STATE OF NEW YORK : SUPREME COURT
COUNTY OF ERIE : PART 24

VINCENT J. TERRANA,

Plaintiff,

-vs- Index No. 814355-2015

JURY TRIAL
(EXCERPT)

THE ESTATE OF ROY L. NEALY, by and through JENNIFER G. FLANNERY, ESQ., as Administrator,

Defendant.

TRIAL TESTIMONY OF DR. WILLIAM J. OWENS, JR.

25 Delaware Avenue
Buffalo, New York
January 8, 2020

B e f o r e:

HONORABLE EMILIO COLAIACOVO
Supreme Court Justice

A p p e a r a n c e s:

SHAWN W. CAREY, ESQ.,
Appearing for the Plaintiff.

JEFFREY C. SENDZIAK, ESQ.
and STEPHEN M. CARDEN, ESQ.
Appearing for the Defendant.

P R E S E N T:

Vincent J. Terrana,
Plaintiff.

CHRISTINE I. GARRETT
Official Supreme Court Reporter

W I L L I A M J. O W E N S, JR., having been duly sworn, testified as follows:

THE WITNESS: I do.

THE CLERK: Please be seated. Thank you. Please state your name for the record, spelling your first and last names.

THE WITNESS: William J. Owens Junior, W-I-L-L-I-A-M, O-W-E-N-S.

THE CLERK: And please state your business address for the record.

THE WITNESS: 1275 Main Street, Suite 110, Buffalo, New York 14209.

THE CLERK: Thank you.

DIRECT EXAMINATION BY MR. CAREY:

Q. Good morning, Dr. Owens. Could you please explain to the jury what your profession is?

A. I am a doctor of chiropractic.

Q. All right. And could you give us a definition of what a doctor of chiropractic is?

A. Doctor of chiropractic is a specialist really in conservative musculoskeletal care. Really the focus is on the spine and surrounding nerves and muscles.

Q. Okay. And how long have you been a practicing chiropractor?

A. I started in 1998, so that would be twenty-two years.

Q. Okay. And how did you become a chiropractor? What was the course of education that you followed?

A. Course of education is undergraduate education. Back when I went through the program, I did a bachelor of human anatomy along with my doctorate degree at the same time, so I transitioned from one of those into the other. So total schooling was close to eight years, about seven and a half, with clinical internships, with active patient care. And I did that in Chicago.

Q. All right. And what was the name of the university or the chiropractic school that you did that at?

A. It was -- back when I graduated it was National College of Chiropractic, but now it's the National University of Health Sciences.

Q. Okay. And where did you go for undergrad?

A. I actually kind of moved between professions. I think at first I started I was actually looking to veterinarian school, believe it or not. And then at that point I kind of bounced around a little bit, went through University at Buffalo. You know, I was sort of that person that really didn't know what they wanted to do. I was kind of like the -- sort of the liberal arts type of student, so I did a little stint at community college, went through UB for a time, but when I enrolled at National, that's when I accelerated the program to do bachelor's and my doctorate at the same time.

Q. Okay. And the bachelor's was in human anatomy?

A. Human biology, yes.

Q. Human biology. And then the doctorate was in chiropractic?

A. That's correct.

Q. And from there, have you had any other education or training or certification?

A. Yes. Actually, additional, I would like to note for the record too that the way that chiropractic is licensed is through a series of board exams, so there was four separate board exams that were taken through that time period of school. The fourth board exam is one hundred percent clinical and that's what allows us to apply, actually, for state licensure. So New York State, among all other states in the United States, has very specific criteria for licensure of health professionals and that's done through the New York State Department of Education, but after that I had started getting involved with the University at Buffalo, predominantly, at the time, exercise science program. And I became a site supervisor for internship programs for that program. So essentially when somebody goes through an exercise science program, at the end of that four-year stint of education, they have about four hundred seventy-five hours of on-site clinical exposure. Some exercise science students want to go into physical therapy, some want to stay as personal trainers, some want to go the

chiropractic route. So I started doing that probably in about maybe the year 2001 or 2002. And as I got more involved with having students come through the practice as we saw patients and kind of managing that, I got introduced to other professors and people at University of Buffalo and that kind of lead into my work with the medical school.

Q. And what is -- could you describe that? What is your work with the UB Medical School?

A. Currently I am on faculty in the family medicine department. And what we're really focused on is interprofessional work from a primary care level, but in a conservative manner, so non-opioid, non-pharmacological and kind of bridging the gap between primary care and, say, pain management and surgery. So I work with second and third-year medical students, they come through the practice. I've also had family practice residents as well as neurology residents rotate through and shadow us at my office.

Now, one of the things that's interesting about that as well is that, you know, to be a kind of a clinical instructor is a little bit different than maybe just standing up in a classroom and being a didactic, where I'm just pointing to a PowerPoint and talking. So having the patient on the table, a student with you, kind of running the office, directing care, there's a lot of things sort of going on and that takes additional training. So I was the first

chiropractor ever, and this is a global thing, to go through the Royal College of Physicians' certified physician education program. So basically what happens --

Q. And tell me, what is that?

A. Okay. Sorry. Basically what happens is that University of Buffalo, as well as other medical schools, takes all of their clinical instructors and allows them to have additional training. So the Royal College was really the first medical organization in the world. I believe it was started in about 1355, which is really sort of amazing to get your head around, but they travel the world and they sit with clinical instructors to help them to understand how to work in an academic and a clinical environment at the same time. So I was invited through the family practice department and I was the first chiropractor to actually go through that program, so --

Q. And does that help you in your practice?

A. At first it kind of distracted me from my practice, to be honest. You know, it's a bit of work. However, I could honestly say over time it's absolutely made me a better doctor, because those aren't chiropractic students that are coming through, those are medical students, right? So the scope of what we're looking for from an assessment and diagnostic perspective is much different than me just sort of maybe being focused just on what I do chiropractically, but also exposing, you know, for a much larger vision, right? So --

Q. Okay.

A. -- what that really sort of entailed over the years was additional training in MRI and spine interpretation, spinal biomechanical engineering, which is really sort of how the spine moves from a mechanical perspective. Most of the research is done on cadavers so, obviously, they're not living, but when you translate that to the clinical world, each person has an ability to move. So all of that science comes into play.

Out of that Royal College training, one of the projects came out was the first real fellowship program in chiropractic and that's in spinal biomechanics and trauma, so I manage and oversee and direct that program nationally.

Q. You do? You're the director of that program nationally?

A. Yeah. That was actually one of my projects in the Royal College, the acronym is RCP, so one of my projects for RCP was -- it turned out to be that fellowship program. So chiropractors go through a didactic training program which is about almost a hundred -- about a hundred fifty hours of didactic work in MRI, spinal biomechanical engineering, stroke, trauma care, triage. And then we put them into rotations. And those are all specialty rotations; MRI physics, MRI surgery, emergency department. So that's sort of from a global perspective of how we're kind of working very closely with the

medical community on patient care.

Q. All right. And could you tell me, sir, what is the -- with reference to your CV, is that what you just testified to, the clinical director of fellowship in spinal biomechanics and trauma, the Academy of Chiropractic?

A. Yeah, that's correct. Yeah.

Q. And could you tell us all, what is it -- how does it relate to your practice, spinal biomechanics and trauma? What is the correlation there?

A. Now, the actual definition of that from a medical perspective is really the mechanics of the spine, so if you try to envision the spine as from an engineering perspective as opposed to a health care perspective, it allows us to understand how the spine moves, how much it should move, if there's motion, what happens when it's healthy and young and flexible and what happens as it ages and/or is exposed to trauma. So spinal biomechanics has really been an important science. The surgeons that I work with, particularly the scoliosis doctors, rely very heavily on that. I'm not, obviously, using instrumentation, but on the chiropractic side that's a lot of what we do to determine whether we can help somebody or we have to refer them out.

Q. Okay. And when you say you're not using instrumentation, what do you mean by that?

A. When a surgeon, like say, a scoliosis surgeon goes to

correct a curve, they're actually going to put metal and they're going to put plates and screws. So from a term of instrumentation, that would be more of what I was relying to as opposed to a tool offering adjustment.

Q. I see. And so you attempt to address those types of issues with the spine by means other than surgery?

A. Right. The core principles of how the spine is constructed and how it works are the same. The only thing that really differs is the type of intervention, you know, is it muscle rehab, is it chiropractic adjustment, is it an injection maybe with another provider or is it maybe an implant or a plate from another provider, but the core science is shared kind of by all.

Q. Okay. And I see from your CV you have another -- you have other clinical director positions and/or you have had. Could you describe a few of those that might be relevant to what we're here about today?

A. From the clinical aspect, for a time I did have a second office in Rochester, but the work with the medical school, it just kind of became too much, so I have the office in Buffalo with three other chiropractors in there that I oversee, but the remaining part of my educational side is really related to chiropractic. So I also have faculty positions at a few other chiropractic colleges as well. And that's predominantly on the graduate level, so when any health

professional or even any professional in New York is looking to renew their license, there is additional continuing education credits that they require. The content of that is highly regulated, but a lot of what I do for the chiropractic profession is once doctors graduate and they're licensed and they're working, we provide those continuing education courses.

Q. Okay. And throughout the course of your career as a chiropractor, have you also presented at or participated in symposiums or other educational events, I guess would be a good way to call it?

A. Yeah. And that's split between live and web-based. You know, today people are pretty busy so we do a lot of that on a regular basis. My chiropractic side of teaching is a little bit more structured, but the medical school, probably doing more at the medical school now with students and approaching what I've done with the chiropractic side, so that's a regular part of what I do, but the key to that is that not only do those have to be approved, but they have to be updated, right? So it's not just about us presenting information that we presented in 2010, really refreshing that and being intimately familiar with research and publication is a key component to that, because otherwise we don't get approval.

Q. Specifically with regards to your training, we talked about chiropractic. And the biomechanical, what is that? What

is your training that you have in biomechanics and how does it relate to your practice as a chiropractor?

A. Okay. So the mechanical aspect of the human body, which is really sort of what biomechanics means, right? So bio meaning biology and mechanics meaning mechanical, so a living creature has a certain type of mechanics that say, you know, a machine, like a car or a garage door would have. Physics are the same, right? Because we're kind of on the same planet, gravity's the same, but because we can control it and we're controlled by the nervous system, that's really the idea behind biomechanics from a chiropractic perspective. So biomechanics is really part of a core curriculum in chiropractic school to begin with, because essentially that's what we're assessing and monitoring and managing, right? But my additional postgraduate is in -- my postgraduate work, my credential, is really also in additional spinal biomechanics. So planes of motion, all the, you know, fundamental biomechanical type of assessments.

Q. And does that assist you in the treatment and diagnosis of your chiropractic patients?

A. It does. And, you know, because we're busy, we don't always apply the depth of that biomechanics to every patient that just comes in. You know, I would say probably seventy, eighty percent of chiropractic patients come in, we can assess them fairly quickly and they get better. I do work very closely with a lot of spine surgeons, so our office gets a lot

of postsurgical patients, people that have failed other treatments, so when we get into that sort of smaller group of people where they might be injured in different regions of the spine, that assessment, the time that it takes and the complexity goes up. So probably that spinal biomechanical side is really probably more done in that subgroup of population just because it's time-consuming and at that point we really need to look at the spine as a full organ system, you know, just like we look at the heart and the digestive tract. You know, we don't look at it just from neck and low back, so to speak, we look at how the whole thing is operating. And that's part of just the complexity when it presents, you know. As I said, it's not something that we always do, but it's there when we need it.

Q. Okay. And with regards to your practice, how many patients do you treat and/or your associate chiropractors under your supervision treat?

A. So in our practice I see every patient that comes in for an initial assessment and I also see them for reevaluation. The other three doctors in the practice are essentially implementing treatment and managing those patients in between. So, you know, we have four doctors in there, you know, we're pretty busy. We'll see sixty to seventy patients a day, you know, five days a week. So you know, among that, plus, you know, with the medical school, you know, we're really kind of

emersed in the clinical world. I will note, though, that probably seventy percent of our new patients come from the primary care community. I work really close with family medicine, family doctors.

Q. What is the name of your practice?

A. Greater Buffalo Accident and Injury Chiropractic.

Q. And why did you choose the name -- Greater Buffalo, we get that. Why did you choose the name Accident and Injury Chiropractic?

A. When I first started out in practice, I was really sort of interested in kind of the nutritional wellness-type model. Taking healthy people and keeping healthy people healthy. And there's absolutely kind of a niche and a paradigm for that. If you oversee and you look at chiropractic as a profession, that's one of the main areas, right? Some people just go just to stay and feel better, right? But as I started seeing more complex patients, I got into the medical school and started being asked to evaluate people, primary care doctors sending people that have had multiple surgeries, you know, I really sort of got interested in that. So that's when sort of my postgraduate education kind of turned and I started really kind of educating myself on the science of how the body responds to trauma and injury. And that's everything from, you know, a fall to, hey, I hurt my back at work or I was in a car accident, you know, those levels all kind of vary, but what I

always felt was I wanted the name of my practice to kind of showcase sort of what I do, right? Because it's a lot easier to -- you know, I want to work with those patients, so for me to have a name that is consistent with that, just like my postgraduate education, that just seemed to make sense to me, so that's why I kind of went that direction.

Q. So is it fair to say that the primary practice or your patients are primarily patients that you're seeing as a result of accidents or injuries?

A. Yeah. I would say probably about sixty-five, maybe seventy percent, that's how patients find us.

Q. Okay.

A. But I would also say that I have a majority of patients that I'm seeing just to sort of manage their case, right? Because sometimes when you're hurt it's not necessarily cured, right? Just like when I talk to primary care physicians, you know, we don't really cure a lot from a medical perspective, right? If I have high blood pressure, I'm continuing to take my pill, but if I stop, high blood pressure comes back. If I have Crohn's disease, if I have pulmonary problems, if I have -- whatever it may be, a lot of what medicine does is manage. So when it comes to patients in our practice at least and, you know, and this is sort of the world I live in, we do help and fix a lot of people, but there's a subset of people that don't get better that need to be managed,

so a lot of that residual patient bases are those patients.

Q. All right. And, Doctor, with regards to your patients, do you ever -- are you ever involved in the decision-making as to whether or not to refer a particular patient on to some other medical specialty?

A. Chiropractic nationally -- so chiropractors have state licenses, so each state kind of has their own rules, but they're all kind of inside the umbrella of the federal umbrella of education.

Q. Okay.

A. So under the federal rules, Medicare in particular, chiropractors are listed as primary care providers. And that's not primary care like a family doctor. That means that any patient can walk in off the street and come into our practice. So we don't work under the direction of, you know, a primary care physician or a surgeon or we don't need any of that.

Q. Okay.

A. Okay. So that's a big part of how the practice operates, is that, when that patient comes in, we have a duty to actually diagnosis and manage that patient even if I'm not going to treat them, right? So there's no order coming in to say, hey, Dr. Owens, do this. The patient comes in and says, hey, my neck hurts and I have a headache. So in that process, taking a history, going through the full exam, that patient, it may turn out that maybe they have a blood clot, and it's not a

neck problem. So in that process, we're trained to really be able to recognize what a chiropractic problem is. If it's not, then we're referring out. And there's a duty to do that. There's doctors that lose their license because they fail to do that. But then there's also the subset of patients where, hey, you know what? It was a chiropractic problem to begin with, but they're kind of stuck, so we need a little bit more help. And then I would ask other providers to help out with that. And that may be a pain management doctor, spine surgeon, massage therapy, acupuncture, you know, kind of helping to direct that patient to the right person.

THE COURT: All right. I think this is a good time to break for the morning, if you don't mind.

Ladies and gentlemen, the lawyers and I have to address a few matters, which I'm going to schedule to do around one-thirty. And I'm hoping that we can begin taking testimony at one-forty-five. So if you could be back at one-thirty, I would appreciate it.

