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 4, 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

I N D E X O F E X H I B I T S

Number	Description	Rec'd
1135-A	Taylor/Records	1982
782	Biography	
ABK-1268	Copy/Photo	
ABK-1269	Copy/Photo	
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(Morning Session - October 3, 2013.)

THE COURT: Morning. How are you, Mr. Hulslander?

MR. HULSLANDER: I'm the same.

THE COURT: The same?

MR. HULSLANDER: Stone is still there.

THE COURT: Okay.

MR. HULSLANDER: But I'm fighting it hard.

THE COURT: No surprise. Okay. Are we ready for the jury to come in?

MR. FIRST: Yes.

(Jury seated in the jury box at 9:36 a.m..)

THE COURT: Morning. You may be seated.

BY MR. FIRST: (Cont.)

Q. Good morning, Dr. Cisaeros.

A. Morning.

Q. Doctor, there's been a lot of testimony in this case about protective stabilization and the papoose. Are you familiar with that?

A. Yes, I am.

Q. And what is the purpose of protective stabilization?

A. Well --

MR. FRANKEL: Excuse me, Your Honor --

A. -- exactly that --

MR. FRANKEL: -- I object until he lays a foundation. The fact he is familiar with it I don't think qualifies him as an expert on it. Lack of foundation.

MR. HULSLANDER: Speaking objection. Sorry, Judge.

THE COURT: Uhm, what was the question? What's the question again.

(Pending Question read by the Reporter.)

THE COURT: Rephrase the question.

BY MR. FIRST: (Cont.)

Q. Doctor, you said you are familiar with protective stabilization and the papoose. Can you describe to the jury how you are familiar with them?

A. How am I familiar?

Q. Yes.

A. As a pediatric dentist, it's something that you or a dentist in general -- it is something you use to help manage and protect a child during dental procedures when it may be necessary, you know, to use because of behavior.

Q. Have you been personally involved in the use of it?

A. Yup. Yes, I have. All throughout my career.

Q. I'm sorry?

A. All throughout my career.

Q. Okay. And, Doctor, I think you kind of said what the purpose of it is. Let me ask you this, there's been testimony about risks relative to protective stabilization. Do you have an opinion that you can state to a reasonable degree of dental certainty as to the risk, if any, related to the use of the papoose or protective stabilization?

A. Yes, I can.

Q. And what is your opinion?

A. My opinion is it's an extremely safe procedure and no known risk. There is none from a standpoint of the standard we use today. It is evidence-based research, you know, and in the literature there's really nothing that demonstrates or documents any known risk.

Q. Now, Doctor, there's been a consent form which has been identified in this case that was used with respect to Jeremy and Miss Varano that says that -- among other things, that there are no known risks to the immobilization procedure. Do you have an opinion you can state to a reasonable degree of medical certainty or dental certainty as to whether that language is consistent with good and accepted dental practice?

A. Yes, I feel it is. And, in fact, at our institutions, both NYU and St. Barnabus, we don't even use a form like that. So it is commendable that they even do something like that.

Q. And, Doctor, there's been some talk in this case about the AAPD guidelines. What are guidelines?

A. Well, my viewpoint of guidelines, you know, the academy put this material together just like those things I showed you yesterday to help guide, help suggest, recommend to people, and also to kind of position themselves in a way as an authority, you know, to be in essence a child advocate, and -- but basically I look at it as they're suggestions. There are things in there sort of like a reference book, something that you can consider using or not using.

Q. Are they standards of care the guidelines?

A. Are they standards of care, not at all, no.

Q. Now, Doctor, there's also been testimony in this case about the role of x-rays in diagnosing and treating dental patients. Can you describe to the jury what the role of x-rays is in treating dental patients?

A. Well, it's supplemental to -- for instance, the primary -- your primary responsibility is to examine the patient. Take a good history why they're there.

Find out the chief complaint. Talk about the historical perspective of whatever they might be experiencing and then do an examination. Okay. And upon that, make a decision and x-rays in the same way like drugs are prescribed, you know, as deemed necessary by the doctor to supplement, you know, or complement whatever there, you know, they see clinically. And often times, at least with children, they might use it for baseline data, you know, baseline, where are they now.

Q. Now, Doctor, are x-rays definitive in diagnosing?

A. No, you would never utilize an x-ray alone to make a -- to make any kind of definitive diagnosis. They have -- amongst themselves they do not do that.

Q. Now, Doctor, you indicated earlier that you had reviewed the case and the records of Jeremy Bohn; is that correct?

A. Yes.

Q. All right. I want to turn you now to May 23rd, 2006, the first time Jeremy went to Small Smiles. Let me first ask you generally, do you have an opinion you can state to a reasonable degree of dental certainty as to whether the care and treatment he received on that date, May 23rd, 2006, was consistent with good

and accepted dental practice?

A. Yes, I do.

Q. And what is your opinion?

A. Uhm, the -- how -- the way the child was treated, how he was managed was perfectly acceptable and reasonable for...

Q. Doctor, did Jeremy come with a history --

A. Oh, yes.

Q. -- to Small Smiles?

A. Yes.

Q. What is the significance of that history specifically?

A. As I talked about, it's -- in this instance, it's -- and many other instances, in all instances, you know, that's important. And in this instance, you have a situation where a pediatrician recognized it. And for it to be recognized, not to be spurt, the pediatrician for them to see it, you know, without the dental expertise is got to be pretty demonstrable, very long. Then he was referred out, and also prescribed so these are important things.

Q. What did she recognize?

A. An abscess, a facial swelling and an abscess. And recognized, too, possibly --

Q. Go on. I interrupted you.

A. And went on to prescribe penicillin-VK, which is the standard for dental infections like that which is pretty good. I'm very surprised that they even noticed that, had to do that, then referred to a general dentist so...

Q. Okay. What is the significance, if any, of the findings of the general dentist?

A. I'm sorry.

Q. What is the significance, if any, of the findings of the general dentist, Dr. Patel?

A. Well, he observed similar condition. And on top of that, he also had difficulty managing little Jeremy at the time, dealing with it, so went further and was referred to Small Smiles.

Q. Now, when Jeremy went to Small Smiles, was part of the history that came with Jeremy what Miss Varano filled out in the --

A. Yup.

Q. -- chart? And what is the significance of that history?

A. Well, the significance is when you review the history, the forms, the health questionnaire and why they're there, things like that, it's documented there, it was pretty impressive that, you know, Miss Varano actually knew the exact teeth in question.

Obviously the doctor had given her the details.

Q. Now, Doctor, there were x-rays taken on that day of teeth B and I, correct?

A. Yes.

MR. FIRST: 601, please.

Q. Doctor, do you still have that laser pointer there?

A. I don't have one. Can I get closer?

Q. Sure. Let me ask a question before you begin. Doctor, these x-rays are -- as depicted on the screen are the x-rays that were taken on May 23rd, 2006. Can you describe the significant findings that you see in these x-rays based on your review of them.

A. Okay. This one is not necessarily all that ideal. It has some problems. You're not seeing all of the tooth structure, but you can see the tooth in question here. This is the one, I is it, where the swelling was noted on the left side of the face, and you can see here that the large cavitation in the radiographic terminology, a large radiolucent. Lucent means it just is that, the x-rays penetrate deep and is actually darker. Lucent generally you think about is light, but it is actually in reverse in this area and you can see how it looks. If you look at this tooth here and this tooth here, the anatomy of these

teeth are very similar in cross-section, except smaller. Okay. So I get a sense as to how impacted that tooth is with the decay. Because, you know, let's see how it should normally look. See it should be smaller. Now, on this side, okay, remember this is the second primary molar, these are the second primary molars. Similar in shape, smaller in size. You can see here --

Q. I'm sorry.

A. Let's see, turn on -- so it's essentially the same size, I'm sorry, same shape, smaller in size. And if you look on the x-ray you can see again the marked cavitation. You know, when I say cavitation, I hope that is understood it is cut into by the decay and radiolucency and because this is what it should be looking like. Should have a, you know, a nice --

THE COURT: You will have to --

THE WITNESS: I'm sorry.

Q. It's a little awkward. Point, then talk maybe.

A. Point and then talk. Okay. And then when you -- when you got -- I'm going to come up a little closer to the screen, and you can see from the standpoint of the pulpal condition or the periapical region, you can see enlarged -- an enlarged pulpous space here which insinuates or documents an

inflammatory response, inflammatory process, or if you will in this instance an abscess. Okay. So it would be consistent with that when there is fluid there is pushing out. Okay. And that's what we get, an enlarged space. Why am I forgetting the name of the space? But I'm sorry. I'm embarrassed.

