STATE OF NEW YORK : FIFTH JUDICIAL DISTRICT

SUPREME COURT : COUNTY OF ONONDAGA

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

Plaintiffs,

vs.

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

FORBA HOLDINGS, LLC, FORBA, LLC n/k/a LICSAC, LLC; DD MARKETING, INC.; SMALL SMILES DENTISTRY, PLLC, including: MAZIAR IZADI, DDS; LAURA KRONER, DDS; LISSETTE BERNAL, DDS; NAVEED AMAN, DDS; KOURY BONDS, DDS; YAQOOB KHAN, DDS; JANINE RANDAZZO, DDS; LOC VIN VUU, DDS, et al.,

Defendants.

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JURY TRIAL

October 1, 2013

Onondaga County Courthouse
401 Montgomery Street
Syracuse, New York 13202

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HONORABLE DEBORAH H. KARALUNAS,

Justice of the Supreme Court and a Jury

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I N D E X

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(Morning Session - October 1, 2013.)

THE COURT: Good morning. I just had an e-mail -- first of all, Kevin, nice to see you.

MR. HULSLANDER: Oh!

THE COURT: How you feeling today?

MR. HULSLANDER: Better than yesterday.

THE COURT: All right. Uhm, I had an e-mail that there was an alternative video of a pulpotomy, and I thought in a couple of minutes before -- because we don't have all the jurors here, we would look at that to see if the -- there are any objections to that.

MR. McPHILLIAMY: Thank you.

THE COURT: Can you play that? Did defendants' counsel want to look at this to see if there are any objections?

MR. FRANKEL: I don't know whether they had a chance to look at it or not.

MR. FIRST: I couldn't open it for some reason.

THE COURT: We're off the record now.

(Whereupon, said video played in open court, all counsel present, outside the viewing of the jury.)

THE COURT: Okay. Uhm, that's the video.

It has not yet been marked as an exhibit, but we'll do that afterward. Don't want to hold the jury up. Are there going to be any objections to the use of that video as demonstrative evidence?

MR. FIRST: Yes, I'm going to object to it, Your Honor, for the same reasons largely as yesterday. It's a different child. Different conditions, dental conditions.

Obviously, it's not an uncooperative child as is indicated in our case. There is a running hearsay commentary about what's going on.

And, you know, equally importantly it's, you know, it's graphic and shows a lot of blood and its prejudicial effect outweighs any probative value. Obviously, how the procedure is done can be fully described by the Doctor.

And, you know, it's like in a surgery case showing a surgery that is similar to the one being performed on the plaintiff. And I've never seen that allowed in all the years I've been doing malpractice cases.

THE COURT: But --

MR. FIRST: In any event, those are my objections.

THE COURT: Okay.

MR. McPHILLIAMY: I have the same objections.

MR. STEVENS: I have the same objection, Your Honor. This is Jeremy, a very particular child, who was brought in already and found to be uncooperative by the prior dentists.

The patient they are talking about here, which is the second visit where the four crowns were put in, behavioral rating was one on the Frankl scale, which is the worst it can possibly be. It's a completely false depiction of what the scene could have looked like with this child.

THE COURT: What the scene could look like with this child?

MR. STEVENS: With Jeremy in terms of the work done on him. And we note that limiting instructions, but the jury will see the pictures, see what it looks like, and they can take that picture back to the jury room as the picture of Jeremy and what happened in that case. Our case is so different than that. I object to this video for those reasons and for all the reasons my colleagues stated.

THE COURT: When you say it is so different, does that depict the procedure?

Putting aside that Jeremy may have been moving -- or I mean I assume he wasn't moving if he was papoosed, but is that an accurate depiction of the process?

MR. STEVENS: Please don't assume that Jeremy wasn't moving if he was in a papoose.

THE COURT: Okay.

MR. STEVENS: There are four moving parts to a kid to a jaw --

THE COURT: Okay. Put that aside for a second. My question is, is that an accurate depiction of the procedure of a pulpotomy?

MR. STEVENS: Well, certainly not similar to the same as the one done in this case. There is a different manufacturer who is promoting a product and the product name is stated there.

I can't say that this -- that the age of this child and the amount of sculpting done on the teeth is at all similar. I have no way of saying this is an accurate depiction the way it was done with Jeremy.

But my objection isn't to those details. My objection is that this gives the impression to the jury that that's how easy it was done and they would do it for production or other reasons.

It's a completely different situation. They went out of their way for a kid who was in a difficult situation, and in a very different situation than the child depicted in this video.

I don't want a picture in this jury's head going back to the jury room. And I think it is -- they say a picture is worth a thousand words. I think this is unduly prejudicial.

THE COURT: Okay. Thank you. Mr. Frankel.

MR. FRANKEL: Your Honor, yesterday afternoon the objection was it's not the front teeth, it's the back teeth.

The second objection was that the local injection gives the wrong impression.

So we cured both of those problems with this video. In terms of Your Honor says you've done it, I can tell you I personally had a trial where the claim was somebody had to have a replacement hip surgery done because of a faulty hip, so the damage was the hip surgery.

And we played a videotape of the process so that the jury can see what it was like. There is a lot of talk about it, and it's the same thing here. I dare say none of the jurors and perhaps

no one in this room, other than the dentists, ever heard of a pulpotomy until they got involved in this case, and it is just a word and this explains what it is.

MR. STEVENS: One brief -- my colleague, who I have a great deal of respect for, this was not my objection yesterday, if the Court remembers back one day.

THE COURT: Okay. You don't have to tell me. I heard your objections yesterday.

MR. STEVENS: Thank you.

THE COURT: Mr. Dorr, is there any way to -- because, for example, you showed it -- showed curing and it showed it twice, two different times. Is there any way to shorten that video this morning? I'm not a techie so I have no clue.

MR. DORR: Your Honor, we can stop it after the point where it gets to the crown selection piece.

THE COURT: I mean you can put the -- but it just -- it went on for another four minutes, which I really don't think --

MR. DORR: Right. We will stop it at that point.

MR. STEVENS: It can also show a still screen shot, one from each section to let the witness comment on and then wouldn't know the patient is moving and allow for description of it, would take away some of the objections. That's technically feasible.

THE COURT: Uhm, all right. We're going to use this with the first witness, right?

MR. FRANKEL: Yes, ma'am, we are.

THE COURT: Okay. Well, we're going to have to get it marked and the Court is going to receive it. And I would say let's shorten it and cut it off at the point of the crown selection. Okay?

MR. FIRST: Judge, may I say something with respect to that point?

THE COURT: Sure.

MR. FIRST: If the Court is going to allow it, I would ask that the whole thing, including the result that they got there, would be shown to the jury.

THE COURT: All right. It's coming in. Okay. We'll have that marked. We'll get the -- are we ready to proceed?

MR. FRANKEL: One moment. Go ahead.

MR. HULSLANDER: Judge, I wasn't here yesterday. I take it you denied the motion for a mistrial?

THE COURT: Yes, I did.

MR. HULSLANDER: Uhm, are we -- are you going to tell the jury that there is no fraud or breach of fiduciary claims any longer, or are we going to continue to deceive them to think that they are there?

THE COURT: I don't think they have been deceived to thinking they are there, because I really didn't identify specific causes of action, just claims. I mean just theories.

And since the Fourth Department has not said that fraud is not an element of some of the remaining causes of action, I'm going to -- I'm not going to do any type of curative instruction.

When the jury gets charged, I won't charge fraud, and the verdict sheet will not include a fraud -- the fraud questions.

MR. HULSLANDER: Okay. So your position is that because of the GBL claim that there --

THE COURT: And I think that it's still -- again, that was why I denied the motion for mistrial. The evidence comes in under the other

claims so there really isn't a limiting instruction or curative instruction that I think is necessary at this time.

MR. HULSLANDER: Okay. Just note our exception, Judge.

THE COURT: Yup.

MR. FRANKEL: One last thing, Your Honor.

MR. FIRST: As well as ours, Your Honor, if I can meet the record.

MR. STEVENS: I join in the motion.

MR. FRANKEL: Yes, he did. We presented, Your Honor, a couple of side-by-side charts. One of which you said take the labels off, which we have. We anticipate that our expert will testify to those, the facts that constitute the labels, and we are prepared if that happens to graphically display that, but we didn't want to do that in light of Your Honor's ruling without getting some pre-approval or at least advising the Court that that's what we would like to do.

THE COURT: I don't think it's necessary to put the terms back on the pictures after the witness testifies.

MR. FRANKEL: Even if you had a chart up here and you wrote on the chart, you don't want us

to do that.

THE COURT: I don't think it is necessary.

MR. FRANKEL: All right.

THE COURT: I'm not sure what the witness will testify to. Maybe she will use a different term, so let's just leave it like that.

MR. FRANKEL: Okay.

MR. McPHILLIAMY: Your Honor, one last point. When plaintiff's counsel served expert disclosure that named experts one through five, and we're just curious which number expert will you be calling?

MR. FRANKEL: I -- I haven't looked. I think it's one.

THE COURT: Okay. Bring the jury in.

(Jury seated in the jury box at 9:15 a.m.)

THE COURT: Good morning.

(Jurors responded with "morning.")

THE COURT: I'm sorry to hold you up this morning. We were dealing with some evidentiary issues in an effort to make the trial day go more smoothly for you. We dealt with those. We won't have to take breaks to deal with those evidentiary issues.

As you can tell, we have all our lawyers

back so all is well, and I appreciate your consideration yesterday. Ready to start?

(Jurors responded with "ready.")

MR. FRANKEL: Your Honor, we call as an expert Dr. Cindy Slack.

CYNTHIA SLACK, DDS, having been called as a witness and being first duly sworn, testified as follows:

THE COURT: All right, you have a very soft voice, Miss Slack. We have a large courtroom with high ceilings, if you can keep your voice up.

THE WITNESS: I sure will. Thank you.

THE COURT: Thank you.

DIRECT EXAMINATION

BY MR. FRANKEL:

Q. Dr. Slack, where do you live?

A. I live in Rochester, New York.

Q. How long have you lived in Rochester?

A. I moved to Rochester in 1980.

Q. So 33 years?

A. Thirty-three years.

Q. Do you have any children?

A. I do. I have three children.

Q. What are their names?
A. My youngest daughter is Mariel. My son is William. And my oldest daughter is Celia.
Q. Any of them still live at home?
A. No. They are all gone.
Q. Any grandchildren?
A. No grandchildren.
Q. Did you grow up in Rochester?
A. I did not.
Q. Where did you grow up?
A. I grew up in Cincinnati, Ohio.
Q. And where did you go to school, starting in college?
A. I went to college in Cincinnati, Xavier University. Then I went to dental school at Case Western Reserve, which is in Cleveland, Ohio.
Q. After you graduated dental school, did you get additional training -- well, first, did you get a dental license?
A. Yes, I did.
Q. Was that license in Ohio where you had gone to school?
A. Actually, it was a Northeast Regional license, and then each state you apply singly.
Q. Okay. Did you get a New York license?

A. Yes.
Q. When did you become licensed as a dentist in New York?
A. In 1980. At that time you could get your license immediately following dental school.
Q. Okay. After graduating dental school, did you go for any specialty training?
A. Yes, I did. I went to Rochester Eastman Dental Center, and I was there for two years.
Q. And what specialty did you train in?
A. Pediatric dentistry.
Q. How many? You said two years --
A. Yes.
Q. -- you had gone there? When did you finish your pediatric dental residency program?
A. I finished it in 1982 in the summer.
Q. Since graduating, have you specialized in treating children?
A. Yes, I have.
Q. What percentage of your patients are children?
A. Well, I would say predominantly most. Pediatric dentistry is really unique in that it's the only specialty that you're -- you have very specific training in dealing with individuals with special needs or caring for individuals with special needs.

So I would say perhaps about ten percent of my patients might be older adults with special needs.

Q. All right. Setting aside those special needs patients, are the rest of your patients children?

A. Yes.

Q. Has that always been the case?

A. Yes.

Q. Are you licensed in any other states besides New York?

A. Yes. I'm licensed in the State of Pennsylvania.

Q. Okay. And do you practice dentistry from time to time in the State of Pennsylvania?

A. Yes, I do.

Q. Are you in a corporate practice or are you in a private practice, a group practice? Tell us what type of practice you have?

A. In Pennsylvania, I'm in a hospital setting. It's in central Pennsylvania in a rural area. The hospital's name is Geisinger, and they just started a residency program there, so I travel there once a month and work in the residency and train young dentists to become pediatric dentists.

Q. All right. And besides your teaching in Pennsylvania, tell us a little bit about your practice

in Rochester?

A. My practice in Rochester is four days a week at this time. There was a point in -- when I worked five days a week and six days a week when I first started it, but I have three hygienests with me and two assistants, and it's a traditional pediatric dental practice.

Q. All right. Do you do -- for example, do you do pulpotomies on children?

A. Yes, I do.

Q. Stainless steel crowns?

A. Yes.

Q. Fillings?

A. Yes.

Q. During your career, how many pulpotomies would you estimate you have done? And a broad estimate is fine.

A. Uhm, thousands, if not tens of thousands.

Q. And stainless steel crowns?

A. Close to the same, if not more.

Q. And how about fillings, how many fillings over the years have you done?

A. Tens of thousands.

Q. Uhm, in each instance where you did a pulpotomy or a stainless steel crown or filling, have you -- do

you have to evaluate through x-rays and clinical examination whether a patient needed a procedure?

A. Sure. There's a very precise protocol that you learn in dental school, and particularly with children it's fine-tuned in your residency where you assess the patient, behaviorally, emotionally, and then clinically, not only on the extraoral which is on the outside, but intraorally as well. And depending on your findings, radiographs, x-rays are taken, and a treatment plan is drawn up from those main findings.

Q. How many times over your career have you reviewed x-rays to evaluate a patient's condition and whether a child needed dental procedures?

A. From my own practice or in the residency or whatever?

Q. Yes, your practice.

A. Uhm, I'd say tens of thousands of times.

Q. Do you provide behavior management guidance to children who come into your office who are uncooperative?

A. Yes, I do.

MR. FIRST: Objection to what the witness does, as opposed to generally what these are about.

THE COURT: Overruled.

Q. How many children --

THE COURT: You answered. Go ahead.

Q. How many children do you see a week that are uncooperative when they come in for dental treatment?

A. I'd say probably about twenty to thirty children a week at least.

Q. And you deal with their fears and concerns as a pediatric dentist?

A. Yes.

MR. McPHILLIAMY: Objection. Leading.

THE COURT: It is. Why don't you be careful not to lead the witness.

MR. FRANKEL: All right.

Q. Dr. Slack, have you been the president of any dental organizations?

A. Yes, I have.

Q. Which ones?

A. Our local Monroe County Dental Society. Uhm --

Q. Excuse me, let me ask you about that. Monroe County is the county where Rochester is?

A. Yes, it is.

Q. The dental society, is that an organization limited to pediatric dentists or all dentists?

A. It's all dentists. It is.

Q. Okay. And have you been the president of other

organizations?

A. Yes. Yes, I have.

Q. Would you tell the ladies and gentlemen of the jury about that?

A. Yes. I was the president of the Seventh District Dental Society, which is a component of the New York State Dental Society. And there are about 800 dentist members in that serving eight counties around Monroe County.

Q. Okay. Does that include general dentists as well as other specialists?

A. All specialists, all general dentists.

Q. Uhm, you mentioned that you're currently teaching one week a month in Pennsylvania. Did you -- have you ever taught any dental students in New York?

A. Yes. Right after my residency at Eastman, they hired me as an attending, and I worked there off and on for about ten years one day a week working with the residents. And I've taught at Monroe Community -- Monroe Community College. I've taught dental hygienests, pediatric dentistry and behavior, and I've taught the residents at Geisinger as well.
And in the early 90s, I was a state presenter, handful of people were chosen for this for there was a mandatory course on child abuse and neglect, and I was

the individual that covered Rochester and Buffalo.

Q. All right. Over the years, Dr. Slack, have you treated children who were -- whose parents were on Medicaid or they were Medicaid patients?

A. Absolutely. Always.

Q. Have you provided the same level of care to those children as you did to all your patients?

A. Yes.

Q. Is the standard of care different for patients according to an economic situation?

A. No, never.

Q. How did you get involved in this case, Dr. Slack?

A. Probably about two and a half, maybe three years ago, I got a phone call from a colleague of mine who knew me from the dental society and wanted to know if I would have any interest in --

MR. McPHILLIAMY: Objection. Hearsay.

MR. FIRST: Hearsay.

THE COURT: Well, I'm not sure the answer's -- maybe it would be offered for the truth of the matter. So you got a call?

THE WITNESS: I got a phone call and --

MR. FRANKEL: Your Honor --

THE COURT: She answered.

BY MR. FRANKEL: (Cont.)

Q. You got a phone call. And through that phone call did you eventually get a phone call from us?

A. Yes, I did.

Q. And what were you asked to do?

A. I was asked to review some cases.

MR. McPHILLIAMY: Objection.

THE COURT: Legal basis?

MR. McPHILLIAMY: Your Honor, may we approach?

THE COURT: Yes.

(A discussion off the record at the Bench, all counsel present.)

THE COURT: All right. I will have to have you step out for a minute, two minutes.

(Jury excused in the courtroom at 9:31 a.m.)

(The following was heard in Open Court, all counsel present, outside the hearing of the jury.)

THE COURT: Okay. We just had an off-the-record discussion regarding the ability of this witness to testify to her review of other Small Smiles cases and whether or not the Court should allow that.

The defendants object to that line of

questioning. Uhm, and the plaintiffs take the position that it's relevant because of the 349 General Business Law claim to show the pattern and practice.

At this point, the Court's reserved decision. I'm going to instruct the witness at this time until you're instructed otherwise, you should not testify about other cases that you -- that you've reviewed, uhm, and the Court will rule on that.

Mr. Frankel said he will not ask questions about that until such time as the Court issues a ruling.

MR. STEVENS: If I can just add one thing to the remarks you made at -- I think at the Bench a moment ago.

Comparing figures that -- and percentages of is against what was done in this group with this company and these clinics where kids are selectively funneled even from other dentists who may keep three easy children and send an unmanageable child where they are concentrating this way, as we heard in some of the testimony, and I believe that makes comparisons even more unfair and prejudicial.

Certain individual dentists to be compared to what's done and not before the jury in cases that we're not able to defend and show the chart and show pictures if there are pictures, radiographs, if there are radiographs, puts them in a situation where they could never dig out from their prejudice.

THE COURT: Okay. Just to respond to one of the points you made. You said that, you know, your clients or Small Smiles patients were referred by other dentists and so it's a different body of children.

However, I know I've heard testimony in the trial so far that at least in one that there's extensive advertising that takes place and that at least in one clinic there were 2,400, I think, children waiting in line to be seen on the day that the Small Smiles clinic opened. So clearly it's not -- the pool of patients is not just referral based.

MR. STEVENS: What we know from this case, I think three children in the Bohn family, and one who is unmanageable, was referred to this clinic.

THE COURT: Okay.

MR. STEVENS: Thank you.

THE COURT: All right. Court will step down for one second. I'm going to --

(Proceedings in recess at 9:35 a.m.)

THE COURT: Okay. Mr. Stevens, I'm going to ask that you speak up, too, when you talk.

MR. STEVENS: Thank you.

THE COURT: I knew you were capable.

(Jury seated in the jury box at 9:42 a.m.)

THE COURT: Ready to proceed?

MR. FRANKEL: We are, Your Honor.

BY MR. FRANKEL: (Cont.)

Q. Dr. Slack, what materials have you reviewed in connection with Jeremy Bohn's case?

A. I have reviewed his file. The chart from Small Smiles, including any clinical notes, x-rays. I've reviewed some testimony from last week and some depositions.

Q. All right. Have you formulated opinions regarding the treatment and care that Jeremy Bohn received while he was a patient at the Syracuse Small Smiles clinic?

A. Yes.

Q. In expressing your opinions, Dr. Slack, today, will you base all your opinions on a reasonable degree of dental certainty?

A. Yes, I will.
Q. And are your opinions based on your education, training and experience as a pediatric dentist in Rochester, New York for the past thirty years?
A. Yes, they are.
Q. Are your opinions based on the standard of care as it existed at the time of the treatment in question?
A. Yes, they are.
Q. Dr. Slack, I'd like to now turn to the dental care that Jeremy received, and start with his visit at the Small Smiles center on August 31st, 2006. There's Exhibit No. 199, Plaintiff's Exhibit 199 is there for you, as is the original chart which is in that box.
A. Thank you.
MR. FRANKEL: Do we have the operative report?
Q. Can you find the operative report for August the 31st, Dr. Slack?
A. Yes.
Q. I don't know if it's simpler for you, Mr. Dorr has put that up here.
A. Oh, for August 31st?
Q. Yes, ma'am.
A. Pardon me.

Q. So on August 31st, 2006, did Dr. Aman perform four pulpotomies on Jeremy Bohn on teeth D, E, F and G?

A. Yes.

Q. What is a pulpotomy?

A. A pulpotomy is a nerve treatment that's done for a baby tooth and sometimes for an immature permanent tooth. Oftentimes it is referred to as a baby tooth root canal. The operator, the dentist, will anesthetize the area and take a burr which is on the end of a handpiece, so a drill, and open up into the chamber where the nerve is located and remove a portion of the nerve, leaving a remainder of the nerve closest to the tip of the root so the tooth still has some capability with regard to being able to -- the root to dissolve and shed properly, so the entire nerve is not removed, a portion, about half of the nerve is removed.

Q. How does the procedure for doing a pulpotomy compare to an ordinary filling?

A. An ordinary filling would never go into the nerve, it would never go into the pulp. So an ordinary filling penetrates the enamel. It will go through the hardest part, which is the part we can all see with our eye, and it will penetrate through the

enamel into the middle layer which is called the dentin and between -- the dentin is kind of the middle part of the sandwich between the enamel and the pulp. So you have to go through the enamel, through the dentin and into the nerve of the tooth.

Q. You have to do that in order to do a pulpotomy?

A. Yes.

Q. How does the -- in New York how does the reimbursement rate for a pulpotomy compare to the reimbursement rate for a filling, Medicaid reimbursement?

A. Medicaid, uhm, from what I recall in this particular record at that time the filling might have been around $50 and a pulpotomy was $80. I hope I'm recollecting, but it's...

Q. Okay. Based on the evidence in Jeremy Bohn's record, did Jeremy need the pulpotomies on four teeth that Dr. Aman performed on August 31st, 2006?

MR. McPHILLIAMY: Objection, form.

MR. FIRST: Same objection.

MR. STEVENS: Same.

THE COURT: Overruled. You remember the question?

THE WITNESS: Yes, I do.

A. He did not.

Q. Did he need three of the pulpotomies?
A. He did not.
Q. Did he need two?
A. No.
Q. One?
A. No.
Q. Was it a deviation from good and accepted dental care for Dr. Aman to perform four pulpotomies on Jeremy's teeth on August 31st, 2006?
A. It was an absolute deviation.
Q. Under what circumstances would it be reasonable for a reasonably prudent dentist to perform a pulpotomy on a child like Jeremy?
A. There probably are two main situations where you need to do a pulpotomy. One might be in the situation of an injury where a child falls and they break their tooth and you actually see the nerve. Then you have to treat the nerve to save the tooth. The other would be if a cavity is very deep, remember it's going to go through the enamel and through the dentin, and it is going to be on the nerve of the tooth and communicate with the nerve of the tooth. When you see that either clinically or on an x-ray or combine both, then one would do a pulpotomy.
Q. Did Jeremy's front four teeth, based on the

x-rays you have seen and the record you have seen, did they need any type of dental treatment in your opinion?

A. The maxillary occlusal x-ray, which is what the Small Smiles refers to as a periapical of his front teeth shows no evidence of decay. No evidence of caries.

Q. Do you believe that it would assist the jury in understanding what Jeremy -- what a pulpotomy is and what Jeremy experienced to look at a videotape of a pulpotomy procedure?

A. Yes, I think that would be very helpful.

Q. Were you able to find an example of a pulpotomy videotape that showed a pulpotomy of front teeth?

A. Yes. And it's reflective of pulpotomies done on a child, so they are baby teeth and it's -- the procedure would be very similar.

Q. Do you believe it fairly and accurately depicts how dentists perform a pulpotomy?

A. Yes, I do.

Q. All right.

MR. FRANKEL: Your Honor, we at this time offer the videotape that we discussed.

THE COURT: Okay. Has it been marked as an exhibit?

MR. FRANKEL: It's Plaintiff's Exhibit 779.

THE COURT: Exhibit 779. So this is being used only for demonstrative purposes?

MR. FRANKEL: Correct, Your Honor.

THE COURT: All right. You can display the video. I understand the defendants have objections that we dealt with this morning before the jury came in. Those objections we can put on the record at a time when the jury is not present.

