1 SUPREME COURT OF THE STATE OF NEW YORK

2 COUNTY OF ONONDAGA: CIVIL PART

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4 RJI No. 33-11-1413
Index No. 2011-2128

5

6 KELLY VARANO, As Parent and Natural Guardian
Of Infant JEREMY BOHN; et al.,

7

Plaintiffs,

8

vs.

9

FORBA HOLDINGS, LLC, FORBA, LLC n/k/a

10 LICSAC, LLC; DD MARKETING, INC.;
SMALL SMILES DENTISTRY, PLLC.

11 ...
Including: MAZIAR IZADI, DDS;

12 LAURA KRONER, DDS; LISSETTE BERNAL, DDS;
NAVEED AMAN, DDS; KOURY BONDS, DDS;

13 YAQOOB KHAN, DDS; JANINE RANDAZZO, DDS;
LOC VIN VUU, DDS, et al.,

14

Defendants.

15 Jury Trial

16 ____x

17

18 September 24, 2013

19

Onondaga County Courthouse

20 401 Montgomery Street
Syracuse, New York 13202

21

22

Before:

23

HONORABLE DEBORAH KARALUNAS

24 Supreme Court Justice

25 And a Jury

1

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1 (September 24th, 2013, Judge Karalunas, continued jury
2 trial:)
3
4 THE COURT: Ready to proceed?
5 Mr. LEYENDECKER: Good morning. Yes.
6 Mr. HIGGINS: Just briefly, I would respectfully
7 ask if the Court could charge the jury with the standard
8 P.J.I. charge as to depositions being read, 1:94, at Page
9 188 of the 2013 edition.
10 THE COURT: Do you have that with you?
11 Mr. HIGGINS: I do.
12 THE COURT: Anybody have any objection to me
13 reading that?
14 Mr. FIRST: No objection.
15 THE COURT: You can bring in the jurors.
16 (Whereupon, the jury was then brought into the
17 courtroom)
18 THE COURT: Good morning.
19 JUROR MEMBERS: Good morning.
20 THE COURT: Everybody can be seated. Again,
21 once the jurors are in, feel free to just go ahead and
22 sit.
23 I mentioned earlier in my opening remarks that
24 from time to time we have testimony that was taken outside
25 of the courtroom, and I think some of the lawyers have

1 referred to that as well. I'm just going to read you the
2 standard charge that governs that, because you are going
3 to hear during this trial testimony that was taken outside
4 the courtroom, and also see some testimony that was taken
5 outside of the courtroom. We have some videos of those.
6 At some point before the trial began, the
7 parties under oath answered questions put to them, the
8 parties and witnesses, by the lawyers. A stenographer
9 recorded the questions and answers and transcribed that
10 into a document, which the witness later signed before a
11 notary public.
12 The portions of the transcript of the
13 examination before trial -- sometimes it's called an
14 examination before trial; sometimes it's called a
15 deposition; sometimes it's called an E.B.T., but those are
16 all statements taken under oath before the trial. The
17 portions of the transcripts taken -- of the transcript of
18 the examination before trial that you will hear are to be
19 considered as if the plaintiff or the defendant or the
20 witness, whoever is testifying, were testifying from the
21 witness stand here.
22 So remember, I told you, you have to consider
23 testimony in the courtroom. That's considered testimony
24 in the courtroom.
25 Okay?

1 You may proceed.
2
3 Mr. LEYENDECKER: Thank you, your Honor.
4
5
6 Dr. WILLIAM A. MUELLER, having been previously duly sworn,
7 continued to testified as follows:
8
9 CONTINUED DIRECT EXAMINATION BY Mr. LEYENDECKER:
10 Q. Good morning, Dr. Mueller.
11 A. Good morning.
12 Q. Are you still licensed to practice dentistry in the
13 State of Colorado?
14 A. No, sir. I'm not licensed to practice dentistry
15 anywhere.
16 Q. If you wanted to reactivate that license today, could
17 you do so?
18 A. I would have to go through a process, but I have said
19 that I'm not going to be licensed in Colorado. As a matter
20 of fact, I can't practice dentistry now anyway.
21 Q. So if you wanted to apply for a new license, you
22 cannot do that at this time, can you?
23 A. I can. I would have to go through a process of doing
24 so that I don't care to go through, since I'm retired and
25 have no intention of practicing dentistry. As a matter of

1 fact, I'm restricted from practicing dentistry by the sales
2 agreement, which restricted me from practicing dentistry for
3 seven years, which ends, as a matter of fact, Thursday, two
4 days from now. That's the first day that I would be allowed,
5 seven years from the date of the sale. I have moved on to
6 other things. I have gotten another degree. I have moved on
7 to other things, and I have no interest in practicing
8 dentistry.
9 Q. And did you agree with the authorities in Colorado
10 that you would never reapply for a license?
11 A. Yes, I did.
12 Q. And you agreed with the authorities in Colorado that
13 you would never try to reactivate your license?
14 A. Yes, I did.
15 Q. Let me hand you what we have marked as Plaintiff's
16 Exhibit Number 167 -- excuse me, Plaintiff's Exhibit Number
17 67. This is an August 18th, 2006 e-mail from Mr. Lane to you
18 and others, containing the 2006 A.A.P.D. guidelines. Can you
19 confirm that for me?
20 A. Yes, it's from Rich Lane, Friday, August 18th, 2006.
21 Mr. LEYENDECKER: Your Honor, the Plaintiffs
22 move Exhibit Number 67.
23 A. It is an unformatted version sent out by the Academy,
24 the American Academy of Pediatric Dentistry, to its members.
25 THE COURT: You're going to have to keep your

1 voice up a little bit.
2 THE WITNESS: Yes, ma'am.
3 THE COURT: Any objection to Exhibit 67?
4 Mr. FIRST: As yesterday, no objection at all to
5 the cover page, but we don't believe the guidelines itself
6 should come into evidence.
7 THE COURT: All right. Any other objections?
8 Mr. HULSLANDER: Same objection.
9 THE COURT: Overruled. Exhibit 67 received.
10 (Plaintiff's Exhibit Number 67 received in
11 evidence)
12 Q. Dr. Mueller, we see again at the top, this is an
13 e-mail from Rich Lane.
14 Here under the C.C. column, we see that you received
15 these again, as did Dan DeRose, Mr. Lane and Mike Roumph,
16 correct?
17 A. Yes, sir.
18 Q. By the way, these are in fact the official but
19 unformatted guidelines?
20 A. That's correct.
21 Q. So these are the guidelines as revised in 2006, a year
22 after the ones we looked at yesterday?
23 A. That's correct.
24 Q. And if I can get you to focus down on the bottom of
25 that page under "methods," here, Dr. Mueller, in the section

1 that says, "This revision," that's the section I want to ask
2 you a couple of questions about. Can we highlight that,
3 Chuck?
4 "This revision reflects a review of those proceedings,
5 other dental and medical literature related to behavior
6 guidance of the pediatric patient, and sources of recognized
7 professional expertise and stature, including both the
8 academic and practicing pediatric dental communities and the
9 standards of the Commission on Dental Accreditation."
10 And having spent 15 years on these committees, you
11 understand these are the kinds of experts and resources that
12 the A.A.P.D. turns to in deciding what the content of the
13 guidelines should be?
14 A. Yes, I do.
15 Q. If we go to Page 11, Dr. Mueller, these are the
16 guidelines on behavior management, right, sir?
17 A. Yes.
18 Q. If you go to Page 11, under "advanced behavior
19 guidance techniques" -- that's Page 10, Chuck. Can we go to
20 Page 11, please?
21 You see, Dr. Mueller, that again, in 2006, having
22 consulted those treatises and experts that we just looked at,
23 the A.A.P.D., "the use of protective stabilization has the
24 potential" -- those are the same risks that we looked at in
25 the 2005 guidelines, are they not?

1 A. Correct, it says the same thing.
2 Q. And you know that, at least at the time of your
3 deposition, which was November of last year, right, sir?
4 A. I'm not sure of the date that I gave my deposition.
5 Q. Okay.
6 A. That's fine.
7 Q. Just as yesterday, I have placed it there for your
8 convenience, if you need to refer to it.
9 A. November 30, 2012, that's right.
10 Q. As of November 30th, 2012, these risks had all
11 remained the same with the exception of this "death," which
12 has been taken out, two or three years ago, right?
13 A. Death was taken out three years after it was
14 originally put in in 2005. In regard to the rest of them, I
15 don't keep up with it. I don't remember what I said, but
16 since I don't use them every day, I don't know if that exact
17 wording is in there or not.
18 Q. Let's see if we can refresh your memory on that, and
19 let's turn to Page 217 of your deposition. Beginning on Line
20 Number 2?
21 A. Yes.
22 Q. Are you with me?
23 A. Yes.
24 Q. The question is: "That the language on Page 11 of the
25 guidelines that are attached to Plaintiff's Exhibit 67, 'the

1 use of protective stabilization has the potential to produce
2 serious consequences,' was that language removed from the
3 guidelines?" And your answer was "No." The next question
4 was, "'Such as physical or psychological harm,' was that
5 language removed from the guidelines?" And the answer is,
6 "No." "It's been in there and it's still in there, isn't
7 it?" And your answer was "Yes, it is." The question was "'A
8 loss of dignity, violation of a patient's rights,' that's
9 still in the guidelines?" And your answer is, "It is." "And
10 it has been since 2005?" And your answer is, "It is,"
11 correct?
12 A. Yes.
13 Q. So all these risks, which you say the A.A.P.D. has
14 gotten wrong, they have been in there from 2005 through at
15 least the time you gave your deposition in November of 2012,
16 with the exception of that "death" that you described.
17 A. Gotten wrong -- I said that yesterday. That's perhaps
18 the wrong term. They're in there, but they're unsupported.
19 They're unsupported by scientific evidence, and as someone
20 who served on that committee for fifteen years, we made a
21 recommendation for a guideline, we looked at the literature,
22 went through the scientific evidence, and found what the
23 research had shown to be the best way to do something,
24 whatever it might be, and we included that in the guidelines.
25 These -- that particular statement is not

1 supported by any evidence.
2 THE COURT: Dr. Mueller --
3 THE WITNESS: Yes, ma'am.
4 THE COURT: I'm going to ask you again to listen
5 to the questions and answer the questions. I'm going to
6 strike the last portion of the answer which was not
7 responsive to the question.
8 THE WITNESS: I understand, your Honor.
9 THE COURT: Thank you.
10 Mr. LEYENDECKER: Chuck, if you can go back to
11 that first page of the -- no, Chuck, the first page of the
12 guidelines, the one that referenced the scientific
13 literature and expert community that it consulted. Zoom
14 in right here.
15 BY MR. LEYENDECKER:
16 Q. Dr. Mueller, isn't that exactly what the A.A.P.D. was
17 saying in 2006, that they consulted those kind of expertise
18 and that kind of literature in putting these guidelines
19 together? Isn't that what this language says?
20 A. That's what the language says, but there is no support
21 for that particular statement.
22 Q. And yet you know they continued this language in 2007,
23 and in 2008 and in 2009 and in 2010 and 2011 and 2012, right?
24 A. Well, they only review the guidelines typically every
25 three to five years, but it has stayed in there for that

1 time, yes, sir.
2 Mr. LEYENDECKER: That's all for this witness.
3 THE COURT: Mr. First.
4
5 CROSS-EXAMINATION BY Mr. FIRST:
6 Q. Good morning, Doctor.
7 A. Good morning, Dennis -- Mr. First, excuse me.
8 Q. I want to talk a little more about your background,
9 where you come from and the like. Let me start, where were
10 you born and raised?
11 A. I was born and raised in Kentucky.
12 Q. Okay. And there came a time when you went to dental
13 school?
14 A. Yes, I went to dental school in 1973 to 1977.
15 Q. What dental school did you go to?
16 A. I went to the University of Louisville in Louisville,
17 Kentucky.
18 Q. And after that, did you do a residency?
19 A. Yes. After that, actually, I was in general practice
20 for two years as a general practitioner, and then I did a
21 residency in pediatric dentistry at the Children's Hospital
22 in Cincinnati.
23 Q. And did you complete that residency successfully?
24 A. Yes, I did.
25 Q. And did you become a practicing pediatric dentist?