Q. Now, Doctor, we've heard testimony from a Dr. Slack suggesting that on the left x-ray, which is tooth B, that that does not show any evidence of abscess. Do you agree or disagree with that?

A. I disagree with that.

Q. All right. And that's for the reasons you just stated?

A. In particular, yeah.

Q. Okay. Thank you, Doctor. Now, with regard to an abscess, what is the standard treatment by a dentist for an abscessed tooth?

A. Yeah, in a pediatric or a primary tooth it's a tooth that's pulled, extracted.

Q. Doctor, you said that Jeremy was treated with penicillin. Will penicillin cure the abscess?

A. No.

Q. Can you explain to the jury why it will not?

A. Well, it will have some temporary effect because it will -- penicillin will destroy the

bacteria, you know, the cause and of the -- of the purulence, the pus that is developing. But if you don't eliminate -- the term we use is the etiology. In other words, the cause of the problem, and in this case it's a dental disease, it's caries, then it will reoccur.

Q. Doctor, I didn't ask you this, but with respect to tooth I, you said that it doesn't show the apex or the top or the roots, it's not on ideal x-ray?

A. Correct.

Q. Based on what you see, is there anything inconsistent with that tooth and an abscess? In other words, differently, is that x-ray to the extent that what you see is that consistent with an abscess?

A. Well, let me put it -- can I answer?

Q. Sure. Go ahead.

A. I would wholly expect because of the extent you can see the pulp right about here, and if you look at it, you can see they're -- it's very, very close so I would expect that the pulp would be involved. But don't forget, that's why x-rays alone, you know, are not definitive. Okay. You have a clinical examination and you have the history as well. Okay.

Q. And, Doctor, do you have an opinion you can state to a reasonable degree of dental certainty as to

whether the extractions of teeth B and I were consistent with good and accepted practice?

A. Absolutely.

Q. Good and accepted practice?

A. Yes.

Q. On May 23rd, 2006?

A. I'm sorry. Yes, I do.

Q. Want me to ask it again?

A. No.

Q. What is your opinion?

A. My opinion is that's definitive. That's the appropriate care to provide, extraction.

Q. Now, Doctor, also on May 23rd, 2006, there's been testimony and the record indicates that protective stabilization was used because Jeremy was in the terms of the records "out of control?"

A. Right.

Q. My question to you is, do you have an opinion you can state to a reasonable degree of dental certainty as to whether or not the use of the papoose in hygiene to diagnose and do hygiene procedures was consistent with good and accepted dental practice?

A. Absolutely.

Q. Can you explain to the jury why that is? That's your opinion?

A. Well, first off, you know, you have a situation where the child has a history, and the risks involved in just letting it go any further, you know, could be very detrimental to the child. You have to, you know, have to get a good look and if it requires, you know, in order to get a good look, you know, to put them in a papoose, then you do it. It's for the safety of the child.

Q. And then, Doctor, there's been testimony and the records indicate that the papoose was used to do the treatment, the two extractions as well as local anesthesia was used on Jeremy on May 23rd to do the extractions. Do you have an opinion as to whether those procedures were in accordance with good and accepted dental practice?

A. Yes.

Q. And what's your opinion?

A. Uhm, I mean it's kind of an extension of what went on from in hygiene. I mean, what I had said before, you know, you have to do something to eliminate this from being a consistent problem. You can't give pen-VK. There are risks associated with that in perpetuity because it doesn't cure the problem, and you need to do something definitively because it is dangerous for the child. So if the

behavior, you know, if you need to do this, you do this without any hesitation.

Q. Now, Doctor, Jeremy returned to Small Smiles on August 31, 2006, and he was treated by Dr. Aman. First let me ask you a general question. Do you have an opinion you can state to a reasonable degree of dental certainty as to whether the treatment Jeremy received on August 31, 2006, was consistent with good and accepted dental practice?

A. Yes, I do.

Q. And what is your opinion, Doctor?

A. That it was an appropriate procedure. Those are appropriate procedures and management for him at that particular point in time.

Q. Okay. Doctor, let me ask you why don't we put --

MR. FIRST: Why don't we put up the x-ray that was taken on that day and that would be 602, please, Craig.

A. No, leave it down.

Q. You like it down?

A. This is the proper orientation.

Q. We will leave it down then.

A. Can't we center?

Q. Move it over.

A. Center on this? Can it be centered? This picture. The one here.

Q. Now, Doctor, I'd like you to assume that Dr. Aman reviewed the treatment plan, examined Jeremy, and felt that based on his clinical examination he thought that and the x-ray, of course, that he felt that crowns and possibly pulpotomies would be necessary. Do you have an opinion you can state to a reasonable degree of dental certainty as to whether that treatment plan and his findings were consistent with good and accepted dental practice?

A. Yes, I have an opinion.

Q. What is your opinion?

A. My opinion is it was -- I thought I answered that, but it was appropriate. Want me to explain?

Q. Yeah, sure.

A. Okay. You have to now put this into perspective. Again, we're looking at an x-ray. Forget about this for now because you're -- you come in to the next visit, you look at the chart, you know, before the patient shows up, you look at the treatment plan, you review the history, and so you have some idea of what may be expected, needs to be done. You then go ahead and you do an examination of the child. And based on the record a mesial, you know, some of

the lesions were mesial facial. Almost all of them were under these four teeth were facial. So as soon as you lift up the lip, you'll see these. And even the mesial which is between the teeth, towards the front of the tooth, okay, you'll see it clinically because these teeth as you can see here had spacing between them. One other reason you take x-rays, amongst many others, is to see in-between the teeth. Okay. But when you have spacing, you don't really need the x-rays for that. Do you understand what I'm saying? You can see it. Okay. So imagine if these were the four teeth. You had already a document of this when this is my smile, you know, it's right there, and you will see between the teeth. So then you take the x-ray then, you know, refer to.

Q. Before you go to the x-ray, I'd like you to define some of your terms. I think it is clear when you say facial what side are you talking about?

A. The front. These, this is the facial.

Q. That's what people see when they look at somebody?

A. This is the facial.

Q. When you say mesial, what are you talking about?

A. It's to the side of the teeth. The front side

of the teeth. Distal is another term. Backside of the tooth.

Q. Doctor, we had a demonstrative exhibit yesterday. If you don't mind stepping down, can you indicate with this demonstrative exhibit which is Old FORBA 1067 --

MR. FIRST: Take that down for one second.

Q. Come down. Could you demonstrate for the jury what you're talking about when you talk about mesial and facial?

A. Okay. This is the facial area. Mesial. This is the mesial of this tooth. This is the mesial of that tooth. This is a mesial of that tooth. The mesial of that tooth. You know, so it's the side towards the front. And a term for the back to the side, back being back of the mouth, the mouth, so to speak, is the distal.

Q. Now, you indicated yesterday that what appears on the demonstrative exhibit is decay that's brown?

A. Right.

Q. Could you address how, if at all, that shows up on an x-ray such as the one that was just up relative to Jeremy Bohn?

A. It may or may not show up on an x-ray. But it's going to affect the overall -- you know, there

are some overlying anatomy you have to deal with when you are going front to back, so it can at times be obscured by the pulp chamber itself. But it's not as if it's, you know, but more than likely you might -- should be able to see it. Especially this one which is probably very consistent to what was seen that day.

Q. Now, Doctor, if you can take your seat again. Now, Doctor, you were going to address this x-ray. This shows teeth what D, E, F and G, among others?

A. D, E, F and G.

Q. Can you describe to the jury what this shows to you, this x-ray that was taken on August 31, 2006?

A. Shows me a -- you want me to go through general or specific?

Q. Specific, what does that show?

A. Well, this is the -- first off, you count teeth. I mean you sort of look to see what are there. And here's a primary, this is C, or the primary canine. D, the primary maxillary lateral. E, central, right central. F, G, H, that's how it goes around from this side to this side. These are the permanent teeth developing, tooth buds. Called in this instance succedaneous. You see the laterals as well and what appears to be the canines from there. That's hard to say what it is. And so you look also

at the general bony area to see if there is any signs of -- of infection or abscesses and things like that. You may see here that widen PDL, I remembered, periodontal ligament space. On these two teeth in particular you see that. That's the space that exists and it's not often not very large sometimes. But it could mean that -- but you can -- can see here is a carious lesion here. One here. Here. It might even extend further here. Here. Here. Here. And I believe here as well. But you can see a discontinuity of the dentin and -- I'm sorry, gingiva, I'm sorry, the enamel and the dentin. Generally see darker to a white, very white to a little grayish, or lighter or darker white down to even a darker area which is the pulp, and you don't really see that as clearly here. In fact, you can see some radiolucencies there as well. So, you know, it's not -- it doesn't -- they don't look good. Then again you have already seen -- you already see the situation clinically.

