State of Ohio,)
)
County of Cuyahoga.)

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IN THE COURT OF COMMON PLEAS

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JAN S. GLASSER, et al.,)
)
Plaintiffs,)
vs.) Case No. 3500062
) Judge Greene
DR. NOEL ABOOD, et al.,)
)
Defendants.)

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DEPOSITION OF DANIEL P. DOCK, D.C.
Tuesday, April 13, 1999

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The deposition of DANIEL P. DOCK, D.C., a witness, called for examination by the Defendants under the Ohio Rules of Civil Procedure, taken before me, Diane M. Stevenson, a Registered Merit Reporter, Certified Realtime Reporter, and Notary Public in and for the state of Ohio, by agreement of counsel, at the offices of Linton & Hirshman, Hoyt Block, Suite 300, 700 W. St. Clair, Cleveland, Ohio, commencing at 11:10 a.m., the day and date above set forth.

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APPEARANCES:

On behalf of the Plaintiffs.

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On behalf of the Defendants:

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DANIEL P. DOCK, D.C.

A witness, called for examination by the Defendants, under the Rules, having been first duly sworn, as hereinafter certified, was examined and testified as follows:

CROSS-EXAMINATION

BY MS. VANCE:

Q. Please state your full name and spell your last name for the record.
A. My name is Daniel Peter Dock, D O C K.
Q. You are a chiropractor?
A. Yes, I am.
Q. Licensed to practice in the state of Minnesota?
A. Yes.
Q. Licensed in any other state, Doctor?
A. No.
Q. Have you ever been?
A. No.
Q. Has your Minnesota license ever been subject to any restrictions, suspension, or investigation of any kind?
A. No.
Q. At any time?
A. No.
Q. What is your office address in Minnesota, please?

A. 4529 East Superior Street, Deluth, Minnesota 55804.
Q. What is located at that address? If I was to drive up to that address on East Superior Street, what would I see?
A. My office. And in my building there is an engineering firm and also a beauty shop.
Q. Where is your office, located, first floor?
A. Well, it is just one floor.
Q. Do you own the building?
A. Yes.
Q. How long have you been at that location?
A. Since 1982. It would be 16, 17 years.
Q. Where is your home address?
A. 3740 Crescent View in Deluth.
Q. You are married; is that right?
A. Yes.
Q. Your wife's name is Karen?
A. Yes.
Q. What is your date of birth, please?
A. October 4, 1956.
Q. Dr. Dock, before we got started here on the record, I was provided with a three-ring binder of materials. Does this represent your file?
A. And that notebook.

Q. And the note pad that is next to it, the yellow note pad; is that right?
A. Yes.
Q. As I briefly went through the binder, I noticed that there are various tabbed materials. We have tabs indicating the names of various doctors and medical records. Is that right?
A. Yes.
Q. And then also there are numbered tabs that contain copies of deposition transcripts; is that right?
A. Yes.
Q. And then interspersed amongst the records and depositions are some handwritten pages of note paper that have been put into the binder. You also have some correspondence from Mr. Ruf's office; is that right?
A. Yes.
Q. In terms of the handwritten notations, these appear mostly on yellow paper, some white paper. Are these all in your handwriting?
A. Yes.
Q. Tell me what these handwritten pages of notes, in general, represent.
A. The first section have to do with abstracting of

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the medical records. I go through and I pick out key parts that I think are relevant to the patient's condition.
Q. Now, you are referring to this first section of both yellow pages and white pages?
A. Yes.
Q. These represent the abstracts of all of the medical records that we have here in the binder?
A. Yes.
Q. Let's have that marked, first.
A. Can we keep those together?
(Thereupon, Defendants' Exhibit 1 was marked for identification.)
Q. Yes, we will. What I am going to do, Doctor, just so it is clear on the record and clear for you, as well, the first yellow page which actually bears a page number, number one, this page which I have marked as Defendants' Exhibit No. 1 shows the name "Dr. Byers" at the top of this page; is that right?
A. Yes.
Q. And we will mark these yellow pages collectively as Exhibit 1, and you have them numbered, it looks like, 1 through 9 consecutively. Is that true?

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A. Yes.
Q. So these yellow pages, nine pages of yellow notes, represent your abstracting of certain doctors' records; is that fair?
A. Yes.
(Thereupon, Defendants' Exhibit 2 was marked for identification.)
Q. Then immediately following the yellow page nine we come to a white page ten, and I will mark that separately. We will mark these white pages as Defendants' Exhibit No. 2. And these white pages run from page No. 10 through page No. 23.
Is that accurate?
A. Yes.
Q. And again, this is a continuation of your notes of your abstracting medical records, office records?
A. Yes.
Q. If we continue on in your notebook, we get to the tabbed section of the individual doctors' records. For the record, I am going to read off the records you have been provided with: The office records of Dr. Keith Byers; the office records of Dr. Ernest Marsolais; office records of Dr. Bruce Morgenstern; records of Meridia

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Hillcrest Hospital, which I believe primarily consist of MRI records; records of physical therapist Michael Lepp; office records of Dr. Theresa Ruch; office records of Dr. Noel Abood; office records of Dr. Robert Leb; office records of Dr. Joseph Frolkis; some records from the Mt. Sinai Medical Center; office records of Dr. Matt Likavec, a two-page report from Dr. Gordon Bell from The Cleveland Clinic; and we also have a tab for Cleveland Clinic records.
Have you received or looked at any other medical records, doctor records, office records, other than these that we see contained in this three-ring binder?
A. Well, I have copies of the x-rays and MRIs back at my office in Duluth, but I don't have those with me.
Q. But in terms of actual paper records?
A. No, that is all.
Q. This is everything. As far as deposition, it looks like you have the deposition of Ms. Jan Glasser; is that correct?
A. Yes.
Q. Prior to her deposition, or in front of her deposition, you have 16 handwritten yellow pages

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which represent what?
A. An abstracting of her deposition.
Q. Then I am going to mark this as Defendants' Exhibit 3. So Exhibit 3 is your handwritten notations based on your review of Jan Glasser's deposition. And this consists of 16 pages?
A. Yes.
(Thereupon, Defendants' Exhibit 3 was marked for identification.)
Q. Did you see the deposition of Mr. Glasser, by any chance?
A. No.
Q. Then we have the deposition of Dr. Noel Abood preceded by 23 handwritten yellow pages, which I presume are, again, your abstracting of Dr. Abood's testimony?
A. Yes.
(Thereupon, Defendants' Exhibits 4 and 5 were marked for identification.)
Q. We will call this Exhibit **4.** And then the third deposition you have here is the transcript of the deposition of Randy Reed, R E E D. And that is preceded by yellow pages numbered 1 through 7. These are your abstractions of Dr. Reed's testimony?

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A. Yes.
Q. And that is it for the binder. So this represents, in terms of the binder material, everything that you have looked at, plus your handwritten notes; is that right?
A. Yes.
Q. And also we have this yellow pad of paper here, which I am going to mark as Defendants' Exhibit 6. And tell me what this represents, Doctor.
A. This represents an abstract of the abstracts. And so I go through and I try to analyze the case, and with regard to this case, what happened, what was her history prior to treatment with Dr. Abood, and I go through and analyze what her clinical condition was, what happened with it. And of that section, there are two pages of that.
Then I go through and analyze what happened after treatment started, and the clinical pain pattern and what happened, medical records, what leads to the clinical conclusions. That is actually four pages of that.
The next section after that has to do with analyzing her subjective complaints after treatments when all this was going on, and analyzing: Is it actually nerve complaints, or

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is it due to scar tissue? Are the complaints due to nerve tissue or due to scar tissue involvement?
Q. And so you analyze that issue, true?
A. Yes. And there are two pages of that. Then I go through the next section after that. Section 4 analyzes the chiropractic care that was obtained from Dr. Abood, and basically abstracting having to do with that. And that goes for four pages.
(Thereupon, Defendants' Exhibit 6 was marked for identification.)
Q. And that takes us through all of the handwritten notes on the legal pad which is marked as Defendants' Exhibit 6?
A. Yes.
Q. Not that these aren't enough notes, but do you have any notes anywhere else?
A. No, that is all there is.
Q. On the table in front of us we have a two-page audit of medical expense. You were provided with a copy of this audit here this morning?
A. Yes.
Q. Had you been provided with a copy of this prior to today?
A. No.
Q. Did anything you saw in this audit alter, change,

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or impact on any of the opinions that you had previously formed based on your review of all of these materials?
A. No.
Q. We also have on the table a couple of envelopes containing various films. You mentioned that you have some films back in your office in Minnesota.
A. Yes.
Q. What do you have back in Minnesota?
MR. RUF: Well, I gave him duplicates of all the films you received. So they are duplicates of all these films.
A. I didn't take any notes of it. I do recall Dr. Abood's x-rays and MRIs. There are no actual paper reports in there. I mean, it is a heavier box, probably this same amount of material here, so I didn't bring those with me because it would be heavy.
Q. Do you have anything else back in your office or home in Minnesota relative to your work on this case?
A. There is one letter that I was sent, and I couldn't find it when I left yesterday. There was a video fluoroscopy done on this case, and I was sent that.

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Usually I do a good job of compiling records and keeping track of records, but I have to honestly say I don't have that.
Q. What were you provided, a paper report or the film itself?
A. Just a paper report. And I presume it is this case. So I am embarrassed to say no, I don't have that.
Q. When did you receive that report?
A. A while ago. Usually I do a good job of keeping track of records. I presume it is even on this case. I couldn't find it, though. It had to do with a low back, I remember that.
The problem is I get a lot of calls from a lot of practitioners, and they send me stuff, too. So sometimes it is hard to keep track of everything.
(Thereupon, Defendants' Exhibit 7 was marked for identification.)
Q. Just so our markings are complete, I am going to mark as Exhibit 7 these various letters and papers that are at the front of your binder. I see that they do include some handwritten notes that you have made here of your work on the case, and there are the various transmittal letters

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from Mr. Ruf providing you with these materials in the binder; is that correct?
A. Yes.
Q. So I will just mark this collectively as Exhibit 7, which we will refer to all of these preliminary letters, it looks like you have one or two fee statements in here, and your handwritten notations that bear a date of October 23, 1998, so that set of materials will collectively be Defendants' Exhibit 7.
Let me hand this back to you in case you need to refer to it.
Let me begin with a little bit of some additional background here about your work on this file. Have you spoken with any of the doctors whose records you have looked at?
A. No.
Q. Do you have appointments to speak with or meet with any of the doctors who were involved in any way in caring for Mrs. Glasser?
A. No,
Q. Have you seen or met with Mrs. Glasser?
A. Yes.
Q. When did you see her?
A. This morning.

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Q. Where did you see her?
A. In this room.
Q. How long did you spend with Mrs. Glasser this morning?
A. Perhaps a half an hour.
Q. What did your meeting consist of?
A. I wanted to re-go over the chiropractic care given by Dr. Abood.
Q. What do you mean, go over it?
A. Well, just to compare her testimony versus Dr. Abood's and see what types of spinal manipulations were done or spinal adjustments were done on the low back.
Q. Did you have some questions that you wanted to have clarified by Mrs. Glasser?
A. Well, I just wanted to clarify -- oftentimes people can describe what occurs, but you are missing their hand motions, you are missing their actual description. That is where you can presume a lot of things from what your knowledge is. But I just wanted to reconfirm that again.
Q. What did she tell you this morning?
A. Well, with regard to the lumbar adjustment, that there was a torquing, twisting motion of the pelvis in it, and that is what I had presumed it

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was from her description.
But, again, without a videotape deposition, you miss the patient's expressions, their demonstrations. So that is what I wanted to go to confirm with her.
Q. Specifically, what did she tell you in terms of the type of adjustment that he performed?
A. Basically, it is a lumbar roll.
Q. Her terms, or is that your term?
A. My term.
Q. What did she describe to you?
A. Well, the same thing that she had described during the deposition. Do you want me to --
Q. Can you just tell me from your memory of meeting her this morning?
A. She was put in the traditional lumbar roll position, and there was a twisting motion of the pelvis in the adjustment.
Q. Did she say how she was positioned? You say it is a traditional lumbar roll position. That certainly would not have been her words to say that?
A. No.
Q. What did she say?
A. Basically, being on her side, arms crossed, with

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the knee brought up, put in a pretzel type position, and then with a rolling, rocking back and forth with a force then on the pelvis, low back, pushing it forward.
Q. You say pretzel position. What does that mean?
A. That is what people use to describe when they get all bent up and twisted, leaning on the side and pull the knee up to the chest and pull the hip over so their knee is upward in that kind of position.
Q. Which knee is up by your chest?
A. The side getting adjusted.
Q. Was she positioned on her back or on her side?
A. Side.
Q. So if she is laying on her side, which knee is brought up to her chest?
A. I believe it would be the left knee.
Q. Let's assume she is laying on her right side.
A. Right side.
Q. Again, I am not asking you to tell me the textbook way to do the maneuver, I am asking you.
A. Basically, I turned to the page in her deposition and wanted to reenter with her what she had described in her deposition.
Q. So what did she tell you?

