? Let's do it this way.

Q Doctor, for example, in this part up here -

A This page I got.

Q It says by the way, EDB refers to what?

A I am not quite sure.

Q Is that the extensor digitorum brevis?

A Most probably, yes.

Q It's a muscle?

A Yes.

Q Muscle where?

A Top of the foot.

Q So they tested a muscle on the top of the foot, right? And where it says lateral MS?

A Yes.

Q Okay, that refers to the actual data that the EMG test got, right, where it says 4.45?

A It's not my area of expertise. I really can't give you an answer.

Q By the way, doctor, knowing that they tested the extensor digitorum brevis, do you want to change your answer about whether or not the EMG tested any nerves in the foot?

MR. LEFFLER: Objection, your Honor.

MR. MILLIGRAM: I will withdraw.

THE WITNESS: Can I respond to that?

THE COURT: No, he withdrew the question.

There is no question before you.

THE WITNESS: Okay.

Q Now, in August, on August 23rd, 2004 she saw Doctor Jaeger, correct?

A Yes.

Q Now, in Doctor Jaeger's records, which are part of the Crystal Run Healthcare records, he noted that, again, may I approach, your Honor? And I am reading from this; "There was normal vibratory sensation in the distal extremities bilaterally", correct?

A Yes.

Q That means that there was normal vibratory sensation in both feet, correct?

A Well -

Q Does it mean that or not, doctor, don't --yes or no?

A This is a very vague kind of a statement.

Q So you don't know whether he was referring to –

A We don't know what he was referring to exactly.

Q Because that doesn't agree with you, doctor?

A No.

MR. LEFFLER: Objection, your Honor.

THE COURT: Sustained.

A Because it's a very vague statement.

Q So, when it says, "Normal vibratory sensation in the distal extremities bilaterally"; distal extremities refers to the feet, correct?

A Distal extremities could mean the feet, it could mean the ankle, it could be the heel. We don't know exactly what part of the anatomy he's referring to.

Q And at this point in time she had difficulty in dorsiflexing, correct?

A If it's on there. Okay.

Q And she had numbness of the lateral calf?

A Is that left or is that both?

Q That's the left.

A Okay.

Q And she had numbness up her left lateral calf, correct?

A Yes, if it's on there, yes.

Q And if I recall correctly, we are talking about before she had trouble inverting the foot?

A Yes.

Q And now Doctor Jaeger finds that she has difficulty in everting her left foot, is that correct?

A Yes. But that wouldn't surprise me. I have to give you –

MR. MILLIGRAM: Move to strike, your Honor.

A I have to give an explanation.

THE COURT: That will be stricken.

THE WITNESS: I can't give a yes or no answer.

Q You can't give a yes or no, if that's what Doctor Jaeger wrote in his note?

A Yeah, but Jaeger is missing something.

Q If Doctor Jaeger is a Board certified neurologist, is he better to talk about nerve injuries than you?

A Not in this case, no. He didn't really know what was going on.

Q Well, let's talk about your training by the way, doctor. You did not do a residency training in podiatric medicine, correct?

A Correct.

Q Now, today to become Board certified you would have to complete at least a one year residency, correct?

A As the head of the -

Q Doctor, hear my question.

A Yes.

Q Please. I don't want to have you come back tomorrow. So please answer my questions.

A Okay.

Q In fact, there is two types of certifications in podiatric medicine; there is Board certified in foot surgery, and Board certified in rear foot and ankle surgery, correct?

A Yes.

Q And to become Board certified in rear foot and ankle surgery you have to do a three-year residency, correct?

A I really don't know what the parameters are today. I know what it was when I took the test.

Q Now, when you were in podiatric school, you told us that there were -- the number of slots in residency were limited, right?

A The good ones were, yes.

Q And a residency means that you complete your training at the college and then you go to work at a hospital setting, treating patients in a hospital, correct? That's what a residency is.

A For the most part, yes.

Q And contrast to that, a preceptorship is basically where you go to somebody's office and follow them and work with them in their office for a limited period, correct?

A Or several offices, yes.

Q And your preceptorship was one year?

A Yes.

Q And you didn't even stay in one office for the full one year?

A Primarily in the one office, yes.

MR. MILLIGRAM: May I have a moment, your Honor?

THE COURT: Yes.