Q. When you say clinical, you mean by looking at the patient?

A. Looking at the patient.

Q. Doctor, Dr. Slack testified in this courtroom that there was a clear enamel, that the enamel looked intact on these teeth. Do you have an opinion on

that?

A. Well, I mean it's not very -- you can see here there's a very thin -- a normally thin level of enamel here. Then there's a radiolucent area here. I mean it goes from very thin, that's abnormal. I mean then it gets a little darker, then you see it -- it's -- it goes light again, so that insinuates that there are undermining of the, you know, the enamel itself. Otherwise, the enamel would be more continuous or white. I mean one solid piece of white. Do you understand what I'm saying?

Q. Now, Doctor, with respect to these anterior teeth, is there a difference between the enamel and dentin and pulp on these four anterior front teeth than what you might find in molars in terms of likeness and the like?

A. Yeah. Every tooth varies from one to the other, that's general.

Q. How are they different from the molars?

A. Well, even the cavities are different. You, know, the way they respond. Smooth surface lesions versus posterior. The whole thing is different, you know, but the -- certainly played by the anatomy itself. As you go further down towards the area where a lot of the plaque -- remember the discussion I had

as to where the plaque, you know, kind of grows in the mouth. In that particular area of an incisor it's a rather thin, the enamel thickness. When you get further up, it's a little bit -- a little larger essentially on the incisor area or the cutting, you know, the top part of the tooth. But relative to the molars, in general, you know, they're thinner. The enamel surface because molars -- because of their -- they chew on food, do most of the work, and incisors cut through, they tend to be -- they don't need the protective that's ethological, it seems to be the case, the way they are designed.

Q. Now, is the pulp based on that nearer to the surface of the tooth than on some of the molars?

A. Well, you can see that, yes. That's normally the case.

Q. Now, Doctor, Dr. Aman performed crowns and pulpotomy, crowns and pulpotomy on these four teeth?

A. Correct.

Q. Do you have an opinion you can state to a reasonable degree of dental certainty as to whether that treatment of these teeth on August 31, 2006 was consistent with good and accepted dental practice?

A. Yes, I have an opinion.

Q. What is your opinion?

A. Opinion is that it was consistent with good and accepted dental practice.

Q. Why do you feel that way?

A. Well, based on, you know, the clinical record, the history, the examination. If you look at the chart, you can see he noted a CPE, which is a carious pulp exposure. What that essentially means is in the process of removing the carious, the disease, it went so deep that it went -- it was into the pulp. And by definition once you do that, you have to treat the pulp. Especially, unlike the other situation which was a dead tooth, infected tooth, and in this instance you have a lot of -- you'll have a lot of bleeding. It's a vital pulp so you do a pulpotomy. Then you have to put the stainless -- you know, have put a crown on for sure. Sorry.

Q. What is the purpose of doing crowns in this situation?

A. Well, once you do a pulpotomy, you really do need to utilize a crown whether it be a posterior tooth or an anterior tooth. That's just to preserve the tooth. Otherwise, if you put anything else in there like resin or, you know, plastic restorations, they do not provide the seal that you need, nor do you -- does it -- will it hold up to it, and then you have

a much higher risk of recurrence. I mean as you know, with individuals with high carious index, high risk, they have a tendency -- high degree tendency to recur so you don't want that to happen and have this continue. So the crown is really the ideal procedure to do something like that.

Q. Doctor, there's been testimony in this case about productivity and keeping track of a dentist's productivity. How do most dentists in this country work? How do they get paid?

MR. FRANKEL: I object to that. There is no foundation that he's an expert on that subject.

THE COURT: Okay. So foundation? Sustained.

Q. Well, you indicated in your testimony yesterday about what you do. You have a private practice?

A. Well, part of a group practice at St. Barnabus but it's a private practice, yes.

Q. Okay. My question to you is what role does productivity -- let me withdraw that. In your experience at that private practice, how is the private practice paid for its services?

A. In my case, I get a percentage. I get 50 percent --

Q. Okay. So --

A. -- of what I generate.

Q. Do you based on that experience keep track of your own productivity?

A. Yeah. I mean I think it's an important -- it's an important tool not only for your private practice, you know, we utilize it at NYU, in our training programs, in, you know, when I ran the department we did monthly productivity. You know, it's kind of how you kind of, you know, you have to keep the business running, even if it's a dental school, and plus there is something attached to that. Productive means that you're doing more procedures, taking care of more people, you know, and it's adds to the overall health, number one, but it also helps from -- I just went blank, sorry. Adds to the overall sense of, you know, it's good feedback, you know, to the doctors as well. But, yeah, this is what I was going to say. For residents, people in training, you know, it makes sure that they're learning and being exposed and being better trained. This is a clinical, you know, clinical field. And the more you do, the more you take care of, not only are you helping people in general, but you're -- you yourself are getting better because everybody is an individual. You learn more from all of your experiences so it's -- I don't like

using term like gold standard. I hate the term, really, generally speaking. But if there is such a thing, you know, productivity is a gold standard across the board with all kinds of institutions. It's an important tool to evaluate what you're doing, how you're doing it, you know, and I think it's a standard that even the government, you know, utilizes when they are talking about hospitals like at Bellevue, you know, in trying to get people to apply for this.

MR. FRANKEL: Your Honor, I object, nonresponsive.

THE COURT: Sustained.

Q. In your experience, is there an expectation by the various employers you identified that a dentist will work hard?

A. Sorry?

Q. Is there an expectation that a dentist will work hard in the various different types of situations you've described?

A. Absolutely, yeah.

Q. And if they don't, may there be consequences?

A. I think that's expected from -- you know, from all employees is to put out good effort. By the way, you know, as a -- remember I talked about me being a tenured faculty, you know, I can't be fired and stuff

like that, if I'm not -- if I don't do my job, I can be fired.

MR. FRANKEL: Excuse me --

Q. Now, Doctor, are you getting paid for the time that you have taken to testify --

A. Yes, I am.

Q. -- in this case?

A. Yes.

Q. And did you get paid for the time you took to review the records?

A. Yes, I did.

Q. Do you have an hourly rate that you charge?

A. $395.

MR. FIRST: Thank you, Doctor.

THE COURT: Okay.

MR. McPHILLIAMY: No questions.

MR. STEVENS: No questions.

THE COURT: No questions. Mr. Frankel?

MR. FRANKEL: Thank you, Your Honor.

THE COURT: We will go to 10:45 and take our morning recess.

CROSS-EXAMINATION

BY MR. FRANKEL:

Q. Dr. Cisaeros, my name is Richard Frankel. We have not met until today, have we, sir?

A. No.

Q. Uhm, you've been hired to be an expert witness by Mr. First and his clients; is that true?

A. Yes.

Q. Do you consider your role as an expert witness to be objective?

A. Yes.

Q. Not being an advocate or for one side or the other?

A. No.

Q. Call it the way you see it?

A. I call it the way I see it. Thank you.

Q. Okay. Did you in evaluating this case tell Mr. First that you wanted to see all the evidence?

A. Yes. I don't know if I really said that. I think it was just understood.

Q. Well, in order to give an unbiased opinion, you want to see everything that you could that would be relevant to expressing your opinion?

A. I didn't say it. I think it was implied.

Q. Certainly you would expect he would send you

what you need?

A. Yes.

Q. And do you feel that he did that as far as you know?

A. As far as I know.

Q. You had a chance to look at the dental chart which is in front of you which is Plaintiff's Exhibit 199?

A. Yes. I see it marked.

Q. You've looked at depositions you said, right?

A. Yes.

Q. Whose depositions did you read?

A. Dr. Muellers. The doctors, Dr. Bonds and Dr. Aman.

Q. Dr. Aman, did you read his deposition?

A. Yes.

Q. Anyone else?

A. The two parents and Jeremy's.

Q. All right.

A. Off the top of my head relative to this case, yeah, that's what remember.

Q. I think you said you read some trial testimony?

A. Yes, I have.

Q. Whose trial testimony did you read?

A. Dr. Bonds, Dr. Mueller, and Dr. Slack.

Q. All right. So before you walked in this morning and expressed these opinions, you had all that information before you, correct?

A. Yes, sir.

Q. Having reviewed all that information, did you find one thing wrong with the care that Jeremy Bohn received, a single thing?

A. Wrong? I'm not judgmental in the sense when I look at -- when I look at charts, I'm not -- I kind of look at it, the face value in understanding the context in which these things kind of received -- or represent, you know. There is no videotaping and all that stuff of what is going on. I take it at face value and I didn't see any.