1 A. Yes, I did.
2 Q. Okay. Now, you said you were affiliated with the
3 Children's Hospital in Denver?
4 A. Yes.
5 Q. Can you describe what your position was there?
6 A. I was the Chief of Dentistry in the Department of
7 Surgery, and I was a director of the residency program that
8 trained people to become pediatric dentists.
9 Q. How many years did you do that?
10 A. From 19 -- fifteen, from 1985 until 2000.
11 Q. And what were your job duties during that particular
12 period of time you were at Children's Hospital in Denver?
13 A. Well, my job duties were to run the department, as the
14 chief of dentistry, to interact with the other departments of
15 surgery, and to be in charge of teaching of not only
16 pediatric dentists but general dentists who came to us,
17 pediatrics, nurses, medical students, and physicians, all of
18 whom came to us, and my job was to coordinate their education
19 in pediatric dentistry.
20 Q. During the course of those years, did you practice
21 pediatric dentistry?
22 A. I practiced pediatric dentistry all through those
23 years, for the entire fifteen years. If you're a resident,
24 you're in a residency director's position. You don't just
25 stand and give someone a lecture. It's not that kind of an

1 education. You work side by side with the residents every
2 day, so that I was practicing and working with the residents
3 every day, all day.
4 Q. Was a percentage of the children that you treated poor
5 kids?
6 A. A percentage of them were poor kids.
7 Q. And what percentage would you estimate, while you were
8 affiliated with Children's Hospital?
9 A. Perhaps a third, maybe a little bit more, but -- I
10 never figured that statistic out, but I would say perhaps a
11 third.
12 Q. Now, one of the things that you mentioned that you
13 did, outside your job duties at Children's Hospital, is to
14 serve on a committee for the A.A.P.D.; is that correct?
15 A. That's correct.
16 Q. And that's the American Academy of Pediatric Dentists;
17 is that what that stands for?
18 A. Dentistry, that's correct.
19 Q. And what is the committee or committees that you
20 served on?
21 A. Well, I served on multiple committees for them. One
22 of the committees is the Advanced Education Committee. I was
23 the chairman of the committee of all the directors of
24 residency programs across the country.
25 Another committee that I served on for them was

1 the Medicaid Committee. I represented the State of
2 Colorado to the Academy in issues of Medicaid, along with
3 a number of other ones that are perhaps unrelated. I also
4 served on the Clinical Affairs Committee, which is the
5 committee that puts together these guidelines that we've
6 been talking about yesterday and today.
7 Q. For how long did you serve on that committee?
8 A. Approximately 14 to 15 years.
9 Q. Now, we've heard a lot about these guidelines now.
10 What are the guidelines in the context of these A.A.P.D.
11 guidelines?
12 A. Guidelines are simply recommendations. They are not
13 standards of care; they are not rules that you have to
14 follow. They are recommendations from the committee that,
15 based upon the evidence that they have, that these are the
16 things that they believe would result in the best outcome for
17 a child.
18 Q. Did they address those issues in the guidelines
19 themselves, what you just said, about guidelines and their
20 purpose and -- that they're not standards of care?
21 A. Yes, they -- actually, that's one of the first things
22 they say, that the guidelines are not standards of care, are
23 not to be treated as standards of care, that they're not
24 rules, and also that they expect that there will be
25 significant deviation from those guidelines because they are

1 recommendations, not rules.
2 Q. Now, you said that you became involved in a number of
3 different committees. How is it that you met Dr. Eddie
4 DeRose?
5 A. I met Dr. Eddie DeRose because I also served -- the
6 State of Colorado asked me to be on the committee advising
7 the State of Colorado on Medicaid. There was three dentists
8 on that committee. Myself and Dr. Eddie DeRose were two of
9 them.
10 Q. Did you come to know him in that committee?
11 A. That's where I came to know Dr. DeRose, yes.
12 Q. Okay. And how did you become involved in the
13 formation of FORBA?
14 A. I knew Dr. DeRose, as I said, for those twelve or
15 fifteen years, I think, approximately, and he talked about
16 his ideas. He talked about what he thought could be done to
17 effectively treat these low-income children, and as we talked
18 about it, as we went to lunch afterwards, the ideas developed
19 between us. It was his idea, but the ideas developed between
20 us. And he asked me if I wanted to be a part of the group,
21 of the original group, the original Legacy Clinics, which I
22 did not at that time. I did not want to leave the job that I
23 had. But ultimately, I left the Children's Hospital in
24 Denver. I went to St. Jude's Children's Research Hospital in
25 Memphis, which you may know as the Danny Thomas Hospital that

1 treats only children with cancer, and I did a year of work
2 there on -- both treating and doing research on the effects
3 of dental care radiation on children with cancer, and that
4 had been one of my research interests, so that's what I did.
5 And then --
6 Mr. LEYENDECKER: Your Honor, I want to object.
7 I would ask that we proceed with question and answer, as
8 opposed to narrative form.
9 Mr. FIRST: I think it's responsive. I asked
10 him --
11 THE COURT: It is. I'm going to overrule that.
12 A. At that point, Dr. Eddie DeRose continued to call me
13 while I was in Memphis working at St. Jude's and said, "We're
14 thinking about putting together a larger group," a group that
15 would expand his idea and would I consider becoming a part of
16 it, because of my background in Medicaid. He knew my
17 background in treating children that were on this program,
18 and he asked me if I would be interested in becoming a part
19 of that group. And that's how I became a part of it.
20 Q. Now, you indicated that the focus would be treating
21 these poor kids who were on Medicaid; is that correct?
22 A. That's correct.
23 Q. Now, do the kids, these poor kids who are on Medicaid,
24 present unique issues with respect to dentistry?
25 A. They do present unique issues.

1 Q. Let me ask you another question. We've heard
2 reference to the term "early childhood caries." Can you
3 describe to the jury what that is?
4 A. Certainly. Early childhood caries is defined as any
5 decay on a child under six years old, any decay on a child
6 under six years old. It was -- it used to be considered
7 normal for children to get cavities. It's not normal
8 anymore. So the definition of early childhood caries is any
9 child with decay who is under six years old, one tooth
10 decayed.
11 Q. Now, Doctor, is there a demonstrative exhibit that
12 would help you explain these issues concerning childhood
13 caries, the characteristics of it?
14 A. Yes.
15 Q. Doctor, if you would, if you could step down -- with
16 the Court's permission, your Honor -- and using this exhibit
17 to the extent you need to, could you describe to the jury the
18 characteristics of early childhood caries?
19 A. Yes.
20 THE WITNESS: Is that acceptable, your Honor?
21 THE COURT: Oh, yes. Go ahead.
22 A. Can everyone see?
23 JUROR MEMBERS: Yes.
24 A. Early childhood caries, and just to start out with,
25 you hear all these terms -- "Caries," which you may not be

1 familiar with, just to explain that, caries is the process of
2 getting a cavity. A cavity is a hole in the tooth that you
3 go to the dentist and have filled. You don't start out with
4 a hole; caries is a process by which you get that cavity.
5 Early childhood caries is defined, as I said, by the presence
6 of one, or more, decayed, missing -- which means it's been
7 extracted -- or filled surface in any primary -- primary
8 refers to baby teeth, so any baby tooth in a child who's
9 under the age of six years old.
10 Cavities are not something that just happen. It
11 doesn't just happen. People think cavities are just a normal
12 thing that just happens in life. It's actually a
13 transmissible infectious disease. Transmissible means it's
14 given from one person to another, transmission of the
15 disease. And early childhood caries is transmitted from a
16 mother, usually a mother, to the child, because the mother is
17 the primary caregiver, and it's usually transferred from the
18 mouth of a mother to the mouth of a child.
19 The key part of that is the bacteria, with a fancy
20 name called "streptmutans," which all of you have in your
21 mouth, which I have in my mouth and everyone in this room has
22 in their mouth, that has teeth.
23 So a mother will transmit that bacteria, just by her
24 normal activities, by fixing the baby's bottle, by using a
25 pacifier, whatever it might be, transmits that bacteria from

1 themselves to the baby when the baby gets teeth, which is
2 approximately six years old. You have to have teeth for the
3 bacteria to colonize in the mouth.
4 So it's a transmissible, infectious disease. That's
5 the first part. The transmission of the bacteria has to
6 occur.
7 The second part --
8 Mr. LEYENDECKER: May we approach, your Honor?
9 THE COURT: Yes.
10 (Discussion off the record at the bench)
11 THE COURT: I apologize.
12 (Continued discussion off the record at the
13 bench)
14 THE COURT: For the record, there was an
15 off-the-record discussion regarding the scope of the
16 testimony of this witness, which is outside the scope of
17 the direct examination of this witness. Counsel for the
18 Plaintiff objects to going beyond the scope of the direct,
19 unless this witness is not going to be recalled. The
20 Court -- Mr. First was asked whether the witness would be
21 recalled during his case, and responded that he didn't --
22 couldn't commit to that, did not anticipate that, but
23 could not commit to that. So I'm going to sustain the
24 objection with respect to the scope of the testimony of
25 this witness.

1 And the Court also notes that the answer really
2 was a narrative, so those are my rulings.
3 Next question.
4 CONTINUED CROSS-EXAMINATION BY Mr. FIRST:
5 Q. You may be seated, Doctor.
6 Now, Doctor, let me ask you. Once FORBA was
7 established, you indicated you became involved in an
8 orientation program?
9 A. Yes, that's correct.
10 Q. Can you describe that, please?
11 A. We -- I -- we oriented the dentists to the kind of
12 disease that they were likely to see in low-income or
13 high-income children. It's primarily concerned, located in
14 low-income children, but it could just as easily occur in a
15 wealthy lawyer's child, in a physician's child. It doesn't
16 have to be low-income, but primarily low-income.
17 Q. And, Doctor, did you put together materials for the
18 orientation?
19 A. Yes, I did.
20 Q. And what did the materials consist of?
21 A. They consisted of three things. One was the
22 appropriate guidelines for -- from the American Academy for
23 Pediatric Dentistry, for the treatment -- the recommendations
24 for the treatment of children who were at high risk for
25 developing dental disease. They consisted also of a short

1 summary that I put at the beginning that I wrote based on
2 those guidelines, that I wrote and put at the beginning, and
3 they consisted of both references to other materials they
4 might want to read or articles that I went ahead and printed
5 out and put in the book that they had, that I thought that
6 they might want to read to learn more about the issue.
7 Q. Now, is there something called the C.M.S. Guidebook?
8 A. Yes.
9 Q. What is that?
10 A. C.M.S. is the federal agency. It stands for the
11 Center for Medicare and Medicaid, and it's the governing
12 organization over Medicare and Medicaid of the Federal
13 Government.
14 Q. And what is this guide that's been issued?
15 A. The C.M.S. issued a guide on the oral healthcare of
16 children in Medicaid.
17 Q. And is that part of the materials that you would put
18 together in the orientation materials?
19 A. Yes, it is.
20 Q. And are those guidelines as well?
21 A. The C.M.S. are standards, not just guide lines. They
22 are the official document, if you will, of the Center for the
23 Control of Medicaid of what the standard is for treating
24 children on Medicaid.
25 Q. Now, Doctor, in addition to the guidelines, does the

1 A.A.P.D. also issue policy statements with regard to the
2 treatment of early childhood caries?
3 A. They do.
4 Q. And would it assist you with the jury in addressing
5 that policy statement issued by the A.A.P.D. in relation to
6 these guidelines that you've been testifying about? Would an
7 exhibit help you?
8 A. Yes.
9 Q. Now, Doctor, could you explain to the jury what the
10 policy is with -- from the A.A.P.D. with respect to the
11 treatment of early childhood caries?
12 A. The policy is that you either treat the child who has
13 early childhood caries or that you refer them to an
14 appropriately trained individual for that treatment. That
15 immediate intervention is necessary if you have early
16 childhood caries, that you don't wait, immediate
17 intervention, to prevent further destruction, as well as
18 other widespread health problems that occur because of the
19 cavities. And because children who experience early
20 childhood caries are at greater risk for new cavities to
21 develop, aggressive preventative and therapeutic measures,
22 including such things as A.R.T., which stands for Alternative
23 Restorative Therapy, aggressive -- yes, regimented
24 applications of topical fluoride; you've all had fluoride
25 treatments -- and full crown coverage are often necessary.

1 Full crowns that they're referring to are stainless steel
2 rods. The dental care provider must assess the patient's
3 developmental level --
4 THE COURT: You can come down.
5 A. Can I? Thank you. I'm stretching. So -- the part I
6 couldn't see. The dental care provider must assess the
7 patient's developmental level -- such as one to four, or
8 whether they're handicapped -- and the comprehensive skills,
9 as well as the extent of the disease -- how bad it is -- in
10 order to determine the need for advanced behavior management
11 techniques such as -- and the three parts of advanced
12 behavior management: Medical immobilization, sedation or
13 general anesthesia. That's their policy on early childhood
14 caries.
15 Q. Doctor, you may take your seat. I want to ask you
16 specifically about some portions of what you just said.
17 "Unique and virulent in nature." What does that mean?
18 A. Unique means it's not the norm; it's something that's
19 unique to this group of children. Virulent, one of those
20 fancy words that doctors use, it means that once you get it,
21 it moves aggressively and attacks the body aggressively,
22 whether it's a virulent cancer or a virulent cavity.
23 Q. And, Doctor, you used words, and they used the words
24 "immediate intervention is necessary to prevent further
25 destruction." What does that mean?