Q And in the course of your preceptorship, you didn't do any rotations with any neurologists, did you?

A No.

Q Doctor, you told us that Doctor ________ took an x-ray of the patient in his office, correct?

A Yes.

Q In fact, he took, on two separate occasions he took x-rays, correct?

A Yes.

Q And those x-rays depicted the location of the heel spur, did they not?

A Yes.

Q And so from Doctor ________ office records, from the x-rays in his office, he knew the location of the heel spur, did he not?

MR. LEFFLER: Objection.

THE COURT: Rephrase.

Q Doctor, if the x-rays in Doctor Atlas' office showed the heel spur, then he would know its location from those x-rays, is that correct?

MR. LEFFLER: Same objection, your Honor, another person's understanding.

MR. MILLIGRAM: I am asking looking at the x-rays would he be able to see it? I will rephrase.

Q Doctor, if those x-rays showed the heel spur, and Doctor _______ saw the heel spur, would he know its location?

A Not unless he took a off weight bearing x-ray, and his x-rays were taken with the patient weight bearing.

Q Doctor, the heel spur shown on the x-ray is not the heel spur this patient had?

A Yes, but when the patient is on the table having surgery, she's not standing.

Q Doctor, isn't it true that the incision for the endoscopic procedure is placed by the --and I don't want to mispronounce the words --I apologize, Judge, I had written down the right words and I can't find them. Here it is. It's located immediately anterior and inferior to the medial calcaneal tubercle, is that where it should be?

A Yes.

Q Now, "immediately anterior" means towards the front of the foot or towards the back of the foot?

A Front.

Q So it should be in front of the --withdrawn. The calcaneal tubercle is a bone, is a portion of bone that can be palpated by a surgeon, correct?

A In my -

Q Just yes or no, doctor, can it be palpated?

A You cannot palpate the actual spur, no.

Q I didn't say the spur. I said the medial calcaneal tubercle?

A I wouldn't rely on palpation, no. My answer is no.

Q You cannot palpate it, is that your testimony? You cannot push on the patient's bottom of their foot and find that area, is that what you are telling us?

A You can find the spot of maximal tenderness, but the actual spur itself would be difficult to find. I would not -

Q Doctor, you are mixing apples and oranges, and maybe it's my fault. The medial calcaneal tubercle is a portion of the heel bone, correct?

A Yes, it is.

Q Okay. Now, I am not talking about spurs, so take spurs out of our dictionary for the moment, would you please?

A Absolutely.

Q Can a surgeon palpating the bottom of the foot, the plantar surface of a patient's foot, locate the medial calcaneal tubercle?

A No. It's too thick on the bottom.

Q Now, when the patient next came back to see Doctor Jaeger in September 2004, did you see those notes also?

A Yes, I did. I believe she saw him twice, right?

Q Right. On that second visit did Doctor Jaeger note that she had strong 5 over 5 dorsiflexion and plantar flexion. It says, "On today's examination had strong 5 over 5 dorsiflexion and plantar flexion", correct?

A He's talking about the leg. Let me read it again.

Q Please. He dorsiflexed the leg, doctor?

A Hold on a second. "Her left leg on today's examination had strong 5 over 5 dorsiflexion and plantar flexion".

Q Plantar flexion and dorsiflexion refer to the foot, correct? It's the movement of the ankle?

A Yeah, that's most probably what he's referring to.

Q Hold on, I am not done. I need another question on this now.
So when he said that she had strong 5 over 5 dorsiflexion and plantar flexion, she now had normal motion of her foot and the ankle, is that correct?

A According to that, yes.

Q And he just described on this visit "give-away weakness", did he not?

A Okay.

Q And give-away weakness is when you put pressure against something such as a foot, and the patient is supposed to push back against you?

A Yes.

Q And that's not an injury from a nerve, is it?

A No.

MR. MILLIGRAM: May I have just a second, Judge?

A I am not exactly sure, though, what he meant by "give-away weakness".

Q Is that because you are not a neurologist, doctor, not doing that exam?

A That's not my area of expertise, correct.

Q Now, but you feel it is within your area of expertise, doctor, to talk about a surgery that you have never trained in, or done yourself, correct?

MR. LEFFLER: Objection, your Honor.

THE COURT: Sustained.

A No, that's not true at all.

THE COURT: Sustained. Don't answer it.

THE WITNESS: Oh, okay.