MR. FRANKEL: And it's our intention to have Dr. Slack narrate the video, I'll ask her questions what is going on here and just let her do that, if that's how we intend to offer the tape.

THE COURT: Okay.

THE WITNESS: May I come down, please?

MR. FRANKEL: Is that all right, Your Honor?

THE COURT: Of course. This is all right. I've seen it.

BY MR. FRANKEL: (Cont.)

Q. What's this?

A. This is a photograph of the child, their front teeth you can see a large cavity there. The lingual

aspect being by the tongue. So this is the back part of the teeth where you can see cavities on these teeth. This is the x-ray. You see the cavity there, in here, circles there.

Q. What is tooth preparation?

A. Tooth preparation is where you take the drill with the burr in it and you're going to actually remove the cavity and reduce the size of the tooth. The tooth has to be made smaller. So this is a round burr that is going in through the enamel, through the dentin, and when you see the red, that's the nerve of the pulp of the tooth. Pulp has nerve and blood vessels and that's why it's bleeding.

Q. When you do a pulpotomy is that more what happens?

A. Absolutely, yes. Then what they are doing is they are taking off part of the enamel on the edge of the tooth so that the crown can fit over. If you don't do that, the crown would end up being bigger than the tooth was naturally.

Q. What are they doing here?

A. Now they are taking a different shape burr and reducing around the circumference of the tooth below the gumline. Why that's important is the crown will tuck under there. You can't have the edge of the

crown showing, and it would be very difficult to clean, plaque would catch there. So you take a different shape burr and go down and around under the gumline. And you can see the red that is coming out there, this is the bleeding from the nerve of the tooth. Just continuing on and making sure there are no ledges under the gumline. Now they will finish the rest of the teeth. Enter into the pulp chamber. You can go from the backside of the tooth, which this dentist has chosen to do on those two teeth, and you're actually taking the burr and pulling the pulp tissue out at the same time and this tooth is doing -- or she is doing from the front part of the tooth. You rinse, want to make sure that the bleeding is under control. And then a cotton pellet is placed with medicament, a medication, that's left in there and then removed, then the pulpotomy paste is pressed into the root canal and that paste acts like a preservative to help keep that tooth there for the life of the tooth, that's the goal. And since baby teeth the crowns aren't custom made, they're sized, so you have to figure out what size is going to fit on that tooth. So crown selection is important. You might try a couple of different sizes before you find the size that you want. You'll try the crown. Make sure it

seats well. Make sure it will offer an aesthetic result and a functional result. Sometimes you have to make some adjustments before the crown fits down perfectly.

Q. What does crimping mean?

A. There's a little metal edge right at the rim of the crown, that edge is pulled in so it tucks in nicely and fits to the contour of the tooth under the gumline. We see it is contoured in. Then it's retried to make sure that they fit in unison as well, particularly if you are doing multiple crowns together. Then they're permanently placed with cement. The inside of the crown is hollow, a cement is mixed up, and it's placed inside and then the crown slides over.

Q. What are they doing here?

A. They're just rinsing to make sure that there's not a lot of hemorrhage or bleeding. Drying it. And with this particular crown, you'll see they're going to be shining a bright blue light. That light will cure or harden this particular cement. But there are different cements that can be used. So you apply a lot of pressure to fit that crown. Make sure it is seated down. And as you do that the cement kind of exudes out and it has to be cleaned off.

Q. Is that the cement itself that they are removing?

A. Yes. It will start to set up and get a little bit hard, and then it is removed with an instrument. If it's left behind, it will cause the gum tissues to become very irritated.

Q. This spraying of water, is that what we're familiar with when we go to the dentist --

A. Right.

Q. -- and get a cleaning?

A. Right. In this particular patient there is a rubber dam on so that spray is not getting in their throat or mouth.

Q. Thank you, Dr. Slack.

A. You're welcome.

Q. You may be seated.

A. Okay.

THE COURT: Just so you understand as jurors, that that video that we just watched does not depict Jeremy or the condition of his teeth at the time of his treatment with Small Smiles.

It is shown to you for demonstrative purposes only to merely show you generally how a pulpotomy of the front teeth is performed. Okay.

BY MR. FRANKEL: (Cont.)

Q. You said that Jeremy had four of these pulpotomy procedures that, in your opinion, were not necessary?

A. Yes.

Q. Uhm, how are you able to know whether the -- how are you able to formulate an opinion as to whether the -- whether he needed a pulpotomy or not?

A. Uhm, well, as far as Jeremy's record?

Q. Yes.

A. I think you can look to two places. One would be the charting and the other would be the x-ray.

Q. Okay. Let's start with the x-ray.

A. Sure.

Q. He did have x-rays taken the very day that they did the procedure, is that true?

A. This day, yes, they did those x-rays that day.

Q. Uhm, have you prepared a chart that shows the x-ray that -- the x-ray that they took of Jeremy and compare it to another patient to compare the level of disease between the two?

A. Sure. Yes, I have.

Q. Okay. Could we --

MR. STEVENS: Objection.

THE COURT: Uhm, this again is an issue we dealt with before. The photographs which are

exhibit what?

MR. FRANKEL: 776.

THE COURT: 776 are for demonstrative purposes only and the one -- one of the x-rays is of Jeremy's mouth and the other one is of another mouth, correct?

MR. FRANKEL: Yes, ma'am.

THE COURT: You can show it.

MR. STEVENS: May we approach, Your Honor?

THE COURT: Yes.

(A discussion off the record at the Bench, all counsel present.)

MR. FRANKEL: Can everyone see this?

BY MR. FRANKEL: (Cont.)

Q. Okay. Dr. Slack, on the left side of this radiographic comparison, do you recognize that x-ray as being an x-ray of Jeremy Bohn's on August the 31st?

A. Yes, I do.

Q. Can you tell the ladies and gentlemen of the jury whether this x-ray shows that Jeremy had caries at that time on those front four teeth?

A. There's no evidence of caries on those front -- four front teeth.

Q. Would you mind coming down and just pointing to what his four front teeth show?

A. Sure. These are the four front baby teeth. These are the adult teeth that are developing underneath. The bright white around the edge of the tooth that you see on each tooth is the enamel. The darker area inside is the pulp tissue, and then the grayer area is the dentin.

Q. All right. And from your review of the x-ray, do you see any evidence of decay?

A. I don't, not on this x-ray.

Q. What -- what would you -- in looking at Jeremy's x-ray, what would you expect to see if he had decay significant enough that it would require pulpotomy?

A. Well, I wondered if we could even go over to the next x-ray because the comparison.

Q. So -- so Jeremy's x-ray shows he did not need any care. Let's look at this, if this will help you, use this pointer, look at this other x-ray. This is not Jeremy, correct?

A. That is not Jeremy.

Q. On the right?

A. No.

Q. It's just another person, another patient?

A. It's another child.

Q. Okay. Just focusing on what the x-ray shows,

what does -- what does that x-ray show as far as the condition of this child's teeth?

A. Uhm, I would point out these are the four front teeth again. These are the adult teeth that are forming underneath. The bright white edge that you see here is not intact on these teeth.

Q. Is that because they broke off or does that have something to do with caries?

A. It has to do with the cavity. You can see the dark area, almost look like holes that are punched in the teeth. There. This hole here. This hole here. A shaping difference right there. And then this tooth is almost lost entirely to caries. It's pretty much to the gumline.

Q. All right. Focusing now on the right side, does the condition of these teeth warrant a pulpotomy?

MR. McPHILLIAMY: Objection.

MR. STEVENS: Judge --

MR. FIRST: Objection.

THE COURT: Overruled.

A. The condition of these teeth may require a pulpotomy.

Q. Okay. And what would you need -- what would you need to know other than this x-ray to be able to make that decision?

A. It's a clinical decision. In other words, the goal in dentistry is to be as conservative as possible. To maintain and preserve as much tooth structure as possible. So with these particular teeth, the practitioner would go in and remove the cavity, and if the cavity communicated with the nerve, that would warrant a pulpotomy. If it didn't, you wouldn't do it.

Q. Okay. Thank you.

THE COURT: She may step back up?

MR. FRANKEL: Yes.

Q. What you just described, Dr. Slack, is that sometimes called carious pulp exposure?

A. Clinically when you're actually working with the child and you're operating and you're removing the caries, when the caries communicates with the pulp that is a carious pulp exposure.

Q. Before you actually -- when you, just looking in the mouth of a child, before you actually start doing any work, can you see carious pulp exposure?

A. I think the only situation where you'd really see a carious pulp exposure is if the tooth was so severely damaged from the cavity that the cavity is already visible to the nerve of the tooth and the pulp starts growing out of the tooth. It's called a pulp

polyp. So you see that in a child, cavity is big and the nerve is actually growing out, but a typical situation, no, you can't visualize a carious exposure.

Q. Can you see carious pulp exposure on Jeremy Bohn's x-ray on August 31st?

A. No.

Q. Is it possible, in your opinion, for a patient to have the condition of his four front teeth look like Jeremy's as expressed on Exhibit 776 and have a carious pulp exposure?

A. Without evidence of caries, no.

Q. Did Dr. Aman have any clinical evidence that would support doing a pulpotomy and stainless steel crown on Jeremy's four teeth based on the x-ray results we have?

MR. STEVENS: Objection. Asked and answered based on the x-rays.

THE COURT: I think that question was confusing. Would you rephrase it?

MR. FRANKEL: Yes, ma'am.

Q. Does -- did Dr. Aman, from your review of the records, have clinical evidence that would support doing a pulpotomy and stainless steel crown on four of Jeremy's teeth?

A. Clinical evidence with regard to the charting?

Q. Yeah. Anything that you --

MR. STEVENS: Objection.

THE COURT: Legal basis?

MR. STEVENS: I'd like to hear the rest of the answer.

THE COURT: I think she was asking him a question. Uhm, so I don't think there was an answer. Were you asking a question?

THE WITNESS: I was.

THE COURT: So you needed some clarification?

THE WITNESS: Please.

THE COURT: Okay.

BY MR. FRANKEL: (Cont.)

Q. From your review of the chart, do you see anything in the chart that would be sufficient clinical evidence to warrant doing four pulpotomies and four stainless steel crowns on Jeremy Bohn on August 31st, 2006?

A. I don't. I don't see clinical notes that reflect that. I don't see what the findings were at the time of the procedure which would be appropriate. I don't see evidence of that, no.

Q. With these x-rays of Jeremy Bohn's teeth, in your opinion is there any way he needed a pulpotomy

and stainless steel crowns on those teeth?

MR. McPHILLIAMY: Objection. Asked and answered.

MR. FIRST: Objection.

THE COURT: Overruled.

A. Could you repeat the question, please.

Q. Yes, ma'am. With the x-ray evidence that we have for Jeremy Bohn, Exhibit 775, is there any way, in your opinion, that Jeremy Bohn needed four pulpotomies and crowns on August 31st, 2006?

MR. FIRST: Objection.

MR. McPHILLIAMY: Objection. Asked and answered.

MR. STEVENS: Same.

THE COURT: Overruled.

A. No.

Q. Uhm, if a dentist does a pulpotomy on a child, is the standard of care to also put a crown on the tooth?

A. Yes, it is.

Q. Uhm, that's what we saw in the video?

A. Yes.

Q. Why do you -- if you're going to do a pulpotomy, why is it standard of care to also do a crown?

A. One of the reasons would be if you're doing a pulpotomy the cavity is big, so there probably isn't a whole lot of tooth structure left and you need to reconstruct that tooth structure for the child for function, for speech, for aesthetics. The other component is the pulpotomy, just the procedure itself you're removing more tooth structure than a typical filling, so the full coverage crown is the standard of care when a pulpotomy is done.

Q. How long does it normally take to put a crown on a patient after you've done this pulpotomy procedure?

A. Front teeth?

Q. Front teeth.

A. As a new dentist or a seasoned dentist?

Q. Why don't we take an average dentist.

A. An average dentist, pediatric dentist or general dentist?

Q. General dentist.

A. My only point of reference would be residents coming into the program have the same level of competency as a general dentist.

Q. All right.

A. And oftentimes it's about an hour each tooth.

Q. When they start out?

A. When they start out, yes.
Q. All right. Then as you get more experienced you can do it more quickly or no?
A. Yes.
Q. Okay. Uhm, in Jeremy's case, did Dr. Aman put crowns on Jeremy's four teeth after he had done a pulpotomy according to the chart?
A. Yes, the chart reflects that.
Q. So how many stainless steel crowns did he put on Jeremy's teeth?
A. Four.
Q. Is that what the SSC stands for in the chart?
A. Yes.
Q. And what -- in your opinion, what does the "W" stand for?
A. Uhm, my -- my best professional opinion would be white.
Q. Okay. When doing front teeth is it a common practice for a pediatric dentist or a regular dentist on children to use some kind of colored crown instead of a metal crown?
A. Yes. A tooth-colored crown.
Q. For aesthetic purposes?
A. Yes.
Q. Uhm, was there any justification, in your

opinion, for doing the four stainless steel crowns on Jeremy's teeth, other than they were necessary because they had done the pulpotomy?

A. Crowns would not be recommended or an appropriate treatment if there are no caries, if there's not a cavity.

Q. All right. Well, we have cavities and we have crowns. What's the difference between the two for children?

A. Between?

Q. Uhm, just filling a cavity and instead of filling a cavity actually putting a crown on the tooth?

A. It speaks to the point that I was making earlier when we were talking about the goal for all dentists is to really maintain tooth structure. With a filling you're maintaining more natural tooth structure, with a crown you're destroying all of the tooth structure that you can see with your eye. So they're not comparable.

Q. You said that in your opinion Jeremy didn't need the four pulps. If he didn't need the four pulps, did he need the four crowns?

A. No.

Q. In the depositions that were taken of Jeremy's

mom and his dad, there is some testimony about discoloration of teeth and what -- let me ask you about that. Okay. You read the testimony?

A. Yes.

Q. Uhm, what does it mean to a pediatric dentist if there is discoloration? What does that tell you about whether what you're seeing on the radiograph there is any different because he might have had some discoloration?

A. An x-ray wouldn't show discoloration. Typically when parents come in and say that their children's teeth are discolored, it can be as simple as plaque on the teeth or what they have eaten that day. Oftentimes it's injury. And the teeth become discolored, they may become gray. That we would see reflective on an x-ray. Uhm, but discoloration as a whole you wouldn't see on an x-ray. It's a visual finding, not an x-ray finding.

Q. All right. Does it tell you anything about whether Jeremy had cavities or not?

A. The simple word discoloration, no.

Q. Okay. And as opposed to radiographic evidence, what would you rely on more, the report from a parent or the x-rays?

A. Well, you'd obviously want to listen to the

narrative from the parent, and try to put the pieces together by asking questions. What does the discoloration come from, about dietary questions, then you would compare it to the x-ray. But the x-ray trumps it, because if there is nothing on the x-ray, what you're seeing is just a surface. It could be a stain. It could just be what's on the teeth, as I mentioned, plaque.

Q. Did you see any notations in Jeremy's chart at Small Smiles about any type of discoloration?

A. I did not.

Q. Did you see any indication that the dentist involved, Dr. Aman or Dr. Bonds or Dr. Khan, gave any treatment for discoloration?

A. No. That word doesn't appear in the record.

Q. I'm sorry.

A. That's all right.

Q. Or did an evaluation of his teeth for -- because of discoloration?

A. No, no evaluation for discoloration.

Q. Uhm, does a reasonably prudent dentist drill and fill teeth that don't have cavities?

A. No.

Q. Is it a violation of the standard of care to fill and drill a tooth without radiographic or

clinical evidence that the tooth has a cavity?

MR. STEVENS: Objection. Two questions.

THE COURT: Overruled.

A. Could you please repeat the question.

Q. Yes, ma'am. Is it a violation of the standard of care to drill and fill a tooth without radiographic and clinical evidence that the tooth actually has a cavity?

A. Is it against the standard of care?

Q. Yes.

A. Absolutely.

Q. Did -- in your opinion, did Dr. Bonds fill and drill and fill some of Jeremy's teeth without any proof that they had cavities?

A. Yes.

MR. STEVENS: Objection.

THE COURT: Overruled.

Q. How many of Jeremy's teeth did Dr. Bonds drill and fill without evidence of cavities?

A. According to this record, I believe there were four.

Q. All right.

A. Three on the left, excuse me, and one on the right.

Q. And what were the letters of those teeth?

A. Uhm, A, J, K, and L.

Q. All right. The J, K and L, were those the three teeth that were filled on October 11th when Jeremy was in a papoose and was not given local anesthesia?

A. Yes, that was October 11th. And, yes, there was no anesthesia and no nitrous oxide.

Q. Let's take two -- these three teeth. How do you know from the record that there wasn't any evidence of cavities on those teeth?

A. This particular record was compared to the x-rays that were taken previously.

Q. All right. And do those x-rays show any evidence that Jeremy had cavity on teeth J, K and L?

A. I believe that x-ray was nondiagnostic.

Q. Tell the ladies and gentlemen of the jury what that means?

A. It means it's of a poor quality, that one can't render a decision about either disease or no disease.

Q. If you were going to drill and fill those teeth, would a reasonably prudent dentist then have retaken the x-rays?

A. Yes.

Q. In the event you could -- couldn't get good x-rays, should the chart reflect that?

A. The chart should reflect it and then it should also reflect going steps further, which means either taking a photograph if an intraoral camera is available so you can capture what you're seeing with your eye. Bringing the parent in and showing them chair side, see this area, do you see the difference between this and a healthy tooth. And all of those are always written down in a record to support justification when a radiograph can't be taken.

Q. Do you see any such notes by Dr. Bonds or anyone else that explains what they were actually seeing in J, K and L?

A. No, there's nothing.

Q. Uhm, without x-ray proof would you expect to have detailed notes identifying clinical findings if you were going to rely on that as a basis for the treatment?

MR. McPHILLIAMY: Objection. Leading.

A. Absolutely.

THE COURT: Sustained. It's leading.

Q. Would a reasonably prudent dentist who is going to do fillings on teeth without x-ray evidence create detailed notes to justify the treatment?

MR. McPHILLIAMY: Objection. Leading.

THE COURT: Uhm, overruled.

A. It's imperative to put in your record very detailed clinical notes. That's the only thing that you have as basis for your judgment at the time of what you're doing. And if it's not written, it didn't happen, so...

Q. In the -- is that in the absence of having radiographic proof?

A. Yes.

Q. And you don't see any of those kind of notes in Jeremy Bohn's file?

A. No, they're not.

Q. Is it important for a dentist to minimize the pain that a child feels during a dental procedure?

A. Absolutely. It's the duty of the dentist.

Q. And why is that, Dr. Slack?

A. Because dental procedures can be painful, particularly with children, being ahead of the pain is very important. If you start a procedure and then a child experiences pain, you've lost them behaviorally and you have lost their trust, so it is very important to make sure that anesthesia is profound and that means that it's complete and total. That the child will be comfortable.

Q. What is the most common method used by dentists to relieve pain during dental procedures?

A. Local anesthesia.
Q. And how does a local anesthetic like lidocaine provide relief?
A. Uhm, from the chemical component of it, what it does is it just blocks the ability for the nerve to conduct so the brain doesn't receive the message that the nerve is actually firing, so on a local level that area is numb.
Q. Does a reasonably prudent dentist give a patient a local anesthetic when drilling and filling a cavity?
A. Yes.
Q. Is that good and accepted dental practice?
A. Yes.
Q. Why is that, Dr. Slack?
A. The goal is to make sure that the patient is comfortable, and if you're opening up in -- into a tooth that has sensation and feeling, you want to prevent that sensation and feeling and pain and the best way to do it is with local anesthetic.
Q. Did Dr. Bonds drill and fill these teeth J, K and L without local anesthesia --
MR. STEVENS: Objection.
Q. -- on October 11th?
MR. STEVENS: Object to the phrase "drill

and fill".

THE COURT: Overruled.

THE WITNESS: I'm sorry.

A. Yes.

Q. How do you know that from the chart, Dr. Slack?

A. The top line where it says management.

Q. Yes.

A. Local anesthesia "no" is circled. Then the next line down where the dentist would designate what anesthetic was used is blank.

Q. All right. Did such conduct deviate from the standard of care expected of a reasonably prudent dentist?

A. Yes.

MR. McPHILLIAMY: Objection.

MR. STEVENS: Objection.

THE COURT: Overruled. All right. It's 10:30, we will take our morning recess. Fifteen minutes. Don't talk about the case or form any opinions.

(Proceedings in recess at 10:30.)

THE COURT: Okay. Okay. Before we bring the jury in, the Court has considered the issue raised with respect to whether or not the witness can testify about other cases that she's reviewed

and the Court is going to overrule the objection. Bring the jurors in.

MR. STEVENS: Respectfully except.

MR. FIRST: Have we made a record on that? A more detailed record?

THE COURT: I think we made a record on it. But we can do that, we will reserve your right to the next break if you haven't made your formal record. Frankly, I can't remember what we have done on the record.

MR. FIRST: I think we approached the Bench on that. I would like to make a record.

MR. McPHILLIAMY: I don't believe we made a record.

THE COURT: We'll do that. Your rights are preserved and we will put it on the record after I discharge the jury next.

(Jury seated in the jury box at 10:44 a.m.)

THE COURT: Continue.

MR. FRANKEL: Thank you, Your Honor.

BY MR. FRANKEL: (Cont.)

Q. Dr. Slack, let's now turn to October 23, 2006. On that day, did Jeremy Bohn have some fillings put in by Dr. Bonds?

A. Yes.

Q. And from the chart can you see whether Dr. Bonds used local anesthetic when he drilled and filled those teeth?

A. On this record there's no local anesthetic used.

Q. Which teeth are we talking about?

A. Tooth number A, which is the upper right last tooth in the mouth for a child. Baby second molar. And tooth S, which is the lower right baby first molar.

Q. Dr. Slack, in your opinion, was -- did Dr. Bonds deviate from the standard of care by doing two fillings, A and S, without a local anesthetic under the circumstances that existed on October 23rd?

A. Yes.

Q. Uhm, did Dr. -- was the reason for that because there was no local anesthetic?

A. Yes.

Q. Did Dr. Aman drill and fill one of Jeremy's teeth on March 22, 2007, without a local anesthetic?

A. Yes.

MR. STEVENS: Objection to form.

THE COURT: Overruled.

Q. Uhm, can we see that chart? Is -- we're looking at an operative report from March 22, 2007,

Dr. Slack. Again, can you tell that Dr. Aman did not use local anesthetic?

A. Yes.

Q. Same place on the chart?

A. Same place that's checked no.

Q. Okay. In this case I notice that he used, have some other form of management for, begins the section called management.

A. Yes. The circle is checked that nitrous oxide was used.

Q. So Dr. Aman used nitrous oxide while he was filling Jeremy's tooth. What tooth was it?

A. Tooth number T, that's the lower right baby second molar right next to S.

Q. Does the use of nitrous oxide when filling a tooth like tooth T, under the circumstances that existed on March 22, 2007, eliminate the need to give local anesthetic?

A. It's not a substitute, no.

Q. Why not?

A. It's not an anesthetic. Nitrous oxide is not an anesthetic.

Q. Nitrous oxide. What's the purpose of nitrous oxide in pediatric dentistry?

A. Nitrous oxide generally in dentistry is called

an anxiolytic, which is a fancy term for reducing anxiety, so it's used for reducing anxiety.

Q. All right. Without a local anesthetic, do you believe that Dr. Aman failed -- deviated from the standard of care by doing a filling on tooth T with only nitrous oxide?

A. Yes.

Q. Last procedure I want to ask you about on this subject is the procedure done in January of 2008, by Dr. Khan. Did Dr. Khan drill and fill tooth L on January 21st, 2008, without a local anesthetic?

A. Yes.

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

THE COURT: Overruled.

Q. And the basis for your opinion?

A. The basis is under the management local anesthesia circled no.

Q. This is what's called -- it's listed as two surf. What does that tell you about the type of filling that Dr. Khan used?

A. It tells you how many surfaces. Each tooth, whether it's a baby tooth or a permanent tooth, has five surfaces. The chewing surface is one and then the other four are called smooth surfaces. One to the

inside, one to the outside, one to the front and one to the back. So when we're talking about two surfaces, this says DO, which is O is the chewing and D is distal the back, so it's between the teeth.

Q. Was Dr. Khan's conduct to drill and fill tooth L in Jeremy's mouth on January 21st, 2008, a deviation from the standard of care in not using a local anesthetic?

A. Yes.

Q. If a cavity is so superficial that it doesn't extend into the dentin is there any legitimate basis to do the filling?

A. No, it's not a cavity. If it's in the enamel and not the dentin, it's not a cavity.

Q. Okay. I heard the term superficial cavity. Is that -- is that a real cavity or not?

A. In my opinion, that's not a scientific term.

Q. Okay. Explain to us what is the definition then of a cavity, say, if it's in the enamel, it's not a cavity, where does the disease or the caries have to go to in order to be considered a cavity?