I'm going to remind you of my instructions to you regarding your conduct and activities during recess periods.

And with that, we'll see you at one-thirty, one-forty-five. Thank you.

Please rise for the jury.

(Jury left the courtroom at 11:54 a.m.)

THE COURT: All right. Doctor, you can step down.

(Discussion held off the record 11:55 a.m.)

THE COURT: Okay. So gentlemen, one-thirty, if you could be back here and I'll entertain your arguments regarding what I believe is now the limited issue of the admissibility of the IME report of Dr. Scott, is it?

MR. CAREY: Yes.

MR. SENDZIAK: Yes.

THE COURT: And I've reviewed Mr. Carey's memorandum of law, read the cases that he's provided. I've done my own research while I've been listening to testimony. If you gentlemen have anything that you wish to supply, if you can e-mail it to Mr. deRosas at J deRosas at NY Courts Dot Gov, preferably before one-thirty, I'll be more than happy to consider that. Otherwise, I'll see you back at one-thirty.

MR. CAREY: Thank you. And, Judge, if I could be heard on just one small piece on, you know, under the rules, I am allowed to offer -- if there's testimony offered, I'm allowed to offer just that section that clarifies the --

THE COURT: What are we talking about?

MR. CAREY: The deposition on recross, which was raised for the first time --

THE COURT: I don't know what you're referring to. Are you talking about the report that you want to have into evidence or are you talking about this person's testimony or what?

MR. CAREY: No, no. I'm talking about Mr. Terrana's testimony.

THE COURT: Yeah.

MR. CAREY: At the tail end of it, the defense came up and showed him a deposition transcript and --

THE COURT: I know, but in this -- the way it's done is you get your direct, you get your cross, you get redirect and recross, because if I let it continue, we'll be here all day with one witness and that's where it ends.

MR. CAREY: I agree with you totally, Judge. All I'm asking for is to read in to the jury one other section of the deposition transcript that should have been read with that. You know, in terms of I don't have an opportunity to -- but it's supposed to be --

THE COURT: But the point is -- and I get your point and I'm sensitive to your question. If I allow people to go back and forth on everything that's read or not read or -- we'll be here forever and that's why I'm not going to allow it. So I appreciate it, I'll note your exception. I'll see everybody back here at one-thirty. Thank you.

(Lunch recess taken 11:57 a.m.)

THE COURT: On the record. So this morning before we began and resumed the testimony of Mr. Terrana, we -- Mr. Carey brought to the Court's attention his issue regarding the report of Dr. Scott -- the IME report of Dr. Scott and wanted to have it introduced into evidence. And I've reviewed his trial memorandum of law that he supplied and I did offer defendants an opportunity to supply any case law in response. I did not receive anything over the break, so -- but I did hear argument this morning on it.

I'm probably going to regret this, but do you wish to make any further argument before I make a decision? And I'll certainly allow it, but if you could limit it and not be repetitive.

MR. CAREY: I think I've made my argument orally and also with regards to our memo.

MR. SENDZIAK: Briefly. First of all, the cases cited by plaintiff's counsel do not apply to the scenario which is before this court. Plaintiff's counsel cited four Fourth Department cases, all of which involve the situation where the plaintiff's expert was testifying at trial, and prior to his giving an opinion testimony, was giving foundation testimony. And as I understand the cases, some of that foundation testimony involved the experts relying upon reports, medical records, that were

not in evidence.

THE COURT: But are you suggesting, and I think we went through this yesterday, that an expert cannot rely on otherwise hearsay documents from which to base an opinion?

MR. SENDZIAK: I do not. But this is not the situation before the Court. What was disclosed to us is the report of Dr. William Owens.

THE COURT: Right.

MR. SENDZIAK: And Dr. Owens, in his report, provides various opinions. He also cites the documentation that he relies upon in reaching those opinions. He did not review Dr. Scott's report. Therefore, any opinions that he's going to testify to this afternoon, and which were disclosed to us, were not based upon his review of Dr. Scott's report. What he wants to do is to have this witness, who never reviewed Dr. Scott's report in coming to his conclusions initially, to read from it and he wants the jury to see it. It is hearsay and Mr. Carey's -- in my opinion, Mr. Carey's options were, one, to obtain the testimony of Dr. Scott either by subpoena or paying him or the missing witness charge. He's requested the missing witness charge. I'm not going to object to it, because I think he's entitled to it. But in this situation, his own expert, in coming to his

opinions that were disclosed prior to trial, did not rely on the report of Dr. Scott.

THE COURT: Okay. Rely on, but did he read it?

MR. SENDZIAK: No.

THE COURT: Okay. Mr. Carey.

MR. CAREY: Yeah. Your Honor, we provided our supplemental expert -- our original supplemental expert disclosure.

THE COURT: Right.

MR. CAREY: Defense has made it very clear they specifically hired Dr. Lifeso in response to our disclosing Dr. Owens.

THE COURT: Right.

MR. CAREY: We then said, well, we've got Dr. Lifeso coming to offer testimony that's completely different than what the noticed IME the defense had the plaintiff go to see --

THE COURT: Can I cut you off there? And forgive me if I'm two steps ahead of you. Are you going -- is it your argument that Dr. Owens will not make reference to Dr. Scott's IME in his direct, but will in his rebuttal?

MR. CAREY: That was going to be the plan and that's why I brought it up today, to see if we could sort of cut to the chase all in one testimony. I have arranged

with Dr. Owens if --

THE COURT: Well, what if Dr. Lifeso, and again, I don't mean to interrupt you, but what if Dr. Lifeso doesn't make any reference to Dr. Scott's --

MR. CAREY: Well, that is actually part of why we've looked at both of them, because he's going to -- Dr. Lifeso is going to be taking a completely different position than Dr. Scott was --

THE COURT: Right.

MR. CAREY: -- which we were prepared to potentially deal with. We're not hearing Dr. Scott, we're going to hear Dr. Lifeso. So we would like to be able to -- and basically this is going to be the extent of it. It's not going to be reading of Dr. Scott's report into the record by Dr. Owens. It would simply be by reference, I would note I've evaluated the IME's, which is customary in his profession to do, we've looked at the IME's that were -- the defense IME's and I would comment that I -- my view or finding is consistent with Dr. Scott's and it's not consistent with Dr. Lifeso's. That's the extent of what he was going to offer. So I can have him come back on, I guess, Friday at two o'clock, that would be when he would be available.

THE COURT: Who?

MR. CAREY: Dr. Owens, if it had to be by

rebuttal, but --

THE COURT: But what about the argument, though, that if that Dr. Scott did not review or include -- that he reviewed the report in his own report?

MR. CAREY: Well, with regards to our disclosure, we disclosed that we would be having him and any other materials that go to the disability and the treatment of -- which included the IME. Now, I will note, Dr. Lifeso, he's going to come testify and he's going to testify according to whatever testimony is offered. We did say that in our original expert disclosure too is that in addition to whatever he's reviewed in doing the report, he'll also testify according to whatever comes into evidence as well. He may rely or refer to whatever comes into evidence. The defendants have -- you know, they want to have Dr. Lifeso come and offer testimony that's completely different to what Dr. Scott said, but they don't want to have to be accountable for what Dr. Scott said.

THE COURT: But you could have called Dr. Scott.

MR. CAREY: He's in Florida, Your Honor, can't really subpoena him.

MR. SENDZIAK: Plaintiff's counsel, as I understand it, is licensed to practice in the State of

Florida.

MR. CAREY: Who, me?

MR. SENDZIAK: Yeah.

THE COURT: Hold on.

MR. CAREY: I'm not licensed to practice in Florida.

MR. SENDZIAK: You had an office there.

MR. CAREY: Yeah, but that was not an office --

THE COURT: I don't let Mr. Carey interrupt you and I don't want you to interrupt him. So anything further?

MR. CAREY: No, Your Honor. Just to clarify, I've never been licensed in the State of Florida.

THE COURT: That's okay.

MR. CAREY: It's just, you know, those are the types of things that go on the record and they come back to bite somebody when you just throw accusations out there. I did not have a license, nor was I practicing, law in Florida. I did reside in Florida. I was continuing to practice in Buffalo for four years. It ended in 2016, but that's just for clarification, so --

MR. SENDZIAK: Thank you. I was under the misunderstanding that you were working in Florida.

THE COURT: Right about now this would be a great time to practice in Florida.

MR. CAREY: You're right.

THE COURT: All right. Anything further, Mr. Sendziak?

MR. SENDZIAK: No, Judge.

THE COURT: No objection or nothing further?

MR. SENDZIAK: Nothing further.

THE COURT: Okay. So if it's no objection, that might be completely different.

MR. SENDZIAK: No. Nothing further.

THE COURT: All right. All right. As I understand the issue, in the plaintiff's memorandum of law and his supplemental expert disclosure, he is looking to allow his expert, Dr. William Owens, to testify as to the findings of Dr. Scott who performed the IME of the plaintiff at the request of the defense. And in that, the plaintiff seeks to use the professional reliability exception to the hearsay rule to allow that testimony. In looking at that, for the purposes of the record, it is well understood that an expert is permitted to offer opinion testimony based upon facts not in evidence where the material is of a kind accepted in the profession as reliable in performing -- in forming a professional opinion. That's Wagman versus Bradshaw, 292 AD2d 84.

The purpose of the exception enables an expert witness to provide an opinion -- provide opinion evidence

based on otherwise inadmissible hearsay, provided it demonstrated to be the type of material commonly relied on in the profession. The matter of the State of New York versus Motzer, M-O-T-Z-E-R, 79 AD3d 1687.

The record, though, has to be appropriate under the circumstances to allow that to be offered.

That said, it is not a completely understood rule that that allows experts to get in all types of written documents, and in this particular case, it's unclear as to whether or not Dr. Owens relied on, reviewed it or incorporated it into his findings.

In this particular case, we have to look at the document itself that the expert reviewed, and as I said, it's unclear as to whether or not he even reviewed Dr. Scott's testimony -- or Dr. Scott's report. And if he did, he didn't certainly reference it.

It is going to be the ruling of the Court that the written report prepared by Dr. Scott is inadmissible hearsay as the declarant, or the preparer of the report, is unavailable for cross-examination.

In the event that the doctor and all or part of his opinion was influenced by or he relied on the reports of Dr. Scott, his testimony can be limited to that extent only. I cannot allow the wholesale admission of the document, Dr. Scott's report, because there is a lack of

an opportunity to cross-examine him and it's subject to interpretation that would certainly be prejudicial for the jury, but there has to be a link between the report and Dr. Owens' testimony.

In the event that you can establish that link, he can obliquely reference it and his testimony can be limited to that. If you cannot, then his testimony cannot include any references to Dr. Scott's independent medical examination, okay?

MR. CAREY: Okay.

THE COURT: All right. Anything else?

MR. SENDZIAK: No.

MR. CAREY: No, Your Honor.

THE COURT: Okay.

MR. CAREY: If I could just have a second to set up the connection here.

THE COURT: Sure.

MR. CAREY: And I will note, maybe we can deal with this. Dr. Owens has reviewed all of the video surveillance which is in evidence. We're not going to put the jury through reviewing that again, but I am going to ask him to comment on it as he's reviewed it and that was all disclosed.

MR. SENDZIAK: Yeah. Yeah, I'm all for not looking at it anymore.

THE COURT: Okay.

(Discussion held off the record 1:51 p.m.)

THE COURT: All right. Are you ready for the jury?

MR. CAREY: We are, Your Honor.

THE COURT: All right. Jury in.

Doctor, you can take your place on the stand.

THE WITNESS: Thank you.

THE COURT: And I'm going to remind you that you're still under oath, sir.

THE WITNESS: Okay.

(Jury entered the courtroom at 1:54 p.m.)

THE COURT: Please rise.

THE CLERK: Court is now in session. All jurors and counsel present, Your Honor.

THE COURT: Okay.

MR. CAREY: May I continue, Your Honor?

THE COURT: Yes, I'm sorry. Yes.

MR. CAREY: All right.

CONTINUED DIRECT EXAMINATION BY MR. CAREY:

Q. Good afternoon, Doctor. I think we left off, we were going through your credentials as an expert. And I wanted to pick up with the -- in regards to your own practice.

How many patients do you typically treat at any -- or do you have in your practice at any one time?

A. Well, as I had mentioned, you know, I'm responsible for examining people when they come in and then the other doctors will implement treatment, but, you know, we're anywhere from, depending on the day, time of the year, you know, fifty, sixty a day.

Q. Okay. And with regards to -- I think you were talking about a particular subset of patient that comes under a category of long-term care?

A. Well, there's, yeah, there's different categories, but probably maybe a little less than -- about a third of my practice is based on just managing chronic pain. In fact, that's really what my role is in the medical school, is discussing how we can implement pain management without narcotics.

Q. All right. And what would you say on a percentage basis would be your practice, you know, the total makeup of your practice with regards to your teaching duties at UB and your duties as a practitioner at your office?

A. Well, I try my best to try to, as odd as it may sound, do all of it at once, right? So a lot of my teaching there is residents and MD students with us.

Q. Okay.

A. So we're seeing people and we're kind of teaching at the same time. But for me now my time is probably sixty percent treating, forty percent teaching.

Q. All right.

A. You know, because I have the other doctors to help.

Q. All right.

A. But I'm still very much active in the daily, Monday through Friday, I'm in the office.

Q. All right. Do you also do, at any time, sort of an independent evaluation of any patients for any purpose?

A. You mean as far as like examining people that I'm not treating?

Q. Correct.

A. Yes, I do.

Q. And how frequently do you do that through the course of a year or over the course of your practice, what would you say percentage-wise?

A. Yeah. I mean, it's probably less than -- it's definitely less than five percent. Maybe three percent --

Q. Okay.

A. -- you know, of my practice volume and certainly income.

Q. Okay. Now -- and I'd like to ask you first, with regards to some of your patient base, I believe you testified this morning that some of your patients come to you after they've already sort of completed their run of treatment with other physicians, correct?

A. That's correct.

Q. Okay. And when those patients come to you, what do you do to try and assess, you know, where they're at and where they're going or how they got there?

A. Well, you know, I think, honestly, the idea is to try to not get super distracted at the beginning and really kind of have a starting point, so we always kind of, you know, just like sports, right, you just kind of go back to fundamentals, so that has to do with the examination, but there's also a reliance on other providers because typically those patients have come, they've seen a myriad of providers throughout the course, right? So the opinions of those doctors are important, you know, I'm probably relying on them to a certain extent, but it helps me to direct, because I'm not going to keep doing the same thing that those patients have had before. We have to look somewhere else, right? Different body region, different technique, things like that.

Q. Do you try and make a determination as to where that patient, you know, how they got there to your office and where their long-term prognosis may take them?

A. Yes, but, you know, to a certain extent you have to be careful not to just jump into a long-term prognosis, right? Because you have to give people kind of a chance to respond, right? So there's a time frame where finally you might be able to look at it and say, okay. Hey, listen, you've tried all these different things, they've responded and then they've

regressed and they've responded and they've regressed, so there's a point where we're not getting any better. And then that's when we start to look at, what are we doing for the long-term to manage it, right? We want to kind of give them the least amount of treatment to keep them stable, but we know that there's a functional problem long-term.

Q. All right. And I believe -- is there occasions also in which you are asked to take a look at a patient -- or I'm sorry. Someone else's patient that's not your patient from a treating standpoint and evaluate where they are, how they got there and what their prognosis is for the future?

A. That's correct. I've been asked that.

Q. And what would you call those occasions?

A. We just call them, at the office, an independent evaluation.

Q. Okay. And did there come a time -- and by the way, with regards to those independent evaluations, do you set out to do them the same every time?

A. Well, my evaluation is the same, at least the structure of it is the same all the time, right? So it doesn't matter the class of insurance, it doesn't matter if it's a cash patient or whatever, right? It's always going -- we're going to approach that patient the same way, so it's not a different set of tasks related to what I do, because I'm really still examining and offering a recommendation. The only difference

is I'm not keeping that patient on to treat, because typically they come at the end.