Q Now, doctor, you told us that you reviewed one other case for the plaintiff's attorneys law firm, is that correct?

A Yes.

Q How did they first contact you?

A I am not sure.

Q Well, did they call you? Was it a letter?

A Oh, I received a phone call.

Q And how did they get your phone number?

A I am not quite sure.

Q Did they tell you how?

A No.

Q Well, doctor, you advertise; you are listed with several services that are known to provide podiatric experts for hire, is that correct?

A Two. I think I am in a couple of others, but two that I pay for.

Q And you pay to be listed on a service so that your services are available as a hired expert, correct?

A Yes.

Q One of them is called, SEAK? S-E-A-K.

A Yes.

Q And you have been listed with them for how many years, doctor?

A I believe two or three.

Q Doctor, according to the entry in SEAK, it says you have testified in 12 cases in the past 4 years; are they inaccurate in your advertisement?

A Which year is that?

Q This is April 17th, 2007. Let me see if it refreshes your recollection, doctor. Does it indicate there that Doctor Widom has testified in 12 cases in the past 4 years?

A You know, I really don't recall, I am sorry.

Q And you are also affiliated with another entity, doctor, the American Association for Justice, is that correct?

A That one I am not aware of. I don't pay for that one.

Q Are you affiliated with something called Podiatric Management on line?

A Again, I don't know where they got my name from.

Q But you know you are listed there?
A No, I didn't. Sorry.

Q Now, as an expert witness, doctor, there are cases that you are called upon to just look at records where you never testify, correct?

A Yes quite a lot.

Q And you review cases in the state of Florida?

A Yes.

Q And the State of New York? Excluding these two cases.

A I think I had one other case, it was a wrongful death suit in upstate, New York.

Q Okay.

A I am not sure what happened to it.

Q Last time I checked, that's the State of New York, doctor?

A Yes, but I don't know where it ended up.

Q Okay. You have reviewed cases venued in, correct me if I am wrong, one of the Carolinas?

A I don't recall.

Q Kentucky?

A Yes.

Q Alabama?

A Wait, wait, the one in Kentucky -

Q I simply asked you if you reviewed cases in the state. We will talk about testifying and other stuff later.

A Yes, I did.

Q And, let's see, Arizona?

A I don't recall, sorry.

Q New Mexico?

A Not that I remember, sorry.

Q Oklahoma?

A I think so, maybe yes.

Q Doctor, instead of going through every state, probably about 12 or 15 states where you have been hired to review cases as an expert?

A I don't recall. I think around maybe 10, give or take.

Q Okay. And in other states outside of New York, doctors prepare written reports, correct? Withdrawn.

Did you prepare a written report in this case?

A No.

Q In other cases you have reviewed, have you been asked to and provided written reports?

A In some, yes.

Q Okay. When did you first start reviewing cases as an expert witness for hire, doctor?

A Well, I started back in --I believe it was around 1993 as an expert witness for the state of Florida.

Q Was it one case in '93?

A No, I was with the state of Florida for about eight or nine years and that had to do with reviewing cases for the state for disciplinary actions.

Q That wasn't my question, doctor. My question was: In what year did you begin reviewing cases as an expert witness?

MR. LEFFLER: Your Honor, I believe the answer was responsive. He wasn't allowed –

MR. MILLIGRAM: I didn't ask him what he did, where, when, I didn't ask him what he did.

THE COURT: Just answer the question.

Q What year did you –

A I worked for the state a number of years.

Q Were you paid by the state or were you a hired expert?

A I received minimal compensation for the state. I did it as a service to the profession. I was asked by the state to do it.

Q My question to you, doctor, when did you begin working as a hired expert?

A For attorneys such as Mr. Leffler?
Q Absolutely.

A Probably about 13 or 14 years ago.

Q So, roughly, '94?

A Probably, yes, in that neighborhood.

Q And since you retired in 2005, you told us, correct?

A Yes.

Q Now, say, for the first 5 years, let's say '94 to 2000 on an annualized basis, doctor, how many cases did you review as a hired expert?

A I don't recall. It could be three, it could be four, it could be six. I don't keep track.

Q Okay. So, roughly, between in those years, roughly say 30 cases?

A In the last 14 years?

Q No, from 1990, whenever you started, until about 2000, you said you reviewed about two or three cases a year?