Q. Not a single thing? You would give Dr. Bonds and Dr. Aman A's if they were your students; is that right?

A. They're not my students so I really...

Q. In evaluating their work whether they're students or just as an expert witness, you thought they did an excellent job, right?

A. I think they did an appropriate job.

Q. All right. By the way, you reviewed this case. How many hours did you spend reviewing this case?

A. I have no idea. I really couldn't tell you.

I'd say about 30 hours maybe.

Q. And have you reviewed any other cases involving Small Smiles?

MR. FIRST: I'm going to object. Object.

THE COURT: Overruled.

THE WITNESS: That means I have to answer? I mean what --

THE COURT: Yes.

THE WITNESS: Okay. I'm sorry. I know my dental stuff.

A. Yes, I have.

Q. How many?

A. I think about approximately ten or so.

Q. All right.

A. A lot of them I think were similar.

Q. Dr. Cisaeros, what is an orthodontist? What is the study of orthodontitry, is that the term?

A. It's -- there's a reasonably long definition technically, but essentially somebody who --

Q. Go ahead.

A. Essentially someone who you puts braces on children and adults.

Q. All right. You understand this case that we're talking about doesn't have anything to do with braces, right?

A. Yes.
Q. You know that?
A. Yes.
Q. All right. While you were at the Montefiore between 1984 and 2001, did you tell us yesterday that you spent maybe a day and a half a week doing pediatric dental patients?
A. Approximately, based on my private practice three days. Half my time was doing that.
Q. So one and a half days a week during that period?
A. Uh-huh.
Q. Since 2001, you've been in the Department of Orthodontics at NYU; is that true?
A. Correct.
Q. Not in the pediatric dentistry department?
A. Not in the pediatric dental department.
Q. You're a professor of orthodontics, not a professor of pediatric dentistry?
A. I'm a professor at NYU in the Department of Orthodontics.
Q. Yes, sir.
MR. FRANKEL: Would you mark this as the next exhibit, please.
(Plaintiff's Exhibit No. 782 marked for

identification.)

Q. Dr. Cisaeros, can I show you what's been marked as Exhibit 782. Ask you --

A. I know this one. Yes, I do.

Q. You're familiar with that, correct?

A. Sure.

Q. That's your biography on the university's website?

A. Right.

Q. Where you teach, right?

A. Yes.

Q. Is it accurate?

A. Without taking the time to read it, I haven't read it in awhile essentially.

Q. All right. Your research interests are in the area of orthodontics, not pediatric dentistry; right?

A. That's not quite true because --

Q. Okay. Let's see what the website says, your website describing you. Does it say right there in your -- in the first paragraph that your main research interest include the evaluation of facial growth and development using nuclear medical imaging techniques, the diagnosis and treatment of patients with obstructive sleep apnea, the impact of fixed orthodontic appliance design upon the efficiency of

tooth movement, and the study of various computer-imaging technologies. Did I read that right?

A. Oh, yeah.

Q. Nothing in here about research in the area of pediatric dentistry, correct?

A. All of this relates to children. Relates to pediatric dentistry. Relates to orthodontist.

Q. Relates to orthodontics?

A. That's true.

Q. That's true. Yes. And the publications you listed you told us yesterday that you've written forty or so articles?

A. Uh-huh.

Q. Those are listed on the back of Exhibit 782, right?

A. Yes.

Q. And of those publications, will you agree with me that about 38 out of the 40 deal with orthodontics; is that true?

A. I've never really counted it, but if you want me to count it.

Q. I don't want you to count it. Is it fair to say, Doctor, your interest, your study, your work over the last 30 years has focused on orthodontics?

A. Absolutely, categorically, no. Okay. Not

alone.

Q. Not true?

A. Not true. Not alone.

Q. I'm sorry, what did you say?

A. No. I mean I've -- everything I've done relates to both areas and my treatment of children.

Q. All right. Your treatment of children with -- that need braces or facial work done because of abnormalities?

A. Amongst other things, yes.

Q. In fact, your private practice that you're in now is strictly orthodontics, isn't it?

A. My private practice what I'm treating, and I think I made that clear earlier is I'm treating children, but I'm also working with the residents on their pediatric dentistry, on their patients as well.

Q. I've written on the board, "I'm primarily in this as an orthodontist to be honest." Do you remember yesterday you told us that you liked to talk?

A. Uh-huh.

THE COURT: Is that a yes?

THE WITNESS: Yes, I'm sorry.

Q. And yesterday when you were asked questions and you gave one of your long answers, did you testify that you're "primarily in this as an orthodontist to

be honest"?

A. I don't recall stating that, but maybe we have -- misheard. What's the context?

Q. Asking whether you were in this as an orthodontist. You -- those are your words, not mine.

A. Relative to what?

Q. What your experience is. Mr. --

A. I think that was misheard. I don't know if I said that.

Q. Okay.

A. If I did it was probably nerves.

Q. Nerves? Is that what you said?

A. Yeah.

Q. And was it nerves when you said "to be honest"?

A. Okay. I guess. I don't recall saying this.

Q. Well, do we need to pull out the transcript?

A. Whatever you want to do.

Q. Okay. Well, let me ask you something, when you've been testifying for the last few hours, yesterday a little bit and today, were you being honest?

A. Yes.

Q. Did you need to say to be honest? The real truth is that you are primarily in this as an orthodontist, not as a pediatric dentist?

A. I think I've stated, you know, I don't know where it comes from so, you know, if I said it, I misstated it. If or it was misheard, I don't know.

Q. Okay. You testified some yesterday about Early Childhood Caries, Dr. Cisaeros, do you remember that?

A. Yes.

Q. You said that it's the most common disease in the world, true?

A. Caries is.

Q. Caries. I thought you -- you didn't say that?

A. No. I qualified and said caries is the most common infection disease in the world.

Q. Okay. Is it true that any child under six who has a cavity treated or untreated qualifies as being a member of the Early Childhood Caries club?

A. In a sense, yes.

Q. That's the definition that you gave us yesterday, right?

A. Uh-huh. Yeah.

Q. From the American Academy of Pediatric Dentistry?

A. Right.

Q. That covers millions of children, right?

A. It covers a good deal of people, yup. Kids.

Q. Millions?

A. Yup. Oh, definitely.
Q. And you're not saying that any child that has Early Childhood Caries can be strapped down in a papoose board and be treated, are you?
A. No.
Q. You're not saying that of the millions of kids that have Early Childhood Caries, it's okay to give them unnecessary dental treatment?
A. Absolutely not.
Q. You're not saying that of the millions of kids who have Early Childhood Caries you can drill on them without local anesthesia?
A. You're qualifying it with everything -- no, that's true.
Q. All right. So Early Childhood Caries doesn't change the standard of care of what is expected of a good and reasonable dentist, does it?
A. Nope.
Q. You were talking this morning a little bit about the pediatrician who evaluated Jeremy a few days before he went to Small Smiles. Do you remember that?
A. Yes.
Q. And you applauded her for being able to assess and in her opinion as a pediatrician what she saw, right?

A. Well, I didn't -- I applauded her ability to recognize that and to prescribe penicillin, pen-VK, to treat the kids.

Q. That was from your review of the record, that was from some swelling on the side of his face, right?

A. Correct.

Q. Will you agree with me that that could be from several sources? Didn't mean that he had a tooth abscess just because he had swelling on the side of his face?

A. I recall there was a recognition on the part of Dr. Taylor that there was. The way the teeth looked as well.

Q. Can I ask you to answer my question. Could a swelling on the side of the face be caused by something other than a tooth abscess?

A. Absolutely, sure.

Q. For example, if you had a popcorn kernel caught in your gum that can cause swelling?

A. Not really to the degree that is recognized outside very --

Q. I'm sorry?

A. Not really.

Q. Not real?

A. Not really, no. That's excessive.

Q. What was the level --
A. That statement is excessive.
Q. What level of swelling did Jeremy have?
A. It was noticed externally.
Q. Beyond that can you be any more specific?
A. No, I couldn't.
Q. All right. Did you review all the -- Dr. Taylor's records regarding her evaluation of Jeremy's mouth?
A. I reviewed her -- I reviewed the records that I was given of Dr. Taylor's, Jeremy's visits to Dr. Taylor.

MR. FRANKEL: Your Honor, we previously had introduced Old FORBA 1135, which was pages from Dr. Taylor's records, and we have one other page we would like to add to that.

THE COURT: Okay.

MR. FRANKEL: I think we should may be call it 1135-A, does that work?

(Plaintiff's Exhibit No. 1135-A marked for identification.)

THE COURT: Before we put it up, is there any objection?

MR. FIRST: I don't know what it is.

MR. McPHILLIAMY: I haven't seen it, Your

Honor.

MR. FIRST: Can we approach on this?

THE COURT: Sure.