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A. Yes, that is what occurred.
Q. So your take on her testimony and in your meeting with her this morning was that she was positioned on her left side or right side?
A. I didn't ask about the side.
Q. So you don't know if she was on her left side or her right side?
A. I can look back in the records.
Q. I mean, this morning, did you ask her if it was her left side or right side?
A. No. What I was merely interested in, Dr. Abood states that he did not enter any type of rotation at all, and the patient does describe a rotation, and so that is what I wanted to reconfirm.
Q. What leg or what knee is brought up to her chest?
A. The top leg. The bottom leg is usually always straight.
Q. Is that what she described to you, is that her bottom leg was kept straight?
A. Let me turn to the page here, and I can go through that for you. Starting with page 30 to page 31. She describes the position, but I don't see where she labels what side that she was actually on.
Q. Do you know from speaking with her this morning,

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or any other material you reviewed, what side she was placed on?
A. I don't recall there being named a side either with Dr. Abood or with the patient.
Q. You told us that she confirmed for you that there were some rotational forces applied to her?
A. Yes.
Q. How did she describe the rotation this morning?
A. Well, she talked about what she described in her deposition, the fetal position, the feet come up to the chest -- this is where I wanted to meet her.
It says, "If moving helps you put it into words, go ahead." That is what I actually wanted to talk to her about.
"The arms are crossed. May have, may have not. Can't be that specific about that. Do the crunch type motion. Would kind of rock my body until he felt it was --" Then he said, "Okay, let go."
So no, there is no -- that describes a rotational type adjustment, which I just wanted to double check.
Q. In your mind's eye, what are you picturing now that you have read her deposition and you have

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spoken with her this morning? What exactly did Dr. Abood do to her in terms of the rotational force? How was that applied to her?
A. By doing the lumbar roll.
Q. When doing the lumbar roll, what sort of rotation is introduced at what pattern or angle?
A. To the side being rotated.
Q. Which side would that be? Let's assume laying on her right side.
A. Then the left side is up, and she describes the knee being pulled to the chest. And then with the rocking formation. So then the low back, for example, if you are on the right side, the vertebral body that would be rotated to the left -- yes, it would rotate to the left. I am trying to think of better ways to describe it.
Q. If you have a patient laying on her right side, her left side is facing up, what is rotating?
A. Well, actually, it is a whole segment. It is not just the vertebra, because the disk is attached to the vertebra, the annulus of the disk versus the Sharpey's fibers. When it moves, the person's leg is brought up.
Q. Before we get into the specifics of the vertebra, a little more grossly, if you will, from the

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patient's perspective, what is moving?
A. From what the patient describes?
Q. Right.
A. The patient describes the low back and the pelvis moving.
Q. What direction is it moving in, again, from the patient's perspective?
A. If the left side was up, for example, then it would be moving around the pelvis. The low back would be moving around.
Q. What does "around" mean?
A. Realizing if you are on your side, the center of motion is in the back, roughly the back third of the vertebra in the disk, so you can't actually push straight forward if the bottom leg is attached, presuming that you are not going to push the person off the table.
Then if the hip is attached to the table and you start moving the pelvis, then you can't push the patient totally forward without the other side moving, too. And since it rotates on the back one-third of the axis of the vertebra of the average person, then it moves then in a rotational motion around there.
Q. Is there any other portion of Mrs. Glasser that

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is being rotated while this adjustment is being performed?
A. Well, the pelvis is rotating around, that is part of the motion in it. It is part of the part that is moving. And the vertebral body, the disk, the whole motion segment in there. I mean, they are all attached.
Q. So based on Mrs. Glasser's testimony and your speaking with her this morning, your conclusion is that a lumbar roll adjustment was performed on Mrs. Glasser?
A. And also considering Dr. Abood's testimony, too.
Q. That is your conclusion based on everything you have seen?
A. And with Dr. Abood's testimony, yes.
Q. Right, that is what I am asking.
A. Yes, yes.
Q. Did Dr. Abood perform any other types of adjustments on Mrs. Glasser that you are aware of other than a lumbar roll?
A. Yes. He did an anterior lumbar, by his definition, he was standing in back. There are various ways of doing it. He describes being in back of the patient and doing an anterior motion on the low back.

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Q. How was Mrs. Glasser positioned for that?
A. I believe sitting, if I recall. Basically, you are trying to move the vertebral body backwards. He did cervical adjustments and thoracic adjustments. Activator, also.
Q. When Mrs. Glasser described this lumbar roll adjustment that was performed, where was Dr. Abood standing or where was he situated as he performed that adjustment?
A. In front of the patient. It is difficult for a patient to go back and recall specifically, because they are not technically orientated to what happens. So oftentimes you will see, as I see here, when a patient comes in your office you say, "What kind of treatment have you had in the past," they say, "I think this or that --"
Q. Before we get into war stories, in terms of Mrs. Glasser, what is your basis for saying that Dr. Abood is standing in front of her?
A. Because you physically couldn't do it from standing in back of her.
Q. Did she recall Dr. Abood standing in front of her, or did she not know that?
A. I believe she does not recall.
Q. So your basis for saying Dr. Abood was standing

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in front of her is not based on anything Mrs. Glasser herself testified to, but it is based on what?
A. Because it can't physically happen the other way, the doctor being in back.
Q. The doctor cannot stand behind the patient and rotate?
A. And do the lumbar adjustment.
Q. The lumbar adjustment, as you are inferring that it was performed in this case?
A. Well, with Dr. Abood's you are asking two different things. You are asking what did the patient tell me? And I also know what Dr. Abood testified, also. So Dr. Abood put himself in front of the patient.
Q. What else did you and Mrs. Glasser cover this morning besides clarifying that particular point?
A. That was what I wanted to talk to her about.
Q. That took a half an hour to get that cleared up with her?
A. Well, going through and explaining what she has and what Dr. Abood has and talking about that kind of adjustment, chitchatting.
Q. Did you perform any physical examination on Mrs. Glasser?

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A. No.
Q. Are you scheduled to do that?
A. No.
Q. Was Mr. Glasser present?
A. No.
Q. Did you take any notes of your meeting with Mrs. Glasser this morning?
A. No.
Q. Do you have plans or appointments to see any of Mrs. Glasser's treating physicians while you are in town?
A. No.
Q. Did you review either any medical literature or chiropractic literature as part of your work on this file?
A. No. I reviewed the file.
Q. Did you do any MEDLWE searches or go to any other resource materials to inform yourself of any point or clarify yourself of any point as you worked through and analyzed any of these file materials?
A. No. I did this (indicating), and looked at the x-rays and MRIs.
Q. Can you cite me to any literature, chiropractic literature or chiropractic texts, or medical

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literature or medical texts, that you feel are supportive of the conclusions that you have reached in your analysis in this case?
A. Texts that can describe it?
Q. Texts that you would feel would be supportive references. Let's say, for example, if you were to prepare up an article for the medical publications or chiropractic publications, and let's say this case was going to be a case report and you were going to set forth in written format for your colleagues in the literature your written analysis of this particular patient's case and your discussions of her condition, or any of the conclusions that you have reached.
Usually in medical literature there will be medical references cited as part of the article that will support the author's conclusions or that he would want to cite to as references that would be supportive or helpful in reaching the conclusions that he reached or his analysis.
So if that was the task before you, and if I was to ask you are there any medical or chiropractic literature, texts, authorities that you would reference or cite to as being source materials for your analysis in this case, what would those

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be?
A. Well, I would have to go dig them up. I read a lot. Do I have those specific things in the lectures I give? There is one having to do with it in Turek's Book of Orthopedic Surgery that documents clearly a disk prolapse that I know I have in my lectures. But no, I don't know.
I am sure that there are articles out there. I know there are because I have read articles. I haven't kept track of them because it doesn't pertain to what I write about. I know they are there, and I have read them.
Q. Do you have any chiropractic texts that you keep in your office as part of your office collection or personal library?
A. I bought one back in chiropractic school. I don't know that I spend much time reading it. I use the medical libraries at the hospitals. I have books I had back when I was in chiropractic school.
Q. Do you keep any medical texts in your personal library?
A. Oh, sure. Like Gray's Anatomy, Hamilton, I have Turek's Book of Orthopedic Surgery. I have different books that I bought back in chiropractic

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school. But beyond that, I update myself in the hospital libraries.
Q. What publications do you subscribe to?
A. I don't. I go to the hospital libraries, and you don't have to pay for them, then.
Q. So you do not receive any, as part of a regular subscription, medical journals or chiropractic journals that come to you, personally?
A. Well, each month -- I just joined the American Chiropractic Association again, and I get their monthly journal.
You get these free periodicals in the mail.
Q. I am not talking about throwaways. I am talking about any of the regular journals.
A. No.
Q. So you go to the local medical library if you need to access or read up on the literature?
A. Oh, yes, and on an ongoing basis, yes.
Q. Are there any medical or chiropractic texts that you consider to be reliable and authoritative?
A. They may think themselves to be authoritative. I can't say there is one book I would say that is authoritative on back pain or any of this kind of topic, or anything.
I know that there are many books out there.

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The problem, as you know, with books is there are some facts and then there are some of their own personal opinions. And the personal opinions may be based on their own experience or viewpoints and may not be reflective of things derived from fact. So I don't rely on those as a factual type thing.
Q. You gave me the names of a couple of medical texts that you purchased back in chiropractic school.
A. Yes.
Q. Do you consider those to be still good references, useful references to look things up?
A. I like Gray's Anatomy. Hamilton, I think that is a timeless book, Hamilton's Book of Anatomy. Turek is a nice guideline for when you are lecturing on for way back when to have different topics. Once again, he enters into opinions times two.
Books are old by the time they are published. I constantly lecture, so I constantly need to be updated with the newest research. And even the newest is a year old. So I don't rely upon a lot of books as opposed to the journal articles that come out.

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Q. Journal articles?
A. Yes.
Q. What journals do you typically reference when you go to the library and want to stay current?
A. The Journal of Neurosurgery, the one called Neurosurgery, the Journal of Neurology, Spine magazine, Stroke magazine, Journal of Radiology, Postgraduate Medicine, Journal of Rheumatology, Clinical Orthopedics Related Research, the American edition of the Journal of Bone and Joint Surgery, the British edition of the Journal of Bone and Joint Surgery, Headache, the New Englanc Journal of Medicine, JAMA.
Those are just a few that I read on an ongoing basis. Archives of Physical Medicine. I will page through some other ones, too. Most state medical associations have their own journal, and they have some of those there. I don't recall which states. For example, I am sure Minnesota. There are different ones there. I couldn't tell you the states.
Q. You wrote a report for Mr. Ruf in this case that was dated October 28, 1998?
A. Yes, I did.
Q. Have you written any other reports other than

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that one?
A. No.
Q. At the time you wrote your report, what materials did you have available to you?
A. Medical records.
Q. Anything else?
A. No. It would be the medical records that they sent to me that would have predated October 28. I have a letter dated October 14, 1998. It outlines the medical records, basically, that I had, the basic medical records with the white tags on them.
Q. Did you also have Mrs. Glasser's deposition transcript?
A. I don't believe at the time I did. No, I -- yes, I recall that.
Q. So you did have her deposition transcript?
A. As I recall, hers, and I recall Dr. Reed's.
Q. The question is at the time you wrote your report, October 28 of 1998, which depositions, if any, did you have?
A. The answer to that would be I recall hers, the patient. I don't have that in here, but I recall Dr. Reed's.
Q. And you had read Dr. Reed's deposition before you

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wrote your report? You may want to check the date of his deposition.
MR. RUF The dates the depositions are taken are on the front.
A. This is Dr. Reed. No, I didn't have that. November 20. I didn't have Dr. Abood's. I believe I had Jan Glasser's, though.
Q. After you received and read Dr. Abood's deposition and Dr. Reed's deposition, did you make any further amendments or changes to your previous report?
A. No.
Q. Did you issue any supplemental or addendum reports?
A. No.
Q. Have you ever been sued for malpractice, Doctor?
A. No.
Q. Who is your malpractice insurance carrier?
MR. RUF Objection. Go ahead.
A. NCMIC.
Q. As part of your practice you spend a fair amount of time traveling and lecturing; is that true?
A. Correct.
Q. You also spend time handling sort of second opinion requests that come to you from doctors

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throughout the state of Minnesota or elsewhere?
A. Yes.
Q. Do you also spend time as part of your practice responding to or getting involved in medical-legal consultations?
A. Yes.
Q. Do you also spend time with a private practice?
A. Yes.
Q. Is there any other major category of activity that you do that would comprise your practice of chiropractic?
A. No. That is the majority of what I do is I lecture and I see patients.
Q. The categories that I talked about were that you give lectures, you see patients on a referral basis for second opinions?
A. Yes.
Q. Is that true?
A. Yes.
Q. You have your own private practice; is that true?
A. Yes.
Q. And you also get involved in medical-legal consultation of one kind or another; is that all true?
A. Yes.

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Q. In terms of a breakdown of your time, looking back, say, over the past year or two years or so, what has been the approximate breakdown of your time devoted to those four different kinds of activities?
A. Well, on a seven-day week, presuming like this weekend I will be at Birmingham. If I wasn't here, I will spend probably a third of my time with lecturing and two-thirds of my time seeing patients.
Q. Well, how much time spent handling the second opinions as distinct from your own private practice? And then I want to also carve out whatever time is spent on medical-legal consultations?
A. I suppose of the two-thirds time that I call seeing patients, a third of my time would be the manual treatment, and a third would be second opinions.
Q. And how much of your time is spent on medical-legal consultations?
A. Of that third of doing second opinions, very small. The vast majority of what I get come from other chiropractors.
Q. And the lectures that you give, I see from your

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CV that you have given a number of presentations around the country on various topics, and it just looks from a glance at your calendar that you may be lecturing several times each month.
A. Yes.
Q. According to the CV that we were provided with, which is dated from December of '98, you had one lecture in the Cleveland area?
A. Yes, I did.
Q. In December of 1995?
A. Yes.
Q. Do you remember how that was arranged or who was your contact with the Ohio Chiropractic Association in bringing you in for that?
A. As I recall, it was Dr. Roger Wilson. And it was actually this district. I don't know that it would be in the state association. Maybe it was run through them, but I believe it was the district here. As I recall, it was Dr. Roger Wilson.
Q. How many times have you lectured in the state of Ohio?
A. Just that time.
Q. Do you have any pending invitations to be returning to Ohio, anything booked or scheduled?