A No, that seems too high. Maybe 20, not even.

Q And of those 20 cases, how many times did you go to court to testify? Withdrawn. Before we get to there, other states you give what are called depositions when either you are in an office, or someplace else, and the lawyers question you out of the courtroom, correct?

A Yes. Most states as a matter of fact.

Q Except New York we are a little archaic?

A Yes, New York is strange. Not --only with regard to this.

Q Of those 20 cases or so, how many did you give depositions in?

A Probably the majority of them. Well, yeah.

Q And how many of those 20 cases did you testify for trial?

A Hold on. Let me stop you for a second. A lot of those cases were –

MR. MILLIGRAM: Judge, please I asked for a number.

THE COURT: Just answer the question.

A Okay, go ahead, of those 20 cases, please repeat?

Q Of those 20 cases you gave depositions in about all of them, you said?
A I don't remember, I am sorry.
Q Half of them?

A Maybe.

Q Three-quarters of them?

A Possibly.

Q All of them?

A Probably not.

Q Okay. Now, in the next five-year gap, say from 2000 until you retired, did the number of cases you reviewed on an annual basis increase, decrease or stayed the same?

A I would say it decreased.

Q In that five-year period what did you review, about 15 or so cases?

A Maybe.

Q And did each of those 15 involve giving a deposition?

A No. Maybe 2/3rds, offhand. I don't keep track, so I couldn't tell you.

Q You told us that you are being paid $5,500 to come here today, correct?

A Yes.

Q And you are paid $2100 for reviewing the records that were sent to you?

A Yes.

Q Is that an hourly basis or a flat fee? I am sorry, that's a poor question. Is the records review an hourly basis or a flat fee?

A The records review are an hourly basis.

Q And how much did you charge per hour, doctor?

A I have to break it down for you because it's not that simple.

Q For records review?

A Yes.

Q Okay.

A When I received an initial case, the review of records I charge $300 an hour. After the reading fee is $200 an hour.

Q Is that today?

A No. There is a flat fee if I go to court.

Q No, no, we will get there.

A Okay.

Q In 2007 so you charge $300 initially for reviewing some records?

A Per hour, yes.

Q That's why I am confused.

A Let me start again.

Q In this case, doctor, after they contacted you -

A I will make it easier for you.

Q Please.

A If an attorney contacts me, I speak with him and give him a free consultation.

Q After he tells you what the case is about?

A I ask him --he tells me what the case is about, whether it's a defendant's attorney or a plaintiff's attorney. I ask him who the individual involved is. If it's somebody that I know, I recuse myself, naturally. Then if they are going to send me the records, I ask for a $1,500 retainer, and I apply my initial reading fee of $300 to that retainer.

Q Is that a flat free of $300, or $300 per hour?

A $300 per hour for the initial review.

Q Got it, okay.

A Now, after the initial review, I call the attorney back. That fee is $400 per hour for a teleconference.

Q Now, is that $400 if it's a ten-minute conference?

A No, it would be whatever that breaks down to, minute-wise. So I believe it's $5 a minute if you do the math.

Q Let's see 60 minutes in an hour, that's closer to 60 an hour, isn't it, 60 a minute, maybe -

MR. LEFFLER: Judge, I don't understand the relevance of this entire line of questioning.

MR. MILLIGRAM: Judge, I am just trying to find out how much this man is being paid.
THE COURT: Overruled.

Q So you get $1,500, and then you call the lawyer and charge him $400 an hour to talk on the phone? A For a conference. And if it's only for a couple of minutes, he gets charged accordingly.

Q How long was the conference in this case?

A Well, I spoke to two different attorneys. The first one I spoke to when Mr. Leffler was on vacation, I believe it was a 45 minute teleconference, so that would be $300. That's easy, right?

Q When was that? By the way, when did all of that take place?

A I received the records probably in early December, so, probably somewhere in the neighborhood of the second week of December, give or take.

Q Let me just --let me interrupt you for a second. You can tell me the rest of it. Let me now understand the process. They contact you, you talk on the phone with the attorney. He tells what the claims in this case are. And who they are suing and he tells you, and you tell him I can review the case for you, correct?

A I tell him –

Q Just yes or no, doctor, is that what you tell him?

A Well, I have got to give you an explanation.

Q Please don't. Let's move along then.

A All right.