1 A. That means that because of the rapid progression of
2 this disease, it's the policy of the American Academy of
3 Pediatric Dentistry that immediate intervention is necessary,
4 that you not wait six months, that you do it now.
5 Q. And lastly, I want to ask you, "Aggressive
6 preventative and therapeutic measures," what does that mean?
7 A. Well, aggressive preventative measures would be two
8 parts: Application of fluoride treatment, and also using
9 materials such as stainless steel crowns to cover the entire
10 surface of the tooth would prevent that tooth from getting
11 other cavities, and therapeutic measures are, once again, the
12 use of things like stainless steel crowns to treat the tooth
13 so that it doesn't get further caries.
14 Q. Now, you referred to stainless steel crowns. What are
15 they and how are they used in treating this disease?
16 A. Stainless steel crowns are simple preformed -- unlike
17 the crowns that you might get from an adult dentist. They're
18 preformed to the size of baby teeth. They generally fit the
19 tooth right away, right out of the box, and they are made of
20 stainless steel instead of gold, and you simply cut away part
21 of the outside of the tooth and you snap on and cement the
22 stainless steel crown on the tooth. It takes about ten or
23 fifteen minutes.
24 Q. Now, Doctor, at Small Smiles, FORBA, were most of the
25 patients that were treated by the Small Smiles dental

1 offices, were they victims of early childhood caries?
2 Mr. LEYENDECKER: I'll object to that as
3 relevance and beyond the scope, your Honor. We're here
4 talking about Jeremy Bohn and the training program is the
5 area of discussion, unless we want to get into all the
6 other children that were treated.
7 THE COURT: I'm going to sustain the objection.
8 Mr. FIRST: All right.
9 Q. Was it -- you said that these materials were provided
10 in orientation: The A.A.P.D. guidelines, the C.M.S.
11 standards, the summaries that you did, various articles. Did
12 all of them relate to the types of issues that dentists would
13 deal with while working at a Small Smiles dental office?
14 A. Yes, they did.
15 Q. Now, you have been asked a lot of questions about
16 pressure to produce, and I want to ask you a few questions
17 about that. First of all, how do most dentists in this
18 country work and make a living?
19 A. Most dentists in this country work and make a living
20 by doing dentistry and their living is determined by how much
21 dentistry they do, how much dentistry they do, how productive
22 they are. It's a fee-for-service business. The more they
23 work, the more they earn.
24 Q. Okay. So they are paid essentially by the amount of
25 dental work they do?

1 A. Yes, that's correct.
2 Q. And when you say fee-for-service, every particular
3 service has a charge, and whatever services they provide,
4 they get paid for?
5 A. That's correct.
6 Q. Based on your experience, you indicated that you were
7 at the college; you obviously worked at FORBA, and you also
8 worked in general practice. Do dentists keep track of the
9 amount of production or the amount of procedures or the
10 amount of fees generated by their services on a regular
11 basis?
12 A. Yes.
13 Q. And why do they do that?
14 A. They do that because they want to know how productive
15 they're being. If there's something that they could do that
16 would make their practice more productive, they want to do
17 that. And in order to do that, you have to have the
18 information, so you collect the information.
19 Q. And does every dentist feel the pressure to produce
20 because of the way they're paid?
21 Mr. LEYENDECKER: Object to the form, your
22 Honor.
23 THE COURT: Sustained.
24 Q. Let me ask it this way : Is it unusual that a person
25 who works for a fee-for-service feels some pressure to be

1 productive in their job?
2 Mr. LEYENDECKER: Same objection, your Honor.
3 THE COURT: It is speculative. I'll sustain the
4 objection.
5 Q. I think you've already said that the amount any
6 particular dentist earns is directly related to the amount of
7 procedures he does or the amount of dental work he does; is
8 that correct?
9 A. That's correct.
10 Q. Okay. And whatever pressure that dentist may feel
11 with regard to financial issues is directly related to the
12 amount of work that he does; is that correct?
13 Mr. LEYENDECKER: Objection, leading, your
14 Honor.
15 THE COURT: Your objection is leading?
16 Mr. LEYENDECKER: Yes.
17 THE COURT: Sustained.
18 Q. Now, when you worked at the university, was there
19 anyone looking over you in the amount of productivity that
20 you had on your job?
21 A. Yes, the department chair. At the University of
22 Florida, I assume you're talking about?
23 Q. Yes. And can you tell us about that?
24 A. At the University of Florida, we taught. There, I was
25 more of an educator. I did work with the students on the

1 clinic floor on a day-to-day basis. However, we had one day
2 a week where we saw our own private patients, and that money
3 that was generated directly went to the department and was
4 divided by the chairman, made the decisions, and that money
5 was added to our salaries, so it directly affected the
6 salaries, and the department chairman was the one who
7 controlled that.
8 Q. Now, did you or would you expect any dentist to
9 compromise his professional judgment because his income is
10 related in part upon the -- well, not in part, is dependent
11 upon fee-for-services and the amount of dental services
12 provided?
13 A. No, I would not. Those are two separate things.
14 Q. Why do you say that?
15 A. Because you have a professional ethic to take care of
16 your patients, and if you take care of your patients
17 properly, you will earn the money that you want to earn.
18 Q. And, Doctor, referring to the doctors who work at the
19 dental offices at Small Smiles, were they on salary or did
20 they work for a percentage of their productivity?
21 A. They were on salary.
22 Q. Okay. So in that sense, they worked on a different
23 basis than the dentists who -- typically in this country, who
24 work fee-for-service?
25 A. Yes, they were.

1 Q. And, Doctor, was there a potential to earn a bonus at
2 Small Smiles dental offices?
3 A. Yes, the potential existed to earn a bonus.
4 Q. Was that individual or was that clinic -- office-wide?
5 A. That was office-wide, not individual.
6 Q. Now, based on your experience in treating the Medicaid
7 population, these poor kids, was there ever a lack of work to
8 do at a Small Smiles office?
9 A. No, there was not. We were overwhelmed with children.
10 Q. Why is that?
11 A. It's because no one would take care of them. There
12 was no dentist who would care for the children, and when we
13 opened our offices, we were inundated with children who
14 needed care.
15 Q. Why is it that no one would treat these kids?
16 A. Well, there's a few reasons. The number one reason
17 cited is that the fees are too low, and it's true that the
18 Medicaid program pays fees less than that would be -- than
19 you would have to pay your dentist. The second reason is
20 that up to 40 percent of these children don't show up for
21 their appointments. For whatever reason, they don't show up
22 for their appointments, and in a traditional dental office
23 where you have a dentist who's set aside an hour to treat a
24 patient, if that patient doesn't show up, they lose that
25 productivity; they lose that hour's worth of revenue. So

1 those two were two of the barriers, the two that were cited
2 most frequently by dentists as to why they did not accept
3 Medicaid patients.
4 Q. Doctor, would it be helpful on this issue to have a
5 demonstrative exhibit that lays some of that out?
6 A. Yes, it would.
7 Q. You can step down.
8 Mr. LEYENDECKER: Your Honor, my objection is
9 this is beyond the scope.
10 THE COURT: Well, there's no question pending,
11 so I'm not sure what is beyond the scope right now.
12 Mr. LEYENDECKER: The chart that he's fixing to
13 ask him about.
14 Mr. FIRST: Well, I think --
15 THE COURT: It's not been marked as an exhibit?
16 Mr. FIRST: Just demonstrative.
17 THE COURT: That's what he just testified to?
18 Mr. LEYENDECKER: I believe in the first two
19 parts, your Honor.
20 THE COURT: So you're using this to refresh his
21 recollection or you're using this to --
22 Mr. FIRST: Using to assist in his testimony for
23 the jury, so the jury can see it.
24 THE COURT: I don't think it's appropriate use
25 of a demonstrative exhibit, given the background right

1 now, so I think you asking questions about this is
2 beyond -- he hasn't suggested that he doesn't have a
3 recollection, and so I would remove the demonstrative
4 exhibit at this point.
5 Q. Okay, Doctor. I think you've set forth the reasons.
6 Any other reasons why these kids cannot get care?
7 A. There's two other reasons, primarily, and one is that
8 the federal system, the Medicaid system, requires different
9 forms and different paperwork than the typical insurance
10 company does, so the office had to have a unique billing
11 system just for Medicaid.
12 Q. Now, you talked about how -- you talked about when
13 FORBA was formed and your involvement and how that came
14 about. How did FORBA deal with those issues to create access
15 to care for these children?
16 Mr. LEYENDECKER: I hate to keep doing this, but
17 objection, beyond the scope, your Honor.
18 THE COURT: Overruled.
19 A. FORBA, in the discussions -- and this was really --
20 this was Eddie DeRose's idea over -- that he developed over a
21 number of years, and it was truly his genius, truly his
22 genius. He thought that if we took the things that were
23 causing the problem and reversed them and put them as the way
24 we operated the practice that we could successfully see
25 low-income children.

1 Q. And how was that done?
2 A. The first issue that we talked about was the dentist's
3 fees were too low. We could not change how much the Federal
4 Government was paying for Medicaid procedures, so we did a
5 number of things: And some of them were of dual purpose.
6 This one is a dual purpose. The first thing is we located
7 the clinic, instead of in the suburbs, where most dentists
8 are, we located the clinic in a low-income neighborhood where
9 the patients were. Our patients were low income, on
10 Medicaid. We located the clinic there. That made it more
11 convenient for the mothers to get there. The second part of
12 that is that we reduced costs because we could get rent for
13 as little as $10 a square foot, instead of $50 a square foot
14 if you rent office space in the suburbs. So it provided two
15 things: It reduced our costs and it put our office close to
16 our patients.
17 Q. What else, to overcome these obstacles?
18 A. The other things to overcome the obstacles -- excuse
19 me, the obstacles to care were once again to go to costs. We
20 had to get our costs low enough so that we could make a
21 profit off of the fees that they were going to pay us, the
22 Federal Government was going to pay us. The way we did that
23 was that we had a single billing system, unlike the offices
24 who had multiple insurance companies, and the Medicaid system
25 was an extra one. In our case, the Medicaid billing was the

1 only one, and so it was very easy for one person to do it
2 rather than having three or four. So we reduced our costs by
3 having less employees to do the billing.
4 The second thing we did, was because we were a fairly
5 large group and were growing and they knew we were growing,
6 the supplier of instruments and supplies to us agreed to
7 negotiate -- we negotiated an arrangement with them where
8 they sold us their instruments and supplies for 35 percent
9 less than they sold them to the dentists who were in the rest
10 of the community. They did that because of the volume of
11 things that we were buying. We got a volume discount. They
12 also put computers in our office. They bought them; they put
13 them in our office; they loaded them with software that had
14 all the typical instruments and supplies that we used so that
15 it was very simple for us to have one employee -- and any
16 employee; we didn't even have to have someone specially
17 trained to do it. Any employee could go into that computer
18 and order the instruments and supplies that were needed.
19 The third thing is the downtime. As I told you, the
20 general dentist wouldn't see these patients because they
21 have -- if they missed their appointment, they sit around for
22 an hour and they were non-productive. We had a large clinic.
23 Ours were 10,000 square feet. They were brand-new, state of
24 the art, and we had four dentists, not one. We knew that 40
25 percent of the patients weren't going to show up. We didn't

1 know which 40 percent weren't going to show up. So the
2 clinic was flexible, and so if Dr. A's patient didn't show up
3 and we had a patient in the exam rooms who had needs, we
4 could either accommodate to the mother's request, and most of
5 the time, this was the mother's request. Most of the time,
6 low-income mothers could not get off work more than one or
7 two days. They asked us repeatedly, "Can you do the work for
8 my child today?" If we had a free dentist because their
9 patient didn't show up, we could say yes; we would take the
10 child and do the fillings or whatever it might be for them on
11 the same day, and therefore we didn't lose the productivity
12 like the general dentist in the community, because we were
13 able to fill that hour time period with another child whose
14 mother wanted the work to be done that day.
15 Q. And, Doctor, did you find that when these dental
16 offices were opened, once the word was out, was there any
17 shortage of patients?
18 A. No. To the contrary. A healthy dental practice in
19 the community -- it's considered a healthy dental practice,
20 very healthy, if they get one new patient a day would be
21 considered a very healthy practice. On our first day, the
22 first day that I opened in Aurora, I had 1,200 patients lined
23 up, asking for appointments, getting appointments. 1,200
24 patients! So we never had a shortage of patients.
25 Q. And I may have asked you this: Based upon this