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A. No, nothing booked or scheduled.
Q. Of these second opinions that you give, I understand that you will get requests or referrals from other doctors around the state of Minnesota asking you to see a patient?
A. Yes, Wisconsin, too.
Q. And those are usually a one-time shot; in other words, you will see a patient, do a review, write a report, and then send the patient on back to the originating physician; is that true?
A. It may be a one-shot. I may see follow-ups. It depends on what the patient has.
Q. Are you taking over the care of these patients?
A. No.
Q. Or are you simply offering a second opinion or consulting opinion to their primary doctor?
A. Merely a second opinion, much like an orthopedic physician would do for a family doctor.
Q. Do you receive these referrals and consultations from chiropractors in Minnesota?
A. Yes, but I -- yes, for the second opinions, yes. I have, rare times, gotten them from medical doctors in small communities.
Q. But the vast majority of those referrals come from chiropractors?

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A. Yes.
Q. And in the vast majority of those cases those patients go back to their treating physician and you do not assume their care on an ongoing basis; is that true?
A. In the vast majority, yes.
Q. Are you considering as part of the one-third of your time spent doing the second opinions incorporating in that time spent doing medical-legal consultations in litigation?
A. Referrals from attorneys, like people that are in collision and Workers' Comp. injuries and stuff?
Q. That's correct.
A. Yes.
Q. So when you gave us an estimate of one-third of your time doing second opinions, that includes referrals from chiropractic physicians, and you also are including in that estimate time or referrals of matters from lawyers; is that true?
A. Yes.
Q. Can you break that one-third block down, subdivide it, if you will, between the referrals that come from attorneys versus the referrals that come from chiropractors?
A. The vast majority come from chiropractors. I

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rarely even take any from attorneys.
Q. But you do some, obviously?
A. Some. We purposely screen all of our calls, and I purposely do not take many at all.
Q. How inany medical-legal consultation matters do you have pending at the present time? And by that I mean matters where you are consulting with an attorney, either a plaintiff's attorney or a defense attorney, in any type of litigation or legal proceedings?
A. Are you specifically talking about people that are in like Workers Coinp. injuries or collisions?
Q. We will include malpractice, Workers' Compensation, auto accidents, any kind of legal proceedings.
A. I don't keep an exact record on that, but it could be 20 cases, perhaps, at this time.
Q. Is that a high number or low number, or is that about an average inventory of medical-legal matters that you will have at any one point?
A. It is an average number because a case that I might have seen two to three years ago, it may still be active and ongoing, and I may not even know about it. I mean, I have seen some back three years ago, and then I will find out that the case is now done. That is why it is

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impossible to have an exact number for you.
Q. Of the medical-legal matters that you presently have, how many of those are malpractice cases?
A. That are ongoing?
Q. Yes, currently, that you know to still be current, active matters that you are carrying on your docket, if you will.
A. That I presume to be ongoing would be a half a dozen.
Q. And you include this case as one of the half dozen?
A. Yes.
Q. From what other states are those other six cases pending?
A. One in New Mexico, Indiana. A couple in Minnesota, two to three in North Dakota. This would be my recollection.
Q. And we have this case here in Ohio?
A. Yes.
Q. Have you given depositions yet in any of those other cases?
A. Yes.
Q. In all of them?
A. No.
Q. In which of those other cases have you given a

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deposition?
A. One case that I haven't heard about for a long time was down in Louisiana. That was in Lafayette, Louisiana.
Then I gave a deposition in a case in -- the deposition happened in Fargo; the case was, I believe, from Thief River. That was a deposition. I was in court twice in Thief River in the courthouse for malpractice cases they have. That is all, I believe.
Q. Do you have deposition requests pending in any of the other matters that you are presently involved in?
A. Not that I know of. I can't think of any.
Q. In these other six malpractice cases, are you retained as an independent expert in all those six cases, or are you a treating physician in any of those cases?
A. No, I am the independent expert.
Q. Have you been retained by the plaintiff or the defendant or a mixture of both amongst these other six cases?
A. The cases that are left, that are ongoing, I would say the majority are to defend.
Q. Which ones are defense cases?

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A. There is at least -- there are two I know of that are defense in North Dakota. I know of one plaintiff one. I recall one plaintiff one in North Dakota.
I am the plaintiff expert in New Mexico, defending expert in the two in Minneapolis, Metro area. Indiana, defending side. Those are the ones I know that are ongoing that I recall.
Q. In the defense cases, you are defending a chiropractor?
A. Oh, yes.
Q. And in the plaintiff's cases, you are testifying against a chiropractor?
A. Yes.
Q. Do you know the names of the defense lawyers that you are working with or the names of the plaintiffs' lawyers that you are working with in of these cases?
A. Current ones, I don't recall the name of the people in Indiana at all. Of course I have them all in files.
Q. Sure.
A. New Mexico, I know it is outside of Santa Fe. I couldn't tell you the name. Minneapolis, Jim Rogge.

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Q. Is the defense lawyer?
A. Yes.
Q. In both of the Minneapolis cases?
A. One, yes. The other one he may not know he is going to be the defense lawyer yet.
Q. What does that mean?
A. I get files from malpractice carriers. They say, "Would you review this? What do you see here," type stuff. And I believe he is the lawyer that they use in that area.
Q. What insurance company sends you those files to review?
A. NCMIC. Another one I believe the file actually came from Jim Rogge. And I believe that was his name, but it was a malpractice carrier out of Michigan, Michigan Physicians Mutual, maybe. That might not even be it, though. I don't recall the attorneys' names in Grand Forks.
Q. Do you know the law firm name?
A. No. There is another one on the plaintiff's side, it is in Bemidji, and the attorney there is from Crookston, Minnesota.
Q. Bemidji?
A. Minnesota, yes. The other ones in North Dakota, I don't believe there is an attorney on the

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defense side yet.
Q. This case where you said that you know that Jim Rogge is going to get the case --
A. Well --
Q. -- or so you think, was that a file that was sent to you by this Michigan Physicians Mutual Insurance?
A. No. That was a stroke case. And that one, the attorney, and I believe that is the name, Jim Rogge, I believe he is the one that sent me that file. The other one is not a stroke case, and that one I believe was sent to me by NCMIC.
Q. You think NCMIC uses Jim Rogge in that area, and that is why he is getting that case, too?
A. That is what I presume.
Q. In any of the other cases that you have pending at this point in time, do you see any issues in any of those cases that pertain to the issues that you see here in the Glasser case?
A. Yes, the one in New Mexico.
Q. What is the issue there?
A. Disk prolapse.
Q. Lumbar disk?
A. Yes.
Q. Do any of the cases that you have presently

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pending involve any lumbar disk involvement or lumbar disk disease of any kind?
A. The one in New Mexico.
Q. Is that the only one?
A. No. Actually, this one here, too, Cleveland.
Q. The Glasser case?
A. This one, too.
Q. Is there yet another Ohio case that you have?
A. Yes. It is a small part of what I do, so I don't keep a tremendous amount of record keeping on these kind of cases because I don't get that many and take that many. That is not the brunt of what I do.
Q. But you have a second case that you are working on in the Cleveland area?
A. Yes.
Q. Who is the attorney that you are working with?
A. Dave Malik -- Mike Malik -- Maholik, something.
Q. Do you know if the case is in suit yet?
A. I couldn't tell you.
Q. Do you know what the issue will be in that case? Have you discussed that with Mr. Malik or determined what the issue will be?
A. The file was sent to me some time ago, and it is a lumbar disk. I don't have the file with me to

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give you any details.
Q. Of the other, again, half dozen or so pending cases, other than the one in New Mexico and this case in Cleveland that you are thinking of, are there any others involving any disk issues involving the lumbar disk?
A. No.
Q. The one that is in North Dakota is not actually a disk prolapse?
A. It is a different issue. It is not a disk prolapse.
Q. What is the issue in that case?
A. Well, it is interesting, it is a chronic arachnoiditis. I don't have -- I don't want to get into the details.
Q. Chronic rachtoid --
A. Arachnoiditis. Real interesting. So it wasn't like this, a disk prolapse type case.
Q. Have you given any lectures, as you look through your list of lectures, that would have a bearing on the issues that you have in this case or that you see in this case?
A. Yes, I do. One of the lectures I give is called permanent soft tissue injuries. Also a lecture I give on lumbar spine conditions, a lecture I give

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on lumbar sciatic syndrome.
Q. Are these listed in your CV? I don't see these listed that you are now describing for us.
A. Well, can I see my CV?
Q. Yes. Let me give you another copy. Here is the copy that was attached to the report that was provided to us. Can you point out, as you look through your list of presentations and lectures, any that you feel have a substantive bearing or similarity to the issues that you see in this case?
A. Well, I will go to the more current ones. I have a better recollection of those. For example the five-minute -- if you go to September 13, 1994, the five-minute orthopedic spinal exam. In that, that is on a book I wrote that we talk about disk prolapses like this and the testing of it.

Even the next date, September 20, 1994, when we talk about records documentation, this is an issue, also, as far as monitoring arm and leg complaints in a case.

If you go to the next page, May 18, 1995, whiplash injuries would have to do with this topic, also.
Q. Whiplash?

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A. Yes.
Q. How is whiplash related to this case?
A. Back injuries.
Q. Does whiplash primarily concern the cervical spine and thoracic spine?
A. Whiplash is an old term that is used, an outdated term that is used as a mechanism of injury. And research shows it is a totally inaccurate term. Now I just use it as a recognition type title. But the current research shows that it is an inaccurate term and it is lacking -- it is not even what happens.

Oftentimes it is given to cases now where it is suspected the patient may not be quite with us.
Q. What is it that you cover in your lecture on whiplash injuries that has a bearing on the issues in this case?
A. Well, this is a lumbar back injury. And that can also happen in a collision, also.
Q. Do you discuss disk injuries in your lecture on whiplash, lumbar disk injuries?
A. If you come forward, it would be easier for me to recall. That is some time ago. But I do know since my book has been published -- go over here

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to December 9, 1995, please. See "Posttrauma injuries," Ohio Chiropractic Association? That is when I my book first came into print, the fourth book I wrote. And I wrote about prolapse.
Q. In?
A. Diskprolapses.
Q. Lumbarprolapses.
A. Just the word prolapses.
Q. So your lecture covers disk prolapse or disk herniations in general?
A. Well, talks specifically about ligament sprains, specifically about annulus tears, specifically about fragmenting disks, also about disk herniations, both contained or nocontained, also about disk bulges.
Q. And this is generic, not specific to the lumbar level; is that true?
A. It is generic as considered to the very specific spine.
Q. Well, to the spine, of course, but it is not focused or concentrated on just lumbar injuries, you talk about these disk conditions occurring throughout the spinal column; is that true?
A. Yes, yes. And then if you come forward, all the titles that you see, "Whiplash," "Trauma," would

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enter into that. "Records documentation," again, also covers, on that page seven of my CV, we also talked about monitoring arm and leg complaints in cases.

Go on to page eight of my CV. More of the same that you are seeing there.
Q. As I look through this, I see basically a handful of similar lectures are repeated frequently in different places that you give your lectures. And I presume you update your topic materials from time to time?
A. If you go to page ten, it is breaking up there. On page ten of the CV, if you go down to January the 22nd, 1998 called "Permanent Soft Tissue Injuries, Now and Then," above that on December 18, 1997, "Postconcussion syndrome. Differential assessment."
Q. The question is: What in those topics or lectures has anything to do with this case?
A. Permanent soft tissue injuries. Then also you see February 3, 1998, that would also have to do with disk herniations, clinical aspects of low impact accidents.
Q. What is it about permanent soft tissue injuries that has anything to do with this case?

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A. That is the section of the book like we talked about in Ohio that has to do with disk herniations, that is that topic, contained or noncontained disk herniation, disk protrusions, disk bulges, annulus tears.
Q. Those are the topics you cover in that lecture?
A. Those topics, and more than that.
Q. The lecture on postconcussion syndrome, what does that have to do with this case?
A. Nothing.
Q. And the lecture about clinical aspects of low impact accidents, is that one you were referencing as well?
A. Yes.
Q. What does that have to do --
A. A mechanism of injury of the spine, for example.
Q. What mechanisms of injury do you discuss at tha lecture, the chiropractic adjustment as being a mechanism of injury?
A. No, how people sprain mid-back, low back in collisions. They go over some of the myths that are out there now, people saying that there is actually a correlation between the amount of car damage and if they get hurt on not. We go through the myths and refute those myths and go through the facts that are current.
Q. So that lecture has to do with low impact accidents, and that is a reference to a low impact auto accident?
A. Yes.
Q. Was Mrs. Glasser involved in an auto accident that I don't know about?
A. No. But in that we also talk about how spinal injuries occur, and that is a very important part of that.
Q. Anything else that you think has a bearing on the issues in this case?
A. A series of lectures I see that are down in Atlanta, Georgia, called "Personal Injury Chiropractic." Basically, that is the multi-section, the Minneapolis ID report four-point section having to do with what we just talked about.
Q. Many of these more current lectures are drawn from the material in your book, I presume?
A. No. There is all the current stuff beyond the book. We could use the book as an outline, but there is so much new that I would like to cover.
Going through on page 11, "Quick Spinal Exam," again, the Georgia lecture. May 27, 1998 "Explain Chronic Soft Tissue Injuries to the Jury in Lake Tahoe."