A. Well, the word cavity means hole, so the process has to penetrate through the enamel, the hard part, and then continue to develop in the dentin, which is the next layer down. If it's in the enamel

only, whether it's something that is a visible catch when you take your explorer and it feels like a tug back but not evident on an x-ray and not a cavity, that tooth is a great candidate for a sealant, which is a protective coating for the enamel.

Q. If a cavity is big enough to need a filling, then does a patient need a local anesthetic? Let's take a small child, does a small child need a local anesthetic when the filling is done?

A. Yes.

Q. Does it hurt when an instrument invades the dentin?

A. Yes.

Q. And why is that?

A. The dentin, if you look at it under a microscope, it looks like tiny straws and these straws run up and down and the straws communicate directly with the pulp of the tooth. And inside the straws are fluid and there's also some nerve endings that come up from the pulp into the dentin as well. So if an instrument, whether it's a burr from a handpiece or a hand instrument like a spoon, is in dentin, and you're disturbing that fluid, and potentially disturbing the nerve endings as well. So, yes, there's sensitivity.

Q. Uhm, were you able to determine by reviewing

Jeremy's chart whether the fillings that Dr. Bonds and Aman and Khan did on Jeremy without local anesthetic extended into the dentin?

A. Yes. There's clear evidence.

Q. And how can you tell? What is the evidence?

A. The fillings are significant, but you could look at the radiographs and see the layer of enamel and see the fillings extending into dentin.

Q. Okay. So you're saying you can look at x-rays that were taken after the procedure and judging by where the cavity is you can tell whether it's in the dentin -- I'm sorry, where the filling is you can tell whether it's in the dentin or not?

A. Yes. After the filling has been done.

Q. Okay.

MR. FRANKEL: Can we put up Exhibit No. 774.

Q. Dr. Slack, these are slides from x-rays taken of Jeremy Bohn's teeth on November 12, 2007. Is that -- are those x-rays that were taken of all but the last procedure, the one that Dr. Khan did in 2008?

A. Uhm, these are x-rays that precede the work done on L, as a DO, and S as a crown.

Q. Two teeth aren't shown on here, but as to the teeth that were drilled on without local anesthesia,

we are talking about the L that was done in 2008?

A. Yes.

Q. So, in November 2007, did these radiographs help you determine whether the fillings that were done extended into the dentin?

A. Yes.

Q. Can you come down and show the ladies and gentlemen of the jury?

A. The bright white here is the enamel. And you can see that's a cavity, but the bright white is here as well. And the depth of the filling goes into the dentin, which is this gray. This dark area is the nerve. So this one is fairly deep.

Q. You're talking about T?

A. T.

Q. All right.

A. And then with regard to L, I'm sorry, that is a cavity. This bright white is the enamel. This gray is the dentin. And this is the nerve of the tooth here. And you can see the filling extends into the dentin, again approximating fairly close to the nerve of the tooth.

Q. All right. And without going through each one of them and pointing at them, is it your opinion that the slide that --

MR. STEVENS: Objection to leading.

Q. Is it your opinion -- I'll rephrase it. What does this slide -- what is the number?

MR. DORR: 774.

Q. Does Plaintiff's Exhibit 774 provide information to you as to whether the fillings that were done on Jeremy Bohn on teeth A, T, S, J, L and K extend into the dentin?

A. Yes.

Q. And what does -- do you believe those slides show?

A. It's clear evidence that the fillings are in the dentin.

Q. All right. If you -- that's fine. If you have a -- if you have a tiny cavity, does that tell you anything or does it tell you that the filling itself is the same size as the cavity?

MR. STEVENS: Objection. Leading.

THE COURT: Overruled.

A. Could you kindly repeat the question?

Q. Can you tell us as a dentist the size of a cavity by the size of the filling?

A. The filling is filling the cavity, so, yes.

Q. When you prepare a filling do you have to prepare the filling bigger or the same size as the

cavity?

A. They're typically bigger, and the reason is, is that you need to extend. Oftentimes the enamel, that top layer is still pretty sound, and once the cavity gets into the dentin it mushrooms out, so you have to extend the top surface, that chewing surface more so, so that you can reach all of the cavity.

Q. This takes care of six of the teeth, Doctor, that were filled without local. But let's talk about the last one. Dr. Khan did -- did his work in 2008. Did you find a follow-up x-ray that gives you information as to whether Dr. Khan's filling and drilling of tooth L extended into the dentin?

A. Yes.

Q. And what's the date of the x-ray that you're looking at?

A. May 28th, 2011.

Q. All right. Was that a Small Smiles's x-ray?

A. I believe it was a Rome dental x-ray.

Q. Would you show the ladies and gentlemen of the jury where on the x-ray you believe is proof that the filling extended into the dentin?

A. Uhm, I'm just going to make a small correction that this is not L.

Q. All right.

A. That actually this is L.
Q. Okay.
A. Uhm, this is the tooth that was filled.
Q. Yes.
A. This is the DO. This is dentin. The enamel is very thin. It gets thinner as you go between the teeth to the gumline. Just a little bit of enamel there. But it's -- it isn't to the dentin.
Q. Thank you.
A. You're welcome.
Q. Are you familiar, Dr. Slack, with a technique in which fillings are done drilling through the enamel, stopping at the dentin and then spooning out the preparation to finish it?
A. No.
Q. Did you see anything in the dental record that says that that's how any of Jeremy's dentists handled his fillings?
A. No.
Q. Is that a standard method of filling a tooth?
A. No. It would be impossible to do.
Q. Do the fillings on the x-rays and the description in the record look to you like typically prepared amalgam occlusal fillings?
A. Yes.

Q. And what is the standard method for drilling and filling occlusal surfaces of baby teeth?

A. Uhm, recognizing where the cavity is. Entering the tooth from the top with the burr and the handpiece. Extending into the grooves or extending as far as you need to go to make sure you remove the cavity that's in the dentin part.

Q. If any of the dentists had deviated from that standard method, would you expect them to say so in the dental chart?

MR. McPHILLIAMY: Objection. Leading.

THE COURT: Overruled.

A. Yes. Anything that's unusual or atypical about a procedure, whether it's an adult or a child, needs to be documented.

Q. Is there anything in the chart that describes this technique that does not -- a technique where you don't use local anesthesia, but instead you drill and then you finish the preparation with a spoon?

MR. STEVENS: Objection. Asked and answered.

THE COURT: Overruled.

A. Could you please repeat the question.

Q. Yes. Is there anything in the dental chart that describes this method of not using local

anesthesia, but instead drilling through the enamel and then finishing the preparation of the tooth using a spoon?

A. No.

Q. Uhm, would that method if it was used avoid the pain associated with entering the dentin?

A. No.

Q. And why not?

A. For the reason that I stated earlier about the anatomy of the dentin. It would feel a rotating instrument like a drill or it will feel a hand instrument as well.

Q. What about the ability of a dentist to use a drill and stop it right at the spot where the enamel ends?

A. It would be impossible.

Q. Questions now about extractions, Dr. Slack. Do you have experience in evaluating whether to extract a baby tooth in a young child?

A. Yes.

Q. How many extractions over your career do you think you've done? I tell you what, let's ask it annually. How many extractions a year do you do?

A. Hundreds, four, 500 extractions a year.

Q. So over the course of 30 years is it fair to

say you've extracted thousands of baby teeth?

A. Yes.

Q. In each instance, do you have to decide whether or not to extract a tooth?

A. Absolutely. It's irreversible, so once it's gone you can't put it back in.

Q. Well, from your review of Jeremy's chart, do you see evidence that would support Dr. Bonds' decision to extract tooth B and tooth I, on May 26, 2006?

A. I'm sorry. Could you please repeat the question?

Q. From your review of the chart, Jeremy's chart, do you see evidence that would support his decision to extract tooth B and tooth I on May 26, 2006?

A. No.

Q. What did Jeremy's x-rays that were taken on that day show about tooth B and then tooth I?

A. Tooth B did show a cavity. Tooth I on the left side, that x-ray was not diagnostic.

Q. Couldn't see anything?

A. You couldn't see well. You could see part of the crowns of the teeth.

Q. Not enough to know whether the tooth should be extracted?

A. No. And the critical part for an x-ray for an extraction is being able to visualize the roots where they start to separate and that's not evident on that x-ray.

Q. And there was -- did you see any attempt to retake the x-ray?

A. No.

Q. Uhm, talking about this tooth B that you said had a cavity, in your opinion, what would be the proper treatment for that cavity?

A. In examining that x-ray, either a filling or a crown.

Q. All right. And as to tooth I, a nondiagnostic x-ray, you just need -- do you need more information in order to evaluate what to do with the tooth?

MR. STEVENS: Objection to leading. The attorney is testifying, Your Honor.

THE COURT: That's leading. Sustained.

Q. What's the significance, Dr. Slack, of a nondiagnostic x-ray of tooth I if you're trying to decide if you're going to pull the tooth or not?

A. Well, one of the parts of that x-ray that you can see is you can see part of the crown of the tooth. And that part of that tooth does not show any cavity. But what you would need is an x-ray that would show

not only the crown, but the root of the tooth to make sure, to diagnose if the tooth is abscessed.

Q. On the information that you had it looked like the tooth was okay?

A. Yes.

Q. According to the chart, did Dr. Bonds and those working with him think that Jeremy had an abscess in one or two of his teeth that day?

A. I didn't see any notation, either in when the hygienest examined him or soft tissue findings of an abscess.

MR. FRANKEL: Let's look at the hygiene from May 23rd.

Q. What is this, this place on the chart that says, soft tissue, what is that for, Dr. Slack?

A. Soft tissue is a name for anything in the mouth that's gum tissue or cheek tissue or tongue. It's anything that's not hard tissue in the mouth. So pretty much everything but the teeth.

Q. And what does a dentist or a hygienest look for when they are evaluating soft tissue? What's the purpose of evaluating soft tissue?

A. What you're looking for are any abnormalities. You would look for any redness or swelling. You would look for any pathology on the tongue, on the floor of

the mouth and the checks. So it's an overall oral exam.

Q. All right. What did that show about soft tissue? What did the hygienest show?

A. She has it blank. So the findings are negative.

Q. What does that tell you about whether Jeremy had an abscess or not, or at least whether the hygienest thought so?

A. It would be reflective that the soft tissue there were no findings in his mouth.

Q. All right. Is there another place in the chart that confirms that?

A. Uhm, actually the first page, which is the charting page --

Q. Right.

A. -- has --

Q. On the far left side, is there a section for soft tissue evaluation?

A. Yes, there is. It is the fifth one down.

Q. What does it say?

A. It's checked normal.

Q. Would you go down a little bit further? Is there a place on the chart for or the dentist involved to evaluate whether the x-ray show evidence of caries

or they're normal or show evidence of an abscess?

A. Yes. The last box there states radiographic findings and that means the x-ray findings.

Q. All right. And what were the x-ray findings on May the 26th of 2006? I'm sorry, May 23. My mistake.

A. The findings are caries, cavities.

Q. If the person evaluating this, Dr. Bonds, thought there was an abscess, would you expect the abscess box to be checked?

A. Sure. Yes.

Q. What -- can you describe for the ladies and gentlemen of the jury, what does an abscess look like on x-ray?

A. What an abscess looks like on x-ray is because it's an infection, the infection starts to deteriorate the bone, so you'd see a dark area because the bone is less dense.

Q. Have you prepared an exhibit that compares Jeremy Bohn's x-rays on May 23, 2006, with an x-ray of someone who had an abscess?

A. Yes.

MR. FRANKEL: Can we see Exhibit 775, please.

Q. Okay. Dr. Slack, can you just tell the ladies and gentlemen of the jury the difference, in your

opinion, between the film on the left side and the film on the right side?

A. May I come down?

Q. Of course.

A. This is the x-ray of Jeremy, May 23rd. This is the tooth that was extracted. Uhm, what you can see on this x-ray is it's called bony trabeculation where the bone -- can actually see the bone evident between the roots of the teeth, and then on the comparative x-ray, you see the -- you can go back to Jeremy's as well, but this is the cavity on that tooth. And then on this tooth the comparative -- slide it over.

MR. DORR: Sorry.

THE WITNESS: That's all right.

A. Uhm, this tooth has a large cavity that communicates with the pulp of the tooth so the cavity is gone inside causing the abscess and bone starts to degenerate so you get a dark area.

Q. All right. Thank you, Dr. Slack.

A. You're welcome.

Q. Are there tests that a dentist can run to evaluate whether a tooth that's abscessed or not?

A. Sure. The first test is interview. You interview the parent. You interview the child. And if children can't articulate what's wrong, sometimes

you'll just say to them can you point, if you have a sick tooth, can you point to it. So you ask the child. And then when you're doing your intraoral or inside-the-mouth examination, you would look at the soft -- the tissue and see is it nice pink color or is it red. That red color is reflective of an infection either of the gum or the tooth. And a hallmark test is called percussion, so in a tooth that's not numb, tooth is awake, you take an instrument like the end of a mirror handle and you tap on the tooth. And when you tap on a tooth, particularly with a baby tooth, if it's responsive and the kids are, oh, that's a hallmark sign that the tooth is abscessed. So we use those clinical cues of the tissue color if it's inflamed and red and puffy like a pimple in the gumline, and percussion.

Q. Do you see anything in Jeremy's chart that Dr. Bonds did any of those tests before he pulled the teeth?

A. No. Not even in the hygiene record.

Q. Is there anything in the chart that supports Dr. Bonds' conclusion that the teeth were restorable, that would be B and I?

A. Yes. I believe he makes that notation on his operative report that day.

Q. My question, Dr. Slack, is there anything in the record as far as you know, have been able to tell, that supports his opinion that the teeth were restorable and that's why he pulled them?

A. No.

Q. Can you tell from the x-ray of Jeremy on this very day that he pulled tooth B, whether the tooth is restorable or not?

A. To my eye and my experience it looks restorable.

Q. What you said has a cavity, is that what you're saying?

A. It does have a cavity.

Q. All right. Is it good and accepted dental practice to extract a tooth without clinical justification?

A. No.

Q. Did Dr. Bonds deviate from the standard of care on May 26, 2006 -- May 23, 2006, by extracting tooth B and I, without clinical justification?

A. Could you please repeat the first part of the question?

Q. Did Dr. Bonds deviate from the standard of care when he extracted those two teeth, B and I, without clinical justification?

A. Yes, he did.

Q. Can you explain for the ladies and gentlemen of the jury, in a minute or less, the process that you used to actually extract teeth like B and I in a three-and-a-half-year-old, how does it work?

A. Uhm, the first order is making sure that you have profoundly anesthesia, good local anesthetic. The next instrument that's used is called a curet, which looks like a small spoon but bigger than a dental spoon to remove a cavity. The curet is placed under the gumline, between the tooth and the gumline and run all the way around the periphery of the tooth, and that loosens the ligament called the periodontal ligament away from the tooth. The next instrument that's used is called an elevator. An elevator, for lack of a better term, looks like a screwdriver. And it has a small end that you put between the teeth. The goal of that is to elevate the tooth out of the socket. Because the roots are in bone you need to expand the bone to get the tooth out. And on baby teeth it's particularly challenging because the roots of the baby teeth are actually wider than the crown. So the next instrument you'll use a forceps, which looks like fingers, pliers, fingers, and that's put on the crown of the tooth, pressure is placed on toward

the root surface of the tooth. And then what you do is luxate which moves the handle back and forth and back and forth. What that does is it takes the roots and they rock and as they rock it expands the bone. And why do you want to expand the bone? If you just pull a tooth out, it would break the root, so you have to be very careful in making sure that when you're luxating and expanding that you're doing it enough to get the tooth out properly. Then you apply pressure because it will be bleeding with gauze. And then have the patient bite on gauze and it's called hemostasis, which the bleeding has to be stopped before you dismiss the patient.

Q. In your opinion, did Jeremy Bohn have to go through that process on two different teeth without justification?

A. Yes.

Q. Do you treat young children who come in and are uncooperative in your office?

A. Yes.

Q. Anxious?

A. Yes.

Q. Afraid?

A. Yes.

Q. How do you get their trust and cooperation, Dr.

Slack?

MR. FIRST: Objection to the Doctor's own personal.

THE COURT: Overruled. You may answer.

A. Uhm, it's a process and it's a dialogue and it's a relationship. So it starts out with a conversation with the parent and the child together going over the medical history and the dental history and finding out what the chief complaint is. Why they're there. And then probably to skip to the chase, we use what's commonly called tell-show-do, which is a behavior guidance technique, and a number of other basic behavior guidance techniques to really assess where the child is developmentally, emotionally, and so on.

Q. Is that what a reasonably prudent dentist should do as a starting place trying to guide a child who's uncooperative?

A. Yes. Children come with all different experiences and all different personalities. And it's up to the dentist to be able to look at those and kind of tease them out to figure out what's the best approach for that particular child. So, yes, it is.

Q. Uhm, do you ever use a papoose board in your practice?

A. Yes.

Q. How frequently have you -- do you normally use it?

A. Not frequently. I say probably a couple, maybe one or two times a year.

Q. All right. Has that frequency changed over your career in the last, let's say, last fifteen years?

A. No.

Q. When does a reasonably prudent dentist put a typical child who's not cooperating in a papoose board to perform dental work?

A. Well, it's a decision that's not made lightly because of the consequences and the potential effects of the papoose. So what a prudent dentist would do is make sure that you've exhausted all basic behavior guidance techniques. Tell-show-do, distraction, parental presence, voice control. And actually seeing what the parents' needs are as well. So it also has to do with the dialogue with the parent, your child's uncooperative, we're at an impasse now, and it launches you to the next level which is advanced behavior guidance, which is what a papoose is.

Q. Before you get to advanced behavior guidance, you mentioned nitrous oxide?

A. Uh-huh.

Q. Is nitrous oxide used as part of a behavior guidance technique by reasonably prudent dentists?

A. Sure. A nitrous oxide is very safe and it's particularly useful for kids with fear. When children come in, part of the fear is the fear of the unknown, so the basic behavior guidance tools remove that fear of the unknown. If there's still anxiety, nitrous oxide is a great go-to for all dentists.

Q. Would a reasonably prudent dentist who's tried the basic behavior guidelines and basic behavior techniques and failed, would that dentist, reasonably prudent dentist at least offer the parents nitrous oxide as an option before considering putting the child in a papoose board?

A. Yes.

Q. I want you to assume for a moment that the dentist involved was evaluating the child where the parent was not allowed back with the child during the evaluation, okay. Under those circumstances, if you have a child that is uncooperative and the dentist hasn't been able to manage the child's behavior, would a reasonably prudent dentist ask the parent to come back and assist -- at least attempt to assist the dentist in managing the child's behavior before

considering putting him in a papoose board?

A. Yes. Often. Sometimes the children are just crying and they're inconsolable and the concept of separation for a young child is very difficult so if you say your mom or dad are in the other room, they don't really know, have they left or are they really there. So sometimes just the mere fact of them seeing their parent is enough consolation to calm them down.

Q. Should a reasonably prudent dentist who has tried all the things we've talked about consider deferring treatment before putting a child in a papoose board?

A. Deferral is a recommended option.

Q. And when you say deferral, what exactly do you mean?

A. Means kids have bad days, too. So on occasion we can have kids that come in and they just don't feel well or they're on the verge of getting sick and they may be more teary than usual and we'll say to the mom, you know, this is an option. Dentistry for the most part is optional. So we'll have them come back on another day or defer even a few months for a child. Particularly if they're a preschooler, they mature so rapidly between three and four that -- three months or six months really bolsters their confidence to be more

independent.

Q. The record's undisputed that Jeremy Bohn was restrained twice, put in a papoose twice on his first visit in May of 2006. Did you see anything on that x-ray that would warrant having a -- not allowing him to defer the treatment, would he have been at risk if based on the x-ray evidence that the dentist, Dr. Bonds, said, come back another day, let's see if we can do this without a papoose board?

A. I did not see any evidence.

Q. Uhm, is it appropriate to put a child in a papoose board in an emergency situation where the child's in pain and the care can't be deferred?

MR. FIRST: Objection.

MR. McPHILLIAMY: Objection, leading.

THE COURT: Rephrase your question.

Q. What -- in what circumstances is it appropriate, Dr. Slack, to restrain a child after all else has failed?

A. It's appropriate if you're facing a serious situation and it's usually trauma or infection. And it's a situation that has to be dealt with that day. In other words, you can't defer it. You can't put the patient on antibiotics and wait, it's something that is emergent that has to be done that day.

Q. Is the standard of care to put a child in a papoose board to conduct a cleaning of his teeth and a routine dental examination?

A. No.

Q. Would restraining a child in that situation so you could clean his teeth and conduct a dental examination is that a deviation from the standard of care?

A. Yes.

Q. Is that what Dr. Bonds did on May 23, 2006 with Jeremy Bohn?

A. Yes.

Q. Why don't we -- why don't you just restrain children all the time? I mean wouldn't it make it easier to do your dental work?

A. It's actually easier to do -- to work with the child. There's a big difference between working on a child and working with a child. So being able to work them and work through their fears and have them learn how to cooperate really empowers the children. So the long answer to that is it's truly easier to work on a compliant child after you've worked through their fears and anxieties.

Q. Uhm, are there risks associated with putting a child in a papoose board?

A. Yes.
Q. Does a dentist have a duty to avoid unnecessary risk?
A. Yes.
Q. Is a papoose board an aversive technique that should be used as a last resort?
A. Yes.
MR. FIRST: Object to the form. He's leading the witness.
Q. What are the risks of using a papoose board on a young child in a dental procedure?
A. Well, there are physical risks which include marks or bruises that can occur from the restraint itself. There are psychological risks that can occur from the standpoint that many adults point back to --
MR. McPHILLIAMY: Objection.
THE COURT: Overruled.
MR. STEVENS: Objection. Beyond the scope.
THE COURT: You can answer.
THE WITNESS: Thank you.
A. Many adults point back to experiences that they had as a child where they have been restrained. And the psychological component can be brief for just that moment or it can be long lasting.

Q. On the psychological side, have you treated patients in your practice who are former patients of the Small Smiles clinic in Rochester?

MR. FIRST: Objection.

MR. McPHILLIAMY: Objection.

MR. STEVENS: Objection.

THE COURT: Overruled.

A. Yes.

Q. Can you describe some of the children that have come to your office who were former Small Smiles's patients, describe their behavior when they came to your office?

MR. McPHILLIAMY: Objection.

MR. FIRST: Objection.

MR. STEVENS: Objection, Your Honor.

THE COURT: Would counsel approach.

(A discussion off the record at the Bench, all counsel present.)

THE COURT: Sustained.

BY MR. FRANKEL: (Cont.)

Q. Dr. Slack, is it good and accepted dental practice for a dentist to tell a parent there are no known risks of putting a child in a papoose board for dental treatment?

A. I'm sorry, could you please repeat the

question.

Q. Is it good and accepted dental practice for a dentist to tell a parent in order to get their consent that there are no known risks of putting a kid -- a child in a papoose board?

A. No, there are risks.

Q. Uhm, is that why it's used as a last resort and only in emergency situations?

A. Yes.

Q. Is it good and accepted dental practice to place a child in a papoose board because a dentist thinks the child may become uncooperative?

A. No.

Q. In a situation in which you recommend a parent put their child in a papoose board, do you get their -- how do you get their permission?

A. Uhm, we're in the operatory having a conversation about what to do next and we've eliminated deferral. It's not a choice so we have to do something. And I will bring a papoose in to the operatory, show the child, will show the parent. We'll explain what it will do. That the child will lie down in it. And we'll wrap them in the papoose. And I will explain to the parent the reason for it is that at this particular point in time the child needs

to be still, we need him or her to be still for this procedure, and explain to the parent the risks with regard to what I spoke to you before the physical and psychological risks. I will then ask the parent if they want to stay. Some parents want to stay. Some parents don't want to stay.

MR. FIRST: Your Honor, excuse me, I'm sorry to interrupt. I object to the witness's own practices. It's not the issue in the case.

THE COURT: Well, I think oftentimes it's done repertory to an opinion question so I'm going to overrule the objection.

Q. Dr. Slack, should a reasonably prudent dentist advise a parent of the risk of psychological and physical harm before as part of getting consent for a papoose board?

A. Yes. And part of that consent is a dialogue, a consent is a -- it isn't just having a parent sign something. A consent is a process.

Q. All right. And from your review of Jeremy's chart, did Dr. Bonds deviate from the standard of care by not telling -- or by telling Miss Varano that there were no known risks associated with the papoose board?

MR. FIRST: Objection.

MR. STEVENS: Form.

THE COURT: Overruled. You may answer.

A. Yes, he did deviate.

Q. Did, in your opinion, Dr. Bonds violate the standard of care when he put Jeremy on a papoose board on May the 23rd, 2006?