Q. Okay. And did there come a time when you were asked by my office, on behalf of Vincent Terrana, to do an independent evaluation of Vincent Terrana?

A. Yes, there was.

Q. All right. And when did that take place?

A. I saw him on September 24th of last year, so 2019.

Q. Okay. And when you saw him, what did that entail? Did you speak with him?

A. Yes. Actually, he came to my office and just like, you know, a patient that came off the street looking for care, I went through the normal protocol; so history, what he's feeling now, what he's felt in the past, who he saw as far as providers were concerned. And then we established sort of a causative event, perhaps if that's there, but in the case of Mr. Terrana, we talked about the motor vehicle accident and the symptoms that he was experiencing. And then once I get that established, then we're moving -- I'm moving into more of a physical examination where I'm looking at sort of stressing different parts of the body to see if that correlates.

Q. All right. And did you do this physical examination of Vincent Terrana on September 24th, 2019?

A. I did.

Q. And, Doctor, is there anything that you brought with

you or anything that would assist you in offering to the jury what your findings were or what evaluation you provided of Mr. Terrana?

A. Yeah. I have my report here, but I think also what helps is sort of being able to demonstrate how I thought through that, right? So it will kind of give a window into what I'm looking for as I'm going through the process. So it's not just words on paper, there's actually a progression of how the body is injured, how it responds and what the evidence really was that I found that allowed me to reach a conclusion, so there's sort of a logic.

Q. Okay. Well, why don't we start with just regards to your physical examination of Mr. Terrana. What did you do on September 24?

A. So there's several different things that we're looking at with a patient. Now, of course, we're dealing with the human being so there's some semblance of his subjective component, right? You know, I always go back to that time where I thought that maybe I wanted to be a veterinarian, right? And animals can't really talk or feedback or any of that stuff, but human beings are a little bit different, so what we want to look for when we're doing an examination is really kind of what happened, what they're telling us, but then also trying to objectify those statements to kind of perhaps correlate what the true problem really is. Once we have that

sort of data and we can compare it, then we rely on more traditional objective findings like imaging and testing to kind of put it together. So the way that I look at it is, it's almost like a book, right? And each chapter of the book tells the story, but you can't rely just on one chapter in each one of these sections. So as far as the exam was concerned, you know, the first thing that I really look for is how much or how little he can move certain areas of the spine. You know, and, again, taking into consideration that that's still under Mr. Terrana's control, you know, that's just one chapter in the book, right? Once we sort of -- once I see how he's moving, then I'm going to zero in on those areas of pain. And the testing that's really done from an orthopedic perspective, and even a neurology perspective in the office is really about taking an area that hurts and see if it hurts more when you do certain things to it.

Q. Okay. Did you do that with Mr. Terrana?

A. I did. I did.

Q. All right. And, specifically, could you describe for us what exactly you did from first to last?

MR. SENDZIAK: Objection. I don't think the doctor's file's been marked.

MR. CAREY: We'll mark it, Your Honor.

THE COURT: I don't know if he needs to rely on the file in order to answer that question, but if he's

going to start thumbing through it, maybe we should --

MR. CAREY: That's fine. We'll mark it, Your Honor.

(A Report and a File were received and marked as Plaintiff's Exhibits 33 and 34 for identification.)

THE COURT: What's 33?

MR. CAREY: 33 is the report.

THE COURT: 34 is the file?

MR. CAREY: Correct.

THE COURT: Thank you.

BY MR. CAREY:

Q. All right. Would it assist you in explaining to the jury the course of your examination of Mr. Terrana to refer to either Exhibit 33 or Exhibit 34?

A. It would, but I can certainly go through what the natural process of what that is as well.

Q. Okay. Well, why don't you go through, with regards to Mr. Terrana, what was the first thing you did with regards to examination?

A. The first thing really is to touch him, you know, for lack of a better term. The health care term is palpation. So, again, in a normal course of care or examination, you don't want to move anything really that you could hurt, right? Or damage further. So touching the patient and looking for muscle spasm is a really key indicator.

Q. And why is that, Doctor?

A. Because muscle spasm or contraction is different than -- that's a response to an injury, okay? So the patient doesn't have control over that in the spine. So what we want to do is see where those problems are because, again, that can correlate to what they're saying hurts and also has implications for range of motion and things like that. So touching them and examining them physically is really just as much a part of it as talking to them directly and also reviewing medical records.

Q. Okay. And you did that with Mr. Terrana?

A. That's correct, yes. And I did that in his neck, his middle back and his lower back, so I was examining the full spine.

Q. All right. Did you see anything significant when you palpated or touched Mr. Terrana's spine?

A. Yes. He had definite areas of muscle spasm or contraction. And that was in the middle -- particularly in the middle and the lower back.

Q. Okay. And that was in September of 2019?

A. That was in September of 2019, yes.

Q. And, Doctor, what next did you do?

A. So once I kind of locate where the problem area really is, then we want to sort of do what are -- what I would maybe term stress tests, right? So it's kind of, hey, can you

do this and does it, you know, what happens when we do that. So as far as the neck, the middle back and the lower back, those are called orthopedic tests. And they are very standard definitions that were part of my education. They're part of what I teach chiropractors and even medical students. So when we move certain things, what we're really trying to figure out is what type of tissue is injured. Is it a muscle problem, is it a ligament or connective tissue, is it a nerve and all of those things. So there's a series of those that we progress to become more forceful, right? So we gently start and then we restrict and we do more and more with the ranges of motion and the test. So for instance, if you watch a football game and somebody runs out on the field and they're moving the knee around, right? Just to make sure and see and do an exam, that's a simple orthopedic-type test. And those are very common.

Q. And what did you do with Mr. Terrana and what did you find was significant? If you could go through sort of just from start to finish what exams you did and if you found anything significant and why.

A. Okay. So when we start, Mr. Terrana was seated and I gently pushed down on his neck, add a little compression. That compression is actually going to stress some of the ligaments, the discs, the muscles. Then I'll lift up on the head, stretch it a little bit to see if that actually creates pain. Now,

those all have correlative factors that what we teach when you do physical exam, is that the patient or the client or whomever doesn't really understand what those results should be, right? So we have a way to start to objectify kind of what's going on based on what they say. So we're moving away from just subjective, moving more into objective. From that point I -- you can stretch and separate the head from the shoulder. And that, again, stresses the ligaments and the nerves in the neck. Then moving down in particular in the middle back, okay? There's a specific test where the patient would be seated, Mr. Terrana was seated, and he would bend to his left and bend to the right, side to side. What that's designed to do is stress each individual vertebrae in the middle back. And, again, an uninjured joint or an uninjured region, there really shouldn't be any response to that from a painful perspective. That, in particular, which is what caught my attention initially, was positive for him for pain on both sides. He was really sort of limited in what he could do side to side.

Q. And that was in the thoracic area?

A. Yes.

Q. Okay.

A. So interestingly, that correlated with what he said during the history. It correlated with the -- where those muscle contractions were. And then when I moved him and he moved himself, it was actually reproduced. So that's sort of

the key, right? As we go down the pathway, is there more reproducibility? Can we have the same reinforcement as we go down?

Q. Okay.

A. So that was important for me for the middle back.

Q. All right. And then what did you do with regards to the low back, if anything?

A. The low back is really designed to stress, again, just like in the middle back where we did side to side, in the lower back, because there's not too much rotation or turning, we're going to have him bend forward and back and lift his legs.

Q. All right.

A. When we did --

Q. And bending forward and back is called what?

A. When a patient bends forward that's called flexion.

Q. Okay.

A. Okay. We're reducing the angle in between our chest and our waist.

Q. Okay.

A. Extension is the opposite of that where we're increasing the angle and we're going backwards. So basically forward bending would be flexion and backward bending would be extension.

Q. I don't want to interrupt you, but with regards to

the cervical spine, would that also be the same?

A. Yes. And that's how -- those tests were specific to the lower back. In the rest of the regions, including the lower back, we did that and measured how far he could move using an instrument. That helps us quantify whether that's a normal -- that's expected to be normal or it's out of normal.

Q. All right. And did you do any other tests moving back to the lumbar spine or the lower back?

A. No. Those were predominantly the main tests because all of his pain was located where the spine was, right? It wasn't shooting into the toes or anything like that. So that's a different sort of -- those exams are designed specifically to stress the bones in the spine, as opposed to the muscle surrounding it.

Q. All right. And did you make any significant findings with regards to Mr. Terrana with regards to his low back?

A. Yeah. Those -- those tests were very localized and they reproduced pain in those regions. So that's a very significant finding, but in and of itself that's, again, that's just one chapter in the book, you know, what was important to me from -- and, again, even if this was a doctor/patient relationship, the imaging really is important. If it was a patient, I would order imaging, because I would want to see the pictures, but in Mr. Terrana's case, he had already gone through all of that, so now the next step was really to sort of

say, okay, you told me that it hurts here, I took a look at it and there's some involuntary reaction, which was the muscle contraction or spasm. We moved it around a little bit and that actually reproduced it and made it a little bit worse. And then now we're going to see if the pictures from the inside correlate with that.

Q. All right. And just before we move on to the pictures, did your -- did your measurements of range of motion show anything significant in terms of limitations of motion?

A. Yes. And what's interesting and what's important to note, is that when you have an injury, there's going to be certain ranges of motion that are more restricted than others. So for me that's another way to objectify.

Q. How so?

A. So instead of a patient, perhaps, saying I can't move at all, there's ranges where they can move and areas that they can and other than they can't, so you're going to have kind of a high/low situation. You're going to have some areas that are near normal and then you're going to have others that are really restricted. But they don't really, from a doctor/patient relationship, the patient doesn't really understand that, that they should correlate, but when I take them and I correlate them to the orthopedic tests, the muscle spasm and the contraction, the subjective complaint, and that all sort of links together, now we're getting a more

comprehensive story. Each piece matters to the whole.

Q. All right. So up to this point, before you go look at the films, are you finding a consistency or an accuracy between what Mr. Terrana's subjective complaints are and what you physically determine as you palpate or touch him and put him through motions?

A. Yes. At this point in the examination, yes, those ranges of motion were restricted in the areas that would have typically caused him the most pain based on his injuries, yes.

Q. All right. And, Doctor, moving on to the films. In evaluating Mr. Terrana, did you determine whether or not any films had been done or ordered in Mr. Terrana's case?

A. Yeah. So part of -- after he was examined and I had my findings, that's when I went through and reviewed past medical records.

Q. All right. And what past medical records did you review after doing your examination of Mr. Terrana?

A. I started with the area where he had the most treatment.

Q. And where was that?

A. That was with his treating chiropractor, Dr. Munroe.

Q. Okay. And with regards to that, did you find anything in those records that was -- that you relied on or that you referred to, you know, in your professional experience you typically will rely on those reports or those records?

A. Yes. But from that, those records, that perspective, what I was really interested in is, was what Mr. Terrana told me, and what Dr. Munroe's findings were, were they consistent with what I found independently.

Q. All right.

A. Again, that's another chapter. Does that sort of jibe, right? Do they correlate.

Q. What did you find in those reports of Dr. Munroe with regards to his treatment of Mr. Terrana?

A. That there was muscle spasm, there was joint restrictions, but most importantly, what I was interested in was the response to care.

Q. Okay.

A. There was some response, then there was some regression and not response. Then there was a little bit of time away because he was doing better, but then he came back. So that all sort of correlates with what my feeling was on what the injury was. That was consistent. But I was also interested in because of his nonresponse to care, what did Dr. Munroe do as a treating doctor --

Q. Okay.

A. -- because, you know, we're bound to not just hold on to the patient if they're not getting better, you know, there's a next step. And those are typically done with consultations with other providers, typically medical specialists.

Q. And did you evaluate or determine whether or not Dr. Munroe had done that, had referred Mr. Terrana on to other medical specialists?

A. Yes. It was clear through the record review that he had referred for an orthopedic spine surgery consult.

Q. Okay. And do you know who he referred on -- referred Mr. Terrana on to for that orthopedic spine consult?

A. Yes. He referred to Dr. Fishkin, Zair Fishkin, at Pinnacle Orthopedics.

Q. And by the way, in your own practice, is Dr. Fishkin and Pinnacle Orthopedic a known orthopedic spine doctor and practice?

A. Yes, they've -- their group's been around for quite a while.

Q. And with regards to your own patients, has there ever been occasions where either you refer your own patients on to Pinnacle or Dr. Fishkin or vice versa?

A. That's true. We have shared patients in the past. I don't pick out one person that I send everybody to, you know, because everybody's got different personalities and some people are good at other things than others. So yes, but I have used Dr. Fishkin in the past. That's a very consistent referral from the chiropractic community.

Q. All right. So as far as that goes, you didn't take any issue or find anything inappropriate with the treatment or

the referral of Dr. Munroe of Mr. Terrana to Dr. Fishkin?

A. No. As a matter of fact, that would have been expected --

Q. Okay.

A. -- at that time.

Q. And why would it have been expected?

A. Mostly because a nonresponse to care could typically mean that there's something more ominous going on that wasn't observed. A second set of eyes never hurts. The thing that binds all of health care providers together is really our duty to diagnose.

Q. What do you mean by that?

A. What makes us different -- duty to diagnose meaning to find out what's wrong.

Q. Okay.

A. What makes our licenses different is what we can do about it. So you take a chiropractor, you take a family physician, you take a pain management doctor, an orthopedic surgeon, when that patient comes in, we're still bound to figure out what's wrong, but my treatment is guided by my license. The orthopedic surgeon's treatment is guided by their license. So even though we diagnose, we still have to work together on treatment because we're different and we're distinct and we have different credentials for that.

Q. All right. As a treating chiropractor -- or as in

performing an independent evaluation, do you rely, to some extent, is there a professional reliance on these reports of other treating physicians?

A. Yeah. And that's very important, you know, because really what it becomes is a collaboration for patient care, right? So we kind of work through the easy ones individually, but just like in a hospital or, you know, you watch it on TV all the time, you have a group of people huddling around the patient to figure out what's wrong. And because we're not all in the same building, we have to do that separately, but because we don't see each other, we have to do that through reports.

Q. All right. And, Doctor, with regards to Mr. Terrana, was there any diagnostic tests ordered by Dr. Munroe's office prior to his referral of Mr. Terrana on to Dr. Fishkin?

A. I believe so, yes. In the report they had outlined that they did order x-rays of the spine.

Q. All right. And was there anything further in terms of films, MRI's or anything like that in your --

A. Further down the road he actually had a second set of x-rays at Dr. Fishkin's office at his orthopedic consult, which is normal and consistent.

Q. All right. And did you -- was there ever an occasion when MRI's were ordered and done of Mr. Terrana?

A. Yes. He also had MRI's of each of the areas of the

spine, so an MRI of the neck, the middle back and the lower back.

Q. All right. And with regards to the x-rays and the MRI's, the x-rays were done at Dr. Fishkin's and with regards to the MRI's that were done -- and do you recall where those MRI's were done?

A. Proscan Imaging, which is located in Williamsville on Main Street.

Q. You're familiar with Proscan?

A. Yes, I am.

Q. And did you review those MRI films specifically?

A. Yes. And that's important. You know, right now the research shows that about forty-two percent of all MRI reports are read incorrectly by the reading radiologist. So as a provider, and that's why my training helps me to do that, is I read every film even before I look at the report.

Q. All right. And with regards to that, I think you were testifying earlier about you have sort of a -- you'd like to sort of walk through your process that you follow in terms of evaluating films or looking at the evidence. Do you have -- could you talk -- or could you explain that? What do you mean by that?