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

THE COURT: Exhibit 1135-A received over objection.

BY MR. FRANKEL: (Cont.)

Q. Dr. Cisaeros, just a question or two about this exhibit. Did the lawyers for Old FORBA, did they show you the record of the examination of Jeremy Bohn on March -- on February 6, 2006?

A. I can't say if I recall.

Q. Okay. So you -- this did not play any role in your opinion, Exhibit 1135-A, right?

A. I'm just reading this right now. This is dated in February? I don't recall, really.

Q. Thank you. You said that you read Dr. Bonds -- did you read his trial testimony?

A. Yes.

Q. Do you agree with Dr. Bonds that before you put a child in a papoose board you must exhaust all basic behavior management techniques?

A. Probably -- you know, you know, I can't say for sure. You know, in the context I must exhaust all. I

think you have to assess the patient's situation and make a good judgment. Do I agree with him per se, to some extent, but that's his call, not mine.

Q. We should go by his evaluation and standard and not yours?

A. In this particular instance?

Q. Yes.

A. I guess so.

Q. All right. And he says that a papoose board should be used as a last resort in evaluating -- in deciding behavior management, do you agree with that?

A. Do I agree with that?

Q. Yes, sir.

A. I think as far as he was concerned that's what he said, yes.

Q. I know that's what he said.

A. Yes.

Q. Are you coming into court and saying you've got a different standard?

A. Different from him?

Q. Yeah.

A. A different standard?

Q. Yes.

A. I don't know if it's a standard per se. This is a clinical choice that a doctor determines and

that's what his feeling was at that particular, you know, point in time.

Q. Let me ask it this way. If the ladies and gentlemen of the jury conclude that Dr. Bonds did not use other basic behavior management techniques and did not use the restraint as the last resort, would you agree that that is not good dental practice?

A. Well, I can't really get into, you know, what decisions how he thinks per se, but I think in this particular case, it was appropriate based on the records.

Q. Well, I'm glad you mention the records. I've got those right there for you, 199. Do you see anything in the records that reflects that Dr. Bonds or anyone else tried any basic behavior management techniques on Jeremy before they papoosed him three times?

A. No, but you wouldn't necessarily document something like that.

Q. Is there anything in the record that shows that they did?

A. That they tried other approaches?

Q. Yes. And they failed?

A. Not that I can see, no.

Q. All right. Do you agree with Dr. Bonds that

you must offer options for parents before you restrain their children such as nitrous, referral or deferral?

A. Again, you're asking me to agree with someone else's opinion, and in essence, you know, I can understand and respect his opinion and that's how he may decide, but that's something that, you know, it depends under the circumstances. Okay. Under the circumstances, you know, I might not have done that. That's all. It's theoretical what you're talking about.

Q. If Dr. Bonds says you need to refer, defer or offer local, you're not saying that's wrong, are you?

A. Say that again.

Q. If Dr. Bonds has testified before this jury that it's the duty of a dentist before they offer a papoose option to a parent that they have to first offer nitrous oxide or refer them to another dentist who can manage the behavior better or offer to just defer the treatment to another day?

A. Well, I mean --

MR. STEVENS: Objection. Mischaracterization.

THE COURT: Overruled.

THE WITNESS: I'm sorry, I didn't hear. It was overruled.

A. The thing is that, you know, I think that the child needed to be dealt with. Couldn't -- because of the abscess that the patient presented with so it had to be expedient.

Q. In however, you quote, deal with him, do you -- are there options that a dentist is under the obligation to offer before you go to the papoose board, the last option?

A. Well, you say obligations? You know, I think these are judgments that the doctors -- doctors make based on the needs, assessment and the specific situation the patient presents with.

Q. Well, you're here expressing opinions that whatever Dr. Bonds did it was okay?

A. Uh-huh.

Q. Are you ready to --

A. That he did. Not his thinking.

Q. Let me -- are you in agreement that in evaluating whether his care was okay we would apply his standards and not yours?

A. He was the managing doctor at that particular time.

Q. Yes, sir. He knows more about this case than you do, correct?

A. Correct.

Q. And he says that when you put a child in a papoose board you need to continuously monitor their vital signs. Do you agree?

A. Do I think you need to monitor a child's vital signs during a papoose board? No, you don't.

Q. Okay.

A. I think it's a safe procedure.

Q. Pardon?

A. I think it's a safe procedure.

Q. You say it's a safe procedure. You told us that you were on the board of trustees of the American Academy of Pediatric Dentistry at one point; is that true?

A. Yes, sir.

Q. Do you take their recommendations seriously?

A. I certainly take their recommendations under consideration. I help formulate some of those recommendations.

Q. Did you help formulate the statement in the guidelines on behavior management that said one of the known risks, possibility of serious risk of papoose boards and other protective stabilization devices is psychological and physical harm?

MR. McPHILLIAMY: Objection. Hearsay.

MR. STEVENS: Objection.

THE COURT: Overruled.

A. Did I have anything to do with that?

Q. Yes, sir.

A. No, I didn't.

Q. You knew that the AAPD says that there are substantial risk to putting a child in a protective stabilization device like a papoose board?

A. That is what's stated in the document, but there is no evidence to support that scientific-evidence based documentation for it.

Q. How many years has the AAPD put in their guidelines that there are substantial risk to protective immobilization?

A. You know what, I can't really answer that question.

Q. Have you ever written to them and told them that it's wrong, they need to change the guidelines, it's inaccurate, according to Cisaeros?

A. According to Cisaeros?

Q. Yes.

A. Have I -- I have had discussions at various times during the academy meetings and things like that where that is going on, sure.

Q. And the opinion of the American Academy of Pediatric Dentistry is that there are substantial risk

to restraining a child; is that true?

A. That appears to be the -- on the document, yeah.

Q. Do you agree with Dr. Bonds that it's not reasonable to restrain a child with a heart rate of 204 and a oxygen saturation rate of 88 to do three fillings?

A. Again, with the pulse oximeter you get information that is sometimes a child could be doing that when they are screaming waiting in the -- during the waiting room. I don't think there is any evidence to suggest what the limits are.

Q. You would just go forward any way, is that what you're saying --

A. Go forward at -- any way --

Q. -- fill three teeth with a kid in a papoose board?

THE COURT: Wait. Wait. Can't have two people talking at the same time.

MR. FIRST: I object. This is --

THE COURT: You would still go forward? You want to answer that question before you ask another one.

MR. STEVENS: Objection.

MR. FIRST: Your Honor, this is beyond the

scope of the direct.

THE COURT: Overruled.

MR. STEVENS: Objection to mischaracterization.

THE COURT: Overruled.

BY MR. FRANKEL: (Cont.)

A. So could you repeat it?

Q. Yes, sir, I can. Would you restrain a child knowing that their heart rate is 204, oxygen saturation rate is 88 percent and go forward with a procedure in a papoose board if what you are trying to do was fill three teeth?

MR. STEVENS: Objection. Multiple questions and mischaracterization.

THE COURT: Overruled.

A. The point is is that the mechanisms with which these things were taken, a pulse oximeter, are highly affected by the patient's agitated state. In other words, you can't -- these things -- I mean that may have been the -- most likely been misinformation. Okay.

Q. Did you hear my question?

A. Yes.

Q. Would you have gone forward, so we can evaluate your standard of care, Doctor, would you have gone

forward and put a -- gone forward with a procedure where a child is in a papoose board, their heart rate is 204, their oxygen saturation is 88 percent and the purpose is to do three fillings?

MR. FIRST: Objection. Misstates the evidence.

MR. McPHILLIAMY: Objection to form.

MR. STEVENS: Objection.

THE COURT: Form objections. Overruled.

MR. STEVENS: No objection to the first part he is saying. Objection to mischaracterization of the second part.

THE COURT: That's a form, right?

MR. STEVENS: Yes, Your Honor.

THE COURT: Overruled.

A. You know, you're asking me about something that quite frankly wouldn't -- I wouldn't be necessarily involved in because of the circumstances, and I wouldn't be utilizing the -- a pulse oximeter this is because of the information that exists with a pulse oximeter. I wouldn't be surprised if I'm in that category right now. So this is, you know, you're taking information, you know, and you're misusing it.

Q. All right. So did you read Dr. Bonds' testimony where he said that shouldn't be done,

shouldn't do that?

A. I read that.

Q. You agree or disagree?

MR. STEVENS: Objection. Form.

THE COURT: Overruled.

A. I think -- I think in a sense, you know, I disagree, but that's his perspective and I respect his perspective.

Q. Do you agree that a child -- that a parent who wants to accompany a three-year-old child, if they're going to be put in a papoose board, should be permitted back with the parent? That's what Dr. Bonds said. I want to know whether you agree with him.