A. Yes.

Q. Both times?

A. Yes.

Q. And what about the third incident in October, the one we talked about where it was filling three teeth and without local and with a very high heart rate was that --

MR. McPHILLIAMY: Objection.

Q. -- violation of the deviation -- a violation of the standard of care?

MR. McPHILLIAMY: Objection to form.

THE COURT: Overruled.

A. Yes, it was.

Q. In your opinion, was Jeremy in an emergency situation any of the times he was restrained by Dr. Bonds?

A. No. There's no -- no notation, no documentation.

Q. Do you see any evidence that he was in pain when they -- before they restrained him?

A. No.
Q. Are you -- do you see any evidence in the chart that Dr. Bonds exhausted the basic behavior techniques before he moved on to restrain Jeremy?
A. No. There's no notation.
Q. Was his failure to do so a violation of the standard of care?
A. Yes.
Q. Was that true on all three of the incidents where he restrained Jeremy?
A. Yes.
Q. The third incident, Dr. Slack, the October 11th incident, what was Jeremy's heart rate before he was restrained or as he was restrained? Would it help, Dr. Slack, can you see it here?
A. Sure, I'll look up there. Thank you. The heart rate is documented preoperatively at 204.
Q. What is an average heart rate for a three-and-a-half-year-old?
A. Uhm, the range is about 75 to 120 with average around 100.
Q. So Jeremy's heart rate was double the average?
A. Double the average in the range, the 75 would be a child resting or sleeping. The 120, 125 would be maybe a child with a fever or a child crying. So it's

kind of the high end of the range.

Q. What does the 204 heart rate tell you about Jeremy's stress level?

A. Physiologically it tells you that he's in great distress.

Q. And is it -- does a reasonably prudent dentist put a child in a papoose board with a heart rate of 204 in order to fill three fillings?

A. Absolutely not. You would speak with the parent and ask that they seek medical help.

Q. All right. The other vital sign that is measured is oxygen saturation. Do you see that?

A. Yes.

Q. What is -- what's the significance from a dentist's perspective of an 88 percent oxygen saturation rate?

A. Normal oxygen saturation rate is between 95 and 100 percent. One starts to get concerned if it drops below 91 percent. If it drops below 88 percent it's -- you're going to want to consider it a medical emergency.

Q. So was a reasonably prudent thing to do to go forward and put Jeremy in a papoose board so he could have three fillings done with an oxygen saturation level of 88 percent?

A. No. The visit should have been scraped.
Q. In dental school, do you -- do dental students receive training in advanced behavior management techniques?
A. No.
Q. Where -- how do you get special training in advanced behavior management techniques, Dr. Slack?
A. My point of reference would be a residency program.
Q. When you say a residency program, are you talking about special training in a pediatric residency program?
A. Yes, in a pediatric residency program.
Q. What are the advance behavior management techniques? We heard that term, what does that mean?
A. Uhm, the advance behavior management techniques would be restraint, a papoose, sedation, general anesthesia.
Q. Okay. Those are the three basic -- three main advance behavior management techniques?
A. Yes.
Q. If a dentist is not experienced in advanced behavior management techniques, does a -- does the dentist have a duty to refer the patient who needs those techniques to someone who has that experience

and training?
A. Yes.
Q. Is that what a reasonably prudent dentist would do?
A. Yes.
Q. Did Dr. Bonds attend a two-year pediatric residency program?
A. Not that I am aware of.
Q. Did you see any information that suggested he had experience and training in advanced behavior guidance techniques before coming to Small Smiles?
A. I believe I read he said he had used it.
Q. How many times?
A. One or two.
Q. And how long had Dr. Bonds been licensed before he started working at -- actually before he treated Jeremy? Do you remember that?
A. Six weeks, eight weeks.
Q. Did Dr. Bonds, in your opinion, deviate from the standard of care by restraining Jeremy twice in May and in October without sufficient training in advanced behavior management techniques?
A. Yes.
Q. Should a reasonably prudent dentist who is unable to manage a child's behavior using the basic

techniques offer the parent referral to a dentist whose trained to handle more difficult situations?

A. Yes.

Q. If a dentist offered a parent a referral let's say to a pediatric dentist or an experienced dentist, would you expect to see that in the child's dental chart?

A. It's always documented, particularly for the reason that your referral is a reflection of your care. So referrals are always documented with the name of the individual you're referring to.

Q. You reviewed Jeremy's chart. Did you see any evidence that Dr. Bonds offered a referral to Jeremy's parents to a pediatric specialist before he restrained Jeremy three times?

A. I did not see any evidence.

Q. Did he deviate from the standard of care by failing to offer that to Jeremy's parents?

A. Yes.

Q. In your experience are pediatric dentists usually able to treat uncooperative children without a papoose board?

A. Yes.

MR. McPHILLIAMY: Objection to form.

THE COURT: Overruled.

Q. I'm sorry, what was your answer?
A. Yes.
Q. Is it extraordinarily unusual or not for a trained pediatric dentist to be unable to treat a child without having to resort to a papoose board?
MR. McPHILLIAMY: Objection to form.
THE COURT: Sustain that objection.
Q. Uhm, Dr. Slack, in helping to relieve anxiety and fear of young patients, how important are the parents in the process?
A. The parents are a real critical piece to it. For a lot of reasons. Oftentimes parents have anxieties themselves that can be translated to the children. But having the parents on board it becomes a team. You work together as a team.
Q. If a parent wants to accompany a child when the child's getting dental treatment, is it good or accepted dental practice to allow the parent back with the child?
A. Yes.
Q. Should a parent also be permitted to accompany a young child say three or four years old into the back if the dentist is planned on using one of the papoose boards?
A. Yes.

Q. Would it violate the standard of care to deprive a parent of the right to be with their child at a time when you're putting him in a restraint device?

A. Yes.

Q. Based on your review of the record, do you see any evidence that Jeremy's mom or dad was with him when he was restrained by Dr. Bonds in May twice, and by Dr. Bonds in October?

A. I did not see that.

Q. Does -- there's been some testimony in this case, a little bit of testimony about something called ECC or Early Childhood Caries?

A. Yes.

Q. You familiar with that term?

A. Yes.

Q. Does any child with one decayed tooth by age six have by definition Early Childhood Caries?

A. Yes.

Q. So there are a large number of kids who have Early Childhood Caries?

MR. McPHILLIAMY: Objection. Form.

THE COURT: It is leading.

Q. What is the treatment, Dr. Slack, for Early Childhood Caries?

A. Treatment for Early Childhood Caries is looking at the factors that are causing the cavities. So one gets very aggressive with prevention. Fluorides, home care, diet. The goal is to stop the process from continuing.

Q. Does Early Childhood Caries affect whether you should perform a pulpotomy on a child or not?

A. No.

Q. I mean is the standard of care for deciding whether you need to do a pulpotomy is that -- do you consider whether the child had Early Childhood Caries as part of the calculus?

A. The concept of Early Childhood Caries is more of a decision on how to make -- how to help the patient not continue with the caries. It's not -- I'm at a loss for words here. It's -- it's not a diagnosis from the standpoint that it launches you into treatment. It launches you into preventative treatment.

Q. So as an example we are talking about preventative treatment. Is fluoride one of the mechanisms for trying to treat Early Childhood Caries?

A. Yes.

Q. And how does the use of fluoride by dentists change once a child is diagnosed with Early Childhood

Caries?

A. Typically a fluoride treatment in the office can be applied every six months. But with children that are at risk that may have one cavity or the potential for cavities you can see them more often and apply a fluoride treatment every three months.

Q. And what about supplemental fluoride, pills or --

A. Sure.

Q. What is recommended for kids that have Early Childhood Caries?

A. If they're in a non-fluoridated area, in other words, if they don't have fluoride in their water, they may have well water or drink bottled water or have a system on their house that removes the fluoride from the water, you can prescribe a pill, a little, tiny vanilla flavored pill, and the children dissolve that in their mouth at bedtime and that helps to mineralize or harden the enamel.

Q. Is the standard of care for when to do these dental procedures like extractions and fillings and pulpotomies, is it any different whether the child has -- is considered to have Early Childhood Caries or not?

A. No. The aggressiveness is on the preventative

side. So when you see children that are more prone to cavities, you just become more aggressive on the preventative side. Not on the fixing side.

Q. Did the dentists at Small Smiles, from your review of the records, did they treat Jeremy as a patient in need of urgent treatment because of Early Childhood Caries?

A. I don't see any sense of urgency not even noted in the chart urgent that the child return, and I don't think that the visits were scheduled close together. I think they were months a part.

Q. Is that consistent or inconsistent with a dental provider being concerned about Early Childhood Caries?

A. It would be inconsistent.

Q. Dr. Slack, besides reviewing Jeremy Bohn's chart, how many other charts of patients from the New York clinics have you reviewed?

MR. FIRST: Objection.

MR. McPHILLIAMY: Objection.

MR. STEVENS: Objection.

THE COURT: Overruled.

A. I've reviewed over 70 records.

Q. What portion of those were from the Syracuse clinic?

MR. McPHILLIAMY: Objection.
MR. FIRST: Objection.
MR. STEVENS: Objection.
THE COURT: Overruled. You may answer.
THE WITNESS: Thank you.
A. Uhm, 25 percent. About 25 percent.
Q. What was the purpose of your review, Dr. Slack?
MR. STEVENS: Objection.
MR. McPHILLIAMY: Objection.
MR. FIRST: Objection.
THE COURT: Overruled.
A. The purpose of the review was to examine the treatment and the care and the work provided for the children in that record.
Q. And did you do that at my request or Mr. Leyendecker's request?
A. Yes.
Q. Uhm, did you ever review a chart where all the treatment was fine?
MR. McPHILLIAMY: Objection.
MR. FIRST: Objection.
THE COURT: Uhm --
MR. STEVENS: Objection.
THE COURT: -- are you talking about the charts -- the Small Smiles's charts?

MR. FRANKEL: Yes, the 70 charts.

THE COURT: Okay. With that clarification, overruled.

A. Yes.

Q. Can you roughly recall how often that happened?

MR. FIRST: Your Honor, can I have a standing objection. I don't want to keep interrupting to this line of questioning.

MR. McPHILLIAMY: Objection.

THE COURT: Yes. Answer.

THE WITNESS: Thank you, Your Honor.

A. Could you please repeat the question.

Q. Of the 70 or so Small Smiles's charts from New York that you've reviewed, how often did you find that the care that you looked at was all fine in your opinion?

MR. McPHILLIAMY: Objection.

THE COURT: Overruled.

MR. STEVENS: Join.

A. Infrequently.

Q. Okay. In nearly all the charts that you reviewed, was at least some of the care appropriate?

MR. McPHILLIAMY: Objection.

MR. STEVENS: Objection.

MR. FIRST: Objection.

THE COURT: Overruled.

A. Could you repeat the question. I'm not quite sure I understand it, please.

Q. You looked at these charts. You looked at Jeremy Bohn's chart. Were there things in the chart -- in Jeremy Bohn's case that you thought the care was appropriate?

A. Yes.

Q. Did he need some fillings?

A. Yes.

Q. Are you disputing that he didn't need any care?

A. No.

Q. And in these other 70 charts that you looked at, likewise, did you find that some of the care was appropriate?

A. Yes.

Q. But did you find that a lot of the care wasn't?

MR. McPHILLIAMY: Objection.

MR. FIRST: Objection.

MR. STEVENS: Objection.

THE COURT: Sustained as to form.

Q. What did you find as a very general matter about the quality of the care on the 70 charts that you reviewed in -- from the New York clinics?

MR. STEVENS: Objection.

MR. McPHILLIAMY: Objection.
THE COURT: Overruled.
A. Uhm, what I found is there -- there was a pattern.
Q. All right. And what patterns did you identify from your review of the charts?
MR. McPHILLIAMY: Objection.
MR. FIRST: Objection.
MR. STEVENS: Objection.
THE COURT: Overruled.
A. Pattern of the diagnosis was not thorough. X-rays were not diagnostic. Treatment was rendered that was inappropriate. Treatment was rendered without local anesthesia. Treatment was rendered with restraint.
Q. Well, in a treatment that was rendered with restraint, did you notice whether or not that treatment was done in emergency situations or not?
MR. FIRST: Objection.
THE COURT: Overruled.
A. There was not any for emergency.
Q. Was it a -- from your review of the charts, did you detect a practice and a pattern of using restraints in nonemergency situations at the Small Smiles clinics?

MR. McPHILLIAMY: Objection.
MR. FIRST: Objection.
MR. STEVENS: Objection.
THE COURT: Sustained as to form. It's leading.

BY MR. FRANKEL: (Cont.)

Q. What did you observe about the nature of the use of restraints at the Small Smiles New York clinics from your review of the charts, Dr. Slack?

MR. McPHILLIAMY: Objection.
MR. FIRST: Objection.
MR. STEVENS: Objection.
THE COURT: Overruled.

A. I'm sorry.

Q. All right. What did you notice about the emergent nature of the treatment from your review of the Small Smiles New York clinic cases where the child was put in a papoose board?

MR. FIRST: Objection.
THE COURT: Overruled.

A. I didn't see emergent treatment. The papoose board was used routinely, in a routine fashion rather than very specific isolated emergent care.

Q. Did you see any patterns regarding referrals of cases to other dentists?

MR. McPHILLIAMY: Objection.
MR. FIRST: Objection.
MR. McPHILLIAMY: Leading.
THE COURT: Overruled.
A. I did not see a pattern of referrals.
Q. Did you see a pattern of restoring teeth without justification?
MR. FIRST: Objection.
MR. McPHILLIAMY: Objection.
THE COURT: I'll sustain that objection.
Q. What pattern did you see with regard to restoring teeth without -- without justification or with justification?
MR. FIRST: Objection.
MR. STEVENS: Objection.
THE COURT: Overruled.
A. I saw pattern of teeth that were restored without x-ray support, without clinical note support, without justification.
Q. What patterns and practice did you see regarding the informed consent process in the chart for a papoose board?
MR. McPHILLIAMY: Objection.
MR. FIRST: Objection.
MR. STEVENS: Same.

THE COURT: I'll sustain the objection as to form.

Q. Did you see a pattern and practice of obtaining informed consent for a papoose board the same way in many cases?

MR. McPHILLIAMY: Objection.

MR. STEVENS: Objection.

MR. FIRST: Objection.

THE COURT: Overruled.

A. Yes.

Q. And what pattern or practice did you observe from review of those charts?

MR. FIRST: Objection.

MR. McPHILLIAMY: Objection.

MR. STEVENS: Objection.

THE COURT: Overruled.

A. The pattern that I saw is the form that was used was used as a cookbook, so checkmarks were made, and no reflection in the clinical notes that a dialogue also accompanied the signed form which is the purest form of informed consent. A dialogue must occur.

Q. In your experience in a situation where the only note in the record is the signed form is that -- under those circumstances, is the form suppose to

reflect the oral communication that took place?

MR. FIRST: Objection.

MR. STEVENS: Objection.

MR. McPHILLIAMY: Objection.

THE COURT: Rephrase the question.

Q. In your experience as a pediatric dentist, Dr. Slack, if there's no other note in the record other than the signed consent form, is that consent form then -- is it suppose to confirm the oral communication?

MR. FIRST: Objection.

MR. STEVENS: Objection.

THE COURT: Sustained.

Q. What does a reasonably prudent dentist do who for whatever reason doesn't write in the chart that he had -- he or she had an oral communication to get consent? What do they do?

MR. STEVENS: Objection. Asked and answered about an hour ago.

THE COURT: Overruled.

A. The signed consent is not substitute for an oral communication. Not only does the oral communication need to occur, but it also needs to contain that all other basic behavior guidance techniques have been exhausted.

Q. In your review of these 70 files, did you see a pattern and practice regarding the use or nonuse of basic behavior management techniques at Small Smiles?

MR. McPHILLIAMY: Objection.

MR. FIRST: Objection.

MR. STEVENS: Objection.

THE COURT: Sustained as to form.

Q. Did Small Smiles have, from your review of the records, a pattern and practice among its dentists regarding the use of basic behavior management techniques?

MR. McPHILLIAMY: Objection.

MR. STEVENS: Objection.

MR. FIRST: Objection.

THE COURT: Overruled. You can answer.

A. Could you please repeat the question?

Q. Yes. Did Small Smiles --

THE COURT: Let's have the court reporter read it back.

(Pending Question read by the Reporter.)

A. I'm a little confused by the question.

Q. Okay. I'll try to do better. Uhm, you testified about basic behavior management techniques --

A. Uh-huh.

Q. -- and the need to use those first. Did you see in the charts that you reviewed any evidence of a pattern and practice as to whether or not Small Smiles dentists in New York were exhausting basic behavior management techniques before they restrained children?

MR. FIRST: Objection.

A. No.

MR. STEVENS: Same.

THE COURT: Overruled. You answered the question.

THE WITNESS: I'm sorry.

THE COURT: It's okay.

Q. Are you saying you didn't see a pattern and practice or they weren't doing it?

A. They weren't doing it.

MR. McPHILLIAMY: Objection.

THE COURT: Overruled the objection. The answer stands.

Q. Dr. Slack, have we paid you for your time to review all these charts?

A. Yes.

Q. And how long have you been serving -- have you been consulting and reviewing records --

A. About --

Q. -- in this case?

A. About two and a half years.
Q. How much do you charge for your services?
A. $300 an hour.
Q. How much time would you estimate you have spent over the last two and a half or three years reviewing all these charts?
MR. McPHILLIAMY: Objection.
MR. STEVENS: Objection.
THE COURT: Legal basis?
MR. McPHILLIAMY: Beyond the scope. Form.
THE COURT: Well, I'm going to sustain the objection. I'm going to sustain the objection.
Q. On average, Dr. Slack, how long has it taken you to review a file?
A. On average about an hour, hour and a half.
Q. Hour to an hour and a half. And you have been paid for doing so?
A. Yes, I have.
Q. Dr. Slack, there's been an argument in this courtroom that Jeremy Bohn hasn't been injured. He's a happy, healthy kid today. In your opinion, as a pediatric dentist, having reviewed this file, and the dental care he received, is it your opinion that Jeremy Bohn has been injured?
MR. McPHILLIAMY: Objection.

MR. FIRST: Objection.
MR. STEVENS: Objection.
THE COURT: Overruled.
A. Yes.
Q. Tell the ladies and gentlemen of the jury how the care that was or wasn't provided to Jeremy Bohn injured him in your opinion?
MR. FIRST: Objection.
MR. McPHILLIAMY: Objection.
MR. FIRST: No foundation for this.
THE COURT: Overruled.
MR. FIRST: Your Honor, may we approach on this issue?
THE COURT: Yup.
MR. STEVENS: Objection.
(A discussion off the record at the Bench, all counsel present.)
THE COURT: I'm going to overrule the objection. Overruled. Could you read back the question, please.
(Pending Question read by the Reporter.)
MR. FIRST: Can I just make sure there is an objection on the record?
THE COURT: Yes.
MR. McPHILLIAMY: Objection.

MR. STEVENS: Same.

A. Jeremy endured two extractions he did not need. He endured having fillings done without local anesthesia. He endured being restrained, uhm, in a very distressing way. One record shows how distressed he was physiologically from his heart rate.

Q. How about --

MR. FIRST: Objection. Leading.

THE COURT: All right. So I'll sustain the objection.

Q. Dr. Slack, in your opinion, did Jeremy endure four unnecessary pulp and crowns?

MR. FIRST: Objection.

MR. McPHILLIAMY: Objection.

MR. STEVENS: Objection. Asked and answered many times.

THE COURT: It has been asked and answered --

Q. Did --

THE COURT: -- sustained.

Q. In your opinion, by going through pulps and crowns that Jeremy did not need, did he experience pain and suffering?

MR. STEVENS: Object to speculation.

MR. FIRST: Objection.

MR. McPHILLIAMY: Objection.

MR. FIRST: No foundation.

THE COURT: Overruled.

THE WITNESS: I can answer?

A. Yes.

Q. Is it these procedures like pulpotomies, are those procedures that dentists want to avoid putting small children through if they can?

MR. STEVENS: Objection. Asked and answered.

THE COURT: Sustained.

MR. FRANKEL: Dr. Slack, that's all I have. Thank you very much.

THE WITNESS: Thank you.

THE COURT: Thank you. All right. We're going to instead of starting cross-examination before lunch, because we will never finish it in twenty minutes, we're going to take our lunch break now. Come back at 1:10. Okay. Thank you.

(Whereupon, Jurors excused for the luncheon recess.)

THE COURT: Okay. One thing that somebody wanted to put on the record before we take our lunch break.

MR. FIRST: Yes. Judge, I would like to

-- Judge, I'm going to renew my motion for a mistrial based upon the admission of the testimony concerning the review of 70 cases on behalf of the plaintiff's lawyers.

This case is not a class action case. They were -- these cases are being tried separately for a very particular reason. And that is that the law in New York is that these kinds of cases should be tried one at a time and that's what the Court has been doing.

I would submit that we are now defending 70 cases, 71 cases, depending on whether to include the Bohn case. Cases that we know very little, if anything about, and that this doctor was being broad generalizations and conclusions about that. Highly prejudices us in this case which is about Jeremy Bohn's care and treatment.

I submit that that proof does not go, does not go to any cause of action that survives in this case, including the GBL provision.

In fact, I don't believe they actually alleged anything along the lines of a pattern of treatment with respect to the GBL. In any event, it's just not relevant. It's not pertinent.

The question is whether under the GBL

whether there was consumer-oriented activity that was deceptive that caused injury to this plaintiff.

That's basically what that statute says. What that Doctor talked about -- what this Doctor has talked about is totally outside the scope of those elements and has highly prejudiced my client, and I respectfully submit we cannot possibly get a fair trial in this case with that kind of testimony being allowed and I move for a mistrial at this time.

THE COURT: Okay.

MR. FIRST: Thank you. Judge, while standing I might as well make a record on the injury part that the doctor was allowed to testify to injury 3101 in this case which is very extensive, very inclusive. Never identified her as a witness that was going to talk about injury in any way, shape or form whatsoever.

It's totally mum on that. And you know just they decided at the last minute to elicit that kind of testimony and I would submit that it was highly improper.

The witness is not really qualified to talk about pain and suffering per se. But in any

event, there is no foundation. She was not the treater. She's just talking about general things. And I would respectfully submit that that was highly improper, too, and I move to strike it from the record if the Court doesn't grant the mistrial.

THE COURT: Thank you.

MR. McPHILLIAMY: Your Honor, I join in Mr. First's objection for all the reasons that he stated. The mere mention that this expert has reviewed any more than Jeremy's case and was allowed to go into the findings, the patterns, whether pro or con, good or bad, has highly prejudiced New FORBA, and I join in his request for a mistrial.

THE COURT: Thank you.

MR. STEVENS: Your Honor, on behalf of Dr. Aman, Dr. Khan and Dr. Bonds, I join in all of the objections that just -- you just heard from my colleagues. The --

THE COURT: Can you read my note?

MR. STEVENS: I have my reading glasses on, Your Honor.

THE COURT: "Can you remind Stevens to speak up."

MR. STEVENS: I appreciate that.

THE COURT: When I hold this up you'll know --

MR. STEVENS: Thank you.

THE COURT: -- the message that you're getting.

MR. STEVENS: I will put on the distance glasses. The -- having this witness who was not identified come to court and talk about 70 charts that are not identified about other patients that she's allegedly reviewed which patients are not identified, talking about injury for which she cannot be cross-examined, creating a situation of guilt by association, I believe it has created -- it's a bell that cannot be unrung.

I have to, again, renew my request for a mistrial, and I don't see how it is even conceivably possible that the jury after hearing this can give a fair and -- fair judgment to the treatment rendered by my clients to this patient in this case, which for those dentists is what this case is about.

THE COURT: Okay.

MR. STEVENS: I respectfully move for a mistrial.

THE COURT: Thank you.

MR. FRANKEL: Your Honor, just so the record is clear, in our disclosures made in January, nine months ago, we identified 71 patients by name. So they've had nine months to do whatever it is they would like to do. They have the charts.

On the subject of whether we identified Dr. Slack as -- on damages, the second page of the disclosure which is lengthy, includes multiple experts, causation, prognosis, trauma and injury suffered as a result of the treatment received is one of the subject matters upon which we anticipated we might call her to testify.

THE COURT: Little too much shuffling going on back there. Thank you.

MR. FRANKEL: That's all I have, Your Honor.

THE COURT: Okay. All right. The Court did have a conference -- a Bench conference with counsel on this issue, and because the Appellate Division while striking the fraud and the breach of fiduciary causes of action has left in the remaining causes of action, all -- but the -- I think all but the malpractice cause of action deal

with the issue of a pattern or practice or concerted action of the dentist with respect to the treatment of -- of the patients that come to those clinics, so I'm going to deny the motions.

MR. STEVENS: Just for the record, with my colleague, Mr. Frankel says quote, they have the charts, close quote, that is not accurate.