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Q. How is that relevant to this case?
A. Talked about spine injuries, evaluation of it. Now, if you go on like the last page, for example, we have like July 30, 1998, and specifically now what I do, I go under general practice type lectures like this, or that topic there you see on July 30, "Lumbar Syndrome, Lumbar Sciatic Syndrome," I do that as an eight-hour lecture in some states. But back home in Minneapolis, I break it into two-, three-, four-hour lectures.
Q. Who do you lecture to, chiropractors, as part of continuing education?
A. Chiropractors and attorneys. Most state bars approve my classes or lectures. But the vast majority it is chiropractors I teach.
Q. This CV that I have given you to take a look at goes to page 13, and the last entry was December 12 to 13, 1998. I presume you have an updated CV that would have any activity that you have had since December of 1998; is that true?
A. Yes. The only thing different, though, would be I rejoined the American Chiropractic Association; and current lectures that have occurred since whatever date you gave me there.
Q. When you give these lectures, for example, the one on lumbar syndrome and lumbar sciatic syndrome, do you have handout materials that you provide to the audience?
A. Yes.
Q. Do you keep copies of those materials, I presume, for your use in future lectures?
A. I can't tell you that the handout that I have now is the same as I had then, because it evolves.
Q. But you have handout materials that are sort of a work in progress on these different lectures that you give?
A. Oh, yes.
Q. So if I was to ask for a copy of your lumbar syndrome and your lumbar sciatic syndrome lecture handout materials, you would be able to provide that?
A. Oh, sure.
MR. RUF: I am going to object to that.
Q. Likewise, for any of these other topics that you described where you believe there may be some material covered that has a bearing on issues in this case, we could ask you for a copy of

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whatever is the current version of those handout materials?
MR. RUF Objection to that.
A. Were you in the class here in Ohio, here in Cleveland?
Q. Maybe.
A. Did you like it? My book hasn't changed since the ones that they handed out there.
Q. And the book you are referring to, the one you have been making some reference to, is the December, 1995 book on whiplash trauma?
A. Yes. The class they gave here was actually the first time it was used.
Q. Who was the publisher?
A. I self-published. I dropped the publishing company, it was too slow. So if you publish yourself, it is so much easier. I don't even sell it anymore. You have to come to the lectures to get the book.
Q. Or mail order?
A. No, I don't do that anymore. Of the book I gave out here, I have actually divided that into three different classes. The first book was "Neurologic and Postconcussion Syndrome," so we actually now only hand out the pertinent chapters

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and, of course, the references.
And the other part of the book has to do with permanent soft tissue injury, But even in that we broke that down into the low impact collision. So, actually, there are three different eight-hour classes on the topic.
Then beyond the book we give a handout with all new relevant current research that pertains to those topics.
Q. Your January, 1995 publication entitled, "A false claim, stroke from manipulation," is that also self-published?
A. No. Those I think are all published through what is called the American Chiropractor.
Q. I am looking on page two of your CV under "Textbooks Published."
A. Oh *sorry.* No, I self-published all of these.
Q. So all four of these publications that you have listed in your CV are available through you or through attendance at your lectures?
A. Well, you have to come to my lectures. You can't buy them anymore.
Q. So these are not available in public bookstores or even through chiropractic mail orders; is that right?

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A. No, I don't sell them to schools anymore or over the phone.
Q. Do you sell them over the Internet?
A. No. What I found is that people, instead of coming to your classes, they will say, "I just want to buy your book." But in the classes you go into so much more in there. So people come listen to me.
Q. Going back over some additional entries on your CV, you attended the University of Minnesota, but you did not graduate; is that correct?
A. That's correct. I went to the University of Minnesota, but also the College of Saint Scholastica, which is also in Deluth.
Q. Are those two separate entities?
A. Yes, they are.
Q. Which one did you attend first?
A. UMD. I went there for the first two years, and then I went to the College of Saint Scholastica for the last two years.
Q. How far did you get in the College of Saint Scholastica? Did you complete your senior year?
A. I went to four years of college, but I would have had to stay for a partial year to get a degree, and I didn't need it to get into chiropractic

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school, so I didn't stay.
Q. How many total credit hours had you accumulated in those four years between the two institutions?
A. I don't recall.
Q. How many credit hours were you shy of graduation at the point when you left to go to chiropractic school?
A. I don't know that, either.
Q. Less than a semester, or would it have taken another full year?
A. I think it was less than a year. I don't know for a fact. Hindsight is always clear. I wish I had stayed and got my degree, but I didn't.
Q. What was your accumulated grade point average by the time you left to go to chiropractic school?
A. I just don't remember.
Q. Were you on any sort of academic probation of any kind at the college of Saint Scholastica?
A. No.
Q. Were you ever placed on any academic probation, academic warning list, anything along those lines?
A. Not that I know of.
Q. What about at the College of Minnesota, Deluth?
A. Not that I know of.

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Q. How were the grades?
A. Oh, they weren't the best at UMD. I was playing college football and track, and spent more time playing than studied.
Q. Would it be fair to say that you flunked out of the University of Minnesota, Deluth?
A. No, I didn't flunk out of UMD.
Q. What about at the University of Scholastica?
A. No. I did good there, good grades.
Q. You weren't asked to leave?
A. No.
Q. You attended the Northwestern College of Chiropractic?
A. Yes.
Q. And that school is still in existence?
A. Yes, in a different building, but yes.
Q. As between straight and mixer, you consider yourself to be a mixer; is that true?
A. Yes.
Q. And you were taught that school of thought, if you recall, when you were at Northwestern College?
A. Well, we were taught both schools. Northwestern, their technique is called diversified. They try to teach you everything, give you good exposure

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to everything. I can't even say within that school it is a mixer school. I think they teach both ways.
Q. Palmer College is recognized as a straight college?
A. Not that I know of. I think that is like most schools --
Q. So you don't agree with that?
A. No. I think they teach both straight and mixer.
Q. Have you ever taken any classes at Palmer College?
A. I took one postgraduate class, one weekend class back many years ago on hospital protocol.
Q. Hospital protocol?
A. Yes. That was back in, I believe in the mid-'80s.
Q. And that was just a weekend course that they offered?
A. Yes.
Q. Have you ever given any lectures at Palmer College?
A. No.
Q. Have you ever been a member in any capacity on their faculty?
A. No. I did not pursue the -- they had sent me letters, but I did not pursue them back.

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Q. Palmer invited you to join the faculty. Is that what you are saying?
A. No, for postgraduate lecturing. You are talking Palmer in Davenport, Iowa?
Q. Yes, I am.
A. No. I had contact with them, and they had expressed interest in postgraduate lecturing, but I just like lecturing on my own.
Q. You approached them about doing postgraduate lecturing?
A. At first I did, yes. But then the more I got into this --
Q. You just decided not to?
A. Yes.
Q. So you have never given any lectures at Palmer College?
A. No.
Q. That's correct?
A. That's correct.
Q. Who was the director for your postgraduate chiropractic orthopedics program at Northwestern?
A. The teacher was Dr. Ron Evans. I don't know if you call him director or not.
Q. Who was the person to whom you reported or was supervising your work in the postgraduate program

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there?
A. Dr. Ron Evans.
Q. Is he still on the faculty there?
A. I couldn't tell you. He has had health problems. I know he is still involved in postgraduate orthopedics, more of the dean emeritus type situation, but he is still actively involved and oversees things. But I don't know that he still supervises the program.
Q. Who supervised the program for the chiropractic neurology?
A. Joel Feresy.
Q. J O E - -
A. Joel Feresy. Maybe it is F E R E S Y.
Q. As far as you know, is he still at Northwestern College?
A. No. Joel is down with Dr. Ron Evans in Des Moines, Iowa.
Q. So Dr. Ron Evans also has left Northwestern? This is the same Ron Evans you just told me about?
A. Yes. But there is a difference between teaching daily classes to undergrad., like graduate students, versus like postgraduate education. You don't have to be in the school to do that.

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You can live in any city.
Q. So when you did postgraduate education in chiropractic neurology and chiropractic orthopedics, you did that essentially long distance from Minnesota?
A. No. They came to the school. Both Ron and, I believe, Joel at that time was living in Minneapolis, so Joel and I went to school together. He was actually teaching at the college then and doing this. Dr. Evans lived in Des Moines, would fly up and do this on weekends.
Q. When you took your course work -- let me back up a little bit. In order to get your chiropractic orthopedics graduate training, did that entail course work, or was that all done long distance?
A. Course work.
Q. Was that done long distance, or was that done on site at the campus in Bloomington?
A. You mean actual classes?
Q. Yes. Did you attend actual classes as part of your postgraduate training?
A. Yes.
Q. Where did you attend classes?
A. Northwestern.
Q. The Northwestern College?

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A. Yes.
Q. How much of the program was comprised of classroom lecture versus other endeavors?
A. You go to class, have weekend classes once a month, and then you are given other materials to study and prepare for testing. Then of course you would be in practice at the same time using it.
Q. When you say you go to classes once a month, is that generally scheduled on a weekend?
A. Yes, 12-hour weekend, generally.
Q. And how many such weekend sessions did you have in order to complete your training in postgraduate chiropractic orthopedics?
A. Three years of them, skipping the summer.
Q. So --
A. So like maybe nine or ten months a year. I don't remember whether we went in June. Maybe we didn't.
Q. And when you did your chiropractic neurology program, was that set up on a similar basis?
A. Yes.
Q. Weekend lectures once a month, nine or ten months out of the year, and then take homework that you would have to do in practice?

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A. Yes, and prepare for testing.
Q. Did you pass the written part of the chiropractic orthopedic exam on your first attempt?
A. Yes.
Q. Did you pass the oral portion of that exam on your first attempt?
A. Yes.
Q. Is the same true for the written and practical parts of the chiropractic neurology exam?
A. Yes.
Q. Both were passed on their first attempt?
A. Yes.
Q. You say that you are recently a member of the American Chiropractic Association?
A. Yes.
Q. When did you renew that membership?
A. Recently.
Q. 1999 or --
A. Yes.
Q. -- 1998?
A. Yes, 1999.
Q. Had you ever been a member of the ACA before that?
A. Oh, years ago.
Q. When did you let your membership lapse in that

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organization?
A. Years ago.
Q. '80s?
A. Could be '80s, could be early '90s.
Q. Are you a member of the state association in Minnesota?
A. No.
Q. Have you ever been a member of the state association in Minnesota?
A. Yes, I am -- yes, I was. I was president of the district, too.
Q. When did you let your membership lapse in that organization?
A. Perhaps early '90s, mid-'90s, early '90s.
Q. Was that voluntary on your part?
A. Oh, yes.
Q. Did you have some disagreement with the state association?
A. Yes.
Q. What was the disagreement?
A. I helped write the standards of care for the state of Minnesota for the state association. But when it came time for them getting printed, the section having to do with the treatment protocol was removed in favor of one that was

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real specific for a Workers' Comp. Law they are trying to pass.

And I felt it was just fundamentally wrong, to start with, wasn't accurate, and I felt that doctors were going to get harmed by it. And this was a long process going on on that, and I had great offense. And doctors are getting harmed by these preset arbitrary guidelines.

Q. You participated in writing the standards of care for the state of Minnesota?

A. Yes.

Q. Were you one of a committee of chiropractors working on that effort?

A. Yes.

Q. Were you the lead author?

A. No.

Q. But you had some contribution to that effort?

A. Yes.

Q. You and other the chiropractors, I assume?

A. Yes.

Q. Have you contributed to developing state standards in any other state or jurisdiction?

A. Yes. I was a member of the Minnesota Board of Chiropractic Examiners Peer Review Committee. In that, too, we helped outline the guidelines. The

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state legislature gives laws and tells the board to write bills, and that is outlining reasonable care kind of thing.

Q. That is for the state of Minnesota?

A. Yes, for the Board of Examiners.

Q. Have you been involved in any other states, for example, the state of Ohio, in drafting or contributing to any state standards?

A. I know that attorneys had called from Cleveland, and they used part of that book to appeal this disk protrusion versus herniation, they used my book as a reference to appeal it in high courts here in Workers' Comp. as to what the definition was for that.

Q. That is in a Workers' Compensation setting?

A. Yes. And they actually called and asked permission to photocopy those pages. I thought that was unique.

Q. Other than knowing some of your material is being used as part of the Workers' Compensation efforts, have you personally contributed any information to any efforts here in the state of Ohio to developing or writing or evaluating standards of care or conduct for chiropractors?

A. Besides the lectures that I gave here, no.

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Q. The onelecture?

A. That lecture, no.

Q. With respect to your private practice of chiropractic, do you actually have private patients who you see on a regular and ongoing basis?

A. Oh, sure.

Q. Approximately how many days per week are you involved in caring for or treating your own patients?

A. Well, I try to have three part days a week at least. Because while I may have to be very limited on how many new patients I take, I always try to be there for regular patients that call.

Q. You have three half days per week?

A. At least that I try to be there.

Q. In the course of a half day, how many hours would you spend in the office seeing patients?

A. Three to five.

Q. In the course of a three- to five-hour day seeing patients, how many patients would you typically see?

A. Five to ten. It could be more than that. That is an average.

Q. Five to ten per half day?

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A. Yes.

Q. What would you say is an estimate of your total number of active patient files that you have of your own patients?

A. "Active" being?

Q. Patients who are regular visitors to your office that you regularly see and treat.

A. I don't have an accurate count on that. Over a period of a year, how many people that keep calling back, come back?

Q. Yes.

A. Perhaps 50 keep coming back. Then I have new patients. But new patients of course you may be done with in just a few treatments. And I don't know if you consider those active patients or not.

Q. On average, would you say that you see anywhere between 15 to 30 patients per week as part of your practice of chiropractic?

A. Could be, yes.

Q. And that is a good average range?

A. Yes.

Q. Some weeks maybe higher, some weeks maybe a little bit lower than that?

A. Yes. Realizing when I do a second opinion in my

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office, that takes me two hours. While it is only one patient, that takes time.
Q. These 15 to 30, I am not counting them as the second opinion patients. Are you?
A. No.
Q. I want to separate that out.
A. Right.
Q. So the 15 to 30 patients per week are your private patients, patients in your office?
A. Yes.
Q. These are not patients who have been sent to you to be examined by anybody else, these are your own private patients?
A. Yes.
Q. Just so we are clear about what we are talking about, have you ever performed a lumbar roll technique on a patient?
A. Well, of course.
Q. Have you ever treated patients for lumbar disk disease?
A. Yes.
Q. Have you ever performed a lumbar roll type of adjustment on a patient with a lumbar disk?
A. Sure.
Q. I think we can agree that there can be different

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definitions or terminology when it comes to talking about disk conditions in the lumbar back.
A. Sure, yes.
Q. And we will confine our discussion here to just the lumbar spine as opposed to the thoracic or cervical spine. Is that okay?
A. Sure.
Q. For purposes of the lumbar disk, the lumbar spine and the disks in the lumbar spine, there can be disk herniations?
A. Contained and noncontained.
Q. Noncontained or contained disk herniations. And then there is such a condition known as a disk prolapse?
A. That is a noncontained disk herniation. There are various names to describe even that.
Q. I want to be sure of our terminology. If we talk about lumbar disk herniations, two categories or subsets would be contained or not contained?
A. Non.
Q. Noncontained?
A. Yes.
Q. And under the noncontained category would be what is sometimes referred to as a disk prolapse; is that true?