A. That's something that gets negotiated between the parents and the doctor. That's a discussion that goes on.

Q. If a parent wants to come back, the doctor should certainly let the parent come back with a three-year-old in a restraint board, right?

A. It really kind of depends on the circumstances. On average most of the time.

Q. Most of the time they should?

A. Most of the time if it's not going to create any problems, and often times it does, you know, most of the time should see no real particular reason why

not but --

Q. All right.

A. -- it can be disruptive. A distraction.

Q. Do you agree with Dr. Bonds when he says when you don't have x-rays, you must make very specific clinical notes to record why you were doing what you are doing; is that right?

MR. STEVENS: Objection to form.

A. That's his statement.

Q. Do you agree with it?

THE COURT: Wait. I have to rule. Overruled. You may answer.

A. Again, that is his statement.

Q. I know it's his statement that's why I'm asking you about it.

A. I agree that was his statement.

Q. Do you agree with his opinion?

A. Read it again. I -- say it again.

Q. When you don't have an x-ray, you need to have very specific clinical notes to record why you are doing what you are doing?

MR. STEVENS: Objection. Mischaracterization.

THE COURT: Overruled.

A. I don't think necessarily so.

THE COURT: We're going to take our break. I apologize, I told you 10:45. Fifteen minutes. Don't talk about the case. Don't do any independent research.

(Proceedings in recess at 10:55 a.m..)

THE COURT: I'm sorry. I thought you were getting them.

(Jury seated in the jury box at 11:18 a.m..)

THE COURT: All right. You can be seated.

BY MR. FRANKEL: (Cont.)

Q. Dr. Cisaeros, turning your attention for a moment to the first time that Jeremy Bohn was at Small Smiles on May 23rd, 2006.

A. Right.

Q. Did I hear you to say that in formulating your opinion that it was okay to extract his two teeth on that day, one of the considerations was that in tooth I there was radiographic evidence, albeit not great evidence, but evidence that there was an abscess?

A. No.

Q. No.

A. I just said that the decay was extensive to approximating and touching the pulp and based on -- and along with the clinical exam and history.

Q. Touching the pulp on May 23rd?

A. May 23rd, we're talking about I, the x-ray?
Q. Yes, sir.
A. The x-ray that just shows the crown part of the crown.
Q. Right.
MR. FRANKEL: Can we see that, Chuck.
Q. This version is not as good as the one that they had up. I don't know whether you can --
MR. FRANKEL: Can we borrow yours?
A. That's not very good.
Q. You want to look at the original?
A. There was -- didn't I look at one on the screen? That looks very different.
Q. I know it's a copy. You want to look at the original we can, or we can pull up the copy.
MR. FRANKEL: Why don't we look at the very one you were using before, if that's okay. Would you do that for us. I appreciate it very much.
MR. FIRST: 601.
MR. HULSLANDER: There it is.
MR. FRANKEL: Thank you.
Q. This was the x-ray you were looking at before, right, Doctor?
A. Yes, sir.

Q. On the right-hand side that's the film that you say gives you some information that shows that there is -- what did you say, extensive caries into the pulp?

A. Approximating the pulp.

Q. All right.

A. Approximating basically means to the point where it seems to be touching it in it. You can see the extent of the decay.

Q. You can see it you say, right?

A. Can I see that on that x-ray?

Q. Yes.

A. Yes, I can.

Q. Have you read Dr. Bonds' deposition? I think you said you did, right?

A. Yeah.

Q. And you read his trial testimony, I think you said you did, right?

A. Yes.

Q. Do you remember what he said about that x-ray on I?

A. I don't remember verbatim. Not at all.

Q. Well, did it matter to you that he said it's not diagnostic, I cannot see --

A. It's not diagnostic.

THE COURT: You have to let him finish.

Q. I said you cannot see anything on that film, it's nondiagnostic, right?

MR. STEVENS: Objection to mischaracterization.

THE COURT: Overruled.

A. Well, I have the advantage of sort of, you know, having a different perspective of it and seeing it blown up and all that stuff. But from the standpoint of nondiagnostic, you know, it's a term that I have seen used a lot and basically again, you're not diagnosing anything. These are supplemental. But when you say nondiagnostic, it means that it hasn't been taken according to a given standard, you know, showing everything that you want to be able to see, but you can see some areas.

Q. You can, but Dr. Bonds couldn't, right?

MR. STEVENS: Objection, mischaracterization.

MR. FRANKEL: Well, let's get his trial transcript out. Can I approach the witness, Your Honor?

Q. You say you read this, right?

A. Yeah.

Q. Recently? He only gave it a few days ago,

right?

A. I think it was. I don't remember. Last week or something like that.

Q. Yeah. So here he is on page 930, he was asked by me, and there's a section there for radiographic findings. These are the two teeth that you could see -- by the way, could you see the two teeth that you pulled on the x-ray? He says, I could see one of the teeth. Yes. One of the two teeth you could see? Yes.

A. Uh-huh.

Q. So whether it's nondiagnostic, whatever term you want, Dr. Bonds said he couldn't even see the other tooth and he pulled it any way. Do you think that was reasonable care?

MR. STEVENS: Objection.

THE COURT: Overruled.

A. Do I think was reasonable care? I think it was. It was not seeing the two teeth that I see.

Q. Okay. Have you ever heard of a rescue expert?

A. Say that again?

Q. Have you ever heard of a rescue expert?

A. A rescue expert?

MR. HULSLANDER: Objection.

Q. Yes.

THE COURT: Overruled.

MR. FIRST: Objection.

A. Can't say as I have. I could probably guess, but I'm not -- it's not something that's right on top of my --

Q. Not a term you have heard where a witness who was there and is answering questions and answers questions one way, that are unfavorable to him, brings in an expert to try to cleanup what he testified to and find things that he didn't find --

MR. FIRST: Objection.

Q. -- have you ever heard of that?

MR. HULSLANDER: Objection.

MR. STEVENS: Objection. Move to strike.

A. I don't even understand it.

THE COURT: You have to let me rule when there is an objection. I'm going to sustain the objection.

Q. Dr. Cisaeros, you gave a bunch of testimony about Early Childhood Caries. Would you look in the chart there, it's right in front of you, you had a chance to review it. Spent 30 hours on the case. Let me ask you this, have you ever seen the term Early Childhood Caries ever mentioned by any dentist whoever took care of Jeremy Bohn?

A. Have I seen it stated in the chart, is that what you're asking?

Q. Yes, sir.

A. Don't recall. I have to --

Q. Don't recall seeing it, do you?

A. I don't recall that being stated, but doesn't change the fact it is what it is.

Q. Well, does it reflect to you that the dentist involved didn't think -- even think about Early Childhood Caries when they were treating Jeremy Bohn?

A. I -- just the fact it wasn't listed doesn't mean they weren't thinking about it.

MR. FRANKEL: Could we look at the treatment plan.

Q. Did I understand you to say that in your opinion if you have Early Childhood Caries there's a greater urgency for treatment?

A. Yes.

Q. And is that one of the reasons he --

A. I'm sorry. Can I correct myself?

Q. Okay.

A. In this specific case with this patient's presenting issues, absolutely. I mean you're taking a general statement about Early Childhood Caries in general, you know, that's that in itself is not

emergent, but for a specific case it could be and it would be.

Q. All right. Well, Dr. Bonds identified eleven teeth that needed to be treated on May 23rd; is that right?

A. Yes. Well --

Q. Two of them were treated on that day and there were still nine to go, right?

A. Right.

Q. And if there was a need for immediate treatment you'd expect they would have had him come back right away to start treating the other nine, correct?

A. When you say right away, I mean reappointment them at a later day, absolutely.

Q. How long was it before they told Jeremy and his mother he needed to come back to treat this immediate problem?

A. I think the next appointment he was seen in August, right.

Q. Did you see on the record, I think it's the operative record, that they told him to come back in September. Do you remember that?

A. I don't remember that.

Q. Does that -- well, you're in court telling the ladies and gentlemen of the jury that everything that

Dr. Bonds did was right. Are you telling us that it was right if he had Early Childhood Caries was it okay to wait three and a half months to have him come back?

A. Any reason to wait that long?

Q. If he had this disease that you were worried about -- that they were worried about?

A. Well, I would imagine at that particular point in time that the teeth that he was looking at, the degree of decay that existed may not have mandated or necessitated anything earlier than that.

Q. It wasn't any kind of infectious disease that was putting Jeremy at some risk and it wasn't treated immediately or Dr. Bonds would have had him back more than four months, three and a half months later?