1 patient population, was there ever a shortage of work?
2 A. No. As we've talked about -- I forget whether we
3 talked about it or not, but 80 percent of all the decay that
4 we talked about is in 20 percent of the population; that's
5 the population of low-income children on Medicaid, and most
6 of them have four to five times as much, as many cavities,
7 and therefore as much work that needs to be done as does the
8 child who might be in the more affluent suburbs. So we were
9 inundated with work, care that needed to be provided for
10 these kids. We didn't have to look for it. It was
11 overwhelming us.
12 Q. Now, I want to ask you about something that Mr.
13 Leyendecker used on his board there. Do you remember being
14 asked about this line?
15 A. Yes.
16 Q. Dental decisions?
17 A. Yes.
18 Q. Was there ever any reason to pressure a dentist to not
19 use his professional judgment with respect to any of these
20 issues, whether it be the papoose board, the fillings,
21 stainless steel crowns, pulpotomies? Any reason to pressure
22 a dentist to not use his own professional judgment with
23 respect to those issues?
24 A. No, there was no reason.
25 Q. Did that ever happen, to your knowledge, that a

1 dentist was pressured to do any of these dental procedures
2 contrary to his professional judgment?
3 A. No. That never happened.
4 Q. Was ever any dentist pressured to do unnecessary work?
5 A. No, not to do unnecessary work. We -- as I said, we
6 were overwhelmed with children who had very necessary work.
7 There was no reason to do unnecessary work.
8 Q. Was any dentist ever pressured to commit dental
9 malpractice?
10 A. No, absolutely not.
11 Q. Now, Doctor, I want to ask you about the medical
12 stabilization, effective stabilization, and first I want to
13 ask you about this, which Mr. Leyendecker brought in as
14 demonstration, not in evidence. Is this what a papoose at a
15 Small Smiles office looks like or looked like?
16 A. No.
17 Q. Is there one in the courtroom that shows what a
18 papoose that would be used at Small Smiles would look like?
19 A. There's one of ours in the back of the courtroom.
20 Q. So, Doctor, is this more like the device that was
21 actually used in Small Smiles dental offices?
22 A. This is typical of the one we used, yes.
23 Q. And this other one that's been used by Mr. Leyendecker
24 is an old one? Do you know what it is?
25 A. I have seen them before, not for a long time. It

1 is -- it was used, I think, at one time years ago, but I've
2 never used one of those. In thirty years of practice, I've
3 never used one that looks like that. And actually, until he
4 brought it out, I hadn't even seen one of those for quite a
5 number of years.
6 Q. Doctor, there's been a lot of testimony about this
7 protective stabilization and the procedure and I'm going to
8 ask more questions myself, but just try to give, if you
9 would, the jury some context. How often does a papoose or
10 protective stabilization come into play overall in the Small
11 Smiles offices?
12 A. Overall in the Small Smiles offices, we used
13 protective stabilization approximately 5 percent of the time,
14 one out of every twenty patients.
15 Q. And is that relative to patients who were in the
16 operatories?
17 A. That's of patients who were in the operatories
18 receiving some treatment, receiving a filling or whatever it
19 might be. It doesn't include -- it doesn't include children
20 who are just there to get their teeth cleaned.
21 Q. Now, generally speaking, are there behavior management
22 techniques before, if they're viable, that you use before you
23 reach advanced behavioral management?
24 A. Yes, there are.
25 Q. I think actually the exhibit that's been marked,

1 Exhibit 66, has what they are. Do you have that handy?
2 A. No, I don't have any of the exhibits, except the one
3 given to me today.
4 Q. May I see that exhibit on top? I believe that has it.
5 You have Exhibit 67 in evidence. If you feel the need, feel
6 free to look at that.
7 A. All right.
8 Q. So behavior management is not just limited to advanced
9 behavior management. There are other techniques as well,
10 aren't there, that are accepted? And what are they?
11 A. That's correct, they are. It starts with the whole
12 office. The office should be child-friendly, and our offices
13 were child-friendly. We had cartoon characters on the wall;
14 we had sport team symbols on the walls in the operatories.
15 If we were here in Syracuse, we might have something from the
16 Syracuse Orange. If we were in Denver, we would have
17 something from the Denver Broncos. So we tried to make them
18 friendly to the children. We put -- and these were on every
19 operatory; they were throughout the hygiene areas, and they
20 were in the waiting rooms, and we had child appropriate toys
21 in the waiting rooms for them to play with. And so the
22 entire -- part of behavior management is setting -- or
23 behavior -- management is fine, is setting the tone so that
24 it's a child-friendly environment. That's one of the ways.
25 Do you want me to continue or --

1 Q. Yes, just techniques, just very briefly, Doctor.
2 A. All right. The next thing is the communication
3 between the dentist and the child. The dentist talks to the
4 child at the child's level. The dentist and staff are
5 accustomed to treating children so they relate to them at
6 their own level. That makes a child more comfortable, in
7 general. They communicate with them in child-friendly
8 language. They use words that are non-threatening. Instead
9 of saying, for instance, "We're going to drill on your
10 tooth," we use a term like "We're going to use Mr. Whistle,"
11 because you've all heard what a dental drill sounds like; it
12 sounds like a whistle. So we would say we were going to use
13 Mr. Whistle, and that was a technique to make the children
14 more comfortable. Let me find the rest of them.
15 The other -- the things that generally make it
16 difficult to treat young children is fears, and the whole
17 point of what I was just talking about is to make the child
18 not afraid of going to the dentist. Some children are also
19 afraid of going to the dentist because their friend has told
20 them they went to the dentist and it hurt, or their mother or
21 father has told them some bad story about going to the
22 dentist. Our entire office, and this is the preliminary
23 stages of behavior management, is to create a child-friendly
24 environment and create the possibility for communication
25 between the dentist and staff and the child.

1 Q. So, Doctor, is it a progress thing, the behavior
2 management, before you get to advanced behavior management?
3 A. It is somewhat progressive. All of those things are
4 generally done together; you do all those. I guess the
5 progressive part is something called tell-show-do. That's
6 where you're talking to -- the dentist is actually
7 communicating with the patient, and that is that you tell the
8 child, "This is what we're going to do." You show them the
9 instrument, let them touch it if they want to. So you tell
10 them; you show it to them, and then you do it for them, and
11 that makes them more comfortable. They're not afraid. They
12 can see what is going to be used. That's called
13 tell-show-do, and that's one of the behavior techniques.
14 Q. Now, Doctor, what are the dangers presented to the
15 child or the staff when a child is uncooperative, when you
16 can't get the cooperation by the behavior management
17 techniques that you described, and you need to do this dental
18 work; he needs dental work? What are the dangers from an
19 uncooperative child, to him or her?
20 A. The dangers are, as you know, we generally give an
21 injection. You've all had one of those probably. Using a
22 sharp needle, which we have to put into the child's mouth,
23 and you have to be still when that goes in because it has to
24 go into a particular spot; you can't just put it anywhere.
25 It has to go into a particular spot. The other danger -- in

1 other words, if they move their head just as you were doing
2 it, you could put the injection, the needle, into the wrong
3 place in the child's mouth.
4 The other significant one is if we're using one of
5 these hand pieces, the Mr. Whistles I talked about. They run
6 at a very high speed and they have a sharp burr on the end of
7 it to cut through the enamel of the tooth. If the child
8 moves at the time you do that, you can cut their tongue; you
9 can cut their cheek; you can cut your own finger if they move
10 suddenly at that time. So there are risks to both the staff
11 and to -- the assistant also has their hands in the child's
12 mouth typically, so there's risk to all of us, the staff, and
13 there's a risk to the child if they were to be uncooperative
14 when we did the procedure.
15 Q. Now, Doctor, looking to advanced behavior management,
16 as I understand it, there are three kinds. You testified on
17 your direct, there's protective stabilization; there's
18 sedation, and there's general anesthesia; is that a fair
19 statement --
20 A. That's correct.
21 Q. -- of what you said? Let me ask you something, since
22 you've been asked about risks. What are the risks of general
23 anesthesia or sedation?
24 A. The risk of general anesthesia, most people are afraid
25 of general anesthesia; you don't want to be put to sleep.

1 The statistics show that approximately one -- depending on
2 the study, 1 out of every 10,000, to 1 out of every 20,000
3 people have an adverse instant. That means they have
4 something that results in permanent damage to them, brain
5 damage or death. In the case -- I'm sorry.
6 Q. I'm sorry. I was going to ask you about sedation.
7 A. In the case of sedation, it's even more dangerous.
8 There's a study done by a well-known anesthesiologist who
9 studied all the cases of sedation he could find, and they're
10 not reported as well as the ones on general anesthesia. He
11 found well over 100 cases of children who had been sedated
12 who had significant brain damage or death.
13 Q. Now, Doctor, I want to focus now on the protective
14 stabilization. Let me ask you first, with respect to the
15 indications for protective stabilization, would an exhibit
16 assist in discussing the indications for protective
17 stabilization?
18 A. Yes.
19 Q. These may also be in your exhibit right in front of
20 you on your deposition.
21 THE COURT: We're going to take our morning
22 recess now, 15 minutes. Don't talk about the case. Be
23 back at quarter of.
24 (Recess taken at 10:29 a.m.)
25

1 Mr. HIGGINS: Judge, just before the jury comes
2 in, I notice that -- again, this is not an objection to
3 anything that's been said before the jury, but I notice
4 that we're talking about a lot of exhibits that are not
5 really identified, and they're also not being asked -- no
6 foundation before they're shown to the jury, and it's just
7 very, very loose. And I'm certainly not making any
8 objection to anything that's been looked at before, but I
9 would just ask as a general rule, if someone's going to
10 offer an exhibit, that they at least mark it, identify it.
11 If they're going to offer it as a demonstrative exhibit,
12 if they lay the appropriate foundation, which doesn't take
13 long, and then they ask other opposing counsel if there is
14 an objection or not, and at least we'll have a record. I
15 mean, two weeks from now, if I go back and look at this, I
16 won't even know what I'm looking at.
17 THE COURT: I agree. I was thinking that very
18 thing myself.
19 Mr. FIRST: Your Honor, these have all been
20 marked. I didn't want to have to mark them while they're
21 going. They've been marked.
22 THE COURT: What do you mean they've been
23 marked?
24 Mr. FIRST: They have been marked. They have
25 stickers on them.

1 THE COURT: But the record doesn't reflect that.
2 Mr. FIRST: I understand that, and I haven't
3 done that because the other side also hasn't done it with
4 respect to demonstrative evidence. I'm happy to do it.
5 Mr. HIGGINS: And again, I'm not, you know,
6 looking to go back and object to anything that's already
7 been shown, but we have things being shown to the jury
8 without a sticker or any foundation at all. And I would
9 just ask that we tighten up a bit.
10 Mr. FIRST: I'm not seeking their admission, but
11 I'm happy to identify --
12 THE COURT: But you're displaying them, so in
13 essence they are being admitted for purposes of what the
14 jury sees and does, and the same for both papoose boards.
15 As far as I know, there's no exhibit number that's
16 attached to the ones that have been shown, so the record
17 is not clean.
18 Mr. FIRST: Well, we should also mark the
19 ongoing blackboard, too, the white board.
20 THE COURT: Well, I think that's a little bit
21 different because that's the lawyer's writing as
22 opposed -- it's just notes. But it frankly is not -- it's
23 basically -- it's demonstrative.
24 Okay. All right. The jury is here. I'm not
25 keeping them. We'll deal with this afterwards. If you

1 would get the jurors, please.
2 Okay. This one, whatever this is, is this a
3 page from one of the exhibits?
4 Mr. FIRST: It's the guidelines.
5 Mr. LEYENDECKER: It's an excerpt from a
6 guideline. I don't know what he's going to say -- it's a
7 guideline from the A.A.P.D. from '04/05, and I don't know
8 what he intends to do with it but...
9 THE COURT: It's not 66 or 67?
10 Mr. FIRST: No, your Honor.
11 THE COURT: Why don't we put it down then and
12 see if there's any objection first. Put it down before
13 the jury comes in.
14 (Whereupon, the jury was then brought into the
15 courtroom)
16 THE COURT: Ready to proceed?
17 Mr. FIRST: Yes, I am.
18
19 CONTINUED CROSS-EXAMINATION BY Mr. FIRST:
20 Q. Doctor, I want to talk to you about the indications
21 for the use of protective stabilization as set forth in the
22 A.A.P.D. guidelines. Would it assist you to have a portion
23 of those guidelines to discuss with the jury what those
24 indications are?
25 A. Yes.