A. So what we talked through was really the history of the patient; touching them, examining them, moving them around to see if that correlates. Doing specific tests to see if the

pain shoots anywhere. And zone in on where the potential source of injury would be. Then looking at the images that were taken to see if that correlates from the inside, because that's difficult, right? If it was my thumb or it was my big toe, we could see that real easy. The spine is difficult because it's inside. So we have a high reliance on imaging. Once we have all of that, then I can take that data, and I do this with my patients and say, okay, now what? Like how does this all fit together and how does the body normally respond to an injury, so that I can kind of determine, is this something that should go away or is this something that we've got to kind of have to collaborate on to figure out what we're going to do about it later.

Q. All right. And, Doctor, have you brought anything to court with you that would assist you in explaining to the jury sort of your process that you follow or the process that you have in mind when you're evaluating, you know, the films and the injuries of the people that you either treat or are examining?

A. I have a few slides that include some definitions that I feel are important because they were included in the medical review. And I also have some of the pictures of actually Mr. Terrana's MRI and his x-rays.

Q. All right. And, Your Honor, if I may -- how did you bring them to court, in what form?

A. I actually have a jump drive that I could plug right in if I'm allowed to get up.

MR. CAREY: Your Honor, we request for Dr. Owens to be able to move to the laptop and to use the screen for demonstrative purposes.

THE COURT: As long as there's questions and answers.

MR. CAREY: Sure.

THE COURT: You can get up.

THE WITNESS: Thank you. It's in my coat. Can I grab that real quick? It's on the chair.

MR. CAREY: Sure.

THE WITNESS: Sorry. Thank you. So I'm just going to take a little time. This should probably be like maybe ten minutes for me to sort of explain to you how we go about looking at patients and how we put things together. So it's --

MR. CAREY: And, Your Honor, if I may. Could I inquire as to -- from the jury as to whether or not they can see the screen -- or what's on the screen?

THE COURT: Okay? All right. They nod affirmatively.

THE WITNESS: So the idea is to look at it from a logical perspective, not just an opinion perspective. So what I try to do, and this is when I teach, we really

try to want to say here's the evidence, this is the logical rationale of going through so that you're really able to make your own decision. So the evidence should demonstrate the same thing to no matter who looks at it. So when we look at the spine here, it's really important for two main pictures. If I'm in your way just tell me to move. On the left is a picture of the whole spine and those are color-coded based on the region of the spine. So on the top is the blue, that's the cervical or the neck. The green is the thoracic or the middle back. And the yellow is the lower. Now, even though we call them different things, that system all works together just like your heart works with your arteries and your veins and your lymph nodes to create circulation. Same with the spine. So we evaluate the spine as a whole model to begin with, but what's also important, particularly in cases of injury, that we look at each individual segment as well. So not only do we have different regions, but we also have different segments similar to knuckles in your fingers, right? If all my knuckles are working fine, my hand functions the way that it should. If I have a problem with one knuckle, now that changes, right? The consequences of that we don't know, but it changes.

Now, when we have the spine and those bones in particular, without any sort of tissue connecting them

we'd just kind of be a pile of bones, right? Like just a bag with nothing holding it together. So the structures that hold those bones together are called ligaments, but they fall under the category of connective tissue. And there's lots of different types of ligaments. There's lots of injuries that could happen. We have them in knees and hips and elbows and shoulders, but it can also happen in the spine.

Now, when we go through certain definitions -- and the reason I put these up is because it's important because they're in the medical records that I reviewed. Now, when I went through my training this group of words was really sort of confusing to me and it took me a long time to be able to sort them out. So I'm hopeful that we can have a quick discussion on this.

Now, the term spondylosis, spondylosis in the spine means arthritis. When it's in the knee or a hip we call it arthritis, but for some reason when we talk about spine everybody gets a little squirrelly and we've got to sound fancy. So instead of saying arthritis, we say spondylosis. So when we're looking at reports, when we're interviewing patients and we're looking at past history, arthritis is really sort of a term that I'm looking for. And I'm looking for it because I want to know if that problem preexisted. Arthritis is a result of a problem in

the past in the body's natural response. In the spine that's called spondylosis.

BY MR. CAREY:

Q. And, Doctor, is this something that you bring to each analysis when you're going to look at the films of every patient or individual that you're going to be evaluating?

A. One hundred percent because -- especially because mostly what chiropractic is is hands-on therapy, right? It's manual.

Q. Okay.

A. So somebody that comes in that has a lot of arthritis, that joint could be more delicate than others, so from a diagnostic and treatment perspective, yeah, it's really important.

So when we look at just a simple picture, there's certain things that go with spondylosis. I'm not really a fan of the term. I'm more of a fan of what compromises. And there's a couple really important words. One is bone spur. And the other is a narrowed disc. So those are the hallmarks of spondylosis. Just like fatigue and a fever would be a sign of the flu, a bone spur and a loss of disc heighth is a hallmark of arthritis or spondylosis in the spine. So we're going to look for those, okay? Those are the things that would typically show up on an x-ray or an MRI. And we'll get into that in a second.

Now it gets a little complicated because we're adding syllables. Spondylolysis. So we had spondylosis, which is arthritis, but spondylolysis is a different term. And what that means is a break in a bone that's very specific to an area of the lower back. And that was in Dr. Fishkin's report and he had talked about it, because it relates to what happened with Mr. Terrana and how he presented. Spondylolysis is a separation of a very specific part of the vertebrae called the pars interarticularis, which I'll show you a picture of that in a second. So even though spondylosis is arthritis, lysis means to break, right? So that's where that term comes from. So spondylolysis is a break in the bone even though they sound similar.

Now, this might be a little bit difficult to see, but really what we're doing is we're looking at a specific area of the spine, and this is my lower back if you're looking this way. With a break in the bone, that's your spondylolysis. And that can occur from a variety of reasons, which we'll get to in a second. So that's what that term means.

Now, lastly, the third confusing word is spondylolisthesis. Spondylolisthesis means that that break had allowed the bone to move forward. It slipped, okay? In this case we're not worried about that, but it's in Dr. Fishkin's report, so there's a progression with certain things, okay? So spondylosis is arthritis, spondylolysis is the break,

spondylolisthesis is the slippage. But what I'm most concerned about is the spondylosis. Is there preexisting degenerative arthritis.

That's the bone, but we also have the disc. We have a vertebrae, a disc and a vertebrae on top. That's a motor unit. And just like we have the whole spine, each one of those motor units makes up the whole spine. So we can't just look at the bone, we have to also look at the disc. So the bone, when it's old, will show this spondylosis, this arthritis, bone spur and a loss of disc heighth. But what happens to the disc? How can we look and see whether the disc is essentially arthritic? And there's one main term that's important just for the disc, okay? And that's called desiccation. Now, everybody's bought shoes and you open up the box and there's a little packet in there and we always throw the packet out because it just says don't eat it, right? So in that packet is a powder that's called a desiccant. And what a desiccant does is it dries out things, right? So that your shoes don't come moldy, gets rid of the humidity. So it's the same thing with the disc. As a disc desiccates, it dries out. So the best example in your brain would be a healthy disc would be nice and juicy, full of water and it would represent a grape. An old, beat up, nasty, arthritic dried-out disc would be like a raisin. And we can have varying degrees, but what we're looking -- what I'm looking for is, is there spondylosis with a bone spur, a loss

of disc heighth and a desiccated disc, which would indicate old problem, or are all of those things absent, which would indicate that this had to be -- it's plausible that it was related to a recent event. That's sort of where my brain's at. It's just about plausibility right now as we sort of work you through.

Now, here's a good example, and I'll say that this is not Mr. Terrana's MRI, that's going to be the next one, but this is a very good example of the difference between a healthy disc and a desiccated disc. The yellow arrow would represent a healthy disc. That's the grape. The red arrow would represent an old, dried out, beat up disc which is desiccated. That's the raisin. So when we're looking at the MRI films, what we're looking for is, are there more grapes than raisins. And if there are raisins, where are they? Are they near the injury, are they not, etcetera, right? Then we're also looking at the bone. Is there spondylosis, is there a bone spur, is there a loss of disc heighth. So all those things sort of tell a story. And, again, this is just another chapter in the book. We're just piecing it together.

Now, when it comes to an injury to the bone, or a fracture, all right? And we have that situation with Mr. Terrana, in the vertebral column, particularly the vertebral body, there's two types of ways that the bone breaks -- or the bone can break. One, on the right is what's called a

compression fracture. And I think a lot of people have heard about that. Usually we see it in the elderly where the actual heighth of the vertebrae is compressed. So it's squeezed together. But that's because the bone compresses and it's not strong enough to hold it. That's what osteoporosis does as an example. But in healthy, strong bone where there's no mineral problem in the bone, that generally doesn't happen. What happens is, the bottom of the bone or the top of the bone, which is here and here, cracks. This area is called the endplate. So this is called an endplate fracture. This is called a compression fracture. Even though they both happen to the bone, they're done at different reasons, different times in different people, okay? One of the other reasons that this is more likely -- there's two reasons. One is that the mineral content of this bone is really good typically in young people and also the integrity of the disc, it's real healthy. So the disc is not likely to tear and it's more likely that the disc is going to go through the bottom of the vertebrae and break it that way, okay? And that's called an endplate fracture, right? So we start to understand the difference.

Q. So, Doctor, in this scenario, the healthy disc will actually break the healthy bone or create a fracture in the healthy bone?

A. In situations, yes.

Q. All right. And -- well, what type of situations

would you see those types of fractures in a healthy vertebral bone with healthy disc?

A. Typically compression, which is not to be confused with a compression fracture, but this type of compressive force that pushes down is what's going to build up and that disc is not going to give because it's done in typical -- it's strong, right? So the weak part, it's always going to go to the path of least resistance, which is, in that style, is the endplate. The path of least resistance on the right side is the demineralization of the bone, it's just weak.

Q. And the endplate, you're talking about the what? The section of the vertebrae that the disc rests on?

A. Yeah. So just think of a plate as something that's straight and there's a top plate and a bottom plate, but it's really part of the vertebrae, it's a block. So the endplates are the top and bottom of the block --

Q. Okay.

A. -- okay? And that's harder bone, right? You ever bite into like a candy bar that has like a lot of nougat in the middle, right? The edge is really dense because that's the chocolate, but the inside is a little bit more fluffy. That's how our bones are, right? That's why our bones are built that way, because if they were solid, we'd weigh like eight hundred pounds, right? So that spongy bone in the middle is important, but it breaks through the edge, okay?

Now we have to look at, okay, great. We understand what's old, we understand what's new. We understand how things can break, but does it really matter? You know, if it breaks and I don't feel it, it doesn't matter. So is there nerve supply? And there's a term that's really important in what we do and that's called innervation. Innervation is a term that means to give nerve supply to. Certain areas of your body have more nerves than others, like your face versus your back. Your face would have a lot more nerve endings than your back for obvious reasons, but the structures of the spine, the connective tissue, the bone and the disc, the intervertebral disc, all have nerve endings in them, some more than others, but when the structure is changed, it's those nerve endings that transmit pain. That transmission of pain then has an automatic response by the body and now we have to deal with it. So giving nerve supply to a structure that's injured is important.

Just a few more -- one more slide and then we'll get into the pictures, I only have a couple, and I'll be wrapping up.

So when we look at the structure of the disc, the disc itself has a real nice spongy interior that gives it a lot of structure, so when I stand and gravity pushes down on me, I can support my spine. This is protected -- this nucleus is protected by all of these bands of connective tissue. Almost

like bubble gum tape, you know, the little thing in the pink circle and you open it up and there's bands around it? Over time, or as a series of a traumatic event, these can be torn. This nucleus material can leak out, but in younger patients that connective tissue is extremely strong. So in a traumatic event this nucleus cannot tear through this, it's going to go up through the endplate, right? And you're going to see that typically in younger, healthier spines, as opposed to more degenerative spines with prior injury, okay? And that's what leads us to connective tissue. The tissue that connects the bones.

Now, when that tissue, connective tissue is injured, that connective tissue then is replaced by tissue. Like if you cut your hand, you're going to have a gap in there, the skin is going to separate, but what happens? That gap is mended, and that gap is mended through a process called wound repair. It's not healing, it's wound repairing because it's replaced with different tissue. That's why if I get cut on my face I'm worried that I'm going to have a what? Scar, right? Because if it's the same tissue, I wouldn't have a scar. You would never be able to see it. And that's why plastic surgeons, good spine surgeons, everybody will hide the scar because you're going to get it, it just depends on how much, okay?

Now, in the ligament there's two terms that are really important as we get through this quickly. There's two

components to connective tissue; collagen, which we've all heard about in makeup and cosmetic aids and things like that, and elastin. Collagen is real rigid, it gives structure. It's like the steel frame of a building. And elastin gives us stretch. So that's how we're able to support ourselves, but move. Now, what's interesting is, in the spine there's a lot more collagen and not so much elastin.

Q. Why is that, Doctor?

A. Mostly for support, right? Because the spine is built to protect our very delicate central nervous system; spine and cord -- or, I mean, brain and cord. So we want to have a rigid structure that can bend a little bit and move, but it's not going to be like -- maybe you had friends or even yourself, people call it double jointed, right? They can bend in all these really interesting ways, or like a contortionist, those people genetically have way more elastin in their connective tissue than collagen. So that's a genetic profile. Some people are real stiff because they have more collagen. But what's important is this process right here, and this is kind of it, and we'll get into the three, four imaging slides.

When we're born, our collagen -- or I'm sorry. Our connective tissue is being formed. And if you look at babies they're mostly elastin. I mean, you can bend them and they move in really interesting ways, right? But as we age, the cells that make that connective tissue, that produce the

collagen and the elastin, those cells, by the time we get to puberty, are dormant, because genetically by the time we reach puberty, we're pretty much matured, right? At least physically. So when we get to that point of maturity, those fibroblasts go to sleep, they go dormant, because they've done their job. They don't die off, but they go dormant. The only time they come back is when there's an injury to that connective tissue. Now they're activated because now you need your workers to repair that, just like in your skin and inside along your bones and your spine. Once that happens, that fibroblast doesn't really know where in your age it really is, it just automatically assumes that you're old. So all it does lay down predominantly is collagen. So you lose elastin, flexibility. Those ligaments aren't able to bend in the way that they used to, which is very common in the knee, in the hand and all that. In the spine it's difficult because we have to rely on imaging and this kind of storybook, right? Because if it's just a knee, we can all look at it and we don't have to build a story, but in the spine we have to do that. And this is the basis for why injury occurs and when it happens, if it's significant, it will persist. So when we look at types of imaging --

Q. Just for our own sake. What are we looking at right here, Doctor?

A. This is a picture of an x-ray.

Q. Okay. Whose x-ray?

A. This x-ray was from Dr. Fishkin's office.

Q. And who is it an x-ray of?

A. Mr. Terrana. So everything that I'm going to show you from an x-ray perspective or an MRI perspective is Mr. Terrana's imaging, right? So we can just kind of look at apples to apples. But, again, this is a picture of the middle back. All of these lines here are ribs. These sort of wispy, billowy looking in the white there, that's his lung field, but the x-ray is through here under the armpit. So you can look and you can see some of the vertebrae here. Here's his liver. You can see some of these things here, but, you know, unless it's an obvious thing, it's there, but it's not really assessing connective tissue. X-rays only do bone. No connective tissue. We can assume connective tissue by the spacing, but that's not what it's used for.