A. Most likely if it was more extensive.

Q. Then he waited another six weeks to take care of more teeth, right?

A. Uh-huh. Yes.

Q. Then more time after that. Two more weeks to take care of more teeth, right?

A. Yes.

Q. Does that sound to you like a dentist who was worried about Early Childhood Caries?

A. You know, again, you're taking things -- we were talking about Early Childhood Caries, talking a

syndrome, explaining from epidemiology -- I used the term epidemiologically, the condition underlying this. Now, whether that suggests anything about him, I can't really say.

Q. Right. The discussion you gave was a general discussion from literature about the whole notion of Early Childhood Caries, but as to whether it had any application to Jeremy Bohn you just can't say, right?

A. Relative to, you know, how early the next appointment should be, you know, is dependent on the doctor's decision to be made at that particular point in time.

Q. If you were a dentist worried about Early Childhood Caries, is it true that one of the first things that you would do was to increase the amount of fluoride that the patient received?

A. Well, you know, it's a possibility, but you have to understand when you do prescribe fluoride, you have to understand that whether the -- you have to make an assessment of the patient's age, what type of fluoride might -- I'm sorry, might be doing. There's danger in having fluoride and ingesting in a child. You know, usually you may, you know, swallow, swish swallow, things like that, and you may not utilize that in a young child because you can't necessarily do

that. You might consider supplementation to the diet and pills and things like that, but that would be dependent upon whether the individual had fluoridated water or whether they drank a lot of water. So these are things that you look at.

Q. But is it true, sir, that in treating Early Childhood Caries, one of the things, not usually treated operatively, it's treated with things like fluoride; is that true?

A. Yes. And it's effective primarily not in the more severe but in the --

Q. All right.

A. It does help retard, you know.

Q. Did you check the record to see what type of fluoride treatments the dentists at Small Smiles were giving Jeremy to see whether they were interested in Early Childhood Caries?

A. I wasn't looking at it. I -- I didn't really look at it from that perspective. I was looking at it from the actual treatment of the teeth that were taken care of and the way he was treated.

Q. Do you know how many times he came to the Small Smiles clinic and was not given fluoride?

A. I can't say if --

Q. The condition of Jeremy's teeth after four

months has gone by -- I'm sorry, five months has gone by from the time he was first seen there until October when they started filling some of his teeth. Do you know the condition of his teeth in October?

A. Maybe x-rays here looking at.

Q. Well, there aren't any x-rays.

A. There weren't any x-rays? Okay.

Q. You read the testimony. You seen the chart. Do you recall that, in fact, his cavities according to Dr. Bonds were so small five months later that he didn't need to use a local anesthetic to fill the cavities. Do you remember that?

A. Vaguely, yes, I do.

Q. Does that sound to you like someone whose got some raging disease where the -- you need to do things immediately because of all this increased risk?

A. Talking about those particular teeth, and in those particular teeth, obviously the disease was not as aggressive. It varies.

Q. Some questions now, sir, about Dr. Aman's treatment. Okay. You weren't -- you didn't treat Jeremy Bohn, right?

A. Nope.

Q. You're relying on, as we said, the record and what these gentlemen who did treat him have testified

to, correct?

A. Correct.

Q. And did I understand you to say that -- did I understand you to say that you thought that one of the key justifications for what Dr. Aman did was his clinical evaluation, that the x-rays, you know, so, so, that you can see things, you might not see things, but when you took that together with the clinical information it justified what he did which is to do four pulps and crowns?

A. I wouldn't call the x-rays so, so. If I did, then maybe I was, you know, misspoken or misstating. I showed you -- I outlined on the x-rays where the caries -- where I saw the caries.

Q. Yes, sir, I know you did.

A. So that, and also on top of the fact that he's looking right at these things. You don't need the x-rays per se. It's a visible condition.

Q. Okay. That's what I remember you saying. He would -- just would lift up the lip and he could see that, the level of disease that would justify the four pulps and crowns; right?

A. It's not the level of disease that would justify the pulpotomies and crowns. When you say a carious pulp exposure, it means you actually gone in

removing the decay, and then upon the removal of the decay, there was a pulp exposure. It's not something you know ahead of time until you follow -- you know, follow the decay.

Q. So if Dr. Aman swore under oath that he knew ahead of time based on his clinical exam and his x-rays he was going to do those pulps and crowns, there's no way that's possible, right?

MR. FIRST: Objection.

Mischaracterization. To the form.

THE COURT: Overruled.

A. Say that again.

Q. If Dr. Aman swore under oath that based on his clinical exam and the x-rays, he -- when he started the procedure on 8/31/06, he knew he was going to do the pulps and crowns based on what he had already decided, there's no way that he could have the information to be able to do that, is there?

A. Wouldn't you make a notation like that -- when you -- carious pulp exposure it means that it was an event that occurred, and he witnessed that event and he documented that event.

Q. Right. So if you're trying to --

A. I don't know what he said.

Q. I'm sorry. You're trying to pull somebody into

thinking that you didn't already plan pulps and crowns, instead it was a surprise to you, and it was when you got in there you saw disease that required you to do that you would write CPE, right?

MR. McPHILLIAMY: Objection. Argumentative. Form.

MR. STEVENS: Objection.

MR. FIRST: Objection.

THE COURT: Overruled.

A. Carious pulp exposure when you utilize that term it's the doctor's observation that that's what happened.

Q. If you wanted to hide your true intentions, if you already had decided going in you were going to do pulps and crowns to make more money for the company, and you wanted to hide that true intention, you'd just put that CPE in there and nobody could -- nobody would know the difference, would they?

MR. McPHILLIAMY: Objection.

MR. STEVENS: Objection.

THE COURT: Overruled.

A. I can't make a statement like that. I mean --

Q. Have you ever heard in your 30 plus years of being a dentist of somebody saying here's how you hide your true intentions in charting pulps and crowns?

A. No. I hope I never will.
Q. Mr. First didn't show you that document?
A. I'm sorry, what document?
Q. The document I believe it's Plaintiff's Exhibit 70 that is an instruction to dentists at the Small Smiles clinics on how to hide their true intentions when it comes to using the term CPE for secret pulps and crowns. He didn't show you that document?
A. I can't recall.
Q. Let me ask you this, Doctor, if the clinical exam was important to you that Dr. Aman did before he performed these procedures, would you please look at the chart and show us Dr. Aman's notes as to what his clinical exam showed?
A. Well, I mean I see color -- color copies of this. And I've seen --
Q. I'll give you --
A. -- a change in the treatment plan that was made, you know, so that's -- so that's what the -- that's how that was done.
Q. Just tell me what -- you got the record, you want to look at the original? I will furnish you that.
A. No, that's all right.
Q. Just let us know what clinical notes it was

that you were looking at that you say persuaded you that what Dr. Aman did was proper?

A. You know, you're asking me a question that's these dual part questions, but there was a change in the treatment -- a treatment plan by him I don't seem to be finding here.

Q. I think this is maybe what you're looking for.

A. Yes. Thank you.

Q. It wasn't his treatment plan. It was Dr. Bonds' treatment plan, right?

A. Yes.

Q. And you remember that he made these notations?

A. Yes.

Q. Without indicating that it was his?

A. On the side, yes.

Q. Yes. Those are not findings -- those are not this NSP, question mark, that's not a clinical finding, is it?

A. No. It's -- in essence, it's really -- I do that myself. You know, question mark, when you put a question mark after something. In this case looking at a pulpotomy, it means that from what I can see on this patient the degree of decay I should anticipate pulpotomy that might be necessary so you have a question mark. You can't say for sure until you go

and go through the -- into the tooth with the removing the decay.

Q. And where is the clinical note or any information that says that Dr. Aman actually did an examination of Jeremy Bohn on 8/31/2006?

A. That's pretty much what is evident right there.

Q. Not a single word of a clinical note, is there?

A. Does not appear to be, yeah.

Q. But there is some information as to whether he actually did the exam, did you see that in the chart?

A. Yes.

Q. And did you see in the chart where on the little section that asks whether he did a limited oral exam he said no?

A. But as I said, you know, with the -- this filled out, didn't fill out a form for whatever reason, the thing is when you go looking in the mouth it's very apparent, you know what it was he was dealing with.

Q. Were you there?

A. No, but I could see the x-rays.

Q. Did he say he doesn't remember anything about Jeremy Bohn six or seven years later?

A. Say that again.

Q. Do you remember Dr. Aman both in his deposition

and at trial saying he doesn't remember what he saw and what he talked to people about on that date, he seen a lot of patients since then?

A. The deposition?

Q. And trial.

A. I don't think I saw his trial testimony at all.

Q. All right.

A. I saw Dr. Bonds and Dr. --

Q. Fair enough.

A. And Dr. Mueller.

Q. Fair enough. In his deposition you know that he didn't have any independent recollection of what he saw that day, right?