1 Q. And we have a board identified as Exhibit 1072, which
2 I would like to use with the witness.
3 THE COURT: Any objections?
4 Mr. LEYENDECKER: No, your Honor.
5 THE COURT: Okay.
6 Q. Now, Doctor, I want to limit my questions at this
7 point to the indications for protective stabilization as the
8 guidelines lay out. Could you step down?
9 JUROR MEMBER: Excuse me, your Honor.
10 JUROR MEMBER: We're having trouble reading
11 that.
12 Mr. FIRST: I'll move it a little closer. Is
13 that better?
14 JUROR MEMBER: Not really.
15 THE COURT: Well, he's going to talk about them
16 anyway, so he can read...
17 It's something that I think the court perhaps
18 needs a little basket of glasses here like they have in
19 restaurants sometimes.
20 Mr. FIRST: Better? Okay. Great.
21 THE WITNESS: Everybody okay?
22 JUROR MEMBER: Yes.
23 Q. Would a pointer assist you, Doctor? Do you need that?
24 A. I'll use my finger, if that's all right with everyone.
25 Q. Doctor, right now, I want to ask -- first, generally,

1 these are the A.A.P.D. guidelines, in part, correct, only a
2 page out of them, or two pages out of them?
3 A. It is a page out of the guidelines from the reference
4 manual of 2004 to 2005.
5 Q. Okay. And the portion that we're going to discuss is
6 the advanced behavior management, particularly the use of
7 protective stabilization?
8 A. Yes, and here it's labeled as medical immobilization,
9 same thing.
10 Q. Okay. Those words have been used interchangeably, I
11 think: Protective stabilization and medical immobilization.
12 Same thing?
13 A. Same thing.
14 Q. All right. Now, with respect to the indications for
15 the use of medical immobilization, as the term is used here,
16 what are those indications?
17 A. Well, there are three, and if you can look all the way
18 down, they're at the bottom, under "indications." Number
19 one -- I'll just read them, in case anyone can't see them
20 all. "A patient who requires immediate diagnosis and/or
21 limited treatment and cannot cooperate due to lack of
22 maturity." This would be, once again, the one to
23 four-year-old, approximately, child who lacks the maturity to
24 cooperate.
25 The second one is similar: "A patient who requires

1 immediate diagnosis and/or limited -- and/or limited
2 treatment and cannot cooperate due to mental or physical
3 disability." This is a handicapped patient or a patient who
4 is mentally incapable of dealing with the situation, so
5 that's the second indication.
6 The third indication doesn't include the first part
7 about immediate diagnosis and treatment. The third
8 indication is "when the safety of the patient and/or the
9 practitioner would be at risk without the protective use of
10 immobilization." And the third one is -- that's subjective.
11 That's up to the dentist who's doing the treatment.
12 Q. Now, Doctor, there's an exhibit, Exhibit 63 -- I
13 believe it's in evidence --
14 THE COURT: Doctor, you may step -- are you done
15 with that exhibit?
16 Mr. FIRST: Yes.
17 Q. Doctor, I show you Exhibit 63, which is --
18 THE COURT: Mr. First, would you move those
19 items while he's looking at that?
20 Q. Now, that is an example -- actually, it's the one that
21 involved Jeremy Bohn. It's a consent for protective
22 immobilization?
23 A. Yes. This is the written portion of it.
24 Q. Okay. And does the form have the indications written
25 in a check fashion, checkmark fashion on it?

1 A. Yes, it does.
2 Q. Okay. What are the three options on the form?
3 A. "I understand the reason my child needs immobilization
4 is the following: Check one. He or she requires immediate
5 diagnosis and/or limited treatment and cannot cooperate due
6 to a lack of maturity; he/she requires immediate diagnosis
7 and/or limited treatment and cannot cooperate due to mental
8 or physical disability; either my child and/or the dentist
9 and staff would be at risk without the protective use of
10 immobilization."
11 Q. Okay. So those -- let me ask you: Do those track the
12 indications as you just indicated are set forth in the
13 guidelines?
14 A. Yes. They are virtually identical.
15 Q. Now, Doctor, in 2004/2005, did the A.A.P.D. guidelines
16 discuss this issue of potential risk in any way at all,
17 relating to medical immobilization?
18 A. No, they did not.
19 Q. So the first time any language appeared in the
20 guideline relative to potential risk was in two thousand --
21 what, five, was it?
22 A. At the 2005 meeting in May of 2005, that was the first
23 time it came up; sent out, as we've seen before, in August of
24 2005, and later published in the fall of 2005. Yes, sir.
25 Q. And as you understand it, what came out in 2005 and

1 2006 has been modified by taking away this "potential risk of
2 death," is that correct? That's what you said on direct?
3 A. Yes, that's correct. That part has been taken away.
4 Q. Now, do you know where the language came from that is
5 in the A.A.P.D. guidelines that counsel highlighted regarding
6 potential risks?
7 A. Yes, I do.
8 Q. Where did that language come from?
9 A. That language is a direct quote from the standards of
10 the Joint Commission -- Joint Commission on Accreditation of
11 Healthcare Organizations, from their section on restraint and
12 isolation of patients.
13 Q. Now, how do you know that?
14 A. I know it because I have the Joint Commission manual
15 and I read it.
16 Q. Does the -- do the A.A.P.D. guidelines generally
17 contain reference sources for their guidelines?
18 A. Typically, in my experience, when I was on the
19 committee, and now, they do contain references as to the
20 scientific source of where the guideline came from.
21 Q. And when you says a scientific source, what does that
22 mean in a dental profession?
23 A. A scientific source would mean an article, a study
24 that was published in a peer review journal, and
25 peer-reviewed means that it is sent around to other experts

1 in that field and they read it and decide whether it's
2 accurate, whether it's publishable, and then it goes back,
3 and it's published as an article in a scientific journal.
4 Those are the kinds of things that are used by the committee
5 to come up with the recommendations that they put in these
6 guidelines.
7 Q. Okay. And with respect to this statement about
8 potential risk, risks relative to medical or protective
9 stabilization, what is the annotation on that? What is the
10 reference source?
11 A. The reference source is listed only as "the Joint
12 Commission of Accreditation on Healthcare Organizations."
13 There's no scientific paper; there's no other source listed,
14 other than the Joint Commission standard.
15 Q. Does the language -- turning to the Joint Commission's
16 standards, you say that the language comes from there. What
17 does that standard say, if anything, about dentistry?
18 Mr. LEYENDECKER: I'm going to object to the
19 form, your Honor. Calls for speculation. We don't have
20 it before the jury.
21 THE COURT: I'm going to sustain the objection.
22 Q. Does the standard, based on your knowledge and
23 experience, that JCAHO sets forth with respect to restraints
24 apply to dentistry?
25 A. No, it does not.

1 Q. And does it contain specific language that excludes
2 dentistry?
3 A. Yes, it does.
4 Q. Now, let me ask you this, Doctor: Are you aware of
5 any scientific literature or research studies that establish
6 or show any risk relative to medical stabilization and
7 protective stabilization?
8 A. I am not aware of any scientific studies that show
9 that.
10 Q. And have you done the research?
11 A. I have done the research. I've done the research
12 because of all the years when I was a residency director, we
13 had what was called literature review. Every week we went
14 through literature and talked about it, and after that, in
15 preparation for this trial, I went to the National Library of
16 Medicine, the med line, and searched every combination I
17 could find that combined medical immobilization, dentistry
18 and risk. And in every single case, the printout showed no
19 findings. No articles, no references.
20 Q. Now, Doctor, I think you already testified that all
21 the A.A.P.D. -- the relevant A.A.P.D. guidelines are part of
22 the orientation materials that you have put together?
23 A. All of the relevant ones. There were others that were
24 on orthodontics or were on sedation and general anesthesia,
25 things that we did not do that I did not include in the

1 guidelines, but all the relevant ones, yes.
2 Q. Doctor, I show you what's been marked as Defendant's
3 Exhibit -- Defendant's Old FORBA Exhibit 1002. Would you
4 take a look at that?
5 A. Yes.
6 Q. Now, Doctor, I realize -- let me ask you: Did the
7 orientation materials change from time to time, over time?
8 Were things added and subtracted?
9 A. They did.
10 Q. Okay. So it's a bit of a moving target. I guess my
11 question is, is this one version of that?
12 A. This is one version, yes, sir.
13 Mr. FIRST: I would offer that.
14 Mr. LEYENDECKER: May I see it, your Honor? I
15 don't believe I've seen this.
16 (Whereupon, a discussion was held at the bench)
17 THE COURT: There's an objection on the basis of
18 foundation. I'm going to sustain that objection.
19 Q. Let me ask you a couple more questions about that. I
20 realize you didn't physically necessarily put that book
21 together, but is that generally materials that you put
22 together for the benefit of doctors who were getting oriented
23 into the Small Smiles practice?
24 A. Yes. I put the book together and then I was not the
25 person who physically sent it out to each of the doctors or

1 gave it to each of the doctors, but I put it together, yes,
2 sir.
3 Q. And that has articles that you put together?
4 A. This contains guidelines from the American Academy of
5 Pediatric Dentistry; it contains short summaries that I
6 wrote, and it contains articles and references to the
7 guidelines.
8 Mr. FIRST: I would offer it.
9 Mr. LEYENDECKER: In light of the testimony,
10 your Honor, I have no objection to it.
11 THE COURT: Okay, Exhibit 1002 received.
12 (Whereupon, Defendant's Exhibit 1002 was
13 received in evidence)
14 Q. Doctor, you have been asked a lot of questions about
15 the A.A.P.D. guidelines, both by counsel for the Plaintiff
16 and myself. Let me ask you about your distribution. You
17 actually identified a couple of exhibits -- actually three
18 exhibits now. You had the orientation materials, correct?
19 A. Yes.
20 Q. And you put the guidelines -- at least the ones that
21 relate to this practice, in the orientation materials,
22 correct?
23 A. Correct.
24 Q. And that would include with regard to protective
25 stabilization?

1 A. That's correct.
2 Q. And in addition to that, there have been a couple of
3 exhibits marked that indicate that the guidelines,
4 particularly when they were modified in any way, were sent to
5 all the lead dentists and to the office managers of all the
6 Small Smiles offices around the country; is that correct?
7 A. That's correct.
8 Q. And that was done in 2005, was it?
9 A. It was done in 2005 and in 2006. I believe I did it
10 prior to that, but the exhibits we have are from 2005 and
11 2006.
12 Q. Okay. And why was it that you distributed the
13 guidelines in your orientation materials and in these e-mails
14 that went to the dentists who practiced at the Small Smiles
15 dental clinics?
16 A. Excuse me. Overall, why did I do it?
17 Q. What was the reason for distributing those?
18 A. It was to help them. It was to help the new dentists
19 who were coming into a new position, dealing with a specific
20 kind of patient population, to understand that population and
21 to understand what the scientific literature, again, the
22 American Academy of Pediatric Dentistry, had to say about
23 what you should do to treat that population. So it was for
24 their benefit, for their assistance.
25 Q. Okay. So do -- let me withdraw that.

1 Mr. FIRST: May I have a moment?
2 THE COURT: Yes.
3 Mr. FIRST: Thank you.
4 THE COURT: Mr. Hulslander?
5 Mr. HULSLANDER: Nothing.
6 Mr. STEVENS: No questions, your Honor.
7 THE COURT: Redirect?
8
9 REDIRECT EXAMINATION BY Mr. LEYENDECKER:
10 Q. You said that the 2004/2005 A.A.P.D. guidelines didn't
11 discuss risks in any way. Do you recall that testimony?
12 A. Yes, I believe that's what I said.
13 MR. LEYENDECKER: Let me hand you Exhibit Number
14 771, your Honor. This is not on our list. It's being
15 offered in rebuttal to the testimony that was just
16 produced by Dr. Mueller.
17 Q. Dr. Mueller, is this the full version of the 2004/2005
18 A.A.P.D. guidelines on behavior management, the subject we
19 have been discussing?
20 A. No.
21 Q. Let me ask you this, Dr. Mueller. Is Exhibit 771,
22 clinical guidelines on behavior management, as set forth by
23 the A.A.P.D. that contains the portion that you were just
24 discussing?
25 A. No.

1 Q. So this section right here, "Medical Immobilization,"
2 right?
3 A. Yes, sir.
4 Q. "Medical Immobilization," appears on Page 92, right?
5 A. Yes, sir.
6 Q. And you've got "Medical Immobilization" here on Page
7 2, "reference manual '04/'05," and if I turn the page,
8 "reference manual '04/05." Do you see that, Dr. Mueller?
9 A. I see what you're looking at. I was looking at
10 "revised 2000." This does say "reference manual 2004/2005,"
11 excuse me.
12 Mr. LEYENDECKER: Plaintiffs offer Exhibit 771.
13 THE COURT: Any objection?
14 Mr. FIRST: Haven't seen it.
15 Mr. LEYENDECKER: You have it. You just talked
16 to your witness about it, part of it.
17 Mr. FIRST: No objection.
18 THE COURT: Mr. Hulslander.
19 Mr. HULSLANDER: No objection.
20 THE COURT: Mr. Stevens?
21 Mr. STEVENS: No.
22 THE COURT: Exhibit 771 received.
23 (Whereupon, Plaintiff's Exhibit Number 771 was
24 received in evidence)
25 Mr. LEYENDECKER: Chuck, can I get that on the

1 screen, please?
2 Q. Let me hand this back to you. This is the clinical
3 guidelines on behavior management from the A.A.P.D., and
4 these discuss the various behavior management concepts you
5 have been testifying about, right?
6 A. Yes.
7 Q. And this is 2004/2005?
8 A. Yes, it is.
9 Q. It's the one that you just testified before this jury
10 that they don't discuss risks in any way, right?
11 A. No, I did not.
12 Q. Let's look over on "Informed Consent," Page 2. Chuck?
13 Informed consent, you understand what that concept is, don't
14 you, Dr. Mueller?
15 A. I do.
16 Q. That's the process by which a doctor explains to a
17 patient or a young child's parents, the risks and benefits of
18 any proposed treatment, correct?
19 A. That is correct.
20 Q. And it's important no doctor, whether it's a surgeon
21 or a dentist, a dermatologist, it doesn't matter. No doctor
22 can perform a medical procedure without obtaining the
23 informed consent of the patient or the patient 's parent;
24 true?
25 A. Some do, but in my opinion, they should.