Q. What is this a photo of?

A. This is a picture of the lower back, the lumbar spine.

Q. Whose lower back?

A. Mr. Terrana's. So he would be standing here and the x-ray would come through the hip. This area here is the part that we call our hip when we put our hands on there. It's really our pelvis. And then the rest of these are bones in here and the lumbar spine, the lower back has five of them, but

the yellow arrow is the site of where Mr. Terrana's injury in the low back is, which I'll talk about in a second. But you can't really see it. And the reason that you can't see it is because when you take an x-ray, it's like me putting my hand here in front of you and then taking this same hand, my left hand, and putting it over my right. You can see the shape, but you can't appreciate both because it's one plane. You're taking a three-dimensional image and you're looking at it in two dimensions. But if I can turn the spine and I can look at both of these now, because it's at an angle, and that's why these x-rays, the next picture I'm going to show you, is a picture of that. So instead of me standing straight or me standing to my side, I'm going to turn just a little bit, and that's called an oblique. The oblique is designed to evaluate the pars interarticularis, that very specific part that's related to spondylolysis and all those other terms that we talked about earlier. That arrow is right where that problem is, but it's kind of --

Q. And this is Mr. Terrana's spine?

A. This is Mr. Terrana's lumbar spine.

Q. Okay.

A. And that's the radiograph from Dr. Fishkin's office. Okay. We can tell that there's a problem there, but it's not really specific. We want to see the surrounding tissue. Now, when we do that --

Q. And are you able to see the surrounding tissue on an x-ray?

A. No.

Q. Okay. What do you need to see the surrounding tissue?

A. Well, x-rays use ionizing radiation, and that penetrates your bones, so basically what happens, I stand -- there's a film behind me, you shoot me with x-rays, my bones absorb all of it, the rest pass through and they leave an imprint on the film, right? That's sort of a simple explanation, but it uses radiation. But all it's showing is tissue that can absorb the radiation, which, at that level, it's bone. In contrast, an MRI is just a big magnet, there's no radiation. You could live inside an MRI tube and it would never hurt you. It's just a magnet. But that's going to give us different looks at muscle and connective tissue. And remember, when we talk about the story at the beginning, it's about what's new and what's old, it's about the bone, but it's also about what connects the bone. So when you see these cases, a lot of these things come at the same -- they come together. I'm evaluating the bone and I'm also evaluating the connective tissue, let's overlie them and see if they match up.

So what I'm going to do -- this first slide is just to show that it's actually Mr. Terrana's MRI. Okay. So what I'm going to do is show you the big slide and then give you a

close-up of what that looks like. So this is a picture of Mr. Terrana's middle back, or thoracic spine, and this is a zoomed in picture of that exact slide. So the first thing we want to look at is, are there more grapes than raisins, are there any raisins in there at all. We see that we have a bone, we have a disc, we have a bone and we have a disc. All of those discs are bright and they're very hydrated. They're very grapy, okay? There's no raisins in there.

Q. What does that mean?

A. The grape is not desiccated, okay? Remember that term? That means that it's old and dried out. It's not desiccated. So what that means to me is that nothing has happened to those discs before. They're still hydrated, they're still healthy, consistent with Mr. Terrana's age and consistent with the idea that there's no preexisting problem with the disc.

Q. Okay.

A. Now, when we look at what could happen, we want to kind of go back to that discussion about what happens to the bone when compressive forces are applied, okay? And, again, the level of the compressive force can vary individual to individual, okay? But here we look at the tenth vertebrae, so this vertebrae is -- the region of the spine gets a letter; C is for cervical, T is for thoracic, and L is for lumbar. Here we're looking at the thoracic spine, so we're getting a T.

Now, because there's twelve vertebrae in the thoracic spine, we have to kind of outline where we're at so we can discuss the individual motor unit, not the whole spine, right? So we're taking the whole spine, going to the thoracic spine and now we're going to a specific region of that spine. Now, T10, T11 and T12, there's endplate fractures in Mr. Terrana's spine that are resultant from the injury.

MR. CAREY: And, Your Honor, if I could interrupt just for one second and inquire as to whether or not the jury can see from that distance clearly what is depicted on the screen?

THE COURT: They seem to be able to.

MR. CAREY: Okay. Thank you.

THE WITNESS: Now, the interesting thing about MRI is, once you get the data and the computer gets the picture, we can, you know, just like when you take your iPhone or your Galaxy phone, I'm an iPhone user, so whatever Android is, you can change the contrast, you can move colors, you can make things brighter, make things dimmer to see what stands out. When we look at MRI, there's two main categories of that and they start with a T, okay? And that has nothing to do with the spine. It's an MRI physics parameter. But there's a T1 image and a T2 image. And a T2 image, the water, is bright. So we have lots of water and this is the fat over the muscle. And

here is the spinal cord with cerebral spinal fluid and then there's fluid in the disc, so the water is really bright. But it doesn't really, I mean, we can see the fractures in here, but what we want to really do is look at -- and look at them better. Take them -- for lack of a better term, take the flashlight out of our eyes and get rid of the bright so we can look at just the edge of the bone, all right? Okay. And that is this picture here. And when you look, these endplates here, obviously, are changed and deformed, because those discs had broken through. That's very consistent with what the neuroradiologist read. That's very consistent with other providers and that's certainly consistent with what I thought and what I looked at, okay? So that's really important to correlate that, but that also correlates when I moved him like this. Remember when I did the orthopedic test? We stressed those. That also correlated with the fact that he said, hey, my middle back hurts, right? And my middle back has hurt. Again, there's a much better picture of those spinal deformities which are fractures.

BY MR. CAREY:

Q. And, Doctor, is that a close-up of Vince Terrana's -- or the MRI of Vince Terrana's spine?

A. Yes. This is a zoomed in version of the last two of this one, which is zoomed in of that one. Okay. So that's the

middle back, so we can see that they're there.

Now, lastly here, there's a few slides on the lower back, so let's take a look at the lower back. And remember, that when it comes to the discs, we can see these discs are very bright, there's no desiccation in the disc, but we're not as concerned about the discs in the lumbar spine as we are concerned about the pars interarticularis. And there's some question of whether it was old, whether it was new. And when we look at the T2 image, okay? Which is where you can see the cerebral spinal fluid here, this is the pars interarticularis. That's at the bottom, way at the bottom, that we couldn't really visualize on x-ray. Now, on the T2 image we can see a bit of a fracture line, but it's not until we go to the T1 image, okay? That we can really see it. Here's a really good picture of it, in here and in there. That's a little bit more zoomed in, okay? So it's there. So the question then becomes, when we look at, was it new, is it old, does it have nerve supply. If the connective tissue is injured, what's the long-term consequences? We know there's going to be scar tissue. So that is part of the rationale that I look at as to whether something was old, something was new. And in the end, kind of what we're going to do about it if it's there. And that's the basis of how I generated the report taking all those things into account.

Q. Thank you, Doctor.

THE COURT: Can we have the lights? Thank you.

BY MR. CAREY:

Q. All right. Doctor, before we move on from the -- from your review of the MRI and the x-rays of Mr. Terrana, were those findings that you made consistent with Mr. Terrana sustaining those injuries from trauma?

A. Yes.

Q. And did you make a determination -- or off of those, do you have an opinion with regards to what were the injuries, and specifically the T -- I think you said T10, T11 and T12 fractures, what the cause of that was -- or what the cause of those fractures were?

A. Yes, I did. And, again, it comes down to plausibility and it also comes down to visualization of preexisting conditions. So those discs were bright, they were new. There was no prior history of any treatment to that area. There was no prior complaint. There was no bone spur. There was certainly no loss of disc heighth. There's no desiccation, but it's clear that that endplate is broken. And that's consistent with what I examined and what Mr. Terrana had opined.

Q. Okay. And I believe, just to be clear, there was the endplates of three different vertebrae that were fractured, correct?

A. That's correct.

Q. And, Doctor, if those MRI's were taken on February 27th of 2015 and Mr. Terrana had been in a motor vehicle -- a rear-end motor vehicle collision on January 22nd of 2015, about five weeks and change earlier, would those findings be consistent with the injuries coming from that motor vehicle collision?

A. Yes. And the reason is that, again, looking at past history, looking at whether there was any evidence of preexisting response to trauma or injury and also timing. You know, from a storybook perspective, it fits well together if you take into account everything. Now, one of the things that is very important on MRI is swelling. And in an MRI they call it edema, right? And sometimes in -- in internal medicine if somebody has breast cancer and they take away lymph nodes, their arm's going to swell because of edema. It's an accumulation of fluid. Accumulation of fluid on an MRI is typically looked at as a sign of injury --

Q. Okay.

A. -- but what's interesting though, just like when you have a bruise, eventually it will be resolved, right? The bruise kind of goes away. Some people bruise forever, some people, it's a day and it's gone. So everybody's metabolism changes that differently. But in fractures in the spine on MRI, edema is only seen in about fifty percent, number one. And even if it is present, typically within four to six weeks

it's resolved. So --

Q. And when you say resolved, what does that mean?

A. It's been reabsorbed. So when you look at it, there is no edema, okay? And that's something to consider and I always consider that. But then if there is no edema, then we have to drop down to the default of, are there other instances of preexisting conditions; desiccation, loss of disc heighth, bone spur. And those are the things that can then help us -- help me to kind of correlate from a timing perspective, a symptom perspective and a past medical history if it's more likely than not that, hey, this is what happened now and this is the result. And my opinion is that it is.

Q. Fair enough. And on those films, did you see any indications of longstanding, preexisting conditions or degenerative conditions in Mr. Terrana's spine?

A. I did not in the thoracic spine and any of those mentioned fracture sites. And there was no significant arthritis even at the level of the pars interarticularis.

Q. Just a couple of things for clarification.

There's been testimony from Dr. Munroe, and I believe you might have reviewed it in Dr. Munroe's records, that there were x-rays taken initially by one of the treating chiropractors at Dr. Munroe's office of Mr. Terrana. And they -- have you reviewed those or reviewed those records?

A. I believe there was comment on the x-rays taken at

his office in the initial report on the very first visit, yes. I did not look at the films, but I did read the words.

Q. All right. Did those -- did the findings of those -- findings in those reports concern you with regards to your opinion with regards to what caused Mr. Terrana's conditions that you've observed on the MRI?

A. There was certain findings in that initial report that didn't correlate with me observing and looking at Dr. Fishkin's x-rays, which was the same body region.

Q. All right. And with regards to the MRI, does that give you a clearer view of what's actually the state of an individual's spine?

A. Yes. One hundred percent.

Q. Okay. And also, Doctor, in reviewing Dr. Fishkin's records, did you note that Mr. Terrana had advised Dr. Fishkin that he had previously, some five years earlier, treated for some period of time with a chiropractor?

A. I'm aware of that.

Q. All right. Did you consider that in your overall evaluation of the situation?

A. Yes, I do, and I did. And what's important, like I had mentioned with the orthopedic testing and the MRI, what we're really looking for is what type of tissue was injured. I have lots of patients that come in with muscle problems or just to get adjusted because it makes them feel better. So a doctor

visit isn't necessarily indicative of an injury or a trauma. I see my primary once a year for a physical. I'm not going in there for an ailment, but I'm going in there to be taken care of. Most chiropractic visits are muscular and those muscular conditions are -- they resolve quickly. So what my view was is that there was no longstanding problem. Certainly, there's no prior MRI, but even with all of that aside, when you look at the MRI that we have now, and you look at whether there was anything preexisting in those images, there was not. So that's more of an arbiter for me above all else, is that imaging.

Q. All right. Thank you, Doctor. I think I might have interrupted your next point, but with regards to having evaluated the films of Mr. Terrana, what did you do then in terms of your evaluation?

A. That's when we -- then I wrote the report.

Q. All right. And at that point, did you have other medical records in addition to Dr. Munroe and Dr. Fishkin?

A. Yes. So Dr. -- Dr. Munroe had referred to Dr. Fishkin and then Dr. Fishkin actually had referred out as well, so all of those records were included, as well as independent evaluations.

Q. All right. And let's talk, first, about any other treating physicians that Dr. Fishkin referred Mr. Terrana on to.

Did you -- did you review or have the records of Dr.

Tracy?

A. Yes. So in Dr. Fishkin's report it was clear that he had discussed surgery as an option, but before that, in his record, he had mentioned that he was referring to Dr. Tracy for an injection.

Q. All right. Sir, do you know who Dr. Tracy is?

A. I do.

Q. All right. And in your practice, have you ever -- and who do you know Dr. Tracy to be in terms of what type of physician?

A. Dr. Tracy is somebody I would send my family to.

Q. Okay.

A. And I've worked very closely with him. I believe he, perhaps, may have retired, but I've worked very closely with him. He's a good clinician.

Q. Based on the records of Dr. Tracy, in his treatment of Mr. Terrana, did you make any determinations as to what treatment was provided?

A. Based on the review of the medical records, it was really clear that the injection therapy was directed right to the area where the pars interarticularis injury was.

Q. And was there other shots or injections in other locations of the spine as well?

A. There's been multiple injections, but they were directed specifically to control pain and inflammation in that

specific area.

Q. All right. And, Doctor, with regards to your practice, is there ever occasions where you make determinations as to whether or not you're going to refer any of your patients on to pain management with a physician such as Dr. Tracy for shots or these injections?

A. Yeah -- yes, to answer your question. And that's generally because injection therapy has really replaced narcotics, and we, obviously, all have experiences with where that got us. So understanding what a provider can do, it's not my expertise, you know, I'm not providing it, but I understand the clinical indications for the referral. And when I read Dr. Fishkin's report and I looked at what Dr. Tracy had done, that was very consistent with how I would have worked with Mr. Terrana if he was actually a patient.

Q. All right. And when you're with your own patients, do you ever discuss with them, you know, what to expect from a particular modality or therapy that you're referring them on to?

A. I do give them a basic education because, again, if we're talking about Dr. Tracy, that's him and his staff's job to go into the details, but, you know, I have a working knowledge. And as a matter of fact, that's one of the rotations in the fellowship program is interventional pain management. So from a research perspective, yes, I do have a

perspective on that and I do talk about that with my patients.

Q. All right. And when you talk about it, do you talk about whether or not the procedure itself is painful or what it entails?

A. I prepare them to not be shocked when they go. If that's what you're asking, yeah.

Q. All right. And what do you mean by that?

A. It's kind of a bear of a procedure, you know, the needle is probably about that long. But you're only really sedated locally, so you're not asleep. So when they put that needle in and then they fill that space with whatever medicine they're using, it's tender, yeah.

Q. And so you try to prepare your patients for that?

A. Yeah. And my experience, again, in twenty-two years, is that the patients that go through that are going through it because they're looking for relief, you know, this isn't an elective procedure that people say, hey, it's Sunday, I feel like getting an epidural. It's a real procedure for -- yeah.

Q. All right. And so did your record review determine that Mr. Terrana had those shots?

A. Yes. That's correct.

Q. Now, in referring your patients to that type of pain management, is there a limit to how many injections an individual can receive or can have?

A. Over my experience and what I've read in the record

and, again, that's not my expertise --

Q. Sure.

MR. SENDZIAK: Objection then if it's not his expertise.

MR. CAREY: Well --

THE COURT: If it's not his expertise he really can't testify to it. So it will be sustained.

BY MR. CAREY:

Q. Okay. With regards to patients that you treat in conjunction with a pain management physician such as Dr. Tracy, is it understood as to there being a limit to how often they can go back to a pain management doctor for injections?

MR. SENDZIAK: Same objection.

MR. CAREY: Your Honor, this goes to --

MR. SENDZIAK: It's asked a different way, same question.

THE COURT: Chris, can you read me back the question?

(Whereupon, the above requested testimony was then read by the reporter.)

THE COURT: He can answer that. Overruled.

THE WITNESS: Epidural injections are not a method to manage pain. They can be treated, but my patients are typically returned to me. And my understanding is that you can get no more than three in

one area, because the steroid just dries out the tissue and you have another problem. So these are curative if they cure. If not, then we have to find other means to manage.

BY MR. CAREY:

Q. All right. And what other means are there?

A. Chiropractic care, exercise. It's really maintenance --

Q. All right.

A. -- you know, and I don't want to say pharmacy, but typically as conservative as possible. But, again, with a permanent condition you have to progress, you know, and that's what we're dealing with here, is a condition that's permanent and it's significant.

Q. All right. And could you explain to us how you arrived at that determination, that Mr. Terrana's condition is permanent and progressive?