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A. Yes.
Q. Anything else you would put under the noncontained lumbar disk category?
A. Some people I believe in the file, too, I believe called it a herniated nucleus pulposus.
Q. And for our purposes here today, a herniated nucleus pulposus would be considered a noncontained disk herniation?
A. Sure.
Q. Anything else you would categorize as a noncontained disk herniation?
A. Those are the basic titles. And I believe that is what is used in the woman's file, too.
Q. For contained disk herniations, are there any specific types of conditions that you would list under that category?
A. No. That is what I would call it.
Q. Sort of a self-containing. Have you performed a lumbar roll technique on patients with a contained lumbar disk herniation?
A. Yes.
Q. Have you performed lumbar roll adjustments on patients with noncontained lumbar disk herniations?
A. I can't say that I did or I would.

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Q. You can't think of a case where you have done that?
A. Not if I know that they have a prolapse where I would. There are different ways of treating that type of thing.
Q. For a disk prolapse?
A. Yes.
Q. All right, Why don't we talk about that, then.
If you have a patient where you suspect they have a disk prolapse in their lumbar spine, how would you treat that?
A. The first thing, you have to assess them neurologically. Some cases you have to get out of your office right away if you have concern of a real focal nerve compression, or if there is compression on what is called the cauda equina. To varying degrees, that is an emergency.
Cauda equina is a "right now" type of thing, where it is a prolapse with real distinctive nerve compression. You would want to immediately set them up with a neurosurgeon. Some people you can even do it. You can tell by the symptom pattern that is what they have without having an MRI -- *sorry,* with a surgeon, I should say.
Now, on that subset of patients, there are

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some people you can actually try treating it.
Q. What subset, disk prolapse?
A. Disk prolapse.
Q. Or those with a focal nerve compression or cauda equina?
A. Not cauda equina.
Q. Not cauda equina, surgical emergency?
A. Gone.
Q. They immediately get referred out?
A. Right.
Q. Disks, perhaps?
A. With a focal neurologic deficit, a focal neurologic involvement, you have to determine at that time how much. If they don't have -- and I know you are going to say how much is how much, and that is a good -- clinically, you have to take it on a case-by-case basis.

Some cases it is a right away type surgical thing, you have to get them off for the surgeon to work them up and get them on the process.

But there are some cases where if you get them on the side with the leg pulled up like that, you are actually opening up the back vertebra.

And realizing with most disk prolapses it

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may well be, depending on the cases, that the nucleus and/or the annulus is still attached. So if you can get on that patient, open them up and do some distraction, you may be able to suck that fragment off of the nerve. And I have seen cases where that has happened.
Q. And would that be a lumbar roll type of technique that you would perform, or some other type of technique, to accomplish that purpose?
A. You set them up on their side. It is not a roll. There is always the fear with the roll of twisting, squeezing out more of the nucleus. That is not the thing to do.

This distraction that sucks the nucleus off, I have seen some cases where it is dramatic, just dramatic, and you save them from the surgery. Some you are not as lucky, and they end up having the surgery.
Q. When you say set up on their side, that is a reference to how you set them for the distraction adjustment?
A. Yes.
Q. You would have them in a sideline posture for that?
A. Yes.

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Q. How would you go about performing that adjustment on a patient if you were concerned that they had a prolapsed lumbar disk, but you were hopeful that a distraction adjustment would help bring that disk back into place?
A. Lay them on their side, always be on the back side of them, and either with both legs pulled up towards the chest -- the word "towards" is very important. It is not like more is better.

You get them pulled up. If they start noticing more neurologic symptoms on the legs, then you have gone too far, back the legs off.

People, you can actually put them in a lumbar roll position, but see, if the nerve is being tractioned over the fragment, that is not a position for the patient. There are so many positions for the patients to go, you have to consider that.

In that side laying, both knees either pulled up to the chest, or one, in the lumbar roll, depending. Then you would get your hands crossed.

There are different ways of doing it, but you push down on the sacrum this way, and on the upper low back, and separate it out. And you can

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feel it sometimes. It is just amazing. You feel this "Whoosh, whoosh" type of feeling.

Other people you put the patient in this position and get down below that with a broad base --
Q. When you say "below"?
A. Below the fragment. And then they will do a quick jerk down.
Q. Down towards the feet?
A. Yes. And the intent would be to try to abruptly separate the vertebra with hopes of creating a suction in there and pulling the disks back in. Other people use a Cox table or Barnes specialist table. It depends who is selling the table nowadays.

They are laying on their stomach. Feet may or may not be in the straps. Once again, the whole idea of separating it gives a good deal of traction, basically, and opens it up, and, hopefully, if it is still attached, will suck it back in.
Q. And you have actually performed that type of adjustment on patients who have had disk prolapse in their lumbar spine?
A. Yes.

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(Thereupon, a short recess was taken.)
BY MS. VANCE:
Q. Real quickly, Doctor, are you a neurosurgeon?
A. No.
Q. Orthopedic surgeon?
A. No.
Q. Gynecologist?
A. No.
Q. Do you perform Activator technique? Do you ever do that?
A. Not with an Activator. No, there are other light force ways of doing that stuff without buying an Activator.
Q. You do not use the actual Activator technique?
A. No.
Q. Have you taken any of the Activator courses or Activator training?
A. No, not the weekend courses that they promote.
Q. Do you know what is referred to as a Logan contact?
A. Yes.
Q. Do you ever do that in your practice?
A. Back when I was first in practice, yes. But I don't do that now. A couple reasons. One, there are other light force ways of treating, and two,

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in this day and age you have to be cautious on where you put hands on people. And that has a contact down towards a person's behind, and that can sometimes be misinterpreted.
Q. Do you use any sort of drop table in your practice?
A. No.
Q. Or drop pieces of any kind?
A. No.
Q. Have you ever taken any courses or training at Palmer College other than the one class that you were describing?
A. No.
Q. Going back now to lumbar disk herniations, contained and noncontained, you were telling us right before our break that you have treated patients who have had disk prolapse on a case-by-case basis when you thought it was something you could accomplish.
A. Yes.
Q. And you described some different types of techniques that you have used.
A. Yes.
Q. In order to help get the disk back into place?
A. Yes.

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Q. If you can?
A. Yes.
Q. Have you described for us the different kinds of techniques that you have attempted to utilize to accomplish that purpose in the case of a disk prolapse?
A. Yes.
Q. Have you ever treated a patient with a herniated nucleus pulposus?
A. Yes. That would be the disk prolapse.
Q. So this is one and the same. All right. But you have also told us that in some situations a patient might have a prolapsed lumbar disk that may be sufficiently severe that it raises a concern about cauda equina syndrome, and those patients get referred out; is that true?
A. Well, both, either cauda equina, or even the specific nerve root itself is amply compressed. You have to be cautious on it.
Q. What are the signs or symptoms that a patient will have that will cause you to not want to treat, but instead you decide that you cannot treat and instead refer the patient out?
A. Well, if the person were to come in with dribbling or incontinence, you have to consider

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spinal cord involvement, in some way along the cord, if they are basically troubled with bladder or bowel control.
Also, if they were to have a clear picture of disk prolapse, if they had significant neurologic dysfunction as far as like motor weakness and numbness, that is the kind of case where you would want to consider referring out pretty much quickly.
But even that, if you have the MRI back and it was still approximated to the disk space, since I have the patient set up with a neurosurgeon, then I would still attempt a mild distraction type of thing to see if I could suck it off of there.
Q. You told us in cases where you have bowel or bladder involvement you would want to refer the patient out.
A. Yes.
Q. But then you said that if they have a disk prolapse, you just told us a few minutes ago in case of a disk prolapse you might well be able to treat successfully. Is that true?
A. Well, the word disk prolapse, in itself, is its own topic. You can prolapse a disk and cause

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cauda equina, or if you prolapse a disk and it is off to the side more and not causing cauda equina, then you might be able to pull it off there. Even amongst that, you have to determine how much of it there is.

Q. How much disk is extruded versus how much is still intact?

A. Yes, and what kind of problems neurologically they are having. There is a very short window of time when you lose a patient, and even then there is a variable factor there, so you have to carefully monitor them as you are going, because the surgeon will start doing their thing, set them up for the surgery, and that is the window of time you can work with them, I feel, as long as you are doing it safely and consciously.

Q. Have you had patients who have had a disk prolapse and had some degree of neurologic involvement, but you have elected to treat them in your office and not refer them out?

A. With a prolapse?

Q. Yes.

A. No, I can't say that I have. I might say that we set up the referral, and then, depending on the case, I will treat them the way I have described.

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And there are a certain amount that you are able to save them from it.

Q. So you are indicating that in every case of a patient with a lumbar disk herniation that is noncontained you make an immediate referral to a neurosurgeon so that the neurosurgeon is working the patient up or preparing them for surgery, but at the same time you will, in some of those cases, continue to treat, yourself, in the hopes that your treatment might relieve the situation and save the patient from surgery?

A. Yes and no. The yes part is yes. The no part --

Q. What do you mean, "The yes part is yes"? That makes no sense.

A. Let me try answering it a little bit, then. Basically, it depends on where the nerve is. The spinal canal has a wide range to it. So if this disk prolapse is sitting out and causing some real focal nerve compression --

Q. Can you be specific?

A. If the nucleus is herniated out and causing a good deal of nerve problems.

Q. When you say "out," I mean it can be central, midline, to the right?

A. Lateral, because the nerve root is going to be in

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the lateral recess, well lateral and side. Then you have to determine how much neurologic compromise they have.

Now, some people you don't have time, and it is an immediate referral, and they will do surgery in a relatively short period of time after that. Some people, if you don't have as much, you have a little bit of time to work with them, but being very cautious of what you are doing.

Q. What if the disk is protruding out in a different direction, central, for example?

A. If it is central, for example, and not causing neurologic compromise -- there is a difference between orthopedics and neurology.

If the neurologic system is not involved, and you are just dealing with an orthopedic disk prolapse, not compressing any nerves, then I don't see where that is a neurological referral. If they are not having any neurologic compromise, once the disk is prolapsed and it is exposed, with time that disk can *dry* up.

When a disk prolapses, two basic things happen. One, when the disk would fragment out, it loses its nutritional supply through the endplates, so the nucleus itself, being water

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concentrate, once you fragment out this disk, this fragment can start to *dry* out, dehydrate.

Q. Desiccate?

A. Yes. Secondly, the nuclei are foreign to our body when we are developing in the uterus, so once the nucleus gets out of the disk, the body recognizes it as being foreign body, attacks it, and tries to get rid of it.

So if it is not compromising a neurologic structure, the fragment can *dry* up, and it is called a disappearing disk.

Q. In your judgment, what was the status of Jan Glasser's disk when she started treating with Dr. Abood?

A. I would say it is fairly representative of what we see on the MRI with this disk prolapse, but slid behind the vertebral body with only mild compromise of the neurologic structure.

Q. So it is your judgment that the patient had a prolapsed noncontained disk at the time she began treating with Dr. Abood?

A. Yes. Based on the MRI reports, yes. A large amount of the herniated disk material --

Q. Which MRI report are you referring to?

A. July 30, 1994 talks about a large amount of the

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herniated disk material lies behind the L5 vertebral body.
Q. And you interpret that to be a reference to a prolapsed disk?
A. Yes, extruded nucleus. I am trying to look for the different wording that they use here. I am sorry, go ahead.
Q. Was there a piece of free fragment of disk present in Jan Glasser's lumbar spine, again, before she began treating with Dr. Abood?
A. We don't know that one way or another from these records because there is always a chance of some of this nucleus still being -- that is coming out here, some of this nucleus still being attached to what is in here. So we don't know if it is a free fragment, if there is still some attachment or not.
(Thereupon, Defendants' Exhibit 8 was marked for identification.)
Q. Doctor, I have just marked as Defendants' Exhibit No. 8 this -- what should we call this?
MR. RUF: It is a colorized MRI.
Q. It appears to have been prepared as perhaps a trial exhibit to show comparative views of the patient's MRI findings from July of '94 and

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October 7, 1996. And you were referring to the image on the left-hand side of that exhibit --
A. Yes.
Q. -- as being a representative image, if you will, of the patient's MRI from July of 1994. Is that right?
A. Yes.
Q. So I was asking you the question: How would you characterize this patient's disk prior to the start of treatment with Dr. Abood? And you state that, in your judgment, it was a noncontained prolapsed disk?
A. Noncontained disk herniation, which can also be called a disk prolapse.
Q. And I was asking you if there was a free fragment that was in front of the L5 disk.
A. I can't tell you that it is free or not because a free fragment means that it is not attached to anything.
Q. That's right.
A. And so we don't know if this is still attached via the nucleus in there or it is not. We do know that it is quite a bit further down there.
Q. Why do you consider the patient's disk condition to be noncontained as opposed to contained?