1 Q. They're supposed to. The standard of care --
2 A. Yes, sir, the standard of care would be that they
3 obtain the informed consent.
4 Q. And in these 2004/2005 guidelines that are talking
5 about the use of behavior management, including use of a
6 papoose board, does it not say that "considerations regarding
7 the need of treatment, consequences of deferred treatment and
8 potential physical/emotional trauma must be entered into the
9 decision-making process"?
10 A. It says that, but that's not what I testified to.
11 Q. Do the 2004/2005 guidelines contain a disclosure to be
12 used by dentists across the country that are considering what
13 they have to say that there are potential physical/emotional
14 trauma, and that physical and emotional trauma must be
15 considered in obtaining the parent's consent before putting
16 their child in a papoose board?
17 A. It does not say anything about a papoose board. It
18 says "considerations regarding the need of treatment,
19 consequences of deferred treatment, and potential
20 physical/emotional trauma must be entered into the
21 decision-making equation," the decision-making equation of
22 the dentist practitioner who is making this, doing this
23 informed consent, that they have to consider those things
24 before they make a decision of any of the management
25 techniques they might use.

1 Q. That's regardless of the behavior management
2 techniques utilized, and using a papoose board is one of the
3 behavior management techniques described in the '04/'05
4 guidelines, is it not?
5 A. It is, but all this says is that they have to consider
6 that.
7 Q. These guidelines do discuss risk, don't they, Dr.
8 Mueller?
9 A. No.
10 Mr. LEYENDECKER: Okay. Mr. First, where is
11 your chart that you had -- that you were using -- the
12 policy statements, something like that? It's the one you
13 left up there most of the time.
14 Q. I want to make sure you can see this, Doctor. You had
15 a bunch of discussion with your lawyer about this early
16 childhood caries concept, right?
17 A. Yes, sir.
18 Q. Okay. What this says is that "dentists who diagnose
19 ECC," right?
20 A. Yes.
21 Q. And you know for a fact that no dentist, neither Dr.
22 Khan or Dr. Aman or Dr. Bonds diagnosed Jeremy Bohn with ECC,
23 right?
24 A. I didn't know we were talking about Jeremy Bohn right
25 now, but no, I don't know that, if they diagnosed him with

1 that or not.

2 Q. You haven't looked at his record to see whether they

3 diagnosed him with ECC before you came in here and testified

4 about all the things that go along with ECC?

5 A. I have looked at his record and he does have ECC.

6 Actually, he has severe early childhood caries.

7 Q. Did you treat Jeremy Bohn, Dr. Mueller?

8 A. No, I did not.

9 Q. Dr. Khan and Dr. Aman and Dr. Bonds treated Jeremy

10 Bohn, right?

11 A. Yes, sir.

12 Q. And you reviewed their treatment and the record for

13 him?

14 A. Yes, sir, I did.

15 Q. And you know to a moral certainty that none of them

16 diagnosed Jeremy with ECC, don't you?

17 A. He had ECC by definition. I don't know what -- this

18 is a policy statement. He had ECC by definition. I don't

19 know what there is to diagnose. He has it by the definition

20 of what early childhood caries is.

21 Q. Isn't that what doctors do? They see their patients,

22 they evaluate their symptoms and then they give them a

23 diagnosis? Isn't that what doctors do?

24 A. Yes, but this is a policy statement.

25 Q. What we know and what you're avoiding answering is

1 that none of those three doctors diagnosed Jeremy with ECC,
2 right?
3 A. No, I'm not avoiding your answer at all.
4 Q. While I'm on the subject of using your lawyer's
5 charts, let's go back to this one that you were focused in
6 on -- this is the one that's hard to see. Excuse me. Can
7 everyone see that? What's the first contraindication for
8 using a papoose board?
9 A. A cooperative patient.
10 Q. A cooperative patient. But in your opinion and what
11 FORBA taught all the new dentists was that it was perfectly
12 fine to strap a child in a papoose board, even though they
13 were cooperative, simply because they thought they might
14 become uncooperative in the future?
15 A. FORBA didn't teach them anything.
16 Q. You did?
17 A. I did not teach them anything. I exposed them to the
18 guidelines so that they could use those guidelines to make a
19 decision for themselves. And I told you, it is a subjective
20 judgment on the part of the dentist, and this is true in any
21 case; it's a subjective judgment as to whether the patient
22 will be cooperative or not. If the dentist believes that the
23 child will not be cooperative, then yes, he can use the
24 immobilization device.
25 Q. Is it fair to say that the A.A.P.D. disagrees with

1 your opinion that it's okay to restrain a child with a
2 papoose board if they're cooperative?
3 A. No.
4 Q. Now, I also wrote down, Dr. Mueller, that you said
5 this was a typical board, which has been marked as
6 Defendant's Exhibit Number -- is that 1252? I can't read
7 that. This papoose board, you said, was typical, right?
8 A. Yes, I did.
9 Q. Now, what I heard you say was that one of the dangers
10 of treating these kids and the reason you put them in a
11 papoose board is because their head can move while you're
12 trying to give them an injection?
13 A. That's correct.
14 Q. How is it that this papoose board, Dr. Mueller, if
15 it's being used because it's a danger of putting a needle in
16 a child's mouth and he might move, how is this papoose board
17 going to have any impact on his head?
18 A. The papoose board is wrapped around the child up to
19 this point. When we give a child an injection, we cradle the
20 child's head in our arm and we give them the injection. The
21 papoose board holds their body still so they can't kick or
22 flip from one side or to the other, but in terms of actually
23 moving their head, the dentist himself or herself does that
24 by cradling the child's head in their arm.
25 Q. So the papoose board is not necessary to prevent the

1 danger that might exist from trying to give a young child a
2 shot, right?
3 A. That's not true.
4 Q. The dentist, as you say, is the one that can, as you
5 describe, gently cradle the child's head while they
6 administer a local?
7 A. The child's head, but not the rest of the body. And
8 if the child is kicking and moving the rest of the body, then
9 you cannot safely give the injection.
10 Q. You didn't talk about kicking feet or moving arms when
11 you described the danger of giving an injection, did you, Dr.
12 Mueller?
13 A. I described -- I said that giving an injection to the
14 child was one of the places -- the question to me was, I
15 think, was that what are the kinds of things that can cause a
16 danger to the child, and one of the ones that I identified
17 was giving an injection to the patient. The other one I
18 identified was using the handpiece on the patient.
19 Q. Now, you testified that the way most dentists work is
20 the more work they do, the more money they make; do you
21 remember that testimony?
22 A. I do. That's true for your dentist and my dentist and
23 all fee-for-service dentists who work.
24 Q. But it's not true of the dentists who work at Small
25 Smiles, is it, because they were paid a salary and the more

1 work they did, the more money FORBA got, right?
2 A. No, that's an inaccurate representation. They earned
3 money -- they earned a salary, but they also had an incentive
4 on top of the salary. So if more work was done, they got
5 more money.
6 Q. I thought you said that was a clinic-wide thing, not a
7 dentist-to-dentist thing?
8 A. It is clinic-wide. The entire clinic -- a dentist
9 alone cannot do -- cannot operate the entire clinic. The
10 bonus system, we wanted to have teamwork, and so the bonus
11 system was given to everyone in the clinic because it
12 requires everyone in the clinic to be productive, together,
13 in order for the children to be treated.
14 Q. Didn't the bonus system, Dr. Mueller, pay the dentists
15 and the front office workers a bonus if and only if they
16 exceeded the minimum expected revenue that FORBA set for that
17 clinic? Isn't that how the bonus system worked?
18 A. The bonus system had approximately eight to ten
19 sections to it. That was one. Actually, that was the last
20 one.
21 Q. And let me ask you about the last one. Is it also
22 true that no bonus could be earned unless the clinic had
23 exceeded the minimum expected amount of revenue that FORBA
24 wanted from that clinic? If they didn't exceed that, the
25 other factors didn't matter; isn't that true?

1 A. Even if they exceeded that and the other factors came
2 into play, they did not get the bonus, even if they exceeded
3 that productivity. If the other factors were not present,
4 they did not get the bonus.
5 Q. Here's my question: Is it true that they could not
6 earn a bonus -- the only way they could earn a bonus is if
7 they exceeded the amount that FORBA set as the minimum
8 expected revenue for that clinic on average every day for
9 that month? If they didn't do that, they weren't even
10 eligible for the bonus, were they?
11 A. If they didn't do any of the ten, they weren't
12 eligible for the bonus. That was one of the ten.
13 THE COURT: Dr. Mueller, can you answer the
14 question with a yes or no?
15 A. Yes.
16 Q. The answer is yes, they couldn't get a bonus unless
17 each and every day for the month that clinic exceeded FORBA's
18 expectations, minimum expectations as to the amount of
19 revenue for each and every day. If they didn't exceed that,
20 then nothing else mattered; they couldn't get a bonus, right?
21 A. Wrong.
22 Q. Well, perhaps we'll visit about that with Mr. Dan
23 DeRose when he testifies about that later in this case, the
24 particulars about that.
25 A. Certainly.

1
2 Mr. LEYENDECKER: If you'll bear with me 30
3 seconds, let me see if I can put my finger on that since
4 we're on the subject.
5 Mr. FIRST: I have an objection at this point.
6 I think we're beyond the scope of cross, my cross.
7 Mr. LEYENDECKER: No, we're not. He discussed,
8 your Honor, the subject of bonus with Dr. Mueller on his
9 examination, and I'm entitled to explore it. The
10 testimony was just given as it relates to whether they
11 could earn a bonus, unless they met or exceeded the
12 production -- the minimum production level.
13 THE COURT: I believe that subject was
14 discussed -- addressed on your examination of your client,
15 so I'm going to overrule the objection.
16 BY MR. LEYENDECKER:
17 Q. You are familiar with the way the bonus worked, I take
18 it, by your sworn testimony to the jury?
19 A. I am.
20 Mr. LEYENDECKER: Your Honor, Plaintiffs would
21 offer Exhibit Number 84.
22 THE COURT: Any objection?
23 Mr. FIRST: It's not on the list.
24 Mr. LEYENDECKER: I have it on my list and I
25 think it's fair to examine the witness about this in light

1 of his testimony about the way the bonus worked.
2 Mr. FIRST: I'll object to it. It's not on the
3 list.
4 Mr. LEYENDECKER: Your objection is it's not on
5 the list, even though he testified --
6 Mr. HULSLANDER: It's not on the list.
7 THE COURT: We have one court reporter with ten
8 fingers. She can only take the testimony of one person at
9 a time. So your objection is it wasn't identified as an
10 exhibit on Plaintiff's exhibit list?
11 Mr. FIRST: That's true.
12 THE COURT: But this is for impeachment purpose,
13 just like you pulled out with a new exhibit, so the rules
14 were on your direct examination, no new exhibits; for
15 impeachment purposes -- so I'm going to overrule the
16 objection on that grounds. Do you have any other basis
17 for --
18 Mr. FIRST: Well, he's offering it. I don't
19 think that's appropriate.
20 Mr. HULSLANDER: Can I see it?
21 Mr. FIRST: We don't know what it is, either.
22 It's not been identified.
23 THE COURT: Is there an objection?
24 Mr. HULSLANDER: Not by me.
25 Mr. FIRST: I object to it coming in. I don't

1 object to -- if he thinks it somehow impeaches him, I
2 don't object to that.
3 THE COURT: Why don't you ask him a question
4 about the exhibit?
5 Mr. LEYENDECKER: May I display it, your Honor?
6 THE COURT: At this time, it hasn't been
7 received, so no.
8 Mr. LEYENDECKER: Fair enough.
9 BY MR. LEYENDECKER:
10 Q. Exhibit Number 84, Dr. Mueller, has a discussion of
11 the Rochester bonus, does it not, if you look at the first
12 page of this e-mail?
13 A. It says "attached is the information you requested."
14 Q. Attachments: Rochester bonus summary; do you see
15 that?
16 A. I do.
17 Q. And you know that the bonus program for all the FORBA
18 clinics worked the same? The amounts that it was necessary
19 to get the bonus might have changed, but the mechanics were
20 the same?
21 A. Correct.
22 Q. Okay. And so if we go to the second pages of Exhibit
23 84, Item 9... are you with me? Item 9 carries a weighting
24 percentage of 65 percent; do you see that?
25 A. Hold on. What page are you on?