MR. FIRST: I'd also like to say that the other prejudice is also that 70 -- these 70 charts were cherry picked by the plaintiff's attorneys so any interpretation she gave is really biased and, you know, not probative of anything.

THE COURT: Well, I'm guessing that you're going to explore that with her on cross-examination, aren't you?

MR. FIRST: It's a little difficult to do when its, you know, anonymous charts and --

THE COURT: I understand it's not anonymous from -- Mr. Frankel is representing to this Court this specific files that this -- that were reviewed, these 70 or 71 charts were identified.

MR. FIRST: They were never produced. They were never -- maybe some of them are, but not part of this lawsuit.

MR. FRANKEL: Well, wait a minute. We're producing -- we don't --

THE COURT: They're defendants charts, right?

MR. STEVENS: I'm sorry. The dentists don't retain any rights to those dental records, nor do they keep dental records of those former patients.

THE COURT: Were they --

MR. FIRST: Nor do we --

THE COURT: Okay.

MR. FIRST: -- Your Honor.

THE COURT: Lunch.

(Luncheon recess.)

(Afternoon Session - October 1, 2013.)

THE COURT: We ready to proceed?

(Jury seated in the jury box at 1:18 p.m..)

THE COURT: Okay. Have a good lunch? Ready to proceed?

MR. FIRST: Yes, I am, Your Honor.

CROSS-EXAMINATION

BY MR. FIRST:

Q. Good afternoon, Dr. Slack.

A. Good afternoon.

Q. I think I heard you say that Jeremy Bohn has ECC, Early Childhood Caries; is that correct?

A. I'm not quite sure if I said he did. I think we were talking about the general definition of ECC.

Q. Okay. You would agree, would you not, that Jeremy Bohn did have Early Childhood Caries when he first went to Small Smiles back in May of 2006 --

A. Yes.

Q. -- correct?

A. Yes, he qualifies for the definition.

Q. So if it had been suggested in this courtroom that he did not have Early Childhood Caries by the plaintiff's side of this case that would be incorrect,

wouldn't it?

A. Yes.

Q. And Early Childhood Caries is known as a unique and virulent condition; is that correct?

A. That is a definition of it.

Q. All right. And it's unique because it doesn't -- it's different than any other conditions that people generally get, correct?

A. No. It's -- no.

Q. Why is it unique?

A. It's not unique.

Q. Okay. I thought you agreed with me. Let's talk about the word virulent. It's a virulent condition, right?

A. It's bacterial.

Q. It's an infectious disease?

A. It's bacterial like a cold or --

Q. A cold is actually a virus, isn't it?

A. Yes.

Q. But it's not --

A. Like an infection, yes. It's bacterially driven.

Q. And it's often caught from other people, people, caregivers around a child; isn't that correct?

A. Transmission is usually from the mother.

Q. And there have been policies, statements issued by the American Academy of Pediatric Dentistry about how to deal with this virulent condition; isn't that true?

A. Yes.

Q. And one of the things that is said is that there should be immediate intervention to avoid further destruction of the teeth; is that correct?

A. Yes, it is.

Q. And you agree then that there should be immediate intervention to prevent the spread of the disease and the further disruption of the disease?

A. Preventatively, yes.

Q. Preventatively that's part of the picture, isn't that correct, you want to prevent further destruction by using preventative techniques, correct?

A. That's what that paragraph is speaking to in the American Academy of Pediatric Dentistry guidelines.

Q. It also speaks to full crown coverage often being necessary to control the condition?

A. Having -- given a large cavity, yes.

Q. Okay. So you agree with me then that often times full crown coverage is necessary to deal with that condition?

A. If there is --
Q. Early Childhood Caries?
A. If there is a large cavity.
Q. And if there isn't intervention there can be serious consequences; isn't that correct?
A. I don't quite understand your question.
Q. Well, if it's not dealt with appropriately and immediately and sufficiently, you can develop more of these carious lesions cavities as you call them, correct?
A. I'm not quite sure what you mean by "dealt with".
Q. Well, they have to be treated. The carious -- the cavities have to be treated, correct, they shouldn't just be left?
A. Cavities should be treated, yes.
Q. And if you don't treat them one of the consequences of untreated ECC, Early Childhood Caries, is that you're going to develop more cavities?
A. Untreated caries will just progress. It's not hopping from one tooth to the other.
Q. So you don't think you can develop further caries on other teeth from untreated caries on another tooth?
A. If the untreated caries leaves a rough surface

between the tooth, and it causes plaque and food to catch there, yes, it will cause caries on the tooth.

Q. So it can spread?

A. It doesn't spread, no. That's inaccurate.

Q. It can go to other teeth?

A. That's sounds like spread to me.

Q. All right. In any event, if these cavities develop, new cavities develop, it can result in all kinds of disruptions to a child's life, correct?

A. If they get more cavities, sure.

Q. I mean it can result in more visits to people like you, it can result in hospitalizations, it can result in missed school, it can result in pain and discomfort on the part of the child, correct?

A. Yes.

Q. All right. So it's important to deal with -- to deal with this condition and to deal with it aggressively, correct?

A. I would take exception to the word "deal" and look at it more as treatment.

Q. Well, the treatment needs to be sufficient to make sure you arrest the disease then, of course, you want to go into preventative treatments as well, correct?

A. The preventative actually goes hand in hand if

not precedes.

Q. But the -- the destruction, the APD, we talked about -- talked about aggressive preventative, and you mentioned that and therapeutic measures to treat what is already diseased, correct?

A. Therapeutic measures can be a lot of things. It can be sealants. It can be interim restorations.

Q. Well, it includes filling cavities, correct?

A. Yes.

Q. It includes in a tooth that's restorable or abscessed, extraction; correct?

A. Yes.

Q. And it includes using crowns?

A. Yes.

Q. All right. Now, is it fair to say that this condition of Early Childhood Caries afflicts and affects children of the lower economic strata and in a much higher percentage than kids who come from families that are not in the lower economic strata?

A. Yes, that is true.

Q. That's well-known, isn't it?

A. Yes, it is.

Q. Now, I want to talk to you about abscesses. What's an abscess?

A. An abscess is an infection.

Q. Okay. So by definition it's an infection. So Early Childhood Caries is an infectious disease as you already described, correct?

A. There's a difference between an infectious disease and an infection.

Q. I'm going to get to that. Early Childhood Caries is an infectious disease and an infection or an abscess is an actual infection of a particular location, correct?

A. Anywhere in the body, yes.

Q. All right. And that includes teeth?

A. Yes.

Q. And if untreated an abscess can have very serious consequences; isn't that true?

A. Yes.

Q. And if untreated an abscess can actually invade other parts of the body such as the brain and actually cause fatal illness, correct?

A. Fatality, yes.

Q. Fatality. So this is a serious matter whether there's an abscess or not?

A. Yes.

Q. And one of the things that is done when an abscess is diagnosed is to prescribe antibiotics, correct?

A. Yes.
Q. And an abscess in a tooth is often characterized by swelling; is that correct?
A. Yes.
Q. And that swelling can be found in the gums? I'm not saying it is found in every case, but it can be found in the gums; correct?
A. Yes.
Q. And it can be found in the cheek? The cheek can swell up?
A. Yes.
Q. And it can be found by symptoms of pain and discomfort, correct?
A. Yes.
Q. Now, in Jeremy Bohn's case, you know, do you know that Jeremy Bohn went to a pediatrician named Dr. Vivienne Taylor on May 17th, 2006, before he ever went to Small Smiles, don't you?
A. Yes, I do.
Q. Have you ever reviewed her records?
A. Yes, I have.
Q. Those were records that were provided to you?
A. Yes, they were.
MR. FIRST: Now, I'd like to offer, I don't think they have been offered into evidence,

so I'm going to offer the Doctor's records?

THE COURT: Exhibit number?

MR. FIRST: That's what I'm checking with the exhibit number. Yeah, the exhibit number is 1051.

MR. FRANKEL: No objection.

MR. McPHILLIAMY: No objection.

MR. FIRST: You have 362.

MR. HIGGINS: Counsel, can I ask for clarification. Are you offering just the entire chart or just --

MR. FIRST: I am offering the entire chart, but I only intend to ask this witness about the 5/17 visit.

MR. FRANKEL: May we approach?

THE COURT: Yes.

(A discussion off the record at the Bench, all counsel present.)

THE COURT: The Court's going to receive page -- what was the page number of that?

MR. FIRST: Exhibit 1051, there's a Bate stamp not showing up on there 0085.

THE COURT: 0085?

MR. FIRST: Correct.

THE COURT: The Court's going to receive

page 0085 of Exhibit 1051.

BY MR. FIRST: (Cont.)

Q. Doctor, you said you reviewed Dr. Taylor's records, did you not?

A. Yes, I did.

Q. And, Doctor, looking at this, which is a record of Dr. Vivienne Taylor, Jeremy Bohn appeared at her office on 5/17/2006, and she reported to her that and she found subjectively that he had left facial swelling for the past one day. You see that?

A. Yes.

Q. And that facial swelling would be consistent with an abscess, would it not?

A. It could be consistent with other things, but yes, it could be an abscess.

Q. And also during that visit Mrs. Varano stated that Jeremy has some tooth decay; is that correct?

A. Yes, that's what it says.

Q. You can agree, can you not, that a layperson when tooth decay gets sufficient enough can identify decay, correct?

A. I'm sorry, I didn't understand your question.

Q. Yeah. Let me try again. Do you agree that a layperson once a cavity gets big enough or decay gets large enough can identify that as tooth decay by

looking at somebody?

A. I think it can happen, yes.

Q. All right. Do you have any reason to believe that Mrs. Varano was incorrect when she said he had tooth decay -- that Jeremy had tooth decay?

A. I have no direct knowledge of it.

Q. Okay. Then there is a history of not brushing his teeth consistently at night. I want to turn to the physical examination. You see where it says the left cheek is swollen and puffy. Correct?

A. Yes.

Q. And this is what about six days before he went to Small Smiles on May 23rd, 2006?

A. Yes.

Q. And she also observes and she notes that she has -- he has multiple dental cavities in the premolar teeth bilaterally. You see that?

A. Yes.

Q. And that means when she uses the term bilaterally that means both sides?

A. Yes.

Q. So this pediatrician who sees kids on a regular basis from her own observation has identified multiple dental cavities in these teeth on both sides; is that correct?

A. When you say "these teeth"?
Q. Well, I'll say what she said, premolar teeth.
A. He wouldn't have premolar teeth.
Q. So you don't really understand that description?
A. Correct. That's a --
Q. It does describe teeth that -- multiple cavities in teeth on both sides?
A. Yes.
Q. And you have no reason to believe that she was wrong about that, do you?
A. I don't. That's her note.
Q. All right. Have you read Miss Varano's testimony?
A. Yes.
Q. And she indicated at or around this time that Jeremy had a swollen gum. Do you recall that?
A. I'm sorry, could you clarify her testimony?
Q. Yes. In her testimony she said at a deposition, she hasn't testified yet in this trial.
A. I'm sorry.
Q. I understand you got that deposition from the attorneys, correct?
A. Yes. I'm sorry, I misunderstood.
Q. It's okay.

A. You said testimony, yeah.
Q. I want you to know what you're answering. So she said that Jeremy had a swollen gum in that testimony. Do you remember that?
A. Yes, I do remember reading that.
Q. And that condition is also consistent with a tooth abscess, correct?
A. It can either be a tooth abscess or what's called a periodontal abscess when food gets -- like a popcorn hull wiggles down into the gum line, that can also make the gum swollen.
Q. But the answer to my question is that is consistent with a tooth abscess, correct?
A. A tooth or a gum abscess.
Q. Now, the doctor assessed Jeremy as having a dental abscess, correct?
A. That's what it reads.
Q. All right. Now, this is a pediatrician who deals with kids all the time, right?
A. Quite honestly, a dental abscess could not be diagnosed purely visually. You would need a radiograph to confirm.
Q. A radiograph is just one of the tools you use. You also use your own clinical judgment based upon what you observed, correct?

A. Right, but it could be a soft tissue abscess and not a dental abscess.

Q. I understand. So you're saying that Dr. Taylor, even though she doesn't say it, is probably wrong?

A. I'm not saying she's wrong, but what I am saying is that's -- that's not the only possibility.

Q. Now, you're actually saying that she's wrong because you already told this jury that you didn't believe that Jeremy had an abscess, but so that would mean that Dr. Taylor was wrong; correct?

A. No. They're two different things.

Q. Well, in any event, she assessed him as having a dental abscess; is that correct?

A. That's what I'm reading.

Q. Okay. She doesn't talk about any other condition or any other diagnosis or assessment, does she, with regard to the tooth and the swelling?

A. With regard to the tooth.

Q. All right. And she prescribes -- that stands for penicillin, pen-VK?

A. Yes.

Q. She stressed proper dental hygiene, and she told him -- she told Mrs. Varano he should be taken to a dentist; is that correct?

A. Yes.
Q. Now, penicillin is an antibiotic --
A. Yes.
Q. -- correct? And isn't it a fact that if a tooth abscess exists an antibiotic is not going to cure it?
A. If it's a -- truly a dental abscess. A gum abscess or a periodontal abscess may resolve it.
Q. All right. But a tooth abscess, a tooth abscess would not be cured by an antibiotic under any circumstances, would it?
A. That is correct.
Q. And, in fact, the source of the infection is the tooth; correct?
A. Yes.
Q. And the standard of care for dealing with an infection to the tooth or an abscess caused by a tooth is extraction?
A. Yes.
Q. All right. So we can agree then that if Jeremy had an abscess, one or two of them, as of that first visit, on May 23, 2006, he had to have that tooth or those teeth extracted; correct?
A. Are you asking if he had them?
Q. Yes.

A. There's no documentation that he did have them.
Q. Well, we'll talk about that. I'm asking you to assume he did have them like Dr. Bonds said and like Dr. Taylor said.
A. She's saying he has one, so if he had one, yes, that tooth would have to come out.
Q. All right. And it should come out pretty soon, right, that's a pretty serious condition to deal with?
A. Yes.
Q. You told us that, you know, you get very serious manifestations from that, including death?
A. Luckily he's on antibiotic.
Q. Right. And that controls the swelling once it goes beyond the tooth, correct, or it helps control?
A. It helps it at the tooth site as well.
Q. So if he had an abscess, he needed prompt dental treatment and he needed an extraction, fair?
A. Yes.
Q. And that would qualify, would it not, as the language you're using is an emergency condition that needs to be dealt with; isn't that correct?
A. If a child presents with an infection, they're in pain and they can't be put on antibiotic, I would guess that would be an emergency.
Q. All right. Now, after Dr. Taylor saw Jeremy on

May 17th, a dentist actually saw Jeremy; isn't that correct?

A. Yes.

Q. And you said you did have Jeremy's records from Dr. Patel given to you to review?

A. I looked at the records for the -- that day that he was seen, yes.

MR. FIRST: Could -- I would like to offer first Exhibit 1052, which are the records of Dr. Patel.

MR. HIGGINS: Dennis, do you have those to see?

MR. FIRST: We have certified copies here if you want to use them, if you want. If you don't care about the certification, we have a book.

MR. HIGGINS: We would like to see them.

MR. FIRST: Judge, for this exhibit, I'd like to actually offer the one that is certified.

THE COURT: Okay. Show it to counsel first.

MR. FIRST: Yeah, absolutely.

MR. FRANKEL: No objection.

THE COURT: Exhibit 1052 received. Your exhibits aren't marked.

MR. FIRST: Mine was marked. I wanted to use the certified one that's why I did that with that.

THE COURT: Why don't you have that marked.

MR. FIRST: That's the only exhibit I will do that with.

(Defendant Old FORBA Exhibit No. 1052 marked for identification.)

THE WITNESS: Thank you.

MR. FIRST: Can we have 71 up.

BY MR. FIRST: (Cont.)

Q. Now, Doctor, this is the record that's in evidence of Jeremy Bohn's visit to Dr. Patel on May 19th, 2006. You see that?

A. Yes.

Q. All right. Now, Dr. Patel tried to examine Jeremy; isn't that correct?

A. I'm sorry, I don't see where he tried to. It says limited oral.

Q. He says it's a limited exam?

A. Yes.

Q. And he described him -- Jeremy as being very, very uncooperative. You see that?

A. Yes.

Q. But he does get to see part of Jeremy's mouth, right, based on the note?

A. Based on the note I don't know if he sees all or part of his mouth.

Q. Well, if you look here it says, looks like carious exposure with tooth I. Doesn't it say that?

A. Oh, yes.

Q. All right. And what is carious exposure?

A. A carious exposure I think we touched on this morning is a condition when on clinical preparation of the tooth and you are removing the cavity, the cavity goes to the nerve of the tooth.

Q. Okay. So based on this dentist's finding, the cavity on tooth I, based on his visual observation because we know he didn't have any x-rays found that that cavity went down into the pulp, correct?

A. If he's saying it's a carious exposure, yes.

Q. That's what it means in dental language, right?

A. Yes.

Q. Okay. So you have a dentist with respect to tooth I, which you said did not have an abscess from what you described earlier, you have a dentist, not at Small Smiles one, who says that he visually observed this carious exposure on tooth I; correct?

A. He says it looks like.

Q. Okay. You don't think that means he saw it?
A. I don't think it's definitive.
Q. All right. That's one of the two teeth that Dr. Bonds extracted, isn't it?
A. Yes.
Q. That's on the left side, isn't it?
A. I is on the left, yes.
Q. And the swelling that we saw, if we could bring back Exhibit No. 362. The swelling that Jeremy presented with on the visit to Dr. Taylor was left sided facial swelling; isn't that correct?
A. Yes.
Q. The left check is noted to be swollen and puffy, correct?
A. Yes.
Q. So we know there is a correlation, do we not, between what Dr. Patel observed the carious exposure in tooth I two days later, and the swollen and puffy cheek that Jeremy had?
A. Again, Dr. Patel does not have an x-ray.
Q. Doctor, isn't it fair to say that in an x-ray is just one of the tools that you have in diagnosing a condition?
A. It's a critical piece to the diagnosis.
Q. Isn't it true that it is one of the tools?

A. It's one critical piece.
Q. All right. And another critical piece is what a dentist observes, correct?
A. Yes.
Q. And when we say observes, we talk about what they see and also what you feel; isn't that correct?
A. It would be. But if this were an abscess with the carious exposure, you would also recognize soft tissue findings as well.
Q. All right. And we know that two days before he had swelling we know that Mrs. Varano said he had -- his gum was swollen, so we do have soft tissue swelling, don't we, in the days preceding the visit to Small Smiles?
A. We would expect it to still be present with Dr. Patel's exam.
Q. It's two days later he's on an antibiotic at this point; isn't that correct?
A. It is.
Q. If I may, so we know he had left facial swelling, we know he had the gum swelling, we know he had carious exposure in tooth I, correct, before he went to Small Smiles, that was by people who have nothing to do with Small Smiles; correct?
A. That's what the note reads.

Q. That's significant to you, isn't it, to you as a dentist?

A. To me as a dentist.

Q. Well, as I understand your testimony, I didn't hear you once on your direct mention any of the findings of these medical and dental professionals who found these things. Don't you think it's significant they found these things before you he ever went to Small Smiles?

A. It's extremely significant particularly for Dr. Bonds who did the exam.

Q. And yet you found that not worthy of mentioning in your direct testimony this morning?

A. I don't know if it's worthy. It didn't come up.

Q. You were asked about this case, you were asked what you reviewed, you never mentioned you reviewed that material and you never mentioned any of the findings of these doctors before you ever went to Small Smiles, don't you think that's important?

A. I didn't know I needed to.

Q. And is the reason why you didn't mention it because it's inconsistent with what you're telling this jury today?

A. Absolutely not.

Q. Now, in addition if we can go back to 71. Dr. Patel not only looked at -- granted, he was working with a very, very uncooperative patient, not only looked at I, he looked at tooth B. The tooth that was also treated by Dr. Bonds on May 23rd, and he notes there B is also very bad. That's bad, isn't it? That's bad, isn't it?

A. It's not a clinical term.

Q. Well, it's a dentist who is saying it? If you said to another dentist, Dr. Smith, that tooth is bad, what would it mean? It would mean the tooth is bad, right?

A. Bad --

Q. Right?

A. Bad is not a clinical term.

Q. Tells you a lot, doesn't it, bad? Means it was a -- in a very bad condition, doesn't it?

A. Appropriate clinical note would detail the exact findings.

Q. Well, Dr. Patel unfortunately has a three-and-a-half-year-old dealing with a patient who is very, very uncooperative; correct?

A. Uh-huh.

Q. Yes?

A. Yes.

Q. But he is also dealing with a patient who had carious exposure in tooth I, history of abscess, a B tooth that is looking very bad, so he knew that Jeremy really should get treatment, even though he didn't feel he can give it because he was being very, very uncooperative; isn't that true?

A. I'm sorry, could you please repeat that.

Q. Sure. Dr. Patel was dealing with a patient who was very, very uncooperative, according to his note?

A. Uh-huh.

Q. Yes?

A. Yes. I'm sorry.

Q. I'm sorry, you say that. I want to make sure I'm understanding what you're saying. So this -- this three-and-a-half-year-old who was very, very uncooperative, didn't allow for a very detailed examination, he kind of implies that, doesn't he?

A. Yes.

Q. And -- but he does give us -- he is able to visualize B and I, which are the teeth what they're beyond the front teeth, they're the top front teeth, is that where they are?

A. They are beyond the fourth tooth back.

Q. So he is able to see that this carious exposure in I and B is very bad. But based on what he knew,

says abscessed, says carious exposure, says very bad, and he was a very, very uncooperative child, he knew he needed to get dental care, Jeremy needed dental care; correct?

A. I think it says abscessed, question mark.

Q. Right. That's the history part; is that true?

A. The fourth line down.

Q. It's a history, it gives a history, correct?

THE COURT: You have --

Q. Is that a history of -- what the history that was given to him by -- probably wasn't given by Jeremy considering he was very, very uncooperative, so maybe it was given to him by Mrs. Varano, correct?

A. Yes.

Q. And if we could, I'd like to actually look at another part of this record that's 179. That should be in there with your packet there. All right. You see it? Or you can look at it up here. It's up to you.

A. Yes.

Q. Okay. This is a patient health record; is that correct?

A. Yes.

Q. I'd like you to assume that Miss Varano has testified that she wrote up this document, filled out

this form. Okay?

A. Yes.

Q. You assume that just for the purposes of the questioning. So she's asked what medications he's on and for what purpose. She writes abscess, tooth. You see that?

A. Yes.

Q. And she also says penicillin. So the information about the abscessed tooth came from Miss Varano?

A. Yes.

Q. And that in turn came from Dr. Vivienne Taylor, who we saw in her record said she felt it was an abscessed tooth, correct?

A. Yes.

Q. Now, as I understand it, you've never treated Jeremy Bohn, right?

A. That's correct.

Q. And you weren't present when Dr. Bonds or Dr. Patel or Dr. Vivienne Taylor examined Jeremy; isn't that correct?

A. That is correct.

Q. And you never were able to make any of the clinical observations that these providers made of Jeremy's condition?

A. That's correct.
Q. And clinical observations play a very important role in dentistry, don't they?
A. Yes.
Q. It's not uncommon then x-rays are actually nondiagnostic in the sense that they don't diagnose a particular condition?
A. I would disagree.
Q. All right. Well, it is true that many -- often times cavities are not picked up by an x-ray?
A. I would disagree.
Q. There are times when a cavity is not picked up by an x-ray?
A. I don't understand the question. I'm very sorry.
Q. Are you saying that every time there's a cavity it's in an x-ray, that it shows up in an x-ray, is that what you're saying?
A. There are occasions where a cavity may not.
Q. All right. So then we can agree that there are occasions when you can detect cavities by clinical observation, and I may mean not only visual, but also tactile I think you call it, I think by touching that are not apparent in x-rays?
A. Right. A great example is a molar. A thick

tooth that may not show up on an x-ray on the side, yes.

Q. Okay. So you never observed what Dr. Taylor observed, you never observed what Dr. Patel observed, and you never observed what Mrs. Varano testified about and observed, correct?

A. Sure, yes, that's correct.

Q. And I'd like you to assume that she testified that Jeremy's two front teeth had like a little space. His front teeth didn't look right. Did you know that?

A. I read that, yes.

Q. All right. Did you know she also described the teeth as being -- the front teeth, top teeth as being brownish in color; isn't that correct?

A. I remember discoloration. I don't recall the brownish.

Q. Well, brownish is consistent with caries, childhood caries, correct?

A. Brown could be a stain as well.

Q. All right. But my question is it's consistent with caries, isn't it?

A. Not always.

Q. I understand you're saying it's not always caries. But isn't it true that a brownish condition of the teeth is consistent with caries?