Q After that conversation he then first sends you records, correct?

A If I feel he has a case, or if I can defend the case, yes.

Q And so you are making a judgment about a case based on what the attorney is conveying to you and not on the records, is that correct? You can say yes or no.

A Only initially, yes. It could change after I review the records.

Q Absolutely. Now, have you been charging this $300 an hour for record review since you have been reviewing cases?

A No.

Q When did you start charging $300 an hour for record review?

A Maybe a year ago.

Q It was less before then?

A Yes.

Q And when did you start charging $400 for the consultations?

A That was raised a couple of years ago as well. It was $300 an hour.

Q You said you had a second conversation with Mr. Leffler, doctor?

A Yes.

Q How long was that conversation, approximately?

A An hour.

Q So, we have $1,500 retainer for record review -by the way, how many hours did you spend reviewing the records in this case?

A I can't remember exactly.

Q Was it more than five?

A Well, you can do the math. I received $2,100 in two payments of 1500 and 600. There was one teleconference for 45 minutes, which is $300.
Q That that was another payment –

A Let me finish. And then there was another teleconference for an hour, so that's $400. So that's 1700.

Q So you got $1,500 to review the records, right?

A Right.

Q And then another $600 -

A Well, that's get applied to the reading.

Q Of course.

A You know what I am saying.

Q And then you got another $600 for record review, correct? And on top of that there was $700 with consultation with the lawyers?

A No, no.

Q Okay, you said now you are getting $5,500 -

A You didn't let me finish your answer.

Q You are getting $5500 for testifying, doctor?

A You don't want me to finish my answer? Okay.

Q Judge --doctor, I would love to, it's now 3:30.

I would like to finish your examination so we could be done today and not come back tomorrow. So, if you want to fight with me, we can debate this all day long.

A I am not looking to fight with you, but you asked me a question.

MR. LEFFLER: Your Honor -

THE COURT: Let's just move on.

Q Doctor, you get $5,500 to come to court?

A Outside of Broward County, yes.

Q By the way, doctor, when you retired in 2005, you gave up your hospital privileges, correct?

A Yes.

Q And had you been slowing down your practice up until the time you retired?

A No.

Q So you just suddenly decided to walk in and closed the doors and that was it?

A My partner and I decided that he wanted to go a different way. And I decided to retire.

Q Okay. So your patients, you walked away and your patients would have been left without you?

A No, he gave them to my ex-partner and I retired.

Q Have you charged --your rates, have they increased since you retired, doctor?

A No, they have stayed the same for a year or a year and a half, or maybe more.

Q And the number of cases you have been asked to review, has that increased since your retirement?

A No, it's actually gone down.

Q Now, doctor, the $5,500 that you are being paid, does that include your travel from Florida to New York, the time being spent in travel from Florida to New York?

A Yes.
Q Did you fly up?

A Yes.

Q Where did you fly into?

MR. LEFFLER: Your Honor, what relevance does this have.

Q Doctor, who paid for your air fare?

A Mr. Leffler's firm.

Q Did you stay in a hotel last night?

A Yes.

Q What hotel?

A The Holiday Inn Crown whatever.

Q Who paid for the hotel?

A Mr. Leffler.

Q Doctor, are you driving an Infinity?

MR. LEFFLER: Your Honor –

THE COURT: You asked about it.

Q Whose car is that, doctor?

A It's owned by Enterprise.

Q So you rented an Infinity?

A Yes.

Q On their dime?

A Yes. Can I finish the answer.

Q Which answer would you like to finish?

A I know a guy at the rental agency. He's giving me the car and charging me for one day. I am having it for three days. And it's going to cost Mr. Leffler a little more than $40.

Q For an Infinity?

A Did you hear what I said? I know the manager at the Enterprises agency. You heard that, right?

Q Yes, three times, doctor.
A Otherwise I would be in a subcompact.

Q Just curious. So, doctor, you have been paid something almost, correct me if I am wrong, my math, $7,600 on this case, plus your hotel, plus your car fare, your car, correct?

A Eventually, yes.

Q And if we don't finish today, what would the charge be?

A I am not sure.

Q Now, doctor, are there such things that are known as complications in the field of podiatry?

A Yes.

Q And isn't one of the known and recognized complications of podiatric surgery, generally speaking, the potential of nerve injury?

A Sometimes, yes.