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A. It is a noncontained disk because it has actually come out of the disk space and has migrated down, so we just know that it is a noncontained.
Because if it was still a contained disk herniation -- let's use this one as an example -- it would not go beyond the outer layers of the annulus if it was contained.
Q. You have indicated to us that you have, in your practice, treated patients who have had noncontained disk prolapses, such as what Mrs. Glasser had?
A. Oh, yes, sure, yes.
Q. And have you treated such patients with a noncontained herniated disk at the L4-L5 level, which is apparently what she had?
A. Sure, yes.
Q. Have you treated such patients without referring thein to a neurosurgeon for thein to be worked up by a neurosurgeon?
A. As a general rule of thumb, if there is neurologic compromise like that, generally I would set the patient up to see a neurosurgeon, as a rule of thumb. I ain thinking of just a recent case where it didn't need to because we had such -- the compromise was very ininiinal to none, very ininiinal

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neurologic compromise.
Q. Let's again confine it to Mrs. Glasser. In her situation, what is your judgment or estimation of the degree of neurological compromise that she had at the point in time when she began treating with Dr. Abood?
A. I would say there is mild neurologic compromise, and I would say she was stable based on history. In her kind of case, you are asking me if she came to me what would I do?
Q. Yes.
A. I wouldn't refer her at that point because she has had that now -- this is a '94 MRI, so she has had this for a while, and she starts back in to Dr. Abood in August of '96. This is two years later. So this patient has been stable for two years.
Q. So if Mrs. Glasser came to see you, or a patient with her profile came to see you, you would elect to treat the patient?
A. Yes, at her current status, at that current status.
Q. In your practice, and in your experience, how many such patients of Mrs. Glasser's profile have you begun to treat in your office?

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A. I don't have an accurate record, but it would be less than ten, but there are more than a few.
Q. So less than ten such patients in all of your 16, 17 years of practice?
A. Yes, ten. It could be ten. I mean, it is more than just a few. It is not a real rare type of thing, it does happen.
Q. Have you had occasion to give --
A. I am talking -- I want to clarify. You are talking just low back? We are not talking cervical at all?
Q. When I refer to Mrs. Glasser's profile, I am talking the condition in which she presented herself when she started treating with Dr. Abood.
A. Of that, maybe ten over the years, a ball park.
Q. Including whatever degree of neurologic involvement she had, L4-5 disk prolapsed, based on the MRI, that is the profile I am trying to call to mind.
A. Her type of thing, yes.
Q. And in your years of practice and experience doing consultation for other chiropractors around the state who have come to you for a second opinion, have you seen patients that fit her profile where you have been asked to comment on

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or give a consultation on how a chiropractor can continue or whether they should continue to see this patient?
A. Oh, yes.
Q. And if we consider the population of such patients that you have seen in consultation from other chiropractors, how many such patients would there be in your years of practice?
A. Maybe that many more again, if not more than that.
Q. Of the patients in your practice, ten, let's say, who have presented to you in Mrs. Glasser's profile for her type of a condition that you have begun to treat, in how many of those ten cases were you successful in relieving the patient's acute symptoms solely through chiropractic treatment and without the patient needing any referral to a neurosurgeon?
A. Three. One just recently. Well, still most are set up with the neurosurgeon because there is a very narrow window of time.
Q. All right. I want to make sure I have these numbers straight. So of the ten patients or so that have come to you with her profile over the years in your private practice, have you, in

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those instances, treated those patients or started to treat those patients strictly using chiropractic and without setting them up yet or making phone calls to arrange for any neurosurgical involvement?
A. Yes, I have treated people like that.
Q. Is that the number ten you gave us, ten would be the number of patients where you have taken them into your office and started to treat them solely on a chiropractic basis, believing that based on their profile and their history and their symptoms that you could help them chiropractically, and that they would not, at least initially, need a neurosurgical consultation or a referral?
A. Not on that date, that's correct.
Q. Now, those, again, ten patients where you started to treat them chiropractically, you told us that approximately three you were successful in giving them relief of their symptoms, so those three never needed to go on and see a neurosurgeon, as far as you know?
A. The appointment would be canceled.
Q. The remaining seven would go on to require some involvement, or at least workup with a neurosurgeon; is that true?

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A. Yes.
Q. Of those seven, do you know if all seven underwent surgical intervention?
A. To the best of my memory, yes.
Q. And they received surgical outcome to their case?
A. Yes.
Q. Of any of those seven, did they ever come back and treat with you after that?
A. You know, they may have for different type of things. I don't recall. They may have come back for mid-back or neck. I don't keep records of that.
Q. Of those seven that went on to be worked up by a neurosurgeon and then operated upon, do you know if in those seven cases the surgeon took any further imaging, MRIs or CT scans, of the patients that you had just sent to them before or around the time of the operation?
A. Oftentimes we will have an MRI or CAT scan done right away, so oftentimes they will walk in with that.
Q. I know. And my question is: Do you know if the surgeon ever repeated the MRI prior to or at the time of the surgery as part of his workup?
A. I have seen where they have done -- not the MRI,

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I have seen where they have done myelogram. But they don't even do myelograms that much anymore. Usually they are relying upon the MRI, but they are so refined now.
Q. I know. But my question --
A. Rochester Mayo, I think that is their protocol,
Q. Most hospitals do, I just wanted to see if that has been your experience.
Have you ever had occasion to look at those patient repeat films?
A. No. I just get the reports back from the surgeons.
Q. Now, we began this discussion talking about these ten patients fitting Mrs. Gasser's profile that initially came under your care where you felt that you could, under your training and experience, be able to give them relief through chiropractic means; is that true?
A. Yes.
Q. Seven then went on to require further involvement with a neurosurgeon. These are the patients, again, all starting with the same basic profile. Of the three that you were successful in relieving their symptoms, approximately what was the average amount of time where you cared for

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those three before you achieved relief of symptoms?
A. Generally the relief you want to see within the first few days or a week, because you are dangerously close to the line.
Q. Why are you dangerously close to the line if the patients are coming in with the profile with a stable, mild to moderate neurologic involvement in a generally thought to be stable condition?
A. With this kind of condition, there is no close to the line as to the way it is.
Q. I am *sorry,* they are --
A. They are not. This exact what she has here, they are not close to the line. The close to the line comes if they herniate further disk out onto the nerve root itself. Then they will have enhanced neurologic symptoms. Then they are dangerously close to the line. But this type of thing here --
Q. As we see on the left-hand side of Exhibit 8, based on the date of --
A. This is not close to the line. She had this stable for two years. If the neurologic symptoms hadn't changed in this type of person, I would not set up with a neurosurgeon right away.
Q. Again, this is the patient on the left-hand side

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of this Exhibit 8?
A. Yes.
Q. You would not necessarily set her up?
A. Yes. And the only reason I would set her up is if the leg complaints changed. If this woman got bad, if she herniated out further nucleus, then you set her up with a neurosurgeon because you are running close to the line of infarct within the nerve root.
Q. Have you had patients that have been under your care, these seven patients that you ultimately referred, I presumed that you ended up referring them because they continued to get worse and not better as you attempted your chiropractic treatments or adjustments?
A. I can't say that they necessarily get worse. They, many times, come in with a fixed neurologic deficit.
Q. Again, we are talking about the ten patients that come in with basically the same profile.
A. No, I have been talking about cases where they have an acute disk prolapse that is a brand-new entity.
Q. That is exactly what we have been talking about for the last 15 minutes.

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MR. RUF: Let's stop. Doctor, to this point, what have you been talking about? Let's put on the record what your understanding was.
Q. I thought that my questions were fairly clear.
A. I just misunderstood them. That is my fault.
Q. Then let me start fresh. Have you had, in your experience, patients who have come to you in Mrs. Glasser's profile, and by that I mean a patient who has had a noncontained disk herniation in the lumbar spine with some mild to moderate but apparently stable neurologic complaints or involvement, and have you undertaken to treat those patients chiropractically in your practice?
A. Yes, I have.
Q. And the number ten, is that an accurate estimate of the total number of patients who you have treated in that manner?
A. It would be more than ten that have her exact type of case scenario going on for two years. I was in a different thought process of a brand-new disk prolapse, something that is brand-new and different.
Q. We are talking about a patient with her profile.

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A. No, there would be more than ten.
Q. Can you give me an estimate of the number of patients that you have treated?
A. More than ten, less than 50, I am sure.
Q. I had also asked you sort of a corollary question. Have you seen patients, again, with this kind of profile, who have been presented to you by way of referral from chiropractors in the state, who have come to you asking for opinion or thought as to how they can be managed?
A. Yes, when they are stable like that.
Q. This profile. This is what we are defining as "this profile."
A. More than ten, less than 50, again.
Q. A similar number?
A. Yes.
Q. Now, returning to between the 10 and 50 number of patients who you have seen come into your office and present themselves to you, have you undertaken to treat those patients chiropractically?
A. Like Jan's case?
Q. Like Jan's case.
A. Yes, I have.
Q. Do you immediately refer out all 10 to 50 patients?

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A. No.
Q. You believe there can be some chiropractic treatment that can be provided to these patients and offer them some potential for relief of their symptoms?
A. Yes, as long as there is no new or different change in the neurologic status. If they come in and say, "I have had this for a couple years, some days better, some days bad, nothing has really changed a whole lot, I was wondering if you can help," no, I wouldn't send them out to anybody.
Q. And what would be, in general, your approach to treatment? What would be some of the techniques that you would consider using, those that we have already discussed here today?
A. Yes, that is what I would do.
Q. Now, of those 10 to 50 patients that have come to you in her profile and you think, "I can help these people and I will try to do so," have you had occasion to refer out any of those patients to a neurosurgeon because their symptoms did not respond to your treatment efforts and they were becoming increasingly symptomatic?
A. If they become increasingly symptomatic, that

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means possibly something new and different has happened. Then that is a different category.
Q. That is what I am asking you. I am trying to follow them through longitudinally. You start with the 10 so 50. How many of those have you had to refer out?
A. If they had not changed, and it is the same pattern, oftentimes you will offer or say, "You have a right to a surgical referral to see if you want to do this or not." Oftentimes patients deny that.
There are too many -- unfortunately, there are stories of people that didn't turn out so well. Oftentimes with her kind of case they will deny that, they don't want to do it.
Q. They stick with you?
A. Right, or I may get to the point where I am not doing anything, and they just quit.
Q. You have had patients where they come in say, "I have had these complaints for a while. Some days better, some days worse. Basically, I am overall stable"?
A. Yes.
Q. And those are the patients you attempt to provide treatment?

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A. Yes.
Q. In the course of your treatment with these patients, is it true that even during the course of your treatment some days may be better, some days may be worse as you are attempting to treat them chiropractically?
A. Sure.
Q. And you will have some of these patients where you have a discussion with them about, "We could refer you to a surgeon," and some of the patients may opt for that, and there may be others that say, "Let's stay put with you, I don't want to go the surgery route," and they continue to stay on and treat with you; is that fair?
A. Yes. But there may be a time that I dismiss them as a patient if something new or different is occurring with them. If something is changing, I may refuse to be part of their health care at that time. At that time I will refer them on, even refuse to schedule them, send them a certified letter.
Q. I understand. But assuming they are not developing anything remarkably new or different, but just some days better, some days worse, sort of bumping along on a fairly stable pattern, some

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days better, again, some days worse, but generally not doing any markedly progressive deterioration, you will continue to treat them, and they may want you to continue to treat with them?
A. Yes.
Q. But some patients, despite your best efforts at treating chiropractically, their condition while under your care will deteriorate and they will show signs of something else going on getting worse?
A. That means something new or different happening.
Q. Exactly.
A. So you are talking a new or different thing.
Q. I am talking patients you try to start out treating them effectively, but something new or different comes up while under your care and you determine this patient needs to be referred out?
A. Correct.
Q. And in that case you will send them to an orthopedic or neurosurgeon?
A. Neurosurgeons always.
Q. That is where you go, neurosurgeons?
A. Yes.
Q. In the cases where you refer to the neurosurgeon, something new has come up, these patients are not

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getting better, in fact, they are saying that something is worse, will you continue to treat them at all, or do you simply make the referral and you are hands off?
A. That is a different situation. Oftentimes they are hands off at that point.
Q. What are the kinds of symptoms or things that you have seen in patients to have, in your experience, developed in terms of signs or symptoms that make you think, "We have something new going on here, and we better get this patient off to see a neurosurgeon"?
A. Well, you can have a marked increase of leg pain, for one thing. Leg pains happen for a specific reason. Generally, it can be due to an enhanced disk herniation. It herniates more, still contained.
Q. Now, we are talking noncontained.
A. Or if it is a noncontained --
Q. That is how we started here, Doctor, noncontained.
A. Then it could be due to further nucleus herniated out. The nucleus causes two effects. One, it has a mass effect. Second, it has a biochemical irritant.
Q. Doctor, I am talking about the signs and symptoms

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when a patient comes in Monday, say you saw Mrs. Smith, she was doing pretty good, much the same as she has been, but Wednesday she is back to see you, only Wednesday now things are worse, something has happened, and now she is complaining of it being worse.
Tell me from the signs and symptoms standpoint what are the kinds of things that the patient presents to you that make you think "This patient needs to get referred out right now." Bowel and bladder involvement?
A. That is guaranteed. Leg numbness, weakness of the nerve root, the muscles involving the nerve root, or enhanced leg pain.
Q. Now, in those situations, might you continue to treat those patients conservatively, sort of in tandem with the neurosurgeon who is going to be working the patient up?
A. On a case-by-case basis, yes.
Q. And I presume bowel and bladder --
A. Bladder, no, that's correct.
Q. But maybe with just increased weakness you can aid the patient chiropractically while the neurosurgeon is doing the workup?
A. That's correct, on a case-by-case.