A. You're asking me to be definitive in my answer and my answer is not always.
Q. So that means sometimes it is?
A. Sometimes it is.
Q. And she also said that his front two teeth had a gap and each side it didn't look normal. Do you recall that testimony?
A. Yes, I do.
Q. And do you recall that she testified that she told Dr. Taylor that he had some decay.
A. Yes.
Q. Do you recall that? And did you read Mr. Bohn's testimony?
A. Yes.
Q. And did you see where he described Jeremy's teeth as having a little bit of rot, R-O-T?
A. Yes, I did read that.
Q. And rot is not a dental term, but that's consistent with caries as well, isn't it?
A. I don't know what it's consistent with.
Q. Now, you know a dentist has to use his clinical judgment, right, his or her clinical judgment?
A. His or her.
Q. And that's a fair correction. And he has to or she has to -- let me withdraw that. And it's not

unusual that two dentists will approach the same problem differently; is that correct?

A. As far as what?

Q. Just generally speaking. Just generally speaking. You disagree with your colleagues sometimes about an approach on a particular problem?

A. There are different treatment approaches and there are different materials that dentists use, yes.

Q. Okay. So the exercise of your judgment is important to that whole process?

A. Yes.

Q. And it doesn't mean that one dentist is violating the standard of care and the other isn't, although you may think that, but it is just a difference of opinion on how to proceed?

A. If they are both practicing within the standard of care, yes.

Q. Now, Jeremy went to Small Smiles for the first time on May 23rd, 2006. And you've talked quite a bit about that record. I'd like to bring up a part of that record 21, please.

MR. FIRST: If we can just get the right side of that over into -- towards the middle for now. Is that doable? The right side. Just move it over a little bit. Yeah, that's good. If we

can blow it up just a bit.

BY MR. FIRST: (Cont.)

Q. Now, Doctor, I'd like you to take a look at this. This is a sheet that Mrs. Varano testified she filled out when she first went to Small Smiles. You've seen that before, correct?

A. Yes. Uh-huh.

Q. Writing is a little light. But one of the things that she said in terms of history is that he's on penicillin. Asks a very similar question to the question posed to her at Dr. Patel, what medications and why he's on. And she lists penicillin. And then she says number I and number B abscess. You see that?

A. I did, yes.

Q. Okay. That's a layperson writing the exact teeth that Dr. Patel had noted in his chart; isn't that correct?

A. Yes, it's pretty unusual for a layperson to use those terms.

Q. So we can assume, maybe we shouldn't assume, we haven't heard her testimony yet, that she probably got that information from Dr. Patel?

A. I wouldn't know.

Q. All right. You wouldn't know and I don't know either. But in any event, that's a very descriptive

way of saying that Jeremy was entering Small Smiles with an abscess at teeth I and B?

A. That's what she wrote, yes.

Q. And we talked about observation. History is important also in dentistry; isn't that correct?

A. Yes.

Q. And you know that if a patient who has a dental abscess has taken an antibiotic that the overt swelling of soft tissue may go down, but as you indicated earlier, that doesn't mean that the condition that is causing the infection is gone, correct?

A. Yes.

Q. And that the patient still needs treatment for that underlying infection that is going on in the tooth, correct?

A. Yes.

Q. And that dental treatment and that particular condition is extraction, correct?

A. Yes.

Q. So we know that Jeremy actually comes in with the history of abscess, and we also know he's on antibiotic. So we know that some of the soft tissue swelling may not be apparent any more, correct?

A. There's usually some remnant of edema, some

redness and swelling. You can visualize that. Particularly, if it's significant enough that the abscess is affecting the face.

Q. Now, an x-ray was done. And as I understand it the -- you described the I x-ray as being undiagnostic; is that correct?

A. Yes.

Q. Now, we know from other parts of the chart that Jeremy was -- I don't think they used the term very, very uncooperative like Dr. Patel, but said he was "out of control." Do you recall seeing that in the chart?

A. Yes, I do.

Q. So he's a very upset child, obviously he's going to the dentist, he has these problems with his tooth and he is obviously an upset child, correct?

A. Yes.

Q. And isn't it fair to say that it is difficult to take an x-ray on a child -- on children generally and in particular on one that's upset or uncooperative?

A. It is a challenge, yes, but they were able to get the one side.

Q. All right. And it's also true, isn't it, that you really shouldn't be repeating x-rays on young

children very much, should you?

A. It depends on the diagnostic yield which is really critical, particularly when you're doing an extraction.

Q. Well, if I could, the reason why you're not suppose to repeat x-rays on a child very often is because the x-ray rays cause cancer, don't they?

A. One way. Just like everything else, the risk versus the benefit, and in order to proceed properly, you do need a diagnostic x-ray.

Q. That's your opinion. But you can also agree, can you not, that if you have a very difficult child and you're just trying to diagnose with an x-ray that's not treatment, you're just trying to diagnose, you shouldn't be taking multiple x-rays knowing this kid has a lifetime in front of him and you're radiating him multiple times when what you see in the mouth, what you see in the condition of the tooth gives you -- and the history that you have gives you a picture of what's going on; isn't that correct?

A. It is not correct.

Q. All right. So you would say you would take Jeremy's I tooth again?

A. The x-ray if I'm doing something irreversible, absolutely.

Q. Say that one is nondiagnostic because he's noncooperative?

A. Maybe he needs to see another dentist.

Q. You think you should go to three?

A. I've had children that I've been the fifth dentist the three-and-a-half-year-old has seen.

Q. I'm talking about x-rays.

A. The x-ray has to be taken until it's diagnostic, yes.

Q. These are baby teeth, right?

A. Yes, they are.

Q. Okay. And they're important, baby teeth are important. In fact, Jeremy needs whatever teeth can be preserved, and I guess it depends on the tooth, but if you talk about D, E, F, and G, which we will talk about in a moment, he needs them to -- what he is, seven years old, right?

A. Seven to eight and a half.

Q. So he has five years to go with those teeth?

A. Yes.

Q. So you really don't want to extract if you don't have to, right?

A. Particularly these teeth are there until ten and ten and a half.

Q. By the way, you're talking about cost. I think

you were comparing the cost of a filling to a crown. Extractions actually are very low cost, isn't it?

A. I don't recall. I'm sorry.

Q. Well, you know, extractions actually is much lower cost than doing a pulp and crown, right, you know that?

A. But if an extraction needs to be done then that's what needs to be done.

Q. I'm just asking about this one point. You're making this suggestion that this pays more. Let's talk about what pays less as well. Doing these extractions of instead of restoring this tooth costs less not more?

A. Sir, I think you're putting words in my mouth. I did not insinuate it was a cost issue ever.

Q. Maybe I did misunderstood you. You were asked by counsel the difference in cost between a crown and a filling.

A. I did.

Q. I remember that. I can only assume that they're insinuating that that was a factor in the decision?

MR. FRANKEL: Argumentive, Your Honor, I object.

THE COURT: Sustained.

Q. Insinuations aside, we can agree that extractions are a low cost way of going?

A. I'm not sure. I don't know. I'm sorry.

Q. Now, let me -- just if I could ask you a little bit. I'm going to come back to that visit. But those teeth were extracted, B and I were extracted by Dr. Bonds without any complications; isn't that true?

A. There's -- I don't know if there's a notation no complication in his clinical note.

Q. Is there a notation of any complication from what you recall?

A. Well, that would be protocol. You would write in your clinical notes extractions within normal limit. Hemostasis obtained, and I don't see that notation.

Q. Okay. So as far as you know, and everything you've read in this case, they were extracted without any problem?

A. I think there was a phone call documented in his chart that mom had called about bleeding or somewhere I had read that.

Q. Actually, I'm glad you brought that up. Didn't she actually call to find out whether or not he should continue on the antibiotic?

A. Yes, she called about that. But I remember

either reading in testimony or something about a bleeding issue she called --

Q. Let's -- I'm sorry. I didn't mean to cut you off.

A. That's all right.

Q. In terms of the chart, it says that she called because she was concerned. It's a valid question, certainly, whether she should continue the penicillin, right?

A. Yes.

Q. And she was advised about that?

A. Yes, usually you're advised at the visit, though, if you know your patient is on medicine, you counsel them then.

Q. In any event, she received the information and presumably finished the antibiotic?

A. Yes.

Q. And I think you heard said earlier today that you didn't see in the chart where they documented where carious lesions were located based upon the clinical examination, is that fair? Did you say that?

A. I don't think I said that.

Q. Are you aware that when the initial examination at Small Smiles occurred on May 23rd, that actually marks were made on that odontogram about where caries

were located?

A. I'm not aware. The odontogram is a little hard to follow.

Q. Doctor, I'm going to use this exhibit because I think it shows up a little better on the screen. Now, Doctor, the odontogram is located here, right? Right here, right?

A. Yes.

Q. All right. It's a color coded odontogram, isn't it?

A. Yes.

Q. And it says here, work to be done in red pencil, completed work blacked out with black pen, you see that?

A. Yes.

Q. All right. So the work noted in red sometimes it can be a little hard to see because it's written over in places when the work is done, actually documents where the lesion is that needs to be treated, does it not?

A. It documents that, but it doesn't document the date.

Q. All right. Well, let's take a look at the teeth D, E, F and G. Do you see those there?

A. Yes.

Q. You're right, they don't say the date, but we know those teeth were treated as of the next visit on August -- what was it August 30th, 2006; is that correct?

A. Yes.

Q. In any event, the August visit. So either on May -- in May or in August it was marked where these carious lesions are located on those four top teeth; isn't that correct?

A. I'm fairly certain this is the only odontogram for his chart, though.

Q. I understand that. But we know based upon what happened afterwards that the teeth were treated with pulpotomies and crowns, that the only time it could have been done was on or before that August visit, correct?

A. Probably.

Q. We know that had to be?

A. I don't know --

Q. Okay.

A. -- because there's no date on the odontogram. It's a perpetual odontogram.

Q. And these markings in red appearing on those four teeth actually show you the location of the caries that the doctor found at the time that he

examined Jeremy; isn't that correct?

A. At sometime, yes.

Q. All right. So when you say that there's a lack of documentation, actually there's quite a bit of specificity as to the location of the caries on those four top teeth before those pulps and crowns were done; isn't that correct?

A. They're red-colored marks, yes.

Q. Right. And by the way, they appear to be between F and G. F and G are the top two front teeth, the ones in the middle?

A. E and F.

Q. E and F, I'm sorry. Are those these teeth?

A. Yes.

Q. And they show decay on the sides towards the center of the mouth?

A. Yes.

Q. And that's exactly the kind of condition that would cause a gap or a space or an appearance of rot; isn't that true?

A. It can, and also a natural space could be present as well.

Q. All right. But according to this odontogram, which I know you don't want to accept because you're here to testify against these doctors --

MR. FRANKEL: Excuse me, that's argumentative, Your Honor.

THE COURT: Sustained.

Q. According to the odontogram that's exactly where the decay was located; isn't that true?

A. I'm sorry, I missed the beginning of your question, sir.

Q. According to the odontogram, the decay is located exactly where Mrs. Varano and Mr. Bohn said that the decay was observable?

A. It sounds coincident.

Q. That's just a coincidence, is that what you're saying?

A. It's not reflective on the x-ray.

Q. But we agree the x-rays don't show you everything, do they?

A. On back teeth.

Q. Well, let's take a look at the x-ray you used for this jury.

MR. FIRST: And if we can have a side by side. I'm sorry, I have to take this down.

Q. Now, Doctor, this is the radiograph -- the depiction of the radiograph you used in front of this jury. Did you prepare that?

A. Did I prepare it, no.

Q. Yeah. Did the attorneys prepare it for you?
A. You'd have to ask them. I'm sorry, I don't know who prepared it.
Q. All right. You see the x-ray on the right, that's the same picture, isn't it?
A. Yes.
Q. Little clearer, isn't it?
A. Yes.
Q. In fact, this -- the one you presented to the jury is actually very washed out looking and foggy, isn't it, very hard to see much of anything in that; isn't that true?
A. I can see.
Q. You say that was good enough for your purposes. But this digital copy of the x-ray shows a lot more, doesn't it?
A. The contrast is better.
Q. And I assume you still will still say to this jury that this x-ray which is much better and clearer and less foggy also doesn't show any decay, is that what you're going to tell the jury?
A. Yes, and I had the opportunity actually to view the originals.
Q. You don't see any decay between those teeth or anything going down between them, you don't see

anything there?

A. That's bone that you're pointing to going down between them.

Q. You don't see any decay there?

A. No.

Q. All right. Doctor, particularly with the facial side, the part of the tooth that faces the front, it's often difficult to see caries on -- with the frontal -- located on the front of the tooth because of how the x-ray goes right through the tooth and the pulp is dark as you pointed out any way and it can conceal caries that appear in that tooth, right, that exist in that tooth I should say?

A. No. Actually the movie that we showed the x-ray there the cavity was on the back surface and you could see it on that x-ray.

Q. On that particular one. But isn't it true on many x-rays the pulp chamber conceals it, a facial cavity, a facial cavity meaning the front of the tooth cavity?

A. I think a good diagnostic eye could be able to pick up the difference between pulp tissue and a cavity.

Q. That's your opinion, right?

A. That is my opinion.

Q. We're going to talk about that other x-ray before the end of the day any way. Now, these front teeth they're -- they're especially prone to pulp exposure, aren't they? Because the dentin is thin? The thin enamel and dentin layers on them?

A. Prone to exposure.

Q. To pulp exposure because they have a thin layer of enamel and dentin; isn't that correct?

A. More so than what?

Q. More so than molars?

A. I wouldn't state that, no.

Q. Well, Doctor, it's not unusual, is it, to find that a caries or cavity extends into the pulp once the dentist excavates the decay; isn't that true?

A. That can happen, yes.

Q. All right. So once again that may not appear on an x-ray, but once you get in there, and you excavate and you try to remove the decay, pulp exposure can be found clinically, correct?

A. You have a pretty good idea with the x-ray what you're going to find.

Q. But -- well, you're backtracking, or do you agree with me that you do encounter pulp exposure when you excavate one of these teeth or any tooth for that matter doing the excavation?

A. Yes.
Q. And that did not show up on an x-ray as pulp exposure, correct, in a lot of cases?
A. I'm sorry, I lost you on that question.
Q. That doesn't show up on an x-ray?
A. I would disagree.
Q. You think it sometimes shows up on an x-ray?
A. Most of the time you can recognize it because you need to prepare your treatment plan appropriately in anticipation of that event.
Q. So you're saying more than half the time, but then there's a substantial percentage where it doesn't show up until you excavate the tooth?
A. I would say close to 90 percent of the time.
Q. That's your estimate?
A. Yes.
Q. Now, I want to ask you a little bit about this, the use of the papoose. You said you used it yourself personally, rarely. I think you said two or three times a year. Is that what you said?
A. I think I said one to two.
Q. One to two. Okay. Uhm, do you use sedation?
A. I do not.
Q. Do you have anybody in your office that uses sedation?

A. I do not.
Q. Now, sedation is another behavioral management -- advanced behavioral management tool, isn't it?
A. Absolutely, yes.
Q. And it has a lot of risks itself, doesn't it?
A. It does have risks, yes.
Q. Those are some serious risks that include death?
A. Yes.
Q. And you could also sustain cardiopulmonary damage and other kinds of brain damage; is that correct?
A. Yes. The most significant is respiratory with sedation.
Q. All right. And that's true of general anesthesia as well?
A. Yes. There are many risks with general anesthesia.
Q. Now, do you say you treat children who are reimbursed by Medicaid?
A. Yes.
Q. What percentage of your practice is it?
A. I say about five percent.
Q. Five percent, so it's a very small number?

A. I have 3,000 active patients so it's a pretty good number.

Q. All right. So you do not -- do you advertise in any way that you accept Medicaid?

A. I don't advertise, but my name is on the Medicaid list.

Q. Do you turn down Medicaid cases?

A. Rarely.

Q. So as I understand it then, the Medicaid practice is a small part of your overall practice?

A. It is.

Q. And is that because of the reimbursement rates?

A. No.

Q. Well, it's well-known that where you're from -- what county is that? That's Rochester is what county?

A. Monroe.

Q. Monroe County. It's well-known that very few pediatric dentists make themselves available to Medicaid kids; isn't that true?

A. I'm not sure. Most of my colleagues do because as I was explaining earlier, we're the only specialty that has training with people with special needs and pretty much all the special needs kids have Medicaid. So yes, I would say all my colleagues accept Medicaid.

Q. Doctor, are you aware of a survey in Rochester

where of the 31 pediatric dentists listed in Monroe County, eight said they were accepting Medicaid patients?

MR. FRANKEL: Excuse me. I'm going to object. This calls for hearsay, Your Honor.

THE COURT: Sustained.

Q. Are you aware whether or not only eight of 31 pediatric dentists accept Medicaid patients?

MR. FRANKEL: Same objection.

THE COURT: Sustained.

Q. Are you at all familiar with that statistic?

MR. FRANKEL: Same objection.

THE COURT: Sustained.

MR. FIRST: May I approach the witness, Your Honor?

THE COURT: Yeah. I thought you wanted to approach here.

MR. FIRST: No, just the witness. Counsel approach, please.

(A discussion off the record at the Bench, all counsel present.)

BY MR. FIRST: (Cont.)

Q. Doctor, you present --

THE COURT: Minute to stretch. Stand up. Just a second. You need to stretch?

TRIAL JUROR: Thank you. Okay.

THE COURT: You, too. I mean I can.

BY MR. FIRST: (Cont.)

Q. As the president of the dental society, I think I heard you say that there at one point; is that correct?

A. Yes.

Q. Did you become aware of the number the percentage of pediatric dentists accepting Medicaid kids?

A. I was not aware, but we also have Eastman Dental Center and that's a big service center for the kids with Medicaid.

Q. And, in fact, most of the pediatric dentists who do accept Medicaid are part of the community-based health clinics like Eastman; isn't that correct?

A. I'm not sure.

Q. Now, I think I heard you say that you reviewed some 70 cases on behalf of these lawyers; is that true?

A. Yes.

Q. And as I understand it, those cases are cases that they reviewed, looked at and sent to you. In other words, they screened them before they were ever sent to you; isn't that correct?

A. They sent them to me. I don't know what their process was but...

Q. So you had no basis to say that that's any representative cross-section of cases at Small Smiles, do you?

A. It's the cases that I saw.

Q. All right. My question is a little different. You have no basis to say that that is any real cross section of treatment at Small Smiles, isn't that a fact?

A. Yes.

Q. And you also said that you were getting paid by these lawyers for reviewing these cases?

A. Yes.

Q. And I think you said it was $300 an hour?

A. Yes.

Q. So how much have you been paid to date?

A. Probably over the past two and a half years close to $50,000.

Q. So it's a cottage industry for you reviewing these cases?

A. Absolutely not.

Q. With respect to the papoose, you indicated you do use it a couple of times a year. Are you -- you said that there's some risk of bruise or a scratch, I

think that's one thing you said, right?

A. Yes.

Q. You talked about the possibility of psychological issues --

A. Yes.

Q. -- is that correct?

A. Yes.

Q. Are you aware of any studies that have established either of those things from a papoose?

A. Studies?

Q. Studies.

A. These are more experimental from my experience.

Q. So if I understand that correctly then, you're not aware of any studies -- I mean this is a whole academic enterprise of doing studies on a whole bunch of different subjects in dentists, correct?

A. I believe there is a hospital study that's listed in the American Academy of Pediatric Dentistry reference manual.

Q. I'm asking you about the study of these dentists, right, you're not aware of any studies concerning dentists?

A. I'm not, sorry.

MR. FIRST: Thank you.

THE COURT: Okay. How about we take our

afternoon recess. Fifteen minutes. Be back at quarter of. Don't talk about the case. Don't do any research. Can I see counsellors for a minute.

(Proceedings in recess at 2:31 p.m..)

THE COURT: Okay.

(Jury seated in the jury box at 2:50 p.m..)

THE COURT: Okay. Just a heads up. We're going to finish this witness today, which means we may end up going a little bit late. I just wanted to give you a heads up on that. Okay.

CROSS-EXAMINATION

BY MR. McPHILLIAMY:

Q. Thank you. Afternoon, Doctor.

A. Good afternoon.

Q. Uhm, I believe before you told us that following completion of your pediatric dental residency you taught?

A. Yes. I was a clinical instructor.

Q. And that was at Eastman Dental School?

A. Uhm, Eastman Dental, yes.

Q. Okay. Now, is there -- are there different levels of instructors that would teach at a dental school or dental school setting?

A. Yes, there are.
Q. Okay. And where would a professor be in that hierarchy?
A. I think a professor is high.
Q. Pretty high at the top, right?
A. Yes.
Q. Okay.
A. I've not been in academics formally, so I'm not really familiar with the stratus of.
Q. I believe you testified that you graduated the pediatric residency program in 1982?
A. Yes.
Q. How long did you teach there for following that graduation?
A. On and off and on for about ten years.
Q. Okay. Ever receive tenure while there?
A. Oh, no. It was just a day position as an attending. I was only on the clinic floor.
Q. So you didn't teach pediatric residents in their -- in their classroom setting; is that correct?
A. Actually, I did do some classroom but not formally. I taught how to make appliances and space maintainers and behavior management at the time it was called, but predominately I was in the clinic.
Q. You're a member of the American Academy of

Pediatric Dentistry?

A. I am.

Q. Have you held any positions with that organization?

A. No.

Q. Are you a member of the American Society of Dentistry of Children?

A. I was. I believe that's since dissolved.

Q. Do you hold any positions with that organization when you were a member?

A. No, I did not.

Q. Are you familiar -- is there something known as board certification in pediatric dentistry?

A. Yes.

Q. Is there a process that the pediatric dentist has to go through to obtain their board certification?

A. Yes.

Q. What does that process entail?

A. Uhm, the process in my time when I finished my residency was a four-step procedure where you take a written board, you do board cases, they would do an office visit, and then you'd have an oral exam. When I completed my residency, I did the written board and I passed. But my peers at the time that were going on for board certification were those individuals that

were going to go into academics, and I knew I was going into private practice so I didn't pursue it.

Q. So you are not board certified in pediatric dentistry; is that a fair statement?

A. I'm not, but I'm a candidate, again, because I took the written board again.

Q. But you're not board certified, correct?

A. You're correct, yes.

Q. Have you published in the area of advanced behavior management with the use of passive immobilization?

A. I have not published, no.

Q. Are you published at all?

A. I have one article with my name attached to it.

Q. What's the subject matter of that?

A. It's the Affect of Artificial Sweeteners on mucopolysaccharide production. It has to do with the adherence of plaque to the tooth and artificial sweeteners.

Q. And the cause of decay, right?

A. Sticky plaque, yes.

Q. When you were in your residency program, did they use textbooks?

A. Yes.

Q. And I believe you said that you were involved

in some type of residency program now in Pennsylvania?
A. Yes.
Q. Do they use textbooks in that?
A. Yes.
Q. And do you consider any of those textbooks as authoritative?
A. Standing alone or as a consolidation?
Q. Either way.
A. I think it's a cumulative body of information. Yes, they are.
Q. Okay. And are you familiar with the textbook, "Pediatric Dentistry Infancy Through Adolescence"?
A. Casamassimo?
Q. Casamassimo, yes.
A. Yes.
Q. Do you have that textbook in your office?
A. I have it at home actually.
Q. Were you trained with the textbook?
A. I was not.
Q. Do you utilize that textbook?
A. I used it for -- to study for the boards.
Q. Would you consider that textbooks as authoritative?
A. It is part of the piece, yes.
Q. It is authoritative?

A. It's part of the whole piece.
Q. All right. Would you agree that the pattern of decay in ECC, Early Childhood Caries is related to the salivary flow patterns in a child's mouth?
A. That's one of the risk factors, low salivary flow, particularly in children over the age of six.
Q. And would you agree that ECC initially presents with smooth surfaces being involved of the tooth or teeth?
A. Yes, I would.
Q. And that would include the maxillary incisors?
A. Yes. Well, yes, the smooth surfaces.
Q. Teeth D, E, F and G?
A. Yes.
Q. And that would be -- let's talk about tooth anatomy for a second. Utilizing Defense Exhibit ABK-1249, do you know what this is?
A. Yes.
Q. It's an enlarged mouth?
A. They're teeth.
Q. Would this assist you in demonstrating to the jury what surfaces of a tooth are which?
A. If you wish.
Q. Sure. The outside surface here that I have my finger on when you smile that's a surface that you see

that's called the buccal surface; is that correct?
A. Sorry to correct you, but the anterior actually is the facial surface.
Q. The posterior teeth it is called the buccal?
A. That's correct.
Q. Side toward the tongue that's the lingual, right?
A. Correct.
Q. And posterior teeth, the biting surface is called the occlusal surface?
A. Yes.
Q. And the biting surface on the anterior teeth is called the incisor surface, correct?
A. Yes.
Q. So the smooth surfaces would be the buccal, the lingual the -- withdrawn. Mesial surface that's the surface of the tooth closest to the front of the mouth; is that correct?
A. Yes. I think we talked about that this morning, too.
Q. So the smooth surfaces of the tooth would be the buccal, the lingual, the mesial and the distal surface; is that correct?
A. Yes.
Q. You told us this morning that Early Childhood

Caries treatment one has to look at the factors that cause it. Do you remember giving that testimony this morning?