Q And in fact, doctor, you saw the consent form the patient in this case signed, did you not?

MR. LEFFLER: Objection, your Honor, beyond the scope.

THE COURT: Overruled.

Q Did you see the consent form she signed, doctor?

A Can you bring it to me so I can look at it again, since you are referring to it?

Q Sure, I would be happy to.

A Are you talking about the consent form in his office, or in the surgery center?

Q I will make it easy on you.

A I don't need reading glasses, you know.

Q That's okay. Have you seen this consent form, doctor?

A Yes.

Q And on the consent form, doctor, one of the potential risks is of nerve injury, correct? Did you read that?

A Yes.

Q And one of the potential complications discussed is of contracture of toes, correct?
A Yes.

Q And it's on this form, doctor, because those are complications that can occur in the performance of an endoscopic plantar fasciotomy, correct?
A Not if it's done correctly, no.

Q That wasn't my question, doctor. Doctor, back to the beginning. The form says Special Consent for Endoscopic Plantar Fasciotomy?

A Yes.

Q And on it contains the risks that can occur with that surgery, correct?

A Yes.

Q And the risks include nerve injury, correct?

A Yes.

Q And contracture of toes, correct?

A Yes.

Q Doctor, before when we were talking about the layers of the foot, the various tissue layers, right?

A Yes.

Q The bone is northward of the plantar fascia, is that correct?

A Depends on the part of the bone.

Q The heel, the calcaneus is to the north of the plantar fascia?

A Part of it is, yes.

Q And in order to put the instrument against the bone that you have talked about, you would have to go through the skin, through the fat, through the muscle, I am sorry, through the plantar fascia, through the muscle, to the area where the nerve is, to the deeper muscles to reach the bone, correct?

A No, that's not correct.

Q Are you telling us that those tissue layers don't lie between the bottom of the foot and the bone?

A Not in this case, no. Can I finish my answer?

Q No, doctor. I am sure Mr. Leffler will ask you that one.

A Okay.

Q Endoscopically, doctor, in fact, Doctor Atlas is staying south of the muscle, correct?

A When you are saying south of the muscle, he's above it or below it?

Q Below it. It's below it. In fact, doctor, if Doctor Atlas' incision was between the tissue called fat and the plantar fascia, correct? It's yes or no. If you don't know it, you tell me?

A No, I have done this procedure, you know, several hundred times.

Q That's not what I am asking you.

MR. MILLIGRAM: Your Honor, I move to strike.

THE COURT: It shall be stricken. Answer his question.

A You are not approaching it correctly.

Q Doctor, when he made an incision, it was in the side of the foot, correct?

A Yes.

Q And that incision is placed so it will be between the layer of the fat and the layer of the plantar fascia, correct?

A Initially it's the layer of the skin and the fat.

Q Right. And as you move across the foot, you are separating the fat from the plantar fascia, correct?

A You are doing dissection, yes.

Q Good. Dissection means separation of tissue plains, correct?

A Yes.

Q And it can be done by either a sharp instrument, a blunt instrument, or even a finger, correct?

A Yes.

Q And in this case Doctor Atlas put what is called a trocar -

A Yes.

Q --between the fat and the fascia, correct?

A He eventually did, yes.

Q And that would be in terms of our north/south analogy, that would be closer to the bottom of the foot than it would be to the muscle, correct?

A In his operative report he states he went right below the medial plantar fascia. Does that answer your question?

Q Yes. And the medial plantar fascia is the layer of tissue that's below --when you look at the bottom of the foot, it's below the muscle and above the fat?

A Well, remember he went in through the side, not through the bottom, so, things are a little bit different that way.

Q Doctor if we took the foot sideways and drew a plain, you would have skin, right?

A Yes.

Q And you would have fat?

A Yes.

Q You have plantar fascia, right?

A Yes.

Q You have muscle?

A There is no muscle in that area, no.

Q The flexor digitorum brevis is not in there?

A No, if you are at the right level you come to the medial plantar fascia and if you are at the portion of the medial plantar fascia where it originates from the bone, there is no muscle in that area. You are above it.

Q Doctor, isn't an endoscopic plantar fasciotomy performed by visualizing the muscle, part of the procedure?

A To a minimal extent.

Q I am sorry?

A To a minimal extent, yes.

Q So, in the area where Doctor _______ performed surgery, he visualized muscle, correct?