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Q. What is your understanding of the facts of this case as it relates to Jan Glasser's course of treatment while she was under Dr. Abood's care?
A. I am sorry?
Q. What is your understanding of Jan Glasser's case and how her condition -- I am trying to think of the right -- how her condition manifested itself while she was under Dr. Abood's care from August to September of 1996?
A. First, the first history from Dr. Abood shows some neurologic compromise, leg cramps, muscle spasms.
Q. That is how she presented?
A. Yes.
Q. Can you tell me, just in general, from your knowledge of the records or your knowledge of this case, in a very general way, how did she do when she was under Dr. Abood's care?
A. She progressively deteriorated, plateau by plateau, continually going downhill.
Q. That is based on what? What have you reviewed and what have you assessed to come to that opinion that that is how her condition changed?
A. Her deposition. I also read Dr. Reed's deposition, talking about the last month has been

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bad. Also reading the different physical therapists at Mt. Sinai. They talked about in the last period of time it has been getting bad. Some of the different -- the surgeon, Dr. Likavec, talked about the last month it has been getting bad.
Q. I am sorry, go ahead.
A. Maybe Dr. Lepp had a reference in there, too, about getting bad.
Q. In terms of getting bad, can you be any more specific in terms of the signs or symptoms that Mrs. Glasser had?
A. Leg pain, leg pain getting bad with increasing weakness and losing the ankle reflex.
Q. Anything else? Any other signs or symptoms that she demonstrated while she was under Dr. Abood's care? You have given us leg pain.
A. Increasing leg weakness.
Q. And you said she lost her ankle reflex?
A. Dr. Likavec, the surgeon had commented on that. She was losing that as a mass effect. Dr. Reed talked about the increasing leg pain, I believe. But Jan also talked about, and so did Dr. Abood, about times of really bad leg pain.
Q. You said that. I am looking for anything else,

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any other new or different symptoms besides her complaining of increasing leg pain, increasing leg weakness.
A. Yes.
Q. And loss of ankle reflex.
A. The losing ankle reflex, the first time that is documented is with the surgeon, Dr. Likavec.
Q. So that did not happen while she was under Dr. Abood's care?
A. The loss of reflex, nobody was checking it. We don't know what the ankle reflex was doing because nobody was checking it. So I can't comment.
Q. So it is your opinion that when a patient presents with Mrs. Glasser's profile, and then complains of increasing leg pain and increasing weakness in the left leg, or the affected leg, that it is a patient who has to be referred out immediately for neurosurgical involvement?
A. I would set them up, yes, I would.
Q. You would not continue to treat?
A. I may continue to do distraction type treatment, yes.
Q. So, in your judgment, such a patient becomes a surgical candidate, but also still a candidate

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for chiropractic treatment, as well?
A. On a day-by-day basis, if they continue to deteriorate, no, I am out of there.
Q. When you say "deterioration," what would you be looking for in terms of --
A. Either leg pain or neurologic symptoms.
Q. What other neurologic symptoms?
A. Leg weakness.
Q. She already has leg weakness. What would you look for in terms of deterioration that would make you stop wanting to treat this patient?
A. Even more weakness in the leg group, tingling, numbness, losing reflex. Then, of course, you would be watching either their presentation as far as their antalgic lean, how they are physically doing, perhaps like the straight-leg-raise test, which can be manifested in how they are moving, also.
Q. And if it becomes positive, that is a bad sign, right?
A. Well, changing, increasing is a bad sign, that is something at that time, and I am not going to continue treating them, no.
Q. Do you believe that there is any evidence in this case that Jan Glasser developed numbness or

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tingling anywhere in her body while she was under Dr. Abood's care?
A. No.
Q. Did she develop an antalgic lean while she was under Dr. Abood's care?
A. I believe she probably did.
Q. Did she have that all along?
A. He was the only person assessing her all along, and, unfortunately, that type of thing is not documented.
Q. Did Dr. Reed say anything about that?
A. That she came in with antalgic lean, yes.
Q. Is there any indication of losing reflexes?
A. Again, it wasn't really being assessed, so we don't know.
Q. Any indication that she was developing weakness while under Dr. Abood's care?
A. Again, the patient reporting it happening, but it was not really assessed, so we don't know.
Q. Any evidence that she was developing leg pain while under Dr. Abood's care?
A. Oh, yes, quite clear in the history both from the patient, Dr. Reed, and other physicians also commented on the leg pain.
Q. Speaking of Dr. Reed, is it your understanding

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that he was the subsequent treating chiropractor?
A. He still considered Dr. Abood to be the treating doctor.
Q. But he did offer some therapies to the patient, so he did try to help relieve some of her symptoms in some capacity?
A. Yes, I believe he did. I would have to actually go back and recall.
Q. And in terms of just the chronology, the patient was referred to him by Dr. Abood?
A. Yes.
Q. So Dr. Abood had been caring for Mrs. Glasser, and then there came a point where he referred Mrs. Glasser over to Dr. Reed?
A. Yes.
Q. And then from Dr. Reed, where did the patient go?
A. To the surgeon, to the medical system. I don't know that Dr. Reed did therapies. If he did, it would be more of just the real passive modalities.
Q. Again, in the patients in the 10 to 50 patients in your experience where you have started to treat them but then they do develop some new problems or new symptoms, signs of deterioration that make you want to refer them out, in each of

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those instances, did you feel that you committed malpractice because the patients got worse under your care and did not get better?
A. No. Just because a patient has something new and different happen to them, not assimilated with me, if that were to happen, that is not my fault. If I were to be doing -- realizing what they have, and I am doing the wrong type of adjustment for that type of condition, and I fragment off the disk more, yes, then I would have considered myself malpracticed, negligent, or whatever.
Q. Patients with lumbar disk disease, those patients can get worse and not always get better, even under the best of care and with the best of experienced hands treating them; is that true?
A. They can -- yes.
Q. Do you have any opinions that you hold in this case, based on your review of the entire file materials, that Dr. Abood deviated from the standard of good chiropractic care in any way in which he dealt with Mrs. Glasser?
A. Yes.
Q. What are your opinions?
A. One is disregarding her actual neurologic

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complaints. I felt that fell below the standard of care.
Q. What do you mean by that?
A. Well, this woman comes in, and in his own forms she describes leg cramps, muscle spasm in the leg, which describes a neurologic deficit.
He does his own testing and actually finds a problem on the other side of the body, and he ignores what the patient is actually telling him.
Q. What do you mean he ignored her?
A. Well, the patient's picture is quite clear. Yet when he has done his own testing, he finds problems on the right-hand side, disk problems in the low back. He does not regard, does not consider, her leg complaints when he is treating her.
Q. How do you know that he is not considering them?
A. He talks about -- basically, the highlight is that on page 80 of his deposition he says he does not look for progressive neurologic, he looks for the subluxation.
So this woman has definite leg problems, she is getting worse, and he does not regard that. He says he is only looking for the actual alignment of the bone.

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Basically, I feel that falls below the standard of care. Her neurologic status is deteriorating, and he is not even regarding it. He does this testing that doesn't reveal it, but if someone tells you so bluntly, "I have this problem here," and you choose to ignore that, then you run into problems with that.
Q. So based on this reference at page 80 of Dr. Abood's deposition, you conclude that he was disregarding the patient's neurological complaints?
A. Well, also starting with the first day when he first starts with the assessment of treatment. Then as you go through and you read the patient's -- putting some credence on the patient's subjective complaints, she is actually complaining of the leg pain getting worse, which is consistent with the actual outcome.
Her actual pre-scan information is totally consistent with what the end result MRI is.
Q. Say that again.
A. Her complaints of the ever-increasing left-sided leg pain, increasing problems on the left, nerve problems, those complaints that she is telling us --

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Q. At the beginning of her care with Dr. Abood?
A. No, as it is deteriorating. These complaints here are consistent with the left-sided picture. But if you read through her complaints, her subjective description of what was happening to her, also considering what Dr. Reed also commented on, those statements are totally consistent with what the end result MRI shows us.
Q. What do you mean, Dr. Reed coimnented on, what he commented to be her physical condition?
A. Well, coimnented about her subjective coinplaints as far as the leg is getting worse, her antalgic lean, to start with.
(Thereupon, a discussion was had off the record.)
Q. I need to get to the high points here.
A. The meat and potatoes.
Q. What are the deviations froin the accepted standard of care? You think he disregarded her neurologic complaints?
A. Yes, and disregarded it as he is treating her, too. And realizing that her subjective complaints, and Dr. Reed, and everyone she saw before the MRI, they describe this.
Q. And by "this," you are referring to the right-

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handed picture of Exhibit 8?
A. Yes. That shows the large disk fragmentation prolapse. Before they even have an MRI to refer to, they are all describing a picture of a progressively deteriorating neurologic condition.
Q. And these are the care providers that saw Mrs. Glasser after she saw Dr. Reed?
A. Yes. And Dr. Reed, of course, as far as what he saw as far as the antalgic lean and what Jan lays out along the way, and that is all consistent with what the end result MRI is.
Q. Any other deviations?
A. Of course then also the failure to diagnose it, too, by disregarding her neurologic complaints. He is only focusing in on the back. And at different parts in his deposition he talks about assessing just the back, only considering the back. He talks about disregarding the disk prolapse. He is only going to regard the subluxation.
Q. Are his comments consistent with the straight chiropractic view of chiropractic?
MR. RUF: Objection.
Q. As far as you know, or don't you know?
A. I teach doctors that are straight doctors of

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chiropractic.
Q. Say that again.
A. I teach doctors from the straight school.
Q. I am not asking that. Do you know, based on his comments, whether those are consistent --
A. No, I can't say.
Q. -- with a view held by chiropractors trained in the straight school of psychiatric?
MR. RUF: Objection. That is not necessarily the acceptable standard of care.
A. His comments are more unique. Even straight schools, for example, Sherman is a very straight school, they use my Orthopedic Spinal Exam, the book, for their textbook in course work, and in that they teach neurologic assessment.
His comments are unique to himself. You may find scattered people such as him, but I would find that to be a very rare entity.
Q. Any other deviations, anything about his technique, or anything about how he managed her care, aside from what you point out as being the failure to make the diagnosis?
A. I believe probably the correct technique for the wrong condition. His technique may be technically fine, but it is the wrong -- how would you say

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it? The right treatment for the wrong case, or the wrong treatment for the right case.
Q. What do you think --
A. By doing the lumbar rolls.
Q. Assuming that he did the lumbar roll, as we talked about earlier in the deposition, why would that not be appropriate for her condition?
A. He does admit to it. He denies that he does the rotation, but he describes it for you. He actually -- I am *sorry,* I know you are short on time.
Can you tell me what the question was again?
MR. RUF: She asked why the lumbar rolls would be improper.
A. Because it squeezes out more disk material. This is a noncontained disk herniation, it is not contained. So with the noncontained disk herniation, with a lumbar roll, you can actually twist out, prolapse out further material, basically.
And there is no other injury mentioned anywhere. Nowhere have any treating providers up to this point that I have seen in here stated "She raked the yard, that is the problem," or did this or she did that, "She really did herself

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in." No one has brought up any kind of trauma or injury or mechanism besides these treatments as being the cause of the prolapsing of the material.

Q. In your experience, Doctor, isn't it true that patients who have lumbar disk conditions, such as a noncontained disk herniation, can aggravate the condition and it can become worsened or more extruded, if you will, through simple movements, activities of daily living, sneezing, bending over funny, lying in bed funny, things like that? Isn't that true?

A. There is a difference between aggravation and new prolapse. Aggravation means to make what you have worse.

Q. And can't -- all right.

A. And this means you are actually prolapsing further material. And can that kind of thing happen?

Q. Can a disk further prolapse through the activities of daily living?

A. I have a hard time believing she could do anything to get there, to get that.

Q. No. Can you move from an extrusion or prolapse to a larger prolapse through activities of daily

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living?

A. You would have to --

Q. Turning funny, lifting, moving?

A. There, no. Carrying a 55-gallon drum and twisting, yes. But basic activities during the day, I have a hard time believing that.

Q. You have never heard of a patient having a protruded disk, protruding their own disk in just activities of daily living?

A. But you are not talking protrusion, you are talking a massive prolapse. I know you are short on time, but protruding means it only goes beyond the wall of a vertebra. So a disk herniation, contained or noncontained, to protrusion just means the annulus goes beyond the wall of the vertebra.

But a simple activity of daily life is not going to give you this, no. Can a person have a simple activity of daily life and prolapse a small amount of disk like this? Yes.

Q. So the activities of daily living can cause a disk prolapse, such as what we see on the left-hand side of this page?

A. Sure they can.

Q. But what you are taking issue with is the degree

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of prolapse and whether the amount extruded can increase significantly from what we see on the left-hand side to what we see on the right-hand side through the activities of daily living?

A. Right.

Q. And you have never seen a patient present with a disk prolapse of a substantial size merely through activities of daily living?

A. Of that size?

Q. Yes.

A. No.

Q. Have you ever seen this develop through simple activities of daily living?

A. No. I have seen disk prolapse, but not to that magnitude. I am talking about what we normally do during the day. I have seen people be on the losing end of a washing machine going down the stairs, and the other guy drops their end, and they lift and torque, they will get this.

But have I seen someone who goes and rakes a yard and gets this? No. Have I seen these kind of things before? Yes, I have. But usually it is a unique situation. I am trying to think of the different cases that I have seen like that.

Q. Are you going to express any opinions on the

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permanency of Mrs. Glasser's condition, or will you with defer to the medical doctors to speak to that issue?

A. The neurosurgeon, the treating neurosurgeon, is the one that I am going to defer to, as they are in the position where they saw the patient at the time of surgery, they saw the MRI, they saw the actual fragment during surgery. So the treating neurosurgeon is actually the one in the position to make the call as far as what happened from this MRI to when he physically took it out. And since he is actually treating the patient on follow-up, he is in the best position to talk about permanency in this case.

Q. Are you going to express any opinion as to whether any of Mrs. Glasser's current symptomatology is related to the care she received by Dr. Abood?

A. Yes.

Q. Or are you just going to confine your commentary about her symptomatology to the time period when she was being treated?

A. No. I can give an opinion as to the facts that I see as to her current symptoms, her symptoms, up to the records I have. as to the treatment.

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Now, the numbness came on in the time period before surgery, but there is a difference between injury versus symptoms. This disk fragmentation is consistent with what the neurosurgeon commented on in surgery. So the mass effect of the prolapse was there.

Now, there is a difference in people between injury versus symptoms. So she gets this fragmentation prolapse, and then she starts developing new neurologic symptoms once the mass effect has been there for a while. But it is the spinal adjustments that prolapsed the disk causing the injury.