1 Q. You may have the shorthand version. Let me see if I
2 can assist you, Doctor. Here we go. Item 9 carries a
3 weighted percentage of 65 percent. Are you with me?
4 A. Yes, sir.
5 Q. And you recognize that Item 9 relates to that factor,
6 which is whether they exceed the minimum expected amount of
7 revenue set for that clinic, correct?
8 A. Well, this is an e-mail sent from Rich Lane to Dan
9 DeRose --
10 Q. That's not my question.
11 A. -- Roumph, to Dan DeRose and our attorney and to me,
12 which I've never seen before.
13 Q. That's not my question. Item 9 carries a weighted
14 percentage of 65 percent; does it say that?
15 A. It does.
16 Q. Does it say "Item 9 has a structured breakdown of the
17 bonus level --"
18 Mr. FIRST: I'm going to object --
19 Q. -- "based on the average daily collectible production
20 and the number of dentists in practice." Do you see that --
21 Mr. FIRST: Object.
22 THE COURT: Wait a minute.
23 Mr. FIRST: The witness has indicated he's not
24 familiar with this exhibit. It's Rochester apparently. I
25 would object to it being used for this purpose.

1 THE COURT: Okay. So your question -- your
2 question that he asked was whether Item 9 has a weighted
3 -- 65 percent weighted -- okay. So you're asking him to
4 read from a document that's not in evidence. I'm going to
5 sustain the objection.
6 BY MR. LEYENDECKER:
7 Q. Dr. Mueller, is it your memory that the component of
8 the bonus program that related to whether the clinic exceeded
9 the expected production was weighted at 65 percent of the
10 model?
11 A. No, it's not.
12 Q. Is it your memory, Dr. Mueller, that Item 9, which
13 relates to the average daily production of the clinic
14 per month in the FORBA bonus model --
15 Mr. FIRST: I'm going to object to asking this
16 witness about an exhibit that he doesn't know of, never
17 has seen --
18 THE COURT: Well, he's not asking him about an
19 Exhibit, so overruled.
20 Do you need the question read back?
21 THE WITNESS: Yes, please.
22 THE COURT: Val, please read the question back.
23 (Whereupon, the record was read by the court
24 reporter)
25 Q. Is it your memory that the bonus put in place for all

1 these clinics of the nine factors which you told us
2 referenced, the single largest was the average daily
3 production factor? Do you remember --
4 A. The 65 percent, as I remember, was based upon the
5 monthly collectible production. You asked me previously if
6 it was based upon the daily collection, which it's not. It
7 was based upon the overall monthly production.
8 Q. Okay. So on the 65 percent, it's not -- according to
9 your memory; that's fair. According to your memory, the 65%
10 is not based on the average daily collectible production and
11 the number of dentists in practice over the course of a
12 month?
13 A. According to my recollection, it's based upon the
14 total amount of money as one of the nine, 65 percent. Each
15 of the other ones has a percentage associated with it as well
16 of the nine, but --
17 Q. Is it your memory that no bonus could be paid to
18 anybody unless they achieved 70 percent or more of those
19 various factors?
20 A. No. If they achieved -- if they failed on any of the
21 factors, they did not receive the bonus.
22 Q. Here's my question, because I think you --
23 A. I don't think I understand.
24 Q. To be eligible for a bonus, it's your memory --
25 whatever happens on factors one through eight, is it your

1 memory that in order for the bonus to be payable, they have
2 to achieve 70 percent or more, 65 percent of which is
3 assigned to the production component? And so if they don't
4 get the 65 percent, they can't ever get to 70 percent and
5 thus can never earn a bonus; is that your memory of how it
6 worked?
7 A. I guess if you put it that way, that makes sense, but
8 they had to achieve all of them. They couldn't just achieve
9 the collections for the month.
10 Q. You made a comment about most mothers wanted their
11 children treated on the day that they -- first day they
12 showed up, or I forget exactly what you said, but you said
13 most mothers wanted the treatment, so that's why we were
14 doing the treatment on that day; do you recall that
15 testimony?
16 A. I think I said many or some. I didn't say most,
17 but -- I said that mothers frequently, regularly requested
18 that we do the treatment on the day that they were there.
19 Q. Did FORBA keep track of the number of patients that
20 were converted from a hygiene visit to an operative visit?
21 A. Not to my knowledge.
22 Q. To your knowledge, did the clinics have to send
23 information back to the offices in Denver about how many
24 patients they had converted from hygiene visits to operative
25 visits?

1 A. Not to my knowledge.
2 Q. To your knowledge, were the clinics and the dentists
3 pressured to increase the number of conversions?
4 A. Not to my knowledge. The dentists were asked to
5 use -- utilize the hour of time that they had. If they had a
6 patient in hygiene where a patient needed care, the mother
7 wanted the care, they were asked in order to increase their
8 productivity to use that hour they had to treat a child that
9 needed care.
10 Q. Are you telling this jury that you have no idea
11 whether FORBA was keeping track of and pressuring clinics to
12 convert more patients; is that your sworn testimony?
13 A. Yes, sir.
14 Q. If that happened, you had no idea it was going on?
15 A. If anyone was being pressured, they were being told
16 that that's what needed to be done in order to do your job;
17 you should utilize the full hour that you have with your
18 patient. And if there is an hour available, rather than
19 going into your office and playing on your computer or
20 reading the newspaper, that -- and if you have a child who
21 needed treatment, you should use that hour to treat the
22 child. If you want to call that "pressure," that's fine, but
23 what I described is what happened.
24 Q. You said that one of the things the dentists are
25 supposed to do before a child is strapped down on a papoose

1 guard is to engage in tell-show-do to try and help make a
2 child feel comfortable and safe and accepting of treatment,
3 positive attitude toward being at the dentist; did you say
4 that?
5 A. I did not say "before." I said that's one of the
6 behavior management techniques that is used.
7 Q. The point of that behavior management technique, Dr.
8 Mueller, is it not to help the child relax and become
9 comfortable and accepting and to cooperate with the doctor?
10 Isn't that the point of it?
11 A. It is a point of it, but as you said, "To cooperate
12 with the doctor," and if we have a child who is between one
13 and four, they are by definition in a pre-cooperative state
14 of behavior, so they can't do that.
15 Q. Is it your testimony to the jury that children one to
16 four can't cooperate under any circumstances with an adult or
17 with a doctor?
18 A. No, that's not my testimony.
19 Q. You do know, do you not, Dr. Mueller, that the dental
20 record that we're going to look at with Dr. Bonds, Dr. Aman
21 and Dr. Khan, that there is no indication, none, that anybody
22 ever tried tell-show-do with Jeremy before they strapped him
23 on this board, right?
24 A. You -- he was an out-of-control child. You can't use
25 tell-show-do on an out-of-control child. So the answer to

1 your question is no.
2 Q. So they didn't try it, did they?
3 A. I believe I've just answered that.
4 Q. And the answer is they did not try --
5 Mr. STEVENS: Objection, speculation, your
6 Honor.
7 THE COURT: Overruled.
8 Q. Just to be clear about your testimony, you're familiar
9 with what happened; you've reviewed the chart, and you know
10 they did not try tell-show-do before they strapped him down
11 on whatever device they strapped him down on --
12 Mr. STEVENS: Objection -- you're asking for a
13 conclusion about what happened between the dentist and
14 patient. It's an improperly phrased question.
15 Q. Let me ask it this way: Is there any indication in
16 Jeremy Bohn's dental chart which reflects the days on which
17 Dr. Bonds strapped him down on one of these papoose boards --
18 is there any indication in that chart anywhere that reflects
19 he tried to get Jeremy to calm down, have less fear, and
20 cooperate by using tell-show-do, any indication whatsoever in
21 that chart that he did that?
22 A. No, there's not nor would I expect there to be.
23 Q. Okay. So let me make sure -- I want to explore that
24 for a minute. If I have a child that is uncooperative and
25 frightened and scared, and that's what you're describing,

1 right?
2 A. Yes.
3 Q. You don't think that it's worth the effort to try and
4 talk to that child and show him the instruments and explain
5 what you're going to do with him? You don't think that's
6 worth the effort?
7 Mr. STEVENS: Objection.
8 A. It's worth -- I'm sorry, did someone --
9 THE COURT: You have an objection?
10 Mr. STEVENS: Yes.
11 THE COURT: The legal basis?
12 Mr. STEVENS: Speculative as to what occurred
13 between the dentist and patient in this case.
14 THE COURT: So speculative. Overruled.
15 A. I'm sorry, with the objection, ask me again, please.
16 I lost the question.
17 Q. Let me try again, all right?
18 A. Sure.
19 Q. We know that children can be fearful and afraid when
20 they're at a dentist's office or -- right? We know that?
21 A. Yes, they can.
22 Q. And so my question is, if we know the tell-show-do is
23 designed to help alleviate fear, is designed to help make a
24 child feel comfortable, to make him less scared, to make him
25 able to hopefully cooperate with the medical professionals

1 that are there to help him -- if those are the things you're
2 supposed to do, are you telling this jury it's not worth the
3 effort to do that simply because he comes in and is acting
4 the way a three-year-old is going to act in that kind of
5 environment?
6 A. In his chart, it says he was out of control, out of
7 control.
8 Q. Here's my question --
9 A. Out of control three-and-a-half-year-old, and you
10 cannot use tell-show-do, in my opinion, on an out-of-control
11 three-and-a-half year old. It's not going to do anything.
12 Q. That's not my question.
13 THE COURT: I'm going to have Val read back the
14 question. Listen to the question and answer the question,
15 if you can.
16 (Whereupon, the question was read back by the
17 court reporter)
18 A. In this situation, yes, that's what I'm telling you.
19 Mr. LEYENDECKER: I have no more questions, your
20 Honor.
21 THE COURT: Okay.
22
23 RECROSS-EXAMINATION BY Mr. FIRST:
24 Q. Doctor, you still have 771 in front of you?
25 A. Let me see. This one.

1 Q. Doctor, you were asked about the clinical guideline on
2 behavioral management, a particular section of it that deals
3 with informed consent, and let me ask you this: That
4 informed consent statement in there pertains to all types of
5 behavioral management; is that correct?
6 A. Yes, that's correct.
7 Q. Okay. And it goes on to say -- may I see it again?
8 I'm sorry, I don't have -- it goes on to say "there needs to
9 be considerations regarding need of treatment, consequences
10 of preferred treatment and potential physical/emotional
11 trauma must be entered into the decision-making equation."
12 That's the part that was highlighted to you, Doctor?
13 A. Yes, it is.
14 Q. Now, that is in relation to informed consent for all
15 types of behavioral management; isn't that correct?
16 A. Yes, although it's under "informed consent." Yes, it
17 says "considerations regarding the need of treatment, the
18 consequences of deferred treatment and the potential
19 consequences of physical/emotional trauma must be entered
20 into the decision-making equation." That means the dentist
21 who is treating the patient must weigh all of these things
22 when they're making a decision of how to treat this child.
23 Q. Okay. And there's nothing in that that pertains
24 specifically to medical immobilization, is there?
25 A. No, there is not.

1 Q. In fact, that would also pertain to things like
2 general anesthesia and sedation and other types of behavioral
3 management, would it not?
4 A. Yes, it would.
5 Q. And that relates to informed consent. It doesn't
6 mention any specific or potential risks relative to any of
7 those scenarios, does it?
8 A. No, it does not.
9 Q. Now, you were asked some questions about early
10 childhood caries. Doctor, counsel asked you about early
11 childhood caries and whether Jeremy Bohn had it, and I don't
12 think you were able to discuss what that's about, what it is,
13 and what that question pertained to, or explain your answer,
14 so I want to ask you about that.
15 Mr. LEYENDECKER: Your Honor, may we approach?
16 THE COURT: Yes.
17 (Discussion off the record held at the bench)
18 (Exhibit 772 marked for identification)
19 THE COURT: Do you want to make a record?
20 Mr. FIRST: I would, please.
21 THE COURT: All right. The Court is limiting
22 the use of that exhibit, whatever exhibit number it is --
23 Miss Meyers, would you tell me what exhibit that is?
24 Ms. MEYERS: Exhibit Number 1066.
25 THE COURT: -- 1066, to the subject matter of

1 specifically whether or not there was a diagnosis in
2 Jeremy Bohn's chart of ECC.
3 Q. In response to Mr. Leyendecker's question, you
4 indicated that based on what you would view, Jeremy Bohn had
5 early childhood caries. I would like you to explain to the
6 jury what that's based on?
7 A. It's based upon the definition of early childhood
8 caries.
9 Q. Which is?
10 A. Early childhood caries is when you have a child that
11 has one decayed tooth before they are aged six years old, is
12 early childhood caries.
13 Mr. FIRST: That's all. Thank you.
14 Mr. LEYENDECKER: Very brief, your Honor.
15
16 REDIRECT EXAMINATION Mr. LEYENDECKER:
17 Q. Dr. Mueller, did you treat Jeremy Bohn?
18 A. No, sir.
19 Q. And you know that the doctors who were on the scene
20 examining his conditions and his symptoms, you know very well
21 they did not diagnose him with early childhood caries,
22 correct?
23 A. Diagnosed him -- by definition, he had early childhood
24 caries. By definition of the policy, are you asking -- what
25 are you asking?