A He may have, yes.

Q And this procedure, doctor, it didn't involve cutting bone, did it?

A No.

Q It involved making a dissection or surgical incision in the plantar fascia, correct?

A Well, he made an incision through the skin that ultimately his objective was to cut the plantar fascia.

Q And he did that?

A Yes.

MR. MILLIGRAM: May I have just a second,

Judge? I think that's it.

Q Doctor, you are aware, are you not, that the plaintiff in this case has said that her heel pain is completely resolved since the surgery, you know that, did you not?

A Yes.

Q And does that indicate to you, doctor, that insofar as that surgery was directed towards addressing that, it was successful?

A Yes.

MR. MILLIGRAM: Thank you. Nothing further, your Honor.

THE COURT: Redirect?

MR. LEFFLER: Just a couple, Judge.

REDIRECT EXAMINATION

BY MR. LEFFLER:

Q Doctor, when EPF came out around the early '90's, did you speak with your residents whom you were training about it?

MR. MILLIGRAM: Objection to form, your Honor.

THE COURT: Sustained.

Q Doctor, did you investigate EPF when it came out?

A I most certainly did.

Q And did you teach about that investigation?

MR. MILLIGRAM: Objection, your Honor.

THE COURT: Sustained.

Q Doctor, what were the fruits of your investigation regarding EPF?
A When I was teaching heel spur surgery as we have been dealing with today, I investigated this new EPF and they were getting a lot of complications with it, especially early on. The residents -

MR. MILLIGRAM: Objection your Honor. I am going to move to strike the entire line of questioning. At this point he's talking about what he did when he was instructing residents. It's not about the claims in this case. There no claim that EPF should have been done in this case.

THE COURT: Let's move on.

Q Doctor, in responding to one of Mr. Milligram's questions, you wanted to explain something further with regard to the layers dealt with when placing an instrument hard against bone?

A Yes.

Q Can you explain that for us now?

A Sure. When you are cutting the medial plantar fascia which is part -- this is that essentially the whole procedure here. Some people take out the bone spur, some don't. In order to avoid any nerve injury, you put your cutting instrument hard against the bone so you are away from the nerves that can be cut.

Q Do the nerves not travel close to the bone?

MR. MILLIGRAM: Objection to form, your honor

THE COURT: Sustained.

Q Well, how does placing the instrument hard against bone keep you away from the nerves that you don't want to cut?

A You are at a different level.

Q You said earlier that nerve injury and contracture of toes as a result of the nerve injury are not a complication if the surgery is done correctly; do you recall that testimony?

A Yes.

Q Why is that the case?

A We wouldn't do this procedure if patients would end up like Mrs. Ewanciw, with contracted toes and the other problems she has.

MR. MILLIGRAM: Objection, your Honor, move to strike, non-responsive.

THE COURT: Overruled.

MR. LEFFLER: I have nothing further.

RE CROSS EXAMINATION
By MR. MILLIGRAM:

Q I am now extraordinarily puzzled, doctor. If you are telling me if any patient could have a bad occupy after a surgery, have a complication from it, you would never do that surgery? That's yes or no.

A No. No, it's not, I want -

Q Okay, then I will rephrase it. I don't want your statements. I don't want your stories. I want an answer.

A These aren't stories.

MR. LEFFLER: Your Honor, your Honor.

THE COURT: The jury will disregard comments of counsel and the witness.

Q Doctor, yes or no; in the field of podiatry, are there things that are recognized complications of podiatric surgical procedures?

A Sometimes yes.

Q And, doctor, could a patient experience a complication when the surgeon uses the best of care?

A Yes.

Q And a complication in that circumstance is not malpractice, correct?

A In that circumstance, yes.

Q And when a patient has a complication, something bad could happen to them, right?

A Yes, it can.

Q So, doctor, as a surgeon, you don't simply not do a procedure because a patient can have a complication from it, if they have a condition that requires surgery?

A I wouldn't do a procedure if it has a high incidence of nerve damage, and/or contraction of toes.

Q So, doctor, you don't believe in the procedure that Doctor Barrett invented in 1991?

A I didn't say I didn't believe in it. I see nothing -

Q Okay, that's fine.