The symptoms may vary depending upon what happens in this time frame. So her neurologic symptoms that she had, as far as the perineum and the leg complaints and the subsequent scar tissue that the new MRIS have shown is a result of this here. For not this here, she never would have had the numbness.

Q. You are referring, again, to the 10/7/96 MRI?

A. Yes. I am sorry.

Q. How do you know that the image that we see in the MRI of 10/7/96 is an accurate depiction of this patient's spinal column and her spinal condition

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when she was actually under the care of Dr. Abood?

A. We know by history of both, the patient follow-up with Dr. Reed and the other providers that saw her, of the progressive deterioration neurologically of this left side. We know that the symptom pattern didn't change, except for the numbness. There wasn't a day where it was gosh, she got out of the car and it really did her in. No one has identified a new injury, a new incident, a new anything. Everyone is relating back with history. This is all the same thing, progressive deterioration.

Q. They are all taking the history from Mrs. Glasser.

A. Yes, they are all uniquely taking it. But there is no coincidence that her complaints pre-scan are totally consistent with a mass effect MRI.

Q. Isn't it possible that the MRI findings that we see on 10/7/96 and this degree of prolapse, that this condition reflects a further worsening of her disk, further extrusion of that disk?

A. It is.

MR. RUF: Objection.

Q. Between the time that she last saw Dr. Abood and when this image was taken on October 7, 1996.

MR. RUF: Objection as to

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possibilities.

A. Do I answer that or not?

Q. Sure.

A. The fact is that we have this 10/7/96 MRI finding, the surgeon goes and surgically makes no other comments that "This is totally -- we have this MRI, but, my gosh, there is more here."

Q. No, no, no, I think you are misunderstanding my question. How do you know that this condition, as depicted on this MRI of 10/7/96, that her condition did not worsen between her last visit with Dr. Abood and when this picture was taken?

A. There are no subjective or objective changes on exam or history anywhere in the records that would state her clinical status deteriorated, except for the onset of the numbness. No one has cemented on anything further or identified a new injury.

Q. You don't think the onset of numbness would correlate with extrusion of that disk material?

A. No. You also had a neurosurgeon that has the MRI presurgery. He has written a report that I reviewed, and also he has surgical findings and subsequent office notes. Nowhere has he identified that, compared to the MRI, in surgery

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there was a lot more in the surgery.

Q. Maybe I am being imprecise in my time frame. I am not talking about how her condition changed between 10/7/96 and 10/14, when she got operated on, although that is a fair question.

I am looking at the question of when she last saw Dr. Abood and when this image was taken, how do you know that this doesn't reflect a worsening of her condition in that interval, after she leaves Abood'is office and when the picture was taken on October 7 of '96?

A. Of all the doctors that examined her in that time period, if you compare their objective findings, their physical examination findings, there has been no dramatic change. You don't see any worsening of her symptomatology from the time she leaves Abood's office until she gets under the care of the neurosurgeon, except for the onset of the numbness.

Q. And does that correlate with further extrusion?

A. No. The onset of further numbness has to do with there is compression there.

Q. Sure, by further disk extruding.

A. Except the only thing that has really changed is complaints of numbness.

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Q. Exactly. More numbness correlate with more disk pressure.
A. No, because there are no other complaints, though.
Q. But isn't the onset of numbness significant enough in a new complaint to suggest that this disk is further prolapsing?
A. No, it is a sign that there is pressure going on.
Q. Pressure from what?
A. This mass, large mass effect, like in the MRI that we see here.
Q. Then why didn't she have the numbness the day before? In other words, why one day do we now have numbness when we didn't have it previously? Shouldn't that correlate with further mass effect, further pressure from this disk material extruding out and impacting on those spinal fibers?
A. There comes a day with nerve compression where there is a thing called a straw that broke the camel's back. It gets compressed, it gets stretched, and eventually you have problems with it. There is this window of opportunity that we have to treat these people, and that is what happens.

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Q. So you don't think that the new onset of numbness complaints correlates with any further enlargement of the protruded mass? Is that your opinion?
A. If there is any further enlargement, it is so minimal as to be nonexistent.
MR. RUF: You cut him off. He did not finish with the deviations.
MS. VANCE: I understand.
Q. (Continuing.) Is there anything else in terms of deviation?
MR. RUF: And failure to refer. You cut him off there.
A. Yes. Also I felt there should have been referral before that when she was deteriorating.
Q. At what point? Do you have a date in mind?
A. Roughly at the one month mark, in reviewing people evaluating, her comments that she made that, "I reached a substantial portion by the one month mark in the care." I know there is reference all over the place that she treated for three months, but she didn't. She had two months.
Q. I know that.
A. This fragment would not have gotten this large. So, actually, had the care actually been stopped or greatly modified way back into this thing, the fragment would have not gotten big enough anyway, possibly, to need a neurosurgeon's referral. It is the ongoing repetitious twisting lumbar rolls that fragments off further disk. Had they been stopped, actually, the lumbar rolls been stopped, the prolapsing wouldn't have gotten to be of big enough magnitude that she would have needed a surgical referral anyway.
But once it got to be a large enough mass, she should have referred anyway at this point a month into it because she is having all the leg problems and all of that.
Two things. If he had stopped, the fragmentation wouldn't have occurred, she wouldn't have needed the surgical referral, had he not kept on going, and not recognizing it, the one month referral, actually helped set the stage for her neurologic complaints at this time.
Q. Any other deviations from the standard of care that you see?
A. The wrong treatment, the lack of recognizing the leg complaints, lack of referral, would be in amongst -- the lack of recognizing that she had nerve compression in the back.

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Q. Any other deviations from the standard of care in terms of anything else that Dr. Abood did to or for or with this patient?
MR. RUF: You can refer to your notes if you need to.
A. He documents, as far as when the disk fragmented further, his records actually document about a month into the course of events he talks about, though I forgot to mention this, "The best it has been in seven years." That is a sign that the nucleus is fragmenting out even further. That is on page 65, 68 in his records.
The annulus of the disk itself is pain productive. So when it becomes overly stretched, you get low back pain. Once the disk is blowing out of here, you relieve the pressure, so the back pain actually relieves.
Q. Why is there back pain?
A. She still has a mechanical back problem in there, too. But the fact that the back pain is actually getting better is actually a sign of her disk prolapsing.
Q. Anything else?
A. I forgot to mention that. He did not watch the neurologic duration. I think that is basically

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it. Lack of referral. If he would have stopped, it wouldn't have needed the referral anyway because it wouldn't have prolapsed and she wouldn't have needed the surgery. Lack of assessment.

Q. You had indicated in your pad that you had some comment or some analysis of whether her residual symptoms are a product or a result of symptoms of neurological damage. What is your opinion on that point?

A. The scar tissue itself, to work backwards, you have the neurosurgeon does a new MRI and says, "My gosh we have a lot of scar tissue here."

Q. Which MRI are you referring to, the post-op?

A. Yes, and the one that Dr. Likavec read and says "I showed it to my partner." In it he says, "There is no change in numbness or neurologic change."

So we have all this enhancement of scar tissue, no new numbness or weakness, and no new pain. So if the scar tissue was causing numbness, you should have more numbness. And the fact is if you will read Dr. Likavec in followup letters, he writes, "The nerves come along in these people nine months after the fact."

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If scar tissue actually were a big set of her problems -- and scar tissue can cause problems, don't get me wrong, it can cause problems. But as far as the numbness and all this other kind of thing, he wouldn't be talking about the nerves can get better nine months later, because the scar tissue is going to stay, it is not going anywhere.

Plus, within a week or so after the surgery he talks in his records, the low back and leg pain was relieved. Scar tissue would be wrapped around the nerves. That is where the pain fibers are.

Q. You are talking in the immediate post-op period?

A. For example --

Q. You were just making a comment about the sudden relief of symptoms in the immediate postoperative period?

A. 2/4/97 letter to Dr. Frolkis. In the 2/4/97 letter, the leg pain and back pain are better, which, now remember the nerve fibers are on the outside of the sheath that wraps around the nerve. If her big focus of problem was scar tissue, the leg pain wouldn't have gotten better. He took out the disk fragment, not removing scar tissue from wrapping around there.

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So while she may have a lot of scar tissue in there now, and that scar tissue may cause problems in the future, the numbness that she is having in the groin, in the leg, and this weakness, was not due to scar tissue, it was due to the mass effect of the disk prolapse.

Q. How do you reconcile that with Dr. Gordon Bell's comments with respect to the fact that he attributes a lot of her symptomatology to the presence of scar tissue?

A. The key word in his record, he says "already." First of all, he doesn't know anything, he is going off the patient thing.

Q. What do you mean, "the patient thing"?

A. The patient history, the patient's reporting third party to him from what Dr. Likavec said. This is Dr. Bell's July 14, '98 record. The word is that "Already there was evidence of scar tissue present at the time of surgery."

But this disk prolapse had become significant roughly about a month or so prior. Plenty of time for scar tissue because of this to start forming. So no doubt there was some evidence there because it has been going on for a while. It has been going for a month prior to this.

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But the concern about: Is this scar tissue a cause of her numbness, the leg pain and back pain? Answer, I would say based on Dr. Likavec and the results, no.

Now, based on results, they take the disk fragment out, and the leg pain and the back pain get better. Now, scar tissue would be sitting on the outside of the nerve sheath, so the leg pain will continue.

If in this patient here, if the leg pain was due to scar tissue, it would still be ongoing. But the fact is that it is very clear that the disk fragment comes off and the leg pain gets better.

Q. Why does she have numbness and tingling if she had improvement as a result of surgery?

A. Tingling is nerves coming back, that is nerve regeneration. The numbness is actually there is nerve damage to that, which can come back, may or may not, I don't know yet.

Q. Do you have any opinion as to the cause of her current complaints?

A. I did not take a current history on her.

Q. Based on the way that she testified at her deposition as to her current complaints or her

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current feelings.
A. I would agree with the neurosurgeon, the treating neurosurgeon.
Q. You will defer to the neurosurgeon?
A. I agree with his records. His April 10, '97 talks about the nerve recovery, and July 15, '97 when the nerves are coming back. I would agree with the treating neurosurgeon that it is a nerve problem due to the mass effect of the disk fragment.
Q. As opposed to a scar problem?
A. Correct. And also remember now there is this post-op MRI that shows the massive amount of scarring. The neurosurgeon specifically states in there that there is no new neurologic complaints.
If scar tissue were her problem at this time -- I am not saying it won't be a problem down the line. But if the scar tissue were a problem right now on her, the enhanced scarring, that would mean that would have enhanced neurologic symptoms. That is not what is happening here.
Q. Say that again. The enhanced scarring means she does not --
A. Well, it wouldn't mean it would -- 11/18/97,

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Likavec's office notes, the MRI shows terrific amount of scar, yet he documents there is no significant pain and no increase of numbness.
So, if you were to conclude at this time that all her neurologic problems, or a big bunch of it were due to scar tissue, then you would take the next step and say you have enhanced scar, you must have more problems. But that is not the fact.
The fact is they take off the mass effect of the disk, and the back and the leg pain get better. If it was just scar tissue, she would have ongoing leg pain. Scar tissue sits on the outside of the nerve and they remove it -- I know you have to go. Once I get talking, you know --
Q. Have you ever performed this operation that Dr. Likavec performed?
A. No.
Q. Have you ever been present for such a surgery?
A. No.
Q. You have shared with me all of your opinions that you hold with respect to deviations from the applicable standard of care for Dr. Abood; is that true?
A. Yes, the ones I can think of yes.

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Q. And we have your notes. Any other thoughts or opinions are reflected in your note pad, Exhibit No. 6? Is that right?
A. Yes.
MS. VANCE: I do not have any further questions for you at this time. Should you be prepared to express any new or different opinions than those that you have discussed here today or that are reflected in your notes that we have marked as exhibits here at today's deposition, then we would ask to be notified of any new or different opinions that you might develop or formulate after this point in time so we could be prepared to depose you on those.
MR. RUF: I don't know if you have covered it, but I am going to ask at trial whether the treatment provided by subsequent medical providers after Dr. Abood was proximally caused due to his malpractice, and he is going to give an opinion at the trial.
MS. VANCE: Whether the medical care provider's treatment --
MR. RUF: Whether the medical treatment and expenses following the treatment by Dr. Abood was proximally caused by his

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malpractice.
MS. VANCE: I will object to that. I don't think he is qualified to get into that. You can take that up with Likavec rather than to put Dr. Dock in that position. Likavec will give you that. I am going to object to that witness --
MR. RUF: I am going to ask him, as well.
MS. VANCE: I am going to object to it, I don't think it is necessarily appropriate, given his background and credentials.
What I would like to do is make copies of all the exhibits so that you can return with your notebook intact. Perhaps Mr. Ruf's office can. Actually, we had 1 through 7, plus the diagram.
Can I just take Exhibit 8?
MR. RUF: Yes.
MS. VANCE: So I will take Exhibit 8, and ask for your office's --
MR. RUF: I will be willing to turn these over to the court reporter to make copies. I would like him to have his original notes.
MS. VANCE: He can take his original notes back. But I want to make sure we

have good, clean copies. If he needs to take the notebook, we can remove the handwritten pages with the binder and send them back up to him.

MR. RUF: Do you want to read or waive signature?

THE WITNESS: I will read.

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(DEPOSITION CONCLUDED.)

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DANIEL P. DOCK, D.C.

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CERTIFICATE

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

I, Diane M. Stevenson, a Registered Professional Reporter and Notary Public in and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness, DANIEL P. DOCK, D.C., was by me first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by him was by me reduced to stenotypy in the presence of said witness, afterwards transcribed by means of computer-aided transcription, and that the foregoing is a true and correct transcript of the testimony as given by him as aforesaid.

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

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

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this _____ day of _____ 1998.

_____
Dime M. Stevenson, RMR, CRR
Notary Public in and for
The State of Ohio.

My Commission expires October 31, 2000.

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