A. Typically, I'll start thinking that with my own patients about a year post injury. And, again, looking at the imaging and taking the whole story, when I saw Mr. Terrana, it was almost five years. So considering the fact that treatment failed -- see, some people believe that failed treatment means that there's nothing wrong. But failed treatment, particularly with the evidence in the imaging, is really an indicator of permanency. So we move from intervention for cure to

intervention for management. And everybody's different. So Mr. Terrana's doctors will be able to help him with that. It's something that has to be monitored over time, but it's long-term and permanent.

Q. All right. And in your review of the records of Dr. Fishkin, is there an indication that at some point Mr. Terrana could -- would need surgery on his spine?

MR. SENDZIAK: Objection.

THE COURT: That is?

MR. SENDZIAK: He's not a medical doctor and certainly not a surgeon, Your Honor. He's not qualified to give an opinion on a medical doctor's records.

THE COURT: He can answer the question.

THE WITNESS: It was outlined specifically in Dr. Fishkin's report that he was a surgical candidate and that he should return in the future if he needed.

BY MR. CAREY:

Q. All right. In your practice do you ever treat patients postsurgically?

A. Yeah. Unfortunately I have a lot.

Q. All right. And in your practice, do orthopedic surgeons actually -- actually refer their surgical patients to you for ongoing conservative management after their surgeries?

A. Yes. Specifically those patients, obviously there's pain persisting, and they're not going to go the narcotic

route. They're out of options with injection. They're pretty much stuck, so we do quite a bit of that work, yes, absolutely.

Q. Doctor, in your treatment of patients with spine injuries, do you find that there is, there are typically -- strike that.

With regards to your evaluation of Mr. Terrana and his spine, could you make a determination with a reasonable degree of chiropractic certainty as to whether or not there is anything that could cure Mr. Terrana's conditions that you evaluated?

A. In my experience, both in teaching and as a clinician, no. Mr. Terrana's condition, at five years out, is a permanent condition, again, that has to be managed long-term.

Q. All right.

A. It's not going to go away.

Q. And you were discussing or explaining how ligaments being stretched or torn will regenerate different material than was there when they were healthy. Does that -- in your evaluation of Mr. Terrana, did you determine whether or not he had ligament injuries at all levels of his spine, some levels or what? What was your determination?

A. So the ligament -- there is a ligament injury in the neck that seems to be managing pretty well, that's typically why I focused on the middle and lower back. I think he has an ability to manage that. It's not really giving him that much

trouble. But it should be noted that the intervertebral disc is a ligament that is connective tissue. So the fact that we have that endplate fracture and the alteration of that motion has more to do with connective tissue problems than just the outside ligaments. So those are absolutely injuries to the ligaments.

Q. All right. With regards to Mr. Terrana, did you make any determinations as to whether he sustained any injuries to his ligaments that would result in restriction -- permanent restrictions of his range of motion?

A. Yes. And that was done through range of motion testing at the office using dual inclinometers, which is a device that actually objectifies measurement.

Q. And when you're talking about connective tissue, does that include the discs?

A. It includes the discs, the ligaments and the tendons, which are how the muscles connect to the bone.

Q. All right. Did you make determinations as to whether or not Mr. Terrana suffered injuries to some or all of those connective tissues in his spine?

A. Well, that's -- you know, that's a difficult thing to really delineate, right? Because if you have the vertebrae and you have that area, everything's kind of on top of each other, right? So we use the term connective tissue because, in the end, if his joint is restricted because of the tendon or the

ligament or the disc, it's still a consequence. And if it's a consequence of the injury, then that's something that we have to project long-term. So those sites aren't just the thoracic spine, aren't just the bone. It's the disc and the surrounding tissue. With the lumbar spine, the tear in the very bottom, the annular tear in the disc and the pars interarticularis, that entire area has also suffered injury, so yes.

Q. And can you say specifically where were the disc injuries in Mr. Terrana's spine that you found?

A. He had a disc herniation in the middle back in the thoracic spine at T9-10, which is just adjacent to where the fracture sites were.

Q. Would that be consistent with that herniation coming -- at the same time as whatever trauma caused the fractures?

A. Absolutely, because the fracture sites probably would have been disc herniations if the discs weren't as strong as they are and cause the endplate fracture.

Q. All right. So -- but those are all right in a row, you've got a herniated disc right above three straight endplate fractures?

A. Without any evidence of degenerative change, arthritis, bone spurs or anything, yeah.

Q. And with regards to the history -- well, before we move on to the history, anywhere else that you determined there was any herniations in Mr. Terrana's spine?

A. There was an annular tear with a disc herniation at L5-S1, which is the very bottom of the lumbar spine, and that was consistent with the area of the pars interarticularis. And as we mentioned and I showed that picture of kind of the bubble gum tape wrapping around, there was a tear in that. And that tear was acute and causally related.

Q. The tear of the annulus, is that painful in and of itself?

A. That's where the nerves are in the disc. As I talked about it being innervated, the circle around that green ball, that nucleus pulposus, that's where all the nerves hide. So if you tear that, you're going to activate pain fibers.

Q. And with regards to the tear, is that something that is a permanent injury?

A. Yes. Again, just like the fracture sites and all that, it has to be managed. It's not cured.

Q. Is that -- is that going to get any better over time?

A. I think -- if you want my experience with that, is people have good days and bad days, you know, that's really the hallmark of a permanent injury. Just like the range of motion. There's certain areas that are highly restricted and other areas that are pretty close to normal, but that correlates with the anatomy. You know, there's days that I'm going to be able to stand on my feet and then there's other days that I'm not going to be able to. So that's a hallmark of, you know, a

moderate disability, you know, you're going to have good times and bad times.

Q. And, Doctor, you mentioned a moderate disability. Do you make determinations as to certain levels of disabilities on your patients?

A. Every day.

Q. And do you do that when you're doing independent exams such as the one you did with Mr. Terrana?

A. Yes, because that's really correlative to the long-term consequences.

Q. Did you make such a determination with regards to Mr. Terrana?

A. I did.

Q. And what was your determination with regards to the level of disability, if anything?

A. Moderate.

Q. All right. What would that entail? What would that -- what would that mean, a moderate disability?

A. Well, mild or no disability would mean that there was no consequence of the injury. Full disability would mean that, you know, he was in a wheelchair or bedridden, but the moderate, the middle part is really -- that's the difficulty, right? I think there's a difficulty in understanding that it exists. I think there's a difficulty in understanding what do we do about it. Everybody's body is a little bit different.

Some people can tolerate pain a lit bit more than others, but in the end the moderate category is really exactly, you have a condition, there's days where it will floor you, there's days where you can go and have a good time and be outside and enjoy the sun, but then you pay for it. My office, I deal mostly with moderate problems, you know, moderate disabilities.

Q. All right.

A. People can walk into the office, they can get treated and they do well for a couple days. And then I might not see them for a month or two and then oh, my gosh, I was in the garden and --

Q. All right. Now, with regards to the condition that you determined Mr. Terrana has, a moderate disability, is that a permanent condition?

A. After five years from injury, yes, one hundred percent.

Q. And, Doctor, in the course of your preparing or performing his independent evaluation, I think you mentioned that you do also, in your practice, receive and/or review other independent medical evaluations?

A. That's correct.

Q. All right. And did you do that in this case?

A. Yes.

Q. All right. And, specifically, whose evaluation did you review?

A. There was two evaluations that I did review; one was from Dr. Scott, which was an independent evaluation related to care, to treatment.

Q. All right. Would that be Dr. Kevin Scott?

A. Yes.

Q. All right. And did you also review an independent medical evaluation of Dr. Robert Lifeso?

A. I did. And I would like to note too that I had reviewed these after my report, so that's why they're not in there.

Q. Okay. All right.

MR. SENDZIAK: Objection to the -- there's no question, Judge. Can we strike that?

THE COURT: I'm going to strike it.

MR. SENDZIAK: Thanks.

THE COURT: Next question.

BY MR. CAREY:

Q. Okay. With regards to -- with regards to those evaluations, was either of those consistent with your findings?

A. Dr. Scott's was definitely consistent with my findings, even including range of motion and opinion on disability.

THE COURT: What's your objection?

MR. SENDZIAK: Never mind.

BY MR. CAREY:

Q. All right. And based on your evaluation, did you determine that Dr. Scott also palpated or laid hands on Mr. Terrana?

MR. SENDZIAK: Objection to that, Your Honor. I think we've crossed the line of the Court's ruling.

THE COURT: Can I just have that question read back to me? I didn't catch the first part of it.

(Whereupon, the above requested testimony was then read by the reporter.)

MR. CAREY: I can ask a different question.

THE COURT: Yes. I think he would know whether he did or not by reading the documents. Sustained.

BY MR. CAREY:

Q. Right. In evaluating these other independent reports, is it relevant to you whether or not the doctor preparing the report actually examined the patient?

A. It was clear that Dr. Scott had visibly, like, interviewed and seen the patient live.

Q. And was it also clear that he had palpated and found muscle spasm on his thoracic and lumbar spine?

A. I would have to look at that.

MR. SENDZIAK: Objection to the leading, Your Honor.

THE COURT: It is leading. Maybe you can rephrase that question.

BY MR. CAREY:

Q. All right.

A. He did talk about residual pain and he had significant restrictions in range of motion.

MR. SENDZIAK: Objection.

THE COURT: There was no question.

MR. SENDZIAK: Yeah.

BY MR. CAREY:

Q. With regards to evaluation of the report, you indicate that Dr. Scott had also palpated and found muscle spasm in Mr. Terrana's spine.

MR. SENDZIAK: Objection to the leading, Judge. And I think we're getting past the Court's instruction about obliquely referencing.

THE COURT: I'm not sure if we are, but the questions do have to be asked the proper way. I understand that sometimes it's easier to do it a different way, but --

BY MR. CAREY:

Q. Would it assist you in reviewing Dr. Scott -- I believe you have Dr. Scott's report in your file of medical records, Doctor?

A. I do.

Q. And would it assist you to refer to that in determining what findings you felt were relevant in Mr. -- or

Dr. Scott's report?

A. Yes.

Q. All right. And in referring to that, can you refresh your recollection as to whether or not Dr. Scott palpated Mr. Terrana's back and found evidence of muscle spasm in his thoracic and lumbar spine?

MR. SENDZIAK: Leading. Objection. Leading.

THE COURT: It is leading.

BY MR. CAREY:

Q. Have you been able to review Dr. Scott's report in your file?

A. Yes, I did.

Q. All right. And was that consistent with regards to whether or not Dr. Scott found evidence of muscle spasm?

MR. SENDZIAK: Objection, Your Honor. Leading again.

THE COURT: You know what? This is a good time maybe to stretch our legs, take a quick break. You know what, ladies and gentlemen? We're going to take five minutes. And I'll have a little chat with the lawyers and we'll get right back to you.

Just remember the instruction that I gave you before.

Please rise for the jury.

(Jury left the courtroom at 3:23 p.m.)

THE COURT: All right. The ruling was that Dr. Scott's report was not admissible, however, he could, and Mr. Sendziak is correct, obliquely refer to what Dr. Scott found. Getting into the weeds, the methods and the tests applied, I would think, strays outside the oblique nature that I alluded to. So I certainly appreciate you not liking the ruling, I get it. And certainly you're very artfully and creatively trying to get around it. That's fine. But I can't allow you to get into this report because, I mean, substantively, because of what my prior ruling was. I think it would be sufficient, and I'm not trying to tell you how to try your case, was Dr. Scott's rulings -- or findings consistent with yours. The answer's yes, move on. I mean, that's about as oblique as you can get. Pardon?

MR. SENDZIAK: He already asked that question and it was answered.

THE COURT: He might have, but I don't remember. You can ask him that of a series of questions on range of motion, on protrusion, etcetera, was his findings similar to yours, Doctor, and the answer may be yes or no, I don't know. But I think to get into the substance and, again, methods, tests that were used really starts getting into the substance of the report, which, again, goes to the need, if you wanted to have Dr. Scott testify and the fact

that he's not allowed -- or not here, creates a disadvantage for somebody that he's not available for cross-examination. Mr. Sendziak had indicated that he's not going to object to the missing witness charge, fine.

MR. CAREY: Okay.

THE COURT: But I think to continue to explore this area is only going to frustrate the members of the jury.

MR. CAREY: All right.

THE COURT: So my recommendation, for what it's worth, is to move on.

MR. CAREY: I'm going to ask one, two questions as cleanly and then move on to something else.

THE COURT: Hope springs eternal, so we'll see. What?

MR. SENDZIAK: I'm just looking at the clock, Judge.

THE COURT: It is, it's three-thirty.

MR. SENDZIAK: Yeah. I'm not going to -- I don't know how much longer Mr. Carey has, but I don't want to be put in the position of getting ten minutes to cross-examine the doctor. It's going to take me a lot longer.

THE COURT: No, I agree. We've been going since ten to two. Unless Dr. Owens is prepared to come back

here tomorrow, which I'll require him to do to allow the defense to have an opportunity to do their examination, let's use our time wisely.

MR. CAREY: Okay. I will do that. We should be able to wrap this in about five to ten minutes tops. Just a couple questions we're going -- and then we're done.

THE COURT: Okay. Let's take five minutes and we'll come back.

(Recess taken 3:27 p.m.)

THE COURT: Okay. Bring in the jury. Please rise for the jury.

(Jury entered the courtroom at 3:34 p.m.)

THE CLERK: Court is now in session. All jurors and counsel present, Your Honor.

THE COURT: All right. You can all be seated.

Doctor, I'm going to remind you you're still under oath.

THE WITNESS: Thank you.

THE COURT: Mr. Carey.

MR. CAREY: Thank you, Your Honor.

BY MR. CAREY:

Q. Dr. Owens, with the benefit of the break, have you had an opportunity to review the report of Dr. Scott?

A. Yes.

Q. And is that report consistent with your findings

regarding the presence of muscle spasm in the lumbar and thoracic spine of Mr. Terrana?

MR. SENDZIAK: Objection.

THE COURT: He didn't even finish his question. What's the objection?

MR. SENDZIAK: What we talked about during the break, Your Honor.

MR. CAREY: Consistent, Your Honor. I've got two questions.

THE COURT: Well, overruled. You can answer the question.

THE WITNESS: Yes. It is consistent that there was muscle spasms found, yes.

BY MR. CAREY:

Q. All right. And with regards to Dr. Scott's IME report, is it consistent with your finding that the cause of the disabilities and the conditions was the motor vehicle accident of January 22nd, 2015?

A. Yes. Causation, he states the injuries --

MR. SENDZIAK: Objection.

THE COURT: Hang on.

MR. CAREY: Is it consistent --

THE COURT: Wait a minute. Hold on. I'm going to sustain the objection, strike any response where you're reading from the document. Just listen carefully to the

question and answer the question.

BY MR. CAREY:

Q. Was Dr. Scott's IME report consistent with your determination that the January 22nd, 2015 motor vehicle collision was the cause of Mr. Terrana's spinal conditions?

A. It was consistent.

Q. And was the report of Dr. Lifeso consistent with yours or Dr. Scott's regarding causation?

A. It was not.

Q. Was it consistent with yours or Dr. Scott's regarding limitations on range of motion or disability?

A. It was not consistent.

Q. All right. And with regards to Dr. Lifeso's report, was it consistent in that Dr. Lifeso actually -- strike that.

Is there any indication from Dr. Lifeso's report that he ever actually physically examined Mr. Terrana?

A. There was no indication that he saw Mr. Terrana.

Q. All right. And, Doctor, with regards to Mr. Terrana, did I also ask you to review some video surveillance that was provided by the defendants?

A. Yes, you did.

Q. And did you do that?

A. I did.

Q. All right. And was that -- what were your findings with regards to that? What were you looking for on those video

surveillance tapes?

A. Specifically I was looking for movements that were inconsistent with the injuries in the areas that he had sustained injuries.

Q. All right. And did you find that on the video?

A. My perspective on all three of those, the videos; the restaurant, the walking the dog and the men's hockey league were all very consistent with somebody that has an injury that's protecting themselves.