A I am okay --I see nothing wrong with doing EPF, provided that it's done properly. There are different ways that people do heel spur surgery, and EPF is perfectly fine, provided that you make a proper incision and you cut the plantar fascia properly, you will not end up with contracted toes and nerve problems.

Q But yet again, doctor, you have never done EPF, and you have never taken any courses in doing EPF, correct?

MR. LEFFLER: Asked and answered, your Honor.

THE COURT: Sustained.

Q Doctor, you told us that you go against the bone so you are not in the particular plain where the nerve is, correct?

A Yes.

Q The nerve lies deep between the layers of muscle, does it not?

A It lies right on the first layer of muscle, right below the plantar fascia.

Q Lies, but first you have the plantar fascia and then the muscle and then the nerve, correct?

A No.

Q The nerve lies between the plantar fascia and the muscle?

A Yes.

Q You are sure about that anatomically?

A Absolutely.

Q By the way, doctor, an endoscopic plantar fasciotomy, that's a surgery that's done under direct visualization, isn't it?

MR. LEFFLER: Objection, beyond the scope of redirect.

THE COURT: Overruled.

A To a certain degree, yes.

Q And that's because the doctor can first see where he's making his incision, is that correct?

A He doesn't see where he's making his incision. He makes an incision and puts the scope in later.

Q Okay. In other words, he just takes "thputt" (sound), I am not looking at what I am stabbing; is that you are what telling us?

A No, that's not what I am telling you.

Q When a surgeon dissects tissue by making an incision -

A You talked about incision, not dissection.

Q Okay. Doctor, when you make an incision in the layer of the skin, aren't you doing a dissection?

A No. Dissection comes after the incision.

Q Doctor, so the first incision is a vertical opening made, correct?

A With regards to EPF, it's a 5-millimeter vertical
incision and if it's made correctly, it's –

MR. MILLIGRAM: Move to strike everything after it's a 5 millimeter.
A Yes, it's a 5 millimeter vertical incision, correct.

Q And after that a trocar is put in, correct?

A No, an elevator is put in.

Q The elevator separates the plantar fascia from the fat, correct?

A If it's done properly, yes.

Q By the way, an elevator is not a sharp instrument, is it?

A No, although it can be.

Q And then a trocar is put in, correct?

A Yes.

Q Which is basically a tube?

A Yes.

Q About the size of a straw?

A Well, a trocar has a sharp point. The canula is a tube.

Q You are right. There is a canula –

A But I know nothing about EPF also. You are the one who does.

Q I only know what the doctor who performs them tells me, doctor.

A Okay.

Q So, the canula is essentially a straw, correct?

A Okay.

Q So, after you separate the fat from the fascia, using an elevator, the canula is put in, correct?
A Okay.

Q And that's basically putting a tube in between the layers of tissue, correct?

A Yes.

Q And a trocar is put in to make the opening go through the other side of the foot, correct?

A Yes.

Q The trocar is then taken out?

A Yes.

Q And the camera is put in, right?

A Yes.

Q And this straw, this tube that we have, has an opening in the upper portions where the plantar fascia would be, correct?

A Yes.

Q And while looking through the camera, the doctor can visualize the plantar fascia, correct?

A Yes.

Q And when he puts in the cutting instrument, which is a right angled instrument, he's able to see what he's doing and cutting on the plantar fascia, correct, what he's dissecting?

A To a certain extent, yes.

Q And it's on a t.v. monitor right in front of him, right?

A Yes.

Q Doctor, when you say to us in fact what he's looking at with a t.v. camera is the area where that incision --where that dissection is being done, correct?

A Yes.

Q And in this case, doctor, Doctor _______ took some photographs depicting that area?

A Yes.

Q And those areas depicted the dissection of the plantar fascia?

MR. LEFFLER: Objection, your Honor, beyond the scope of redirect, well beyond.

THE COURT: Let's move on.

MR. MILLIGRAM: I will withdraw the last question. Nothing further, your Honor.

THE COURT: You may step down.

Do you have any further witnesses?

MR. LEFFLER: No, your Honor.

THE COURT: Are you resting?

MR. LEFFLER: Yes.

THE WITNESS: Thank you, your Honor.

THE COURT: You are welcome.

Tomorrow, what time do you have your expert?

MR. MILLIGRAM: 10:00.

THE COURT: We will recess then until tomorrow morning at 10:00. Have a wonderful evening.

(Jury exits courtroom.)