1 Q. Are you confused by my question?
2 A. No, I'm not confused by your question.
3 Q. Did they or did they not diagnose Jeremy with early
4 childhood caries? It's a yes or no question.
5 THE COURT: It isn't exactly because you asked
6 him did they or did they not.
7 Mr. LEYENDECKER: Excuse me. Fair point.
8 Q. You know they did not diagnose Jeremy with early
9 childhood caries, correct?
10 A. Did they write in his chart, is that what you're
11 asking me, that he had early childhood caries?
12 Q. Did I ask you what they wrote in his chart or did I
13 ask you if they diagnosed him? Is there a diagnosis of early
14 childhood caries in that chart?
15 A. Well, sir, I'm sorry, but unless someone writes it in
16 the chart, I sure don't know how it would get there.
17 Mr. LEYENDECKER: That's all I have.
18 THE COURT: You may step down.
19 (Whereupon, the witness was then excused)
20 THE COURT: The video is half an hour; is that
21 correct?
22 Mr. LEYENDECKER: Maybe 25 minutes, plus or
23 minus, in that range.
24 THE COURT: Why don't we do that before lunch?
25 Mr. LEYENDECKER: There was a question with the

1 exhibits --
2 THE COURT: I have looked at the exhibits. With
3 respect to Exhibit 514, would counsel approach?
4 (Discussion off the record at the bench)
5 THE COURT: Okay. We're going to see a
6 videotape. We have physician testimony that was taken
7 under oath before the trial began. There were a number of
8 exhibits that were marked at that deposition and some of
9 which are being offered by Plaintiff's counsel. The
10 exhibits that are being offered are Exhibits 58, 514, 8,
11 103, 12 -- 12's already in -- 24, 31, 35, 511, and 513.
12 It's my understanding that the Defendants object
13 to admission of Exhibit 58, 8, 511, and 530. The Court
14 overrules those objections and will receive those
15 exhibits. Did I miss one?
16 Mr. LEYENDECKER: No, I think you may have said
17 513 originally. I'm not sure. 530 is the exhibit we
18 discussed and is being offered.
19 THE COURT: 530?
20 Mr. LEYENDECKER: Yes, your Honor.
21 THE COURT: I might have said the wrong number.
22 It's 530 that's being offered, that is being objected to,
23 but the Court is overruling the objection. So those
24 exhibits are received.
25 (Exhibits 58, 514, 8, 103, 24, 31, 35, 511 and

1 530 received in evidence)
2 THE COURT: All right.
3 (Whereupon, the video of Richard Lane was then
4 played)
5 THE COURT: Is that it?
6 Mr. LEYENDECKER: I believe so, your Honor.
7 THE COURT: Okay. Were there counter --
8 Mr. FIRST: Just a very brief one. I'll just
9 read it.
10 THE COURT: Was it one that we discussed
11 previously?
12 Mr. FIRST: Yes.
13 "Question: All right. Now, if you would, let's
14 get Plaintiff's Exhibit 24 back in front of me. That was
15 just a little bit, little earlier. That's your e-mail
16 setting out the responsibilities of various people to DD
17 Marketing --
18 Answer: Yes.
19 Question: -- in their activity on behalf of
20 FORBA, right?
21 Answer: Yes.
22 Question: And we have gone over your role and
23 that of Mr. DeRose and you've indicated you were in charge
24 of operations. What did that involve?
25 Answer: Do you want it from the beginning or

1 from the time of this document?
2 Question: Just give it to me at the time of the
3 document.
4 Answer: Okay. So, primarily, make sure that
5 the clinics were up and running, that they had everything
6 they needed as far as H.R. was concerned; they had their
7 operations manual; they had their H.R. manual, that they
8 had all the supplies, whether it was front office supplies
9 or dental supplies, that they had the proper equipment,
10 whether it be dental equipment, the X-rays, the
11 handpieces, the chairs, the computers, Eagle Soft
12 software, which is a software that was used to run the
13 dental side of the business, and make sure if there were
14 any issues that came up, if there was a request for
15 information from an outside agency, whether it be a state
16 agency or a private insurance payer or a Department of
17 Labor request for information, that all those would come
18 through me so that we could coordinate getting the proper
19 information to whoever needed it. We also would do chart
20 audits. We would do site audits. I didn't necessarily
21 need to be at the site to do the site audit. We might
22 have another representative from DD Marketing who would go
23 out and do the site audit. Chart audits were typically
24 done where we would request anywhere from 10 to 20 charts
25 a month to send back to our office. Initially when the

1 business first started, I was doing the chart audits by
2 myself and we created a template at all of the -- I'll
3 call it non-dental. Since I am not a dentist, I would
4 look at all of the administrative things to make sure that
5 what was on the patient charts matched what was on Eagle
6 Soft, make sure the height, weight, name, the date of
7 birth, the dentist's signature was on there and the
8 dentist assistant's signature was on there, did we bill
9 for the services that we said we did, were the consent
10 forms in place?"
11 That's all I have. Thank you.
12 THE COURT: Okay.
13 Mr. HULSLANDER: May we approach for 30 seconds,
14 please?
15 THE COURT: Yes.
16 (Discussion off the record at the bench)
17 THE COURT: Okay. We're going to take our lunch
18 break now, an hour. According to this clock, it's 20 of
19 1. If you can come back at 20 of 2. Don't talk about the
20 case with anybody. Don't do any independent research, and
21 don't eat too much.
22 (Whereupon, the jury was excused from the
23 courtroom)
24 THE COURT: Just so the record is clear, I know
25 the list that I received about the exhibits to be used

1 during the Lane deposition did not include 94, 95, 96, 97
2 or 98. That was the shorthand version. I don't have the
3 transcript with me. I don't know whether those are being
4 offered. They were shown to the jury. We didn't talk
5 about that with the counsel, so --
6 Mr. LEYENDECKER: That was my mistake on the
7 shorthand version yesterday. They were obviously in the
8 designations, and I apologize for that. As soon as I
9 recognized that, I asked Mr. Dorr to -- "don't show any
10 more of those." They certainly are being offered in
11 connection with the testimony and your Honor did review
12 the substance of that testimony on the objections last
13 week, so it was my mistake yesterday, and I didn't want to
14 make it worse, so that's why I said, "take them down."
15 THE COURT: So I guess just to protect the
16 record, we need to know whether there are any objections
17 to Exhibits 94, 95, 96 -- well, you're offering those
18 exhibits, is what you're saying?
19 Mr. LEYENDECKER: Yes, your Honor.
20 THE COURT: I had ruled on the testimony that
21 was given with respect to those, but there hasn't until
22 now been an offer with respect to Exhibits 94, 95, 96, 97
23 and 98. Is there any objection to those exhibits?
24 Mr. FIRST: I would object to 94 as being
25 irrelevant and immaterial to any issue in this case. I

1 would note in particular --
2 THE COURT: You're going to have to face Val
3 when you're talking. Can you bring your book that way?
4 Mr. FIRST: I would note in particular that the
5 e-mail has to do with the Dayton facility, nothing to do
6 with Syracuse. Should I go through all of them, Judge?
7 THE COURT: Yes, because I'm going to look at
8 them at my lunch break and --
9 Mr. FIRST: I would object to the e-mail --
10 well, I'm talking about 95, which half the e-mail is
11 actually from Judy Mori, D.D.S., who works at one of
12 the -- one of the dental clinics, so that is actually
13 hearsay as to me and my clients, and I would also object
14 to it that it does not deal with the Syracuse clinic. I
15 believe that's Albany, and I would object to it as being
16 irrelevant and immaterial.
17 And, your Honor, I've just been reminded that on
18 94, going back to that, you previously -- that came up
19 before in this trial and you sustained the objection to
20 it.
21 THE COURT: It was sustained because it had to
22 do with foundation and Lane was -- it was with one of the
23 other witnesses but it was an e-mail from Lane, I believe,
24 or --
25 Mr. FIRST: This is not an e-mail from Lane; 94

1 is not. It's not from Lane. It's from Dr. Knott.
2 THE COURT: Dr. Knott. Okay. All right.
3 Mr. FIRST: And he's not c.c.'d, either. Going
4 back to 95, I think I fully stated that it's immaterial
5 and irrelevant to this case.
6 96, once again, it's immaterial and irrelevant
7 because it does not deal -- it does have a number from
8 Syracuse but it does not specifically address any issue at
9 Syracuse, and it otherwise addresses facilities that have
10 nothing to do with Syracuse.
11 97, I would also note with 97 that it's --
12 actually half the e-mail is from Janine Randazzo, who
13 apparently works at one of the clinics. That is certainly
14 hearsay. And in addition, I would object to that as
15 immaterial and irrelevant.
16 98, this e-mail deals with Rochester. I would
17 submit it's immaterial.
18 THE COURT: Okay. Mr. Hulslander?
19 Mr. HULSLANDER: Same objections.
20 THE COURT: Mr. Stevens?
21 Mr. STEVENS: Your Honor, I'll just, so my voice
22 isn't entirely silent on the issue... in the ruling you
23 already made on the sequencing motion, you decided the
24 issue, the Defendant dentists believe they're trying the
25 case cheek by jowl and the broad case against the

1 corporation prevents them from getting a fair trial at
2 all. I object to being in the same trial with all of the
3 corporate defendants. That's a general objection and you
4 have ruled on it in sequencing in motion.
5 THE COURT: All right.
6 Mr. HIGGINS: Judge, just very briefly, just to
7 try to clean up the record a little bit, Exhibit 772 has
8 been marked for identification. That is the demonstrative
9 exhibit, which is the papoose board which is on the
10 Plaintiff's table now. The Defendants have also marked a
11 papoose board, which is marked as Exhibit 1252. So at
12 this time, we would move in Exhibit 772 just for
13 demonstrative purposes only.
14 THE COURT: Okay.
15 Mr. FIRST: I understand if it's demonstrative,
16 it's not moved into evidence at all, just marked for
17 identification. That's my understanding.
18 THE COURT: So you're objecting to its receipt?
19 Mr. FIRST. Object to its receipt.
20 Mr. HULSLANDER: I'm going to object, too,
21 Judge. You can mark it, but it shouldn't be permitted
22 into evidence, in my view.
23 Mr. STEVENS: Same.
24 Mr. HIGGINS: Judge, when I say "demonstrative
25 exhibits," I'm not saying this goes back to the jury room.

1 It's marked and admitted for demonstrative purposes to
2 show the jury during the course of the trial, just like an
3 exhibit board or something like that.
4 Mr. HULSLANDER: Exhibit boards should not be
5 admitted into evidence. It's either in evidence or it's
6 not in evidence. For demonstrative purposes, it's marked
7 so they have something marked, but it should not be
8 admitted into evidence. I submit that.
9 THE COURT: Anything else to address before we
10 break for lunch? All right.
11 (Lunch recess taken at 12:46 p.m.)
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$10 [1] - 565:13
$50 [1] - 565:13

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'04/'05 [2] - 590:7, 593:3
'04/05 [2] - 578:7, 590:8
'A[1] - 542:7
'Such[1] - 542:4
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1 [3] - 575:2, 619:19
1,200 [2] - 567:22, 567:23
10 [3] - 6:7, 540:19, 618:24
10,000 [2] - 566:23, 575:2
100 [1] - 575:11
1002 [4] - 6:15, 586:3, 587:11, 587:12
103 [3] - 6:21, 616:11, 616:25
1066 [2] - 613:24, 613:25
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10:29 [1] - 575:24
11 [4] - 540:15, 540:18, 540:20, 541:24
12 [2] - 6:6, 616:11
12's [1] - 616:11
1252 [2] - 596:6, 623:11
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14 [1] - 547:8
15 [3] - 540:10, 547:8, 575:22
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167 [1] - 538:16
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18th [2] - 538:17, 538:20
19 [1] - 545:10
1973 [1] - 544:14
1977 [1] - 544:14
1985 [1] - 545:10
1:94 [1] - 535:8

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2 [4] - 541:20, 590:7, 591:12, 619:19
20 [4] - 568:4, 618:24, 619:18, 619:19
20,000 [1] - 575:2
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