MR. CAREY: All right. Thank you, Doctor. No further questions.

THE COURT: Mr. Sendziak.

CROSS-EXAMINATION BY MR. SENDZIAK:

Q. Hello, Doctor. Is this your first time testifying in court?

A. It is not.

Q. How many times have you come to court to testify?

A. I would say over the course of my career, maybe a few dozen.

Q. Have those few dozen times all been on behalf of people bringing personal injury claims like Mr. Terrana?

A. I'm sorry. I didn't hear.

Q. Have all of those occasions been on behalf of people like Mr. Terrana who are bringing personal injury claims?

A. I believe, because most of my testimony was related

to me being a provider, so, yeah, I would say that's pretty consistent.

Q. Okay. And in this particular case, you're an expert witness, you're not a treating provider?

A. Correct.

Q. And have you, over the years, come into court to testify as an expert witness like you're here doing today?

A. Maybe once or maybe twice other.

Q. Okay. And you were hired by plaintiffs' lawyers?

A. That's correct.

Q. Okay. Have you ever tried to market yourself to the plaintiffs' lawyers in town such as Cellino and Barnes, William Mattar, Brown Chiari?

A. I've done continuing legal education seminars.

Q. Okay. And what plaintiffs' firms have you gone to to do your continuing education seminars?

A. I've not. They -- typically a CLE is approved by the New York State bar --

Q. No, no, no.

A. -- and they come to me.

Q. What I meant was, have you ever gone to Cellino and Barnes to give them a seminar on spinal injury and chiropractic treatments?

A. No.

Q. Okay. You haven't done any of that stuff? No?

A. No.

Q. And in this case, an attorney by the name of Wayne Felle sent you to -- or sent Mr. Terrana to see you?

A. That's correct.

Q. And did you know Mr. Felle before he sent Mr. Terrana to you?

A. I did. I had testified as a treating doctor for him once maybe about three years ago --

Q. Okay.

A. -- two years ago.

Q. Okay. So did Mr. Felle call you up and say, hey, Doctor, I've got a client I want you to examine?

A. I did get a letter from him and then I believe we did talk on the phone.

Q. Okay. So how much did you get paid for your review of the records and the films and your examination and writing the report?

A. Fifteen hundred dollars.

Q. And you're getting paid today, true?

A. Correct.

Q. And how much are you getting paid today?

A. Thirty-five hundred dollars.

Q. Okay. So do you, from time to time, get patients that come in off the street who have been involved in accidents that do not have lawyers?

A. Perhaps. It's not something that we necessarily track, but I would assume that people probably come in before they do that.

Q. Okay. And do you refer patients from time to time to lawyers if they don't have one?

A. I could make some suggestions, but I don't refer directly, no.

Q. And have you made suggestions to patients before?

A. I have when asked.

Q. Okay. And when asked, have you recommended Mr. Felle?

A. Not that I recall.

Q. Okay. So you mentioned Dr. Tracy in your direct testimony. You were his landlord, weren't you?

A. That's correct.

Q. So you and Dr. Tracy shared space for how many years?

A. He shared space with me for about a year.

Q. Okay. So he saw his patients and you saw your patients and he paid you rent?

A. Correct.

Q. Okay. Now, I want to go over the records that you looked at briefly. You don't have Dr. Fishkin's report from April 29th, 2019, do you? Feel free to look at your binder.

A. Thank you. I'm sorry. What was the date?

Q. April 29th of 2019.

A. I do not have that one.

Q. And you don't have the reports of Dr. Tracy from April 19th and June 15th of 2019, do you?

A. I'm sorry. What was that date?

Q. Both in 2019, Doctor. April 19th and June 15th of 2019.

A. I do not.

Q. And when you wrote your report, you mentioned that you had reviewed sixty-six office visit notes from Dr. Munroe's office, is that true?

A. I believe it was sixty-one, but I could look.

Q. I'm sorry. Sixty-one. And please feel free to refer to your report if you need to.

A. Okay.

Q. Okay. Now, you came to your conclusions based on sixty-one -- your review, in part, of sixty-one visits from Dr. Munroe, true?

A. Are you asking about my conclusions on --

Q. Well, you wrote your report --

A. Sorry.

Q. -- and you said you had reviewed sixty-one reports from Dr. Munroe, correct?

A. I had said that he had received sixty-one visits, but that's what I counted, yes.

Q. But he had a lot more than sixty-one visits, he had a

hundred and two visits?

A. Okay.

Q. Did you know that?

A. Well, that's consistent then with a permanent injury, but go ahead. I'm sorry.

MR. SENDZIAK: Well, can we strike that last comment as unresponsive, Your Honor?

MR. CAREY: Your Honor, it was responsive to the question.

THE COURT: Yeah, I would say so. And I'm not going to strike it. I'll allow the answer.

BY MR. SENDZIAK:

Q. So let me get this straight. Mr. Felle sends you the records to review, correct?

A. Correct.

Q. And you get yourself sixty-one reports from Dr. Munroe's office and you read those reports, true?

A. True.

Q. You don't call Dr. Munroe up, you don't talk to him, is that true?

A. That's true.

Q. You don't call Dr. Tracy up and talk to him about his care and treatment, true?

A. That's true.

Q. You don't call Dr. Fishkin or his office to talk to

his people about his care and treatment, okay? Is that so far so good, we're on the same page?

A. Well, the reason for that is I didn't have a HIPAA release from Mr. Terrana --

Q. I'm not asking you the reason, I'm asking you if you called --

A. I can't talk about Mr. Terrana's case with another provider --

MR. CAREY: Objection.

THE WITNESS: -- without permission. That's a HIPAA violation.

THE COURT: Okay. This is what we're going to do. We're going to ask a question, we're going to answer the question asked. We're not going to interrupt each other, okay? And we're just going to ask -- I'm sorry. We're going to just answer the questions that are asked, all right? So why don't you rephrase -- or reask your question and we'll try to get through it.

BY MR. SENDZIAK:

Q. It's true, Doctor, that in coming to your opinions you had no conversations or communications with Doctors Tracy, Fishkin or Munroe, true?

A. That's true.

Q. And when you wrote your report and you came to your conclusions which you put in your report, that was based, in

part, on your review of sixty-one reports from Dr. Munroe's office?

A. True.

Q. Okay. And when you wrote this report, you didn't have all of Dr. Munroe's records, true?

A. True.

Q. Okay. Now, when Mr. Terrana came to your office, did you have him fill out any questionnaires?

A. I did not.

Q. You took a history from him though?

A. That's correct.

Q. And you asked him if he had any prior injuries to his neck, middle or low back, did you not?

A. Yes.

Q. And, in fact, he denied having any prior injuries to his neck, mid back or low back, true?

A. True.

Q. And in this particular case, you know from speaking with Mr. Carey that the plaintiff has testified that five years before this car accident he saw a chiropractor for a period of two months. Are you aware of that testimony?

A. I am.

Q. You're also aware of the testimony, I presume, that Mr. Terrana doesn't remember the name of his chiropractor or for how many visits he went or for what part or parts of the

spine he treated for. You're aware of that testimony?

A. I am aware.

Q. Okay. Now, it would be helpful to you, wouldn't it, to know that information, specifically, who he treated with, why he went there, how he injured his spine and what treatment was rendered, true?

A. True.

Q. Now, you conducted a physical examination of the plaintiff, true?

A. True.

Q. Now, you have looked at the records of Dr. Fishkin, have you not?

A. I have.

Q. And can you find for me Dr. Fishkin's first visit?

A. Yes.

Q. Okay. Now, did Dr. Fishkin make any notes as to the results of his physical examination?

A. Yes, he did.

Q. Now, Dr. Fishkin noted that the plaintiff was able to walk with a normal gait, and that means he had no problems walking, true?

A. No neurological problems. Gait is an indication of central nervous system disorder.

Q. So he had no problems walking, true?

A. From a central nervous system standpoint, that's my

assumption. I'm not Dr. Fishkin, but that's typically, when you record gait, that's what you mean.

Q. Okay. Chiropractors and medical doctors report gait the same way, don't they?

MR. CAREY: Objection, Your Honor.

THE COURT: What's the objection?

MR. CAREY: Well, just in terms of argumentative.

THE COURT: It is a little argumentative.

MR. CAREY: That's fine. Objection withdrawn.

THE COURT: Okay. Move on.

BY MR. SENDZIAK:

Q. Do you need the question read back?

A. Please.

THE COURT: Well, I had the objection. I thought he answered.

MR. SENDZIAK: No.

THE COURT: No? Okay. Do you want to read back the question, then, Chris?

(Whereupon, the above requested testimony was then read by the reporter.)

THE WITNESS: It's not about the reporting, it's about the definition, so I can't say what Dr. Fishkin did or didn't do, but that's the definition. That's all I'm applying.

BY MR. SENDZIAK:

Q. You're associated with the medical school, aren't you?

A. Correct. The definition of gait is to evaluate central nervous system disorders.

Q. Well, anyway, moving on. Dr. Fishkin noted that the plaintiff was able to stand from a seated position with no difficulty, did he not?

A. That's what he wrote, yes.

Q. And I want you to assume that we've had testimony from Dr. Munroe that at some point after this accident the plaintiff was unable to stand from a seated position with no difficulty, meaning he had difficulty. Dr. Fishkin's finding in that case would be inconsistent, would it not?

A. It would be consistent with the type of injury, a moderate disability, sure.

Q. I'm not asking you that, Doctor. All I'm asking you is this --

MR. CAREY: Your Honor, objection. He's answering the question and if defense counsel doesn't like the answer, that's another matter, but --

THE COURT: Well, that's one way of looking at it. The witness is instructed to answer the question that is asked and not in a circumlocutious way get around the question and impart an opinion. Mr. Carey can ask you

questions on cross-examination and I'm sure he will, but please answer the question that is asked.

BY MR. SENDZIAK:

Q. So one provider says he has difficulty going from a seated position to a standing position, that would be the exact opposite of what Dr. Fishkin found on this visit, true?

A. True.

Q. And, in fact, Dr. Fishkin put his hands on the plaintiff's spine, did he not?

A. That's my assumption from the record, yes.

Q. Okay. He found no muscle spasms, true?

A. True.

Q. Now, he tested the range of motion of the spine, so let me ask you this. The neck, flexion means what?

A. Bending forward.

Q. Like this?

A. Correct.

Q. Extension is bending backwards?

A. Correct.

Q. His cervical range of motion of his neck on May 21st, 2015 was absolutely normal, was it not?

A. For flexion and extension, yes.

Q. In fact, Dr. Fishkin, four months after this car accident, tested his lumbar range of motion, flexion and extension, did he not?

A. He did.

Q. It was completely normal, true?

A. True.

Q. And he tested his strength in his hands, absolutely normal, true?

A. True.

Q. In fact, he did neurological testing of his spine, true?

A. True.

Q. It was all normal?

A. True.

Q. What is the straight leg raise test?

A. The straight leg raise test is when a patient is lying on their back and the leg is straight, the knee is locked and the leg is extended upwards toward their head.

Q. The purpose of that test is what?

A. It's multifactorial, but the main test is to see if there's a pinched nerve.

Q. You performed this test?

A. Correct.

Q. It was positive?

A. Correct.

Q. Meaning, you found evidence of a pinched nerve?

A. Reproduced pain, yes.

Q. Dr. Fishkin did it four months after this accident

and it was negative, true?

A. True.

Q. In fact, when Dr. Fishkin saw him -- well, I'll withdraw the question.

Now, is it your testimony that this L5 pars fracture was caused by this accident?

A. That's my opinion, yes.

Q. Okay. Are you aware that Dr. Munroe, the plaintiff's treating chiropractor, testified yesterday in court?

A. I'm aware that he was here, yes.

Q. And are you aware that Dr. Munroe was of the -- was unable to give us an opinion as to whether or not it was caused in the accident?

A. I'm not aware of Dr. Munroe's testimony.

Q. Okay. I want you to assume that yesterday Dr. Munroe testified, under oath, that he could not say whether the pars fracture was caused in this accident. With that assumption, you would disagree with the plaintiff's treating chiropractor?

A. I would, but I would agree on the effect though.

Q. I didn't ask you that. I asked you, assuming that Dr. Munroe testified that he could not state whether this car accident caused the L5 pars fracture, whether that testimony is inconsistent with your opinion?

A. No, because that would mean that he partially -- he didn't say either way, right? So the fact that I -- that's my

opinion. That's ambiguous.

Q. Okay. You say the pars fracture's related to the accident.

A. Correct.

Q. I want you to assume that Dr. Munroe said he doesn't know one way or the other. That's different from you saying it's caused, true?

MR. CAREY: Your Honor, objection with regards to what Dr. Munroe stated. My recollection is he said it's fifty/fifty.

THE COURT: That was my recollection as well, but that's ultimately a question for the jury to decide, but you can ask him a hypothetical if you'd like.

BY MR. SENDZIAK:

Q. Yeah. I want you to assume that Dr. Munroe testified that he could not give an opinion one way or the other whether the car accident caused the L5 pars fracture. Assuming that testimony, would you disagree with Dr. Munroe?

A. No. I would agree with him if he partially believed that it did exist. So I'm in agreement with him there, but I'm in disagreement with him on the other half where he said he's not sure.

Q. Okay. You're sure? You're certain?

A. I'm -- based on the evidence and the lack of degenerative change --

Q. Yes or no, are you certain?

A. Yes.

Q. Okay. Are you aware that Dr. Fishkin, the spine surgeon, disagrees with you?

A. Yes, I am.

Q. Okay. So Dr. Fishkin, who's actually a medical doctor that operates on the spine, is of the opinion this pars fracture was not caused in the car accident and you disagree with the medical doctor, true?

A. My opinion is different, yes.

Q. Now, you haven't looked at the x-rays that Dr. Munroe's office took on the first visit?

A. I have not viewed the films. I've seen the report, yes.

Q. And you're aware that there was, in the opinion of the chiropractor who looked at those films, arthritis in his neck and in his thoracic spine. You're aware of that testimony?

A. I'm aware that -- well, I'm aware of the document, yes. I don't think that was testimony.

Q. Okay. And you disagree with that as well?

A. Well, it's not consistent with the images I reviewed with Dr. Fishkin.

Q. Okay. So yes or no, do you disagree with that?

A. I disagree, yes.

Q. Now, you mentioned a phrase called epidural injection during your direct.

A. Correct.

Q. Okay. And what is an epidural injection?

A. Well, it's one of several injections that a pain management would do, so --

Q. Okay. So an epidural injection, a needle, is put into the disc, true?

A. False.

Q. False. Where does the needle go?

A. It goes into the epidural space.

Q. Okay. Is an epidural injection different than a facet injection?

A. That's one of several, yes.

Q. Okay. Just so we're clear, a facet injection is different than an epidural injection?

A. Correct.

Q. And you think that Dr. Tracy administered epidural injections?

A. No. My example was epidural injections.

Q. Okay. The plaintiff never had epidural injections?

A. Right. That was my example. That's what I said.

Q. Yeah, he didn't have any --

A. Okay.

Q. -- right? He had facet injections --

A. Okay.

Q. -- true?

A. True.

Q. Well, you read the records, didn't you?

A. Yes.

Q. Do you agree with me?

A. I do.

Q. And you were asked some questions about how many times can you get epidural injections, weren't you?

A. I was.

Q. Well, he never had any to begin with, did he?

A. He did not.

Q. Okay. Now, you were asked some questions about a report from a Dr. Scott.

A. Yes.

Q. And I guess the sum and substance of your opinion is that you and Dr. Scott agree on everything?

A. No.

Q. Okay. And did I understand you correctly to say that your physical findings were the same as Dr. Scott's physical findings?

A. I had said that my findings of spasm was consistent with his report.

Q. Okay. But Dr. Scott's findings of range of motion were not consistent with yours?

A. Well, that's because he measured him wrong too, so that's the first thing. So they were not consistent, to answer your question.