A. Yes.

Q. What did you mean by that?

A. Factors that cause it have to do with biological factors, environmental factors, protective factors.

Q. How about diet is that a factor?

A. Yes.

Q. How about oral hygiene is that a factor?

A. Yes.

Q. And a diet that's high in sweets what effect does that have on ECC?

A. It's part of it. Carbohydrates really drive it equally, if not more so.

Q. Okay. How about sugary snacks like gummy bears?

MR. FRANKEL: Your Honor, object to that question as a violation.

THE COURT: Overruled. You can answer.

THE WITNESS: Thank you.

A. Uhm, the teeth that tend to generate the most caries are the ones that are still on the teeth after you've eaten them. So a great example would be an

Oreo. You eat it and you open your mouth and it is all over there.

Q. And that's -- I'm sorry, you finished?

A. Yes.

Q. Were you finished with your answer?

A. Yes.

Q. That's why oral hygiene is important, too, right?

A. Yes.

Q. Because you have to get rid of the Oreo that is left on the teeth, correct?

A. Yes, but typically what you're doing you want to remove the plaque because the plaque has the bacteria, and the goal of the brushing is not only to remove the debris, but to remove plaque.

Q. Now, the upper anterior teeth D, E, F and G, there are no salivary glands in that area of the mouth, are there?

A. No.

Q. And those are the -- those are the teeth that are most prone to Early Childhood Caries, is that a fair statement?

A. I'm not quite sure. I think the thought use to be when the term was used "baby bottle" that those were the surfaces that were more exposed to children

that were on prolonged bottle feeding, but that's not the case.

Q. That's not the case in this case, correct? That's not the situation in this case?

A. That's not the case currently with regard to current literature.

Q. Okay. Can we agree that with ECC, the top teeth, the upper teeth are more often affected than the lower teeth?

A. I'm not quite sure because the definition of ECC is one or more area on a tooth. I'm not quite sure if it specifies where.

Q. What about patterns?

A. Patterns of caries?

Q. Yes.

A. It depends on what's causing the caries.

Q. Okay. Diet?

A. Diet, kids tend to snack a lot. I'm sorry.

Q. That's all right. You took the words right out of my mouth. Snacking a lot. Poor oral hygiene?

A. Children that tend to snack a lot will be more prone to getting cavities on the chewing surface where all the grooves are.

Q. If they don't brush their teeth, they get them on the smooth surfaces, too; correct?

A. If you don't brush your teeth, you get them everywhere so...

Q. Are you familiar with something known as the caries risk assessment tool?

A. Yes.

Q. Okay. And that assesses the risk of a pediatric patient?

A. Yes.

Q. And would you agree that Jeremy would be considered, taking all those factors into consideration, a high risk or at high risk?

A. Taking -- I'm sorry, what factors?

Q. Well, other factors in assessing or determining the caries assessment risk?

A. Yes.

Q. Okay. What are they?

A. Uhm, they're children that snack more than three snacks a day. Uhm, the mother has a high caries risk or high cavity risk. It has to do with the titer of streptococcus mutans, the bacteria that generates -- that you test for the amount of bacteria in the saliva. Has to do with fluoride exposure. Has to do with socioeconomic group. It has to do with whether you're an immigrant or not. Those are the factors that I can remember now off the top of my

head.

Q. What do you mean by socioeconomic group?

A. I think the other gentleman and I were speaking of that when he asked me the question about individuals that are a lower socioeconomic group to have a higher incidence of getting cavities.

Q. And that would be pediatric patients that are covered through Medicaid?

A. It may. I mean don't necessarily have to have Medicaid to be poor.

Q. Lower income, right?

A. Low income, right.

Q. All right. You were asked about some fees by Mr. Frankel. I believe you said that the fee for Medicaid reimbursement for a filling is about $50 and for stainless steel is about $80?

A. It was an estimate. I don't know the true fees.

Q. And in your private practice you perform fillings and stainless steel crowns; is that correct?

A. I do.

Q. How do Medicaid fee compare to your fees in your private practice?

A. Quite honestly, I don't know.

Q. How much do you charge for a stainless steel

crown?

A. I honestly don't know.

Q. You're a sole practitioner, right?

A. I am.

Q. No other dentist working for you?

A. Right.

Q. You don't know how much the fees are for your patient, is that what you're telling this Court?

A. I am.

Q. You have a website for your office, don't you?

A. I do.

Q. What's it called?

A. Rochester Children's Dentist dot com.

Q. Is it Rochester Dentist dot com?

A. I think it is children.

Q. Now, let's go to tooth anatomy. Would you agree that the enamel portion of the tooth is the hardest portion of a tooth?

A. Yes.

Q. Okay. It's highly mineralized?

A. Yes.

Q. And actually you as a dentist when you're drilling on the enamel, you know you're in the enamel because it's shiny; is that a fair statement?

A. It's -- I'm sorry, I don't understand.

Q. Okay.
A. It's shiny?
Q. The enamel is shining as you're drilling through it?
A. It's whiter than the dentin. I'm quite sure I would describe it as shiny.
Q. And the dentin you're -- you know you're in dentin because it has a darker color?
A. Yes.
Q. And it has a dull flat finish; is that correct?
A. Yes.
Q. Between the enamel and the dentin is something known as the dentoenamel junction, correct?
A. Yes.
Q. One side is enamel, the other side is dentin?
A. Yes.
Q. The dentin portion of the tooth is much softer than the enamel; is that a fair statement?
A. On a hardness scale, if enamel is five, dentin is about a three to four.
Q. It's less mineralized than enamel, isn't it?
A. Yes.
Q. Okay. And would you agree that once decay reaches the dentin it spreads relatively quickly?
A. It does spread.

Q. I believe you described it as mushrooming before; is that correct?

A. It does.

Q. Now, would you agree that it's better to -- withdrawn. We used the words cavities and caries. Those are the same things; is that correct?

A. Yes, it is.

Q. But decay and cavity and caries are two different things, correct?

A. I believe they're used interchangeably.

Q. The decay process is what causes the cavity, would you agree with me on that?

A. Sure.

Q. Okay. So would you agree that if decay goes untreated it's going to cause a cavity or result in a cavity?

A. No.

Q. Is the decay going to get better?

A. Often times it can be arrested.

Q. Is it going to get better is my question?

A. Often times -- and often times it can be arrested.

Q. That's not my question. Is it -- does -- if you don't treat decay, does it get better?

A. Get better? It can't heal itself so the answer

to that is no.

Q. In fact, most times it's going to get worse if it's not treated; is that a fair statement?

A. Yes.

Q. Okay. Now, would you agree that the process of developing a cavity in the enamel portion of the tooth, very hard portion of the tooth is a much slower process than once it hits the dentin? Yes or no, Doctor?

A. I'm sorry, then you'll have to ask the question again because I had an answer formulated for you.

Q. Okay. The decay process --

A. Yes.

Q. -- in enamel is slower when compared to dentin?

A. Yes.

Q. Once it gets to the dentin, it spreads relatively quickly; is that correct?

A. It can, but not always.

Q. Okay. It can. And if left untreated once it gets to the dentin the next step is getting into the pulp, correct?

A. It can either go to the pulp or go laterally.

Q. And eventually --

A. Across the D-E-J.

Q. And eventually makes its way into the pulp?

A. Yes.

Q. You said something very interesting. Once it goes along the D-E-J you have a much more extensive cavity that has to be treated; is that correct?

A. Yes.

Q. Would you agree that typical recall period for children and a for adults is every six months, correct?

A. That's the average, yes.

Q. So if you have a cavity, when the patient comes into the office and they you see, there is decay and you see it's just in the enamel, do you want to tell that patient, oh, I don't need to fill this, come back in six months, is that what you tell your patients?

A. You're exactly right, we see them every three months and that's the recommendation, and even Medicaid will cover for fluoride every three months.

Q. Three months is a long time for decay; is that correct? A lot can happen? Withdrawn. A lot can happen to a tooth in the decay process in three months, would you agree with me on that?

A. I would disagree.

Q. Okay. Now, would you agree with me that the height of the crown portion of the tooth, I know this is a posterior tooth, in a child is about six

millimeters? An upper anterior tooth?

A. Okay.

Q. Quarter inch, is that a fair height for upper primary tooth?

A. Six millimeters, seven millimeters, yes.

Q. All right. And the enamel portion of upper anterior baby tooth is approximately one millimeter?

A. Yes.

Q. And it has been argued in this Court that the thickness of the enamel of a baby tooth, upper anterior baby tooth is the thickness of a sheet of paper; would you agree with me on that?

A. I would disagree.

Q. Approximately ten sheets of paper to a millimeter; is that correct?

A. Yes.

Q. And would you agree that the enamel of children's anterior teeth is thin?

A. That's a relative term "thin." Relative to what?

Q. Okay. How about adult teeth?

A. Relative to adult teeth?

Q. Yes.

A. Yes, it is.

Q. Okay. And the dentin portion of the tooth is

approximately one millimeter in depth also; would you agree with me on that?

A. It's slightly deeper.

Q. Slightly more than a millimeter?

A. Yes.

Q. You familiar with the phrase pit and fissure?

A. Yes.

Q. What -- describe for us what a pit and fissure is, fissure?

A. A pit and fissure is a term that's used when we were talking about the five surfaces of the teeth, the chewing surface has the fissures or the grooves, so a fissure is another name for a groove, and a pit is where when the lobes of the teeth fuse together and the tooth is forming and it may leave a little a tiny pit or opening.

Q. You would examine during a recall examination, initial examination the pit and fissures of the molar teeth with what is commonly known as the hook?

A. Explorer.

Q. Okay. And that's what we marked as ABK-1267? I'm holding in my hand. Is that an explorer?

A. Thank you. Yes.

Q. Okay.

A. It is. Thank you.

Q. You're welcome. And you as a dentist would go take the explorer and go around the occlusal surface of the tooth, into the pit and the fissures and you look for resistance; is that correct?

A. That's not correct.

Q. Do you look for some type of stick in that area?

A. That is not correct.

Q. What do you look for, Doctor, during your clinical examination?

A. You pull the explorer across the grooves, excuse me, because quite often because the instrument is metal and the enamel is hard, if you push hard, you can get what's called a mechanical catch which is the sensation that there really is a catch in the tooth, but it's just the explorer being forced between the grooves of the tooth. So one does have to be -- particularly on newly erupted teeth, the enamel is very frail and still undergoing remineralization and demineralization, so the explorer is not used to push down.

Q. Okay. When you examine the tooth, posterior tooth, like the -- with the explorer, you also use a mirror, too, right?

A. Absolutely.

Q. Okay. And you -- if you get some type of resistance, you know there is some decay there?

A. No. It could be mechanical resistance as well.

Q. Okay. You can look at an x-ray, bite wing x-ray which shows the upper and lower teeth together, and you could see whether that decay has gone through the -- what we call the dentoenamel juncture, separating the enamel from the dentin; is that correct?

A. You can visualize that, correct.

Q. And would you agree that when one takes an x-ray of the upper anterior teeth, the x-ray can show decay on the mesial and distal surface?

A. Yes.

Q. Also show decay on the biting surface which I think we call the incisor surface?

A. Yes.

Q. How does decay appear in an x-ray?

A. It appears as I showed the jury earlier today as a dark area.

Q. Okay. Is it an area that's different in contrast than the enamel?

A. Yes.

Q. An area that is different in contrast to the dentin?

A. Yes.
Q. And, in fact, high quality x-rays show different degradations of grayness in a tooth or whiteness?
A. Most x-rays do show that, yes.
Q. And the more contrast there is, I'm sorry, the more different -- the more levels of grayness or contrast the better the x-ray; is that correct?
A. The more contrast the better, yes.
Q. Okay. Would you agree that when one takes an x-ray of the upper anterior teeth they can't see how much decay is on the buccal surface, that front surface of the tooth?
A. I would disagree because it can be visualized.
Q. On the x-ray?
A. Yes.
Q. Doesn't the pulp, which is very dark, which looks like decay, doesn't that -- isn't that superimposed over any decay on the buccal surface or the lingual surface of the tooth? Yes or no, Doctor?
A. I'm sorry, you'll have to ask the question again.
Q. Would you agree that the decay on the buccal surface or the lingual surface when looking at it on an x-ray the pulp tissue is going to superimpose any

decay in that area?

A. I would not agree.

Q. Would you degree that on x-rays alone one cannot evaluate the amount of decay present on the tooth on either the buccal or lingual surface?

A. I'm sorry, I'm going to ask that you repeat that.

Q. Would you agree on x-rays alone one cannot evaluate the amount of decay present on that tooth on the buccal and lingual surface?

A. The x-rays are a piece of the diagnosis.

Q. The other piece is the clinical examination; is that correct?

A. Yes.

Q. Would you agree that the amount of decay present in a tooth is more extensive than what is seen on the x-ray?

A. I'm terribly sorry, the amount of decay?

Q. The amount of decay present on a tooth is actually more than what is depicted on the x-ray of that tooth?

A. That is correct.

Q. Has to do with demineralization of the tooth?

A. That is absolutely correct.

Q. And typically one has to be 30 percent

demineralization of an area until you actually see something on an x-ray?

A. I think it depends on the x-ray.

Q. Would you agree that even the removal of small carious lesions often compromise the structural integrity of an anterior tooth?

A. Any removal of tooth structure will compromise a tooth.

Q. And a tooth has a typical shape to it; is that correct?

A. Yes.

Q. Okay. And if you're looking at an x-ray and you see a portion of the crown, does not have the typical shape, could that be indicative of decay in that area?

A. It could be or it could be an injury. One tends to look at the shape of it. If it's more square, it could be a fracture. Little chip off the tooth.

Q. How about in -- approximately how about between the teeth looks like something missing there?

A. Between the teeth you'll get more of the V-shape as you were explaining earlier. It won't penetrate the enamel quite as much as the dentin, so you'll get that V-shape look rather than a square

look.

Q. As in some type of trauma, the child slips falls, bumps their tooth?

A. Chips a little tooth, yes.

Q. I believe you mentioned before about teeth could be discolored because of some type of trauma; is that correct?

A. Yes, sure.

Q. They become darker?

A. They can. In baby teeth, they can turn gray. They can turn yellow. They can turn back white again. So they can get yellow from trauma.

MR. McPHILLIAMY: Craig, can I have 23 up.

Q. Now, looking at the treatment plan developed by Dr. Bonds on May 23rd, he diagnosed decay on the mesial surface of -- mesial and facial surface of E, mesial-facial surface of F, and decay on the facial surface of G; is that correct?

A. Yes.

Q. And would you agree that the x-ray --

MR. McPHILLIAMY: 23, please.

Q. -- taken on August 31st, 2006, that there was decay on those teeth?

A. I don't.

Q. Okay. Doctor, were you ever approached by

plaintiff's counsel and asked to read and sign an affidavit in this case?

A. I don't understand your question. I'm sorry.

Q. Were you ever approached by plaintiff's counsel and asked to read and sign an affidavit or affirmation in this case maybe five or six months ago?

A. Yes, I was.

Q. And in that affirmation you stated that there was decay on teeth D, E, F and G. Do you remember that?

A. I don't, I'm sorry.

Q. Doctor, do you remember affirming the statement that said the x-rays Dr. Aman obtained of D, E, F and G show minimal decay. Do you remember signing and affirming something to that effect?

A. If I signed it, yes.

Q. Okay. So six months ago when you looked at these x-rays you said that there was decay in teeth D, E, F and G; is that correct?

A. Yes, I must have.

Q. And since we're talking about your affidavit, skipping around a little bit, would you agree that an abscessed tooth always requires extraction?

A. Yes.

Q. Yes or no, Doctor, you would agree with that?

A. Am I permitted to comment about the last question?

THE COURT: No. There is no question. You answered the question. So no, you're not.

THE WITNESS: Okay.

Q. You would agree that an abscessed tooth always requires extraction; is that correct?

A. Yes, I would.

Q. Now, Doctor, I believe you told us before that decay can progress over a three-month period. Was that your testimony?

A. It can.

Q. Okay. And the notations made by Dr. Bonds as to teeth E, F and G, did not note how much decay was present in May of 2006 -- May 23rd, 2006, do you remember that?

A. His charting --

Q. Yes.

A. -- or his treatment plan?

Q. Either one. Just said that there was decay on those three teeth on the --

A. On this treatment plan, yes.

Q. Okay. Decay on two surfaces for teeth E and F, and decay on one surface for the letter G?

A. Yes.

Q. Now, as a pediatric dentist, if a patient has an emergency situation, you would -- in your office you don't personally take care of the scheduling of patients, do you?

A. I don't, no.

Q. You have a front desk person do that, right?

A. Yes.

Q. If a patient needs to come in and this is an emergency you need to take care of right away, then you're going to give instructions and have this patient come back next week, have this patient come back in two weeks; is that correct?

A. To my staff?

Q. Yes.

A. Depending on what the need is. We triage the call.

Q. No. Talking about the patient in the office you see for the first time?

A. I'm sorry. I thought you were talking about a phone call coming in.

Q. In the office, see the patient, you determine you treat whatever their condition is on that date. You see they need additional work. If it's emergent work, you are going to give your front desk special instructions to have that patient come back in a

relatively short period of time; is that correct?

A. Correct. They're two areas where I would do that on my treatment plan in accordance to the need, so the treatment plan is outlined to the most urgent teeth first. And then I would instruct on my treatment plan when I would want to see the patient back.

Q. And patients that need routine fillings you would give instructions whenever they can come in or whenever the office can accommodate them, give them an appointment for that?

A. Yes.

Q. Would you agree in the summer time your practice is more particularly busy?

A. Yes.

Q. All the kids are off from school, more time for them to come into the practice?

A. Yes.

Q. Have to wait a longer period of time to see you during the summer because you're busier with other children for routine dental work?

A. For routine I wouldn't say longer, longer than average, no.

MR. McPHILLIAMY: Can I have 22, Craig.

Q. You would agree that the hygiene visit notes

that Jeremy had poor hygiene on this date; is that correct?

A. Yes, I do see that.

Q. Also notes he had gingivitis?

A. Yes.

Q. And what effect does poor hygiene and gingivitis have on existing decay?

A. It doesn't help it.

Q. It hurts it, doesn't it?

A. Well, it doesn't help, no.

Q. In fact, on your website -- withdrawn. On your -- on your website, don't you make a statement that it's important to bring the child to the dentist when their first tooth comes in, but no later when they are one year of age?

A. That's the American Academy of Pediatric Dentistry's recommendations, yes.

Q. You state on your website they should brush their teeth twice a day?

A. Yes.

Q. Also say that the diet should be modified -- withdrawn. Does it say that the diet should be observed so there are few snacks or sweets during the day?

A. It's more the frequency than the -- what you're

eating, so it's frequency.

Q. Okay. And would you agree that for a teeth D, E, F and G, a white stainless steel crown would be the restoration of a child with ECC, if they have decay?

A. No.

Q. You would say the alternative is a composite restoration, a white filling?

A. Yes.

Q. And white fillings crack, especially when on the biting surface?

A. But they won't be on the biting surface. They're between the teeth.

Q. Do they discolor?

A. Typically, no.

Q. Can you get recurrent decay around them?

A. Any filling you can.

Q. That's especially true in a child who has ECC; is that correct?

A. I'm not aware of that.

MR. McPHILLIAMY: Craig, can I have 24, please. Two-four, thank you. Blow them up. Make it bigger. All right.

Q. Okay. Doctor, do you see the -- this is tooth letter B, which I'm pointing to right now; is that correct?

A. Yes.
Q. Okay. Let's look at tooth letter A, is right behind it, correct?
A. Yes.
Q. In your opinion, looks like a healthy tooth?
A. Yes.
Q. Okay. What's that big gray hole on the area between -- or actually closer to tooth letter A, what is that?
A. I'm sorry, the gray hole?
Q. The gray area right there?
A. On B?
Q. On B, yes.
A. I pointed that out earlier. That's a cavity.
Q. That's a large area of decay, would you agree with me on that?
A. Yes. And I mentioned we would restore that with either a filling or a crown.
Q. Okay. And on the front portion of that tooth looks like part of the tooth is missing there?
A. It's probably a cavity as well.
Q. Deep cavity?
A. Not to the pulp.
Q. Extensive cavity?
A. It's a large cavity. Three surfaces.

Q. Now, that little -- well, between the roots of tooth letter A, you don't see any dark shadows there, do you?

A. I do not.

Q. How about by B, see a dark shadow there?

A. The only thing that I do visualize is perhaps what is called the crypt, which would be the area where the permanent tooth might be resting under. I don't see any evidence of a dark area.

Q. Okay. That gray area there, that dark area between the roots of tooth letter B, that's an area where there is bone destruction; would you agree with me on that?

A. I would not.

Q. The abscess that you were shown earlier with your counsel that was an area of -- that was also an area of darkness, and you said that was an abscess; correct?

A. Yes, but it's right at the furcation, right at the junction of the root.

Q. Well, go back. Right here, this semicircle here?

A. That's not the junction of the root.

Q. The root -- two roots in tooth B, correct?

A. There would be three.

Q. Okay. All three roots meet right here?
A. I disagree. They meet further down. I think you may be seeing the superimposition of the palatable root.
Q. The superimposition of a root that will appear whiter in color, correct?
A. It's white. I don't see gray as I would in the abscess.
Q. You're telling us this area here looks like a U, is not bone loss, is that what you're telling me?
A. I am telling you that.
Q. It's not bone loss?
A. Yes. I'm telling you it is not bone loss.
Q. And tooth letter I, which is up here, we look at J, which is in back of it that looks like a relatively healthy tooth; is that correct?
A. Yes, it does.
Q. And tooth letter I, a big, old dark area, it looks like it is taking up half the tooth. What is that?
A. I'm going to let you know that the x-rays that I was looking at when I was reviewing the case were copies. I had the opportunity to see the originals so...
Q. What is that on the x-ray, Doctor?

A. It looks like a shadow. It could be a cavity. It could be a fracture.

Q. That could be a fracture in the tooth?

A. Sure.

Q. In this case, is it more likely that's an area of a great deal of decay?

A. I don't know.

Q. Okay. Now, you spoke about abscesses before.

A. Yes.

Q. Isn't abscess by definition accumulation of pus or purulent material?

A. Yes.

Q. And that is a clinical finding?

A. Yes.

Q. And would you agree that in treating an abscess you have to mechanically get rid of that accumulation of pus or purulent material; is that correct?

A. Actually, you need to get rid of the tooth which is the cause of it.

Q. Okay. Are you familiar with something known as incision and drainage procedure?

A. Yes, I am.

Q. What is that?

A. That's a procedure that's done on adult teeth, not on baby teeth with abscess.

Q. Well, the incision and drainage procedure is done actually on the -- not on the tooth itself, it's on the issue; is that correct?

A. That is correct.

Q. And if you have an abscess in a baby tooth, you could do an incision-and-drainage procedure on that tooth; is that correct?

A. I don't believe that's protocol.

Q. If you did an incision-and-drainage procedure, that would mechanically allow all the pus, all the purulent material to drain from that area; is that correct?

A. I wouldn't know. I've never done incision and drainage on a baby tooth.

Q. Okay. Now, would you agree with me that when Jeremy first came to Small Smiles on May 23, 2006, that he had a resolving infection?

A. Could you kindly repeat the question?

Q. Sure. Would you agree when Jeremy was first seen at Small Smiles, May 23rd, 2006, he had a resolving infection?

A. I don't know that.

Q. Well, he was -- it was noted in -- by two prior treating healthcare providers he had abscesses; is that correct?

A. Yes.
Q. Okay. It was noted that he had carious exposure by one of the dentists?
A. Yes.
Q. And it was noted he was placed on antibiotics?
A. Yes.
Q. And that was by his pediatrician?
A. Yes.
Q. By the way, what was the dosage or the instructions with regard to the taking of those antibiotics?
A. I don't know.
Q. Do you know if it was adequate or not?
A. I don't know what the dosage was.
Q. Okay. Would you agree with me that when Jeremy was seen on May 23rd, he had a resolving infection, he had resolving infection in teeth B and I?
A. I can't commit to that because I don't see any reflection in the records, Small Smiles's record that that's so.
Q. Well, how about the totality of everything you were asked today, when you didn't tell the jury when you first were on the witness stand that you reviewed Dr. Patel's or Dr. Taylor's record since Mr. First brought that to everyone's attention, you are looking

at Dr. Patel and Small Smiles and Dr. Taylor's records, would you agree when Jeremy was first seen he had resolving infections on his upper teeth B, and I?