Q. Okay. So they weren't consistent. So Dr. Scott, who's an MD, you criticize the way he measured the range of motion, yes or no?

A. One hundred percent, yes.

Q. Oh, okay.

MR. SENDZIAK: Thank you very much, Doctor.

THE WITNESS: Thank you.

REDIRECT EXAMINATION BY MR. CAREY:

Q. Doctor, could we go back to the Dr. Fishkin report from May 21st of 2015?

A. Yes.

Q. Just with regards to -- let's clarify a few things on the history. Dr. Fishkin reported, did he not, that at that time when he saw Vincent Terrana, Mr. Terrana had had chiropractic adjustments, trigger point injections, muscle relaxants, ibuprofen and rest, is that correct, as to what was reported?

A. That's correct, yes.

Q. And would that have an effect on Mr. Terrana's condition or his range of motion on a given day?

A. I would assume that there would be an effect of care, yes.

Q. Dr. Fishkin also reported that Mr. Terrana reported to him the previous chiropractic treatments, correct?

A. Correct.

Q. And -- but also that Vincent reports no previous injury to the spine prior to the said motor vehicle accident, correct?

A. Correct.

Q. And he also reported no previous issue to the spine. This was all with regards to Dr. Fishkin's own evaluation of Mr. Terrana, correct?

A. And that's consistent with the imaging findings, which, in my opinion, is the most important.

Q. All right. What do you mean by that?

A. As he explained, there was no desiccation and there was no bone spurs, there was no preexisting arthritis mentioned in any of the reports, particularly around the injury sites and specifically on the MRI.

Q. All right. And by the way, is that -- within Dr. Fishkin's report, he also reviewed the lumbar and thoracic and cervical MRI, correct?

A. That's correct.

Q. And with regards to any preexisting degenerative changes, was his opinion regarding those films consistent with yours?

A. Yes.

Q. And he also, as a result, had x-rays that he took in his own office, correct?

A. That's correct.

Q. And those are the same x-rays that we reviewed today?

A. Correct.

Q. And, Doctor, is it fair to say that Dr. Fishkin also determined there was no evidence of degenerative changes or arthritis in Mr. Terrana's spine?

A. That's correct.

Q. All right. And is it also true that with regards to Dr. Fishkin's assessment on page four of his report --

MR. SENDZIAK: Objection to the leading, Your Honor.

THE COURT: Not yet. Overruled.

MR. SENDZIAK: Okay.

BY MR. CAREY:

Q. What was Dr. Fishkin's assessment as to his evaluation of Mr. Terrana?

A. His assessment was that the injuries were caused by the motor vehicle accident and he had listed L5 pars fracture, herniated disc in the lumbar spine and cervical and thoracic disc bulges as well.

Q. All right. And what was -- did he specifically say with regards to his assessment of Mr. Terrana's injuries on page four of his report of May 21st?

A. The paragraphs that follow the diagnosis are really sort of outlying long-term history of the condition that he has --

Q. Correct.

A. -- and his discussion with him.

Q. With regards to page four of the May 21st report -- are you looking at the May 21st report?

A. Yes.

Q. Okay.

A. Do you have a specific paragraph?

Q. Yes. Where the heading assessment --

A. Um-hum.

Q. The line immediately under assessment.

A. Oh, yes. That it was his opinion that those injuries were causally related, direct result of the motor vehicle --

Q. Right, but how did he describe those injuries?

A. Significant.

Q. What did he specifically say? Just -- could you just read that sentence?

A. Yeah. It is my opinion that Vincent sustained significant injuries to spine as a result of the motor vehicle accident.

Q. All right. And then he says, Vincent has a diagnosis of?

A. L5 pars fracture, lumbar HNP, which stands for

herniated nucleus pulposus, cervical and thoracic disc bulges.

Q. And then throughout his assessment, he also goes through an analysis of spondylolysis without spondylolisthesis, correct, as you described?

A. Right. There was a break without slippage, but no spondylosis, which would indicate arthritis.

Q. All right. And that was also laid out in Dr. Fishkin's report, correct?

A. That's correct.

Q. And with regards to his plan for Mr. Terrana, what did Dr. Fishkin recommend at that time?

A. He had recommended continued conservative care, which is, you know, chiropractic adjustments, bracing when needed, and either an epidural or a focused injection of the pars region.

Q. Did he ever prescribe a back brace for Mr. Terrana at the same appointment?

A. Yes. And that's what LSO means in there, lumbar support orthotic.

Q. What does that mean, an LSO?

A. Lumbar support orthotic.

Q. All right. So is it fair to say that Dr. Fishkin found a lot more problems with Mr. Terrana's condition related to the motor vehicle collision than defense counsel asked you questions about? Is that fair to say?

A. That's fair to say.

MR. SENDZIAK: Objection, Your Honor.

THE COURT: What's the objection?

MR. SENDZIAK: One, it's argumentative.

THE COURT: What's the other one?

MR. SENDZIAK: And it's leading.

THE COURT: Overruled.

BY MR. CAREY:

Q. And at the bottom, last big paragraph of page four of the -- Dr. Fishkin's report. What did Dr. Fishkin report with regards to causality?

A. He had said, it is my opinion that the motor vehicle accident is the competent and producing cause of Vincent's current spinal conditions.

Q. Okay. And further on in the reports -- you have other reports from Dr. Fishkin as well, correct?

A. Correct.

Q. And Dr. Fishkin discusses with Mr. Terrana at other dates the prospect of surgery, does he not?

A. He does.

Q. All right. And, in fact, on October 6th of 2015 Dr. Fishkin is discussing with Mr. Terrana his lumbar herniated nucleus pulposus, is he not?

A. That's correct.

Q. What does that refer to?

A. That refers to the annular tear that was found on the MRI, but what's most important is he talks about impact and pressure upon the nerve and the nerve root, which is consistent with the odd finding of a positive straight leg raise, which is consistent with my report.

Q. All right. And does he also -- by the way, he does a range of motion on Mr. -- functional range of motion of his lumbar on October 6th, 2015, six months after his May, 2015 report. Was his range of motion okay at that time, in October?

A. And specifically in lumbar he had only half of the stated range of motion for lumbar low back extension, which is consistent with the pars fracture.

Q. And what about with regards to flexion, was he limited in flexion on October 6th of 2015, according to Dr. Fishkin?

A. Yes, he was limited.

Q. And with regards to a plan on October 6, '15 -- I'm sorry. October 6th of 2015, what was the plan that Dr. Fishkin was offering Vincent Terrana?

A. Well, he recommended continued chiropractic care, possibly starting physical therapy or massage. And decided or discussed about surgical treatment of the pars fracture.

Q. All right. And did he say anything about Vince's young age and that impact on the decision to have surgery or not on the top of page four of the October 6th, 2015 report?

A. Yeah. And he indicated that together they would attempt to avoid surgery if they could.

Q. All right. And specifically why? What did he say about age, Mr. Terrana's age?

A. Given his young age and functional demands, we will attempt to avoid surgery for as long as possible.

Q. Okay. And then you had the 5/9/2018 report of Dr. Fishkin?

A. Yes. Yes.

Q. And so whatever the situation was, he was continuing to treat Mr. Terrana still in 2018, correct?

A. That's correct.

Q. All right. About at this point, 5/9 of 2018, three and a half years or three years and four months after the collision of January of 2015?

A. Correct.

Q. All right. And three and a half or three years and four months later, what was Dr. Fishkin reporting with regards to his plan in Mr. Terrana?

A. About continuing to manage nonoperatively if they could, but he also prescribed him pain medicine too.

Q. All right. And did he continue to opine -- was it still his opinion that the January 22nd, 2015 motor vehicle collision was still the cause of the treatment for which he was providing Mr. Terrana on May 8th of 2015 -- 2018?

A. That's correct. It's still his opinion.

Q. And Mr. Sendziak asked you about a couple of reports that you didn't have. I'd like to -- was one of them 4/29/2019 --

A. I believe so.

Q. -- of Dr. Fishkin?

A. Which is maybe the most recent one. I'm not certain.

Q. All right. I'm going to show you what is -- and this is in the record, but is there anything in that report that's inconsistent with your opinions today or Dr. Fishkin's opinions regarding Mr. Terrana's conditions or the causal relation of those conditions?

A. No. He talks about his frustration and that it's been four years, he's taken oral medicine and interventional pain management, inquiring about surgical intervention and he still relates it causally to the persistent pain.

Q. He still relates it causally to the motor vehicle collision of January 22nd, 2015?

A. He does.

Q. So seeing that report that Mr. Sendziak asked you about, does that change your opinion in any way about the opinions that you've made here today regarding Mr. Terrana's conditions or their causal relation to the motor vehicle accident?

A. It doesn't change it. It actually enforces it, I

would say. It's very consistent.

Q. All right. And I'm going to show you one other one that he asked you about. And, by the way, with regards to the -- you saw sixty-one treatment reports from Dr. Munroe's office?

A. That's correct. That's what I have.

Q. Does it change your opinion one way or the other to know it wasn't actually sixty-one, there is actually a hundred and two?

A. I'm not surprised by that. That's consistent with somebody that's trying to manage a long-term injury nonoperatively.

Q. Specifically, does the fact that there's actually forty other treatments with Munroe Chiropractic, does that, in any way, change or strengthen or weaken the opinions that you have today or that you've shared with the jury?

A. Well, I feel that he absolutely followed Dr. Fishkin's recommendation of continue conservatively, so that's consistent with that. And as I mentioned, you know, unfortunately, these problems have to be managed and, you know, you can't go in and be treated and be cured when you have these injuries. So those types of visits are very consistent with somebody that's struggling to stay functional.

Q. And, by the way, throughout all of these records, was Mr. Terrana reporting identical -- well, strike that. Let me

first ask you. Are you familiar with the pain -- how you ask a patient, could you give me what your pain is on a scale of one to ten?

A. Yes. I'm familiar.

Q. All right. And is it fair to say that Mr. Terrana -- that was reported with Mr. Terrana literally hundreds of times in his reports what his complaints of pain were?

A. It's pretty consistent, you know, he has good days and bad days, but yeah, he was consistent for what he has.

Q. Did you find, in fact, that his -- the pain levels that he reported varied throughout the treatment?

MR. SENDZIAK: Objection to the leading, Your Honor.

MR. CAREY: Well, Your Honor --

THE COURT: It is leading.

BY MR. CAREY:

Q. Okay. Did you find that on some visits he gave, you know, he advised that my pain was a higher number and on other visits --

MR. SENDZIAK: Objection to leading.

BY MR. CAREY:

Q. Did you find any variation in the pain, you know, the reporting pain levels that Mr. Terrana gave the treating physicians?

A. His report did vary and that's consistent with

somebody, again, that has a moderate disability.

Q. Why is that consistent?

A. Because there's cycles of inflammation, there's response to care. When you're under active treatment, you feel better, you get back to your life, your daily activities increase and then you start to become more restricted, so you revisit your physicians, they help you, you go back to your life. The consistency -- the inconsistency is the consistent component of a permanent injury.

Q. And I would just ask you, you know, hearing this case, the defense is making the claim that Mr. Terrana is not as injured as he claims to be.

MR. SENDZIAK: Well, I'll object to the form of that question, Your Honor.

THE COURT: Perhaps you can rephrase it. I don't want to cut you off though, but we have about ten minutes left before we have to break and Mr. Sendziak still has to finish his cross -- recross, so just keep that in mind, if you would.

BY MR. CAREY:

Q. All right. All right. With regards to -- with regards to Mr. Terrana's reports of pain and the varying numbers, would that be indicative to you of somebody that is being honest and truthful or someone that is attempting to make his claim stronger?

MR. SENDZIAK: Objection to the form. It's for the jury to decide, Your Honor.

MR. CAREY: Well, he's evaluating.

THE COURT: Overruled. For what it's worth, he can answer the question.

THE WITNESS: I would say it's absolutely consistent with managing a condition. I have diabetic patients, some days their blood sugar is four hundred, other times it's one twenty and it's normal, so those are absolutely hallmarks of somebody that's not playing games. Somebody that's playing games would say I'm eight out of ten all the time.

BY MR. CAREY:

Q. Okay. And that's not what Mr. Terrana has done in these reports?

A. That's correct.

Q. Okay. All right. Is anything you've heard on cross-examination or anything that we've reviewed of the records that Mr. Sendziak asked you about, does anything change your opinion with regards to any of the opinions that you offered with regards to the causal relation or the significance of Mr. Terrana's injuries?

A. They do not.

MR. CAREY: All right. And -- thank you. Nothing further.

THE WITNESS: Thank you.

THE COURT: Mr. Sendziak.

RECROSS EXAMINATION BY MR. SENDZIAK:

Q. So pain is a subjective complaint, Doctor?

A. That's correct.

Q. Subjective complaint means you can't hook him up to a machine and say whether or not he's telling the truth, correct?

A. Correct.

Q. So when Mr. Terrana comes in and says to a doctor, my pain today is six out of seven, there's no way to prove it?

A. Correct.

Q. An objective finding is such when you perform the straight leg raise test, is it not? Bad question.

The purpose of your physical examination and the physical examinations that have been done on Mr. Terrana throughout this, the purpose of those physical examinations was to try to find an objective piece of evidence to correspondence with his complaints of pain, true?

A. True.

Q. Okay. And we know from Dr. Fishkin's reports the four, five times that Dr. Fishkin saw him, he had a normal neurological exam, true?

A. True.

Q. He had normal strength?

A. True.

Q. On the first visit he had normal range of motion of his low back?

A. True.

Q. On the second visit he did not have a normal extension of range of motion of his low back?

A. True.

Q. And on the other visits that had improved, true?

A. True.

Q. So the only objective finding that Dr. Fishkin found was on a couple of visits, his range of motion of his low back was restricted somewhat, agreed?

A. On physical exam.

Q. On physical exam?

A. Yeah. His other objective findings were on the MRI, yes.

Q. On physical exam.

A. Correct.

MR. SENDZIAK: Thank you.

THE WITNESS: You're welcome.

THE COURT: All right. Doctor, you can step down. Thank you very much. I would just ask that anything that has been received into evidence, stay here.

THE WITNESS: Sir, do you want that?

MR. CAREY: Thank you.

THE COURT: Okay. It is now four-twenty-three,

probably not enough time to begin anything substantively. So ladies and gentlemen, that will conclude day three. We'll begin promptly tomorrow. If you can be here by nine-fifteen, I'd appreciate it.

I'm going to remind you about my instructions to you regarding your conduct outside the courtroom. I'm sure you'll be able to abide by those, as you already have. And unless there's anything further, I'm going to ask everybody, please rise for the jury.

(Jury left the courtroom at 4:22 p.m.)

THE COURT: All right. You can all be seated. What are our plans for tomorrow?

MR. CAREY: I have Mr. Daniel Kelly, Mrs. Terrana and Dr. Reigles in the morning. He's the economist.

MR. SENDZIAK: Dr. Reiber.

MR. CAREY: I'm sorry. Dr. Reiber.

THE COURT: Reigles is a hockey player.

MR. CAREY: Well, Reigles is a life care planner. Dr. Reiber.

MR. SENDZIAK: Dr. Lifeso will be testifying tomorrow afternoon.

THE COURT: Is that it?

MR. CAREY: Yep.

THE COURT: And then we'll talk about Friday

tomorrow.

MR. SENDZIAK: Yes.

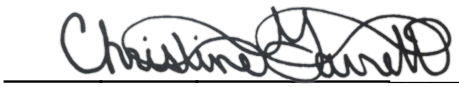
THE COURT: Okay.

MR. CAREY: Okay.

THE COURT: All right. Thank you all. Make sure everything that has been received into evidence remains in the courtroom.

* * * * *

This is to certify that the foregoing is a correct transcription of the proceedings recorded by me in this matter.



CHRISTINE I. GARRETT
Official Supreme Court Reporter