MR. FRANKEL: That's been asked and answered. I object.

THE COURT: Overruled.

THE WITNESS: Could you repeat it, please.

MR. McPHILLIAMY: Your Honor, can I have it read back, please.

(Pending Question read by the Reporter.)

A. He may have.

Q. Okay. And if those infections were not treated when he went to Small Smiles when the antibiotics ran out, what would happen to those infections?

A. If he had infections?

Q. He had resolving -- he had abscesses a week before he goes to Small Smiles, he's placed on antibiotics, if he didn't receive any treatment at Small Smiles the first day, he would have finished the antibiotics at some point; is that correct?

A. You can always give another antibiotic if a child isn't ready. If a child is not ready for the treatment and they can't comply, it's not an urgent issue, you can prescribe another course of antibiotic.

Q. Didn't you tell us before that a child with an

infection would be an indication as emergent treatment, did you tell us that before?

A. If they came in with a fulminating emergency situation and it had to be taken care of and it was a serious condition. His condition was not serious.

Q. Well, was it going to get better by itself?

A. No, of course not.

Q. It was going to get worse, right? Withdrawn. The infections would come back over time, wouldn't they?

A. They would eventually come back.

Q. Okay.

A. But there was a different alternative.

Q. You're telling us now it is better to keep a kid on antibiotics for a prolonged period of time than actually treat the source of the infections which you yourself said were the teeth; is that correct?

A. It's not just the teeth. It's the child attached to the teeth. It's not about the teeth. It's about the boy.

Q. Okay. You told us before that if a tooth has an abscess they always have to be extracted; is that correct?

A. Yes.

Q. Now, with regard to the decay that was evident

on the x-rays, when Jeremy first went to Small Smiles, is that a child who -- are those findings consistent with a child who brushes his teeth regularly?

A. I wouldn't know. I see children with caries and they brush well, and I see children that don't brush and don't get caries. You can even see it in family patterns as well.

Q. Doctor, you're familiar with the AAPD guidelines; is that correct?

A. Yes.

Q. And you would agree that the AAPD guidelines are not considered the standard of care; would you agree with me on that?

A. Are not considered the standard of care?

Q. Are not considered the standard of care?

A. Well, it's what we abide by.

Q. Okay. They're not -- not considered rules that you have to follow; is that a fair statement?

A. Absolutely. They are guidelines.

Q. Right. They are only guidelines?

A. Yes.

Q. And would you agree that one of the goals of the guidelines is to allow for the practitioners to utilize their clinical judgment?

A. Within reasonable constraint of the guidelines,

yes.

Q. Okay. And in 2005 were the guidelines changed?

A. Uhm, I'm not sure.

Q. Mr. First asked you if you performed sedation in your office, and you said no; is that correct?

A. Yes, it is.

Q. And you do not perform general anesthesia in your office; is that correct?

A. I don't think one can in New York State. And no, I don't.

Q. And if they -- as an alternative to protective immobilization if someone wanted to receive sedation or general anesthesia, they would have to go to some type of hospital setting for that?

A. Uhm, there are a couple of practitioners in Rochester that do offer sedation for children in their office. If not, they are referred for general anesthesia at either two hospitals in Rochester.

Q. Okay. Rochester, how far is that from here, Syracuse?

A. Miles?

Q. Miles, time, you tell us?

A. It's a little over an hour.

Q. Okay. And that's the way to the nearest dental school from Syracuse; is that correct?

A. It's actually not a dental school.
Q. Eastman is not a dental school?
A. No.
Q. They're a pediatric dental residency program there?
A. It's all postop work. No dental school.
Q. No undergraduate program there?
A. There is no dental school there.
Q. So if someone wanted to go to a pediatric dental residency program to be treated, the nearest one from here is Rochester; is that correct?
A. Yes, that's correct.
Q. Okay. And do you know where the nearest pediatric dentist is from here that accepted Medicaid in 2006?
A. I'm not from this area.
Q. You don't know, do you?
A. I don't know.
Q. Would you agree that only approximately one in eight dentists -- pediatric dentists in the State of New York accept Medicaid for their pediatric patients?
A. I'm not familiar with the statistics.
Q. And with regard to physical injuries, you told us before that the patient -- the child can have markings or bruising's; is that correct?

A. That could happen, yes.
Q. Could happen. And if the papoose is used -- I'm sorry. If the protective immobilization is used properly, that's going to reduce the risk to that; is that correct?
A. It really depends on the actions of the child. If they're pulling against it, that's really what causes the bruising and marks.
Q. The papoose is actually soft, isn't it?
A. Yes, it is. It's cloth.
Q. All right. Doesn't have any sharp edges?
A. No.
Q. Kind of like a swaddling for a child?
A. I'm not quite sure I'd call it a swaddling.
Q. Now, did you review the records from Rome dental?
A. I reviewed some of them.
Q. Some of them?
A. Yes.
Q. Uhm, let's see. Doctor, handing you Plaintiff's 736.
A. Thank you.
Q. Now, would you agree that if a child has a -- some type of bad episode, some bad event in a dentist's office that that may carryover to later

dental visits?

A. Oh, sure, yes.

Q. Okay. If a child is traumatized, you'd expect to see that all throughout their dental treatment; is that correct?

A. No. The goal would be to extinguish that.

Q. Okay. Well, based on your review of this Small Smiles records, Jeremy was -- they used protective immobilization on the first and third visit, is that your understanding?

A. Twice on the first visit and once on the third visit.

Q. And he was seen over a period of two years at Small Smiles?

A. They did not use it after that third visit.

Q. Okay. Well, was he seen for two years at Small Smiles?

A. Oh, yes. I'm sorry.

Q. He was seen a total of ten occasions from start to finish; is that correct?

A. Yes.

Q. And after the third occasion there was no need to use any type of protective immobilization on him; is that correct?

A. According to his record, yes.

Q. He was behaving better for the treatment based on the records?

A. I'm not sure if you look at the behavior grading. Many of them still stay at one.

Q. Okay. So let's go to the next dentist that he saw, Dr. Bellini?

A. This record?

Q. Yes. Flip through his records. Look at the visits and tell us is there any indication that Dr. Bellini had any problems with Jeremy getting in the chair, having tantrums, opening his mouth, not cooperating at all?

A. He's a lot older so he's --

Q. Is there any indication, Doctor, yes or no?

A. I'm sorry. No.

Q. Okay.

A. No documentation.

Q. Thank you.

A. You're welcome.

Q. I believe you said if it's not in the record, it didn't happen. Was that your comment earlier, if it's not in the record, it didn't happen?

A. Yes. That is my comment.

Q. Now, would you agree that parents exert a significant influence on their child's behavior?

A. Yes.
Q. And would you agree that an unknown or fearful patient -- parent, sorry, can affect the child's behavior negatively?
A. I'm sorry, I don't understand the question.
Q. Okay. Would you agree that the presence of a parent has a negative affect on the communications between the child and the dentist?
A. No.
Q. Okay. Doctor, on your website you talk about the child's first visit there; is that correct?
A. Yes.
Q. And on your website don't you state that any child over three years of age you want them to go in there by themselves, to be treated by themselves, is that what you state?
A. No, I don't. I say the parents are more than welcome in the treatment area as long as the children are good helpers, then it's a conversation that I have with the children and the parents.
Q. Doctor, would you agree that on your website it states, if your child is over the age of three, we ask that you allow him to accompany our staff through the dental visit. Did you -- is that what you put on your website?

A. Well, accompany.
Q. Yes or no, Doctor?
MR. FRANKEL: Excuse me, Your Honor. She's trying to answer the question and he anticipated that he wasn't going to like it so he argued and -- objection.
THE COURT: Okay.
MR. FRANKEL: Badgering the witness.
THE COURT: He's not badgering. He's asking a question. Can you answer that with a yes or no?
THE WITNESS: That -- I'm sorry, I don't even know what the question is right now.
BY MR. McPHILLIAMY: (Cont.)
Q. Is that on your website?
A. It's on the website, then it's on the website.
MR. McPHILLIAMY: Thank you.
THE COURT: Can I see counsellors for a minute.
(A discussion off the record at the Bench, all counsel present.)
Q. Doctor, would you agree that radiographic evaluation of occlusal surfaces have found to have been of minimal diagnostic value in detecting enamel caries and superficial dental caries?

A. It's a misnomer, enamel caries.
Q. Would you agree with that statement, Doctor?
A. Because they -- the caries is not in the dentin, yes.
Q. Okay. Would you agree that the enamel does not have any nerve endings in it?
A. Yes.
Q. So if a dentist is going to drill and confine drilling solely to the enamel, the patient should not feel that; is that correct?
A. There would be no reason just to drill in the enamel.
Q. Yes or no, Doctor, would you agree with my statements that if a dentist is going to confine their drilling to just the enamel, that the patient should not feel it because there is no nerve endings in the enamel?
A. They may feel the heat generated from and they may feel the cold, so yes they may feel it.
Q. Heat generated, Doctor, the high speed drills in your office don't they have water coming from them?
A. Yes.
Q. Doesn't that water cool the drill bit?
A. It can feel cold, yes, it -- they could feel.
Q. And, Doctor, would you agree that a properly

used spoon excavator which one decay -- what's the consistency of decay in a tooth?

A. Leathery.

Q. Leathery, like thick oatmeal?

A. More like tough leather.

Q. And it can be removed with a spoon excavator?

A. Yes.

Q. In fact, where there is decay, there are no nerve endings right there, because the tissue is dead, correct?

A. Correct.

Q. As you're removing the dead tissue with no nerve endings the patient should not feel that, correct?

A. Hypothetically.

Q. Doctor, would you agree that there are risks associated with the use of local anesthesia on when treating patients with -- would you agree there are risks of utilizing local anesthesia when a dentist is treating lower teeth in a patient?

A. No.

Q. No risks at all?

A. To bite themselves postoperatively.

Q. How about the dentist coming in contact with one, the patient has to be perfectly still for the

injection, correct?

A. Yes.

Q. Injection to the lower jaw is a more -- a more involved injection than the top teeth; is that correct?

A. I think they both require equal skill.

Q. Okay. They require a patient to be staying perfectly still; is that correct?

A. Still.

Q. Okay. Would a lower injection you have the risk of injuring the nerve that you're trying to anesthetize, correct?

A. If you're -- if you know what you're doing, no.

Q. Doctor, is it a risk of giving a lower -- an injection to a lower tooth a risk of nerve injury, is that a risk?

A. I would -- it may be, but it's not something that I've known of.

Q. Okay. And at that nerve is called the inferior alveolar nerve, correct?

A. Yes.

Q. If you injure the inferior alveolar nerve, it affects the sensation of everything forward in the jaw; is that correct?

A. Yes.

Q. And that means that if the injury is permanent, you're going to have a numb lip and a numb chin for the rest of your life, is that correct, if you injure the inferior alveolar nerve?

A. Yes, and that can happen with extraction of wisdom tooth.

Q. That's adult patients. Kids don't have wisdom teeth?

A. I'm sorry, I thought you were talking in general. I've never read nor heard of an article from a children -- from a child having paraesthesia. That permanent nerve damage I'm not aware of that.

Q. Okay. After you give a patient -- a child an injection to numb the bottom teeth, their lip and chin feel fat; is that correct?

A. Yes.

Q. And that sensation lasts for two or three hours?

A. About two hours, yes.

Q. Okay. During that time frame the child can chew up their lip and not even know it?

A. If appropriate directions are given to the parent and the child postoperatively, and you distribute cotton rolls for the child to bite on, it rarely happens.

Q. Okay. You are not a psychiatrist; is that correct, Doctor?
A. No, I'm not.
Q. You're not a psychologist?
A. No, I'm not.
Q. And you're not a specialist in the area of mental healthcare?
A. No, I'm not.
Q. You never personally examined Jeremy, correct?
A. I did not.
Q. Never sat and never put him in a dental chair, never spoke to him; is that correct?
A. That is correct.

MR. McPHILLIAMY: I have nothing further, Judge.

THE COURT: Thank you. Mr. Stevens.

CROSS EXAMINATION
BY MR. STEVENS:
Q. Doctor, you have some patients from Rome, New York?
A. I'm sorry.
Q. Where does Kelly Varano live?
A. I don't know what her address is.
Q. Okay. You told the jury a bit about patients

and you mentioned how patients are treated when they live in an area with unfluoridated water. So did Jeremy grow up in an area with unfluoridated water?

A. I'm not sure.

Q. Isn't it true that Rome, New York has fluoridated water in their municipal water system?

A. I'm not sure of that.

Q. Isn't it true you read Jeremy's record from Small Smiles and from other providers and you know very well that they live in Rome, New York?

A. Yes, but I'm not from this area so I don't know what the fluoridation status is.

Q. You told us -- the jury that the behavior grades continue to be bad even after the third visit. The last papoosing you said they remained at a number one. Do you remember saying that a few minutes ago?

A. One and two, then I think one visit did have a three.

Q. Isn't it true that there's not a single visit after the third visit where his Frankl scale is a one?

A. I'd have to look.

Q. Take my word for it. Okay?

A. Okay.

Q. The -- forgive me for asking you a very few questions because my colleague has really covered you

thoroughly. But it seems to me, and tell me if I'm wrong, that this idea it didn't happen if it's not in the chart is the reason why on the direct testimony you've denied that Jeremy had problems when he came to Small Smiles, and am I correctly stating your testimony?

A. As far as the accuracy of the notice in the Small Smiles record.

Q. Let me ask you this, did you tell the jury that it's important to read the chart together, one page with another in order to get a good understanding of what is going on?

A. That's correct.

Q. And you told the jury, for instance, that the odontogram is essentially meaningless to you because it's not dated. Do you remember saying that?

A. Yes, I do.

Q. Okay.

MR. STEVENS: Could we see number page 21, please. Would you just blowup the odontogram. Okay.

Q. The -- let's just use teeth E and F, the two front teeth. The ones in your affidavit you said were -- had decay, although you said opposite under oath this morning?

A. Those two teeth.
Q. Okay.
A. The reason for that is I had the opportunity to look at the originals.
Q. Okay. I'm correct, though, right, you said they were decayed in your affidavit?
A. I did. You're correct.
Q. This morning you said they weren't?
A. You're correct.
Q. Now, on the odontogram, did E and F have markings on them to show exactly where the decay was seen by the examining dentist, true?
A. Yes.
Q. Shows the facial and the mesial portion of each of those two teeth, true?
A. Yes.
Q. And you told the jury that that has less meaning because you don't know when it was written?
A. That's correct.
MR. STEVENS: And may I have number 23, please. The same date, May 23rd, 2006, blowup the left hand section.
Q. Dr. Bonds makes a treatment plan and with respect to E and F, now he writes out in letters, in English letters, that as to the mesial and facial

surface M and F have decay, and as to tooth F, the same thing. True?

A. That is correct. That's what he wrote out.

Q. You know the date he saw that has to be May 23rd of 2006?

A. There have been subsequent people writing over that chart that was my --

Q. As to E and F, am I correct?

A. That looks like that was there. It matches.

Q. And it also shows you not only where the decay exists, but the exact date of that finding, true?

A. I can't say that for certain.

Q. Well, the date of this -- withdrawn. Looking at the operative report of --

MR. STEVENS: Could I have number 35, please.

Q. Came a time on the next visit when Dr. Aman did work on those decayed front teeth, true?

A. This is the operative report, yes.

Q. And Dr. Aman did some work on those decayed front teeth, true?

A. Yes, those are E and F.

Q. Okay. As to tooth E, Dr. Aman identified tooth E and tooth F, and he identified a diagnostic code carious pulp exposure to say exactly what he found

when he removed the decay, true?

A. It's a diagnosis, not a finding.

Q. Isn't it true that you can only make that diagnosis after removing the decay and seeing how close or how close to the pulp or into the pulp that decay exists --

A. That is true.

Q. -- true? And by making that diagnostic code carious pulp exposure, by reading the chart together we know what Dr. Aman found on that date, he found carious pulp exposure, fair statement?

A. That's what that record writes.

Q. And you have -- withdrawn. It's the habit of the dentists at Small Smiles to make pertinent positive findings on their records, are you familiar with that, the phrase pertinent positives?

A. I'm not familiar with that.

Q. Are you familiar with the phrase, if it's not written, it doesn't exist. That phrase you're familiar with, true?

A. Yes.

Q. Okay. When the dentists at Small Smiles have a discussion with the parent, you've criticized them, you say the discussion doesn't exist because they don't write it out in notes. Is that what you do in

your practice?

A. I do.

Q. Do you believe that there was no discussion with parents on any occasion in this case if it's not written out in longhand in the chart, is that your belief?

A. I believe that's protocol.

Q. I'm sorry, it's protocol to believe that no discussion occurred if it's not written in the chart; is that what you're saying?

A. I would say if it's not written, the conversation didn't happen.

Q. Well, you've read the testimony of the plaintiff in this case, and the plaintiff's, mother, Kelly Varano, so you know the conversations exist according to her, true?

A. Yes.

Q. But you were saying they don't exist by looking at the chart; is that true?

A. The only way that it can be connected is that it's confirmed by writing in the chart.

Q. And if it's the habit of these dentists to treat the child, to treat the decay, to treat the injury, but not to write in longhand about the discussions, just to write what they have done, what

the decision was, that's a fair way to practice, don't you agree?

A. I don't. It's not justifying the treatment that's been done.

Q. Isn't it a fact that the decay itself justifies saving the child from that decayed situation? I withdraw the question.

THE COURT: Would counsel approach.

(A discussion off the record at the Bench, all counsel present.)

THE COURT: Redirect?

MR. FRANKEL: Yes, Your Honor.

REDIRECT EXAMINATION

BY MR. FRANKEL:

Q. Dr. Slack, Mr. McPhilliamy questioned you about whether you in fact had said in an earlier time -- today you said from looking at the x-rays of D, E, F and G, there was no decay. And at an earlier time you signed an affidavit saying there was decay?

A. Yes.

Q. Okay. Let me show you what is actually your affidavit dated, June 19th, 2013. Would you read for the jury, if you don't mind, this sentence that he's talking about that starts with "the x-rays"?

A. The x-rays show minimal decay, none of which reached the pulp chamber. Dr. Aman made no clinical notes of any observations he made of Jeremy's teeth and his diagnosis of carious pulp exposure on each of the four teeth is flatly contradicted by the radiographic evidence he obtained.

Q. All right. So what you said in your affidavit was minimal decay, but Mr. McPhilliamy left off the "minimal" when he asked you those questions; is that true?

A. That's true.

Q. And did you say that you've had a chance to look at the original x-rays since?

A. Yes, I have.

Q. And is that the reason that instead of minimal decay that didn't justify any of the treatment, you said you didn't see any decay?

A. Yes.

Q. Uhm, Mr. McPhilliamy asked you some questions about your website and read something and then wouldn't let you explain. I'm going to ask you to explain to the ladies and gentlemen of the jury the statement in your website dealing with children accompanying your staff.

A. Right. Uhm, our office is set up like an open

bay. We have no walls. So the goal is to really have the child have the experience themselves. The first visit is always with the parent, and the child doing an interview in the clinic area, and then the staff may accompany the child at another visit.

Q. Do you ever deny your parents the right to be with their children if that's what they want?

A. No.

Q. Okay.

MR. FRANKEL: Uhm, do you have the odontogram?

Q. This is the odontogram we've been talking about, and I'm going to ask you in particular to look at tooth D. All right. This is suppose to be the holy grail for where the decay is.

MR. McPHILLIAMY: Objection.

Q. The tooth D was one of the four teeth that had the pulps and crowns on August 31st, right?

A. Yes.

Q. And in order to have a -- to need a pulpotomy, what did you say the level of decay needed to be?

A. To the pulp.

Q. To the pulp. Did Dr. Bonds on the initial visit, May 23rd, did he make a recommendation on what in his treatment plan did he say what the treatment

should be on D?

A. Uhm, he has no surfaces for the cavity and just New Smile as the description.

Q. And do you understand New Smile means a crown, it's a company that makes crowns?

A. It is a company that makes crowns.

Q. And Dr. Aman took that and went from a crown to pulps and crowns on August 31st, right?

A. Yes.

Q. In order to even need a crown how many surfaces would you need to find decay on?

A. Typically three.

Q. All right. So we're looking at D. And this is -- this was a supposedly the basis upon which these decisions are made. Do you see any surface that's filled out in red that reflects what surface Dr. Bonds or Dr. Aman thought were the basis for the treatment plan?

A. I don't.

Q. Okay. So you have red lines coming down, but none of the actual -- none of the five surfaces are actually filled in, right?

A. That's correct.

Q. That's consistent with the treatment plan itself, that's blank when it comes to surfaces?

A. That's correct.

Q. So is there anything on the odontogram, the chart or any other place that justifies that treatment on D?

A. No.

Q. So is that what you're saying when you say you can't tell because there's -- it's not dated? This same odontogram they're adding information different visits, you don't know when it was filled out; is that right?

A. Yes, that's what I was trying to say.

Q. And can we --

MR. FRANKEL: The picture show the top.

Q. Up here, Doctor, is anything filled out when Jeremy comes for his first visit?

MR. STEVENS: Objection. Beyond the scope.

THE COURT: Sustained. You have just a couple more minutes.

MR. FRANKEL: That's all I have. Thank you.

THE COURT: Thank you. Recross?

MR. FIRST: I have no questions.

THE COURT: Okay.

RECROSS-EXAMINATION

BY MR. McPHILLIAMY:

Q. Doctor, I will show you what is marked Old FORBA 147-A. Tell us what that is?

A. It's a page from my website.

Q. That page is entitled, "Your Child's First Visit?"

A. Yes.

Q. Read to the jury on there -- it says that for the first visit you will be back there with your child for the entirety of the visit. Read where it says, Doctor --

A. It's described to the parents when they call.

Q. Where does it say that?

A. I don't know.

Q. Why don't you take a minute to read through it.

A. It does say it.

Q. Where does it say on -- read where it says that for the first visit the parents are going to be back there for the entirety of the visit, read that portion?

A. You're pulling it out of context the whole paragraph.

Q. I'm reiterating what you told this jury not less than three minutes ago. It's not on there, is

it, Doctor?

A. It is. It states, parent may accompany their children initially for examination where we will have the opportunity to review your child's history.

Q. Says, parents may not. I always have the parents in there. You're leaving it up to the parents; is that correct?

A. I always leave it up to the parents.

Q. But they're not always in there for the first visit, are they, Doctor, yes or no?

A. Sometimes they chose not to be.

Q. So the parents are not always there for the first visit; is that correct?

A. They are there for always going over the medical examination, then they chose to leave if they don't want to be there.

Q. And the medical examination is reviewing the medical history form; is that correct?

A. That's absolutely correct.

MR. McPHILLIAMY: Thank you. Nothing further.

THE COURT: Thank you.

RECROSS-EXAMINATION

BY MR. STEVENS:

MR. STEVENS: Quickly, number 35, please. And would you blowup the middle part where it says tooth D.

Q. Doctor, a moment ago the attorney, Mr. Frankel, asked you about tooth D, and he showed you the odontogram. Do you recall that testimony?

A. Yes.

Q. And he had you identify the fact that there were three lines through it, but individual surfaces on that odontogram were not marked and you stated that, do you recall?

A. Yes.

Q. Isn't it a fact, Doctor -- by the way, do you know what the three red lines mean?

A. I don't.

Q. Don't you think that would be important to know?

A. I don't know what they mean.

Q. Don't you think that would be important to know?

A. Some people put red lines through when they are extracting teeth. Every dentist has a different way of charting. I would assume it's for the crown. It's

an indication for the crown.

Q. You may have left intentionally or otherwise left the jury with the impression there was no diagnosis made for tooth D. Isn't it the truth that the question of whether decay goes into the pulp or in fact has carious pulp exposure is one that can't be made until you follow the decay, until you treat the tooth, true?

A. Sure. We spoke of that earlier.

Q. And isn't it true when Dr. Aman treated this tooth, tooth D, that he found there to be carious pulp exposure and he wrote that diagnosis on the chart, that's true, isn't it?

A. He did write that, yes.

MR. STEVENS: Thank you.

THE COURT: Okay. Thank you. All right. We're excused. Have a good evening. Don't talk about the case. See everybody tomorrow morning at 9:00 a.m..

I do want to see counsellors upstairs in Chambers just to review a couple of things for tomorrow, and the rest of the courtroom does need to get cleaned out.

(Proceedings in recess at 4:16 p.m..)

C E R T I F I C A T I O N

It is hereby certified that I am an Official Court Reporter in the Fifth Judicial District, State of New York; that I attended the foregoing proceedings as acting Senior Court Reporter, made stenotype notes thereof; and that the same is a true, accurate and complete transcript of the proceedings had therein to the best of my ability and knowledge.

Anne M. Messineo, RPR

DATED: October 1, 2013.

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