A. You know what the impression I had from the deposition?

Q. I'm asking you whether you remember him saying he did not remember -- he does not remember?

A. I don't remember that specifically.

Q. So without any memory, Dr. Aman not having a memory, doesn't have any notes, the one place we have some evidence in the records is that he did do an exam. You say based on his exam, his care was proper; right?

A. Yes. Based on the x-rays.

Q. I'm sorry?

A. Based on the x-rays.
Q. Oh, now it's the x-rays. I thought you said it was the clinical exam and the x-rays and the x-rays really aren't that important, it's the clinical exam that is so important?
A. If you're about to treat a patient, you're looking at the mouth and it's readily apparent.
Q. All right. Did you give some testimony -- general testimony about keeping track of statistics or production?
A. I was asked about productivity reports --
Q. Yes.
A. -- in general.
Q. Is it improper for a nondentist to provide -- to interfere with the independent judgment of a dentist?
A. Independent judgment of a dentist?
Q. Yes, in treating a patient?
A. As that statement stands alone, a nondentist should not be involved the diagnosis and treatment of a patient.
Q. Or anything that would interfere with the independent judgment of the diagnosis and treatment of a patient, correct?
A. Sure. But production reports aren't that.

Q. They're not in and of themselves. I agree with you on that. Let me ask you this, when you used production reports, do you use them to pressure other dentists to do more procedures on patients and make more money for your business?

A. No.

Q. Would it be proper to do that?

A. From the -- from a standpoint of letting them know how productive they are, it gives them -- it gives them an opportunity to kind of discuss amongst themselves or with others as to how the overall practice may be doing, you know, and by comparison it helps to see how others are performing as well, you know, and so you want -- you want to perform well.

Q. You want to perform financially well or you want to perform what -- do what is best for your patients, whether it is good or bad for your pocketbook?

A. Well, it's complicated these multiple-part questions. You want to do -- you want to do the best for your patients.

Q. Does that come first, that's the number one goal?

A. Yeah. Why not.

Q. Yeah. And if somebody -- some nondentist, a

corporation or an individual who is not a dentist tries to influence a dentist to do more procedures on a patient to make more money for the company that's wrong, isn't it?

A. Yes. It doesn't hurt for the company to ask people to work hard, that's one thing. But you're right, they should not be pressured into doing something they feel they shouldn't be doing.

MR. FRANKEL: That's all I have. Thank you very much.

THE COURT: Redirect?

MR. FIRST: Yes.

REDIRECT EXAMINATION

BY MR. FIRST:

Q. Doctor, I just have a few questions for you. Do you remember being asked by counsel about some testimony you gave yesterday in the beginning of the cross-examination?

A. I guess so, yeah.

Q. Okay.

A. I'm sorry.

Q. I'd like to read you whether you gave these answers to these questions to give the context to what you said. Question, the case involves, as you know,

carious or cavities and various dental restorations, including fillings and crowns and pulpotomies and extractions. Answer, right. Question, can you give the jury some idea of your background just in doing that kind of dentistry and doing those procedures? Answer, well, most of my, you know, during my time in private practice at Montefiore, I was there for 17 years, and at Brookdale pretty much on average would spend, you know, half my three days, you know, seeing pediatric dental patients and also going to the OR, you know, where you get -- you do a lot of procedures and you have to do them very quickly. And then as my career moved on, as my practice aged, 'cause, you know, a lot of my pediatric patients became my orthodontic patients and they went on for -- on, you know, college and all that stuff, it's kind of neat to see that happen, you know, would instruct, you know, guess I --

Question, if you're looking from the standpoint of procedures or number of things or -- procedures or things -- numbers or things like that? Answer, how often? Question, you have an idea? It's -- answer, it's hard to say, certainly upwards of 1,000 pulpotomies, crowns. I mean we just have to do things fast and do them well so it's -- I'm doing a little

less now. More supervising the students, you know, at St. Barnabus, you know, helping them and, you know, when you get -- when you're supervising sometimes you have to get in and help them out with it and show them -- demonstrate somethings so it's not something -- it's not part of my practice one day a week. I'm primarily in this as orthodontist to be honest.

That's the full context of what you said yesterday, isn't it, Doctor?

A. I was referring when I'm at my practice in private practice in the Bronx at St. Barnabus at the time. I was just transfixed by all the "you knows," sorry.

Q. We never like the way it looks in the record.

A. What?

Q. We never like the way it looks in the record. That's not uncommon. Doctor, let me ask you this, you were asked about urgency and the like. By the time of October, 2006, Jeremy had had his abscess in teeth B and I taken care of?

A. Correct.

Q. You said that was an emergent situation?

A. Right.

Q. By that time he had had D, E, F and G treated and restored; isn't that correct?

A. Absolutely.
Q. That was also another one of his major problems?
A. Yes, it was.
Q. So as of the time of the later visits, his -- the problem teeth, if you will, had a different character, meaning less disease?
A. Exactly.
Q. And, Doctor, you were asked about Dr. Aman with teeth D, E, F and G. I want to ask you about something you said. I want you to explain it. You were asked about Dr. Aman's notes, and you said -- you described what notes you saw, the New Smile note, the question mark.
A. New Smile, right.
Q. In order to treat those teeth, would you have to see them?
A. In order to treat those teeth?
Q. Let me ask it differently. In order to provide any treatment, would you have to make a clinical examination of those teeth?
A. Absolutely, that's what I was trying to say.
Q. Okay.
A. It's staring you right in the face.
Q. I know it seems obvious. I want you to explain

to this jury why? It's obvious to you, may not be obvious to everyone else. So explain?

A. I mean it's obvious just like if you had a, you know, something growing out of your -- I mean, you know, it's there. You know, anybody would see it. You saw some of those pictures. That's what it was. It was front and center smile. You know, you see the teeth. I've kind of -- it seems to me like one of those commonsensical things, you know. You can't avoid it as soon as you look in the mouth. I don't know. Trying to come up with a scientific -- I'm kidding. I don't know. I can't answer that.

Q. You just did.

A. Oh, okay.

Q. Doctor, you were asked about your publications. Have you published on Early Childhood Caries?

A. Well, actually, you know, one of -- there is an article that we did, a paper we did, research we did looking at the impact on at that particular time I think tooth bottle.

Q. Tooth bottle?

A. Milk bottle or breast, you know, decay. We were looking at individuals that had severe, you know, rampant decay or give you more severe aspect of ECC. And we saw that and, you know, eventually we took to

under general anesthesia if we are at a major hospital, major center, you can do these kinds of things. In the rural communities, it's not always readily available. So what we did is we took their height and weight, and we saw they were all beyond, you know, in the -- below the fifth percentile. Low growth or weight and height. I'm sorry. I should be talking to you. These are essentially children that were across the board very small and beyond the normal range. Okay. So -- and then later on, it was a second study that we had conducted that showed that with --

MR. FRANKEL: I object. This is not responsive.

A. I don't remember. The article's in here.

THE COURT: I think it is at this point. You might have asked ever have any articles.

A. I think it is quoted and it's a line item within there.

Q. Okay. In the resume?

A. In the risks. One of the -- in the first board that we looked at the line item.

MR. FIRST: Okay. Thank you.

THE WITNESS: Thank you.

THE COURT: Well, New FORBA?

MR. McPHILLIAMY: No questions.

CROSS-EXAMINATION

BY MR. STEVENS:

Q. Dr. Cisaeros, I represent the three dentists in this case.

A. Sorry.

Q. I represent the three dentists in this case. We never met?

A. No.

Q. True. Never spoken?

A. Nope.

Q. Okay. How are you today?

A. There's always better days.

Q. Doctor, you were asked about Dr. Aman and something you saw in the chart called limited oral exam. Do you remember being asked that by Mr. Frankel?

A. Correct.

Q. And did you say you read some of the testimony of Dr. Aman that he gave to this jury in this courtroom?

A. Not Aman's testimony.

Q. Were you aware that from any means that Dr. Aman explained to the jury that the limited oral exam

has a specific meaning for a specific type of emergency treatment, emergency condition that does not apply to Jeremy Bohn?

A. Yes, that's the -- that's the standard that they, you know, the documentation of Small Smiles. It's consistent with that.

Q. Doctor, were you aware that every single visit to Small Smiles, there's a one, there's a two, three, four, five, six, seven, eight, nine and ten, all of them say no as to LOE, because limited oral exam just doesn't apply to Jeremy Bohn one way or the other?

A. Right.

Q. Okay. Should we put each and every one of those up on the board to show you, or will you take my word for it that's exactly what they said?

A. Word for it. I don't -- I think it has a specific meaning for, you know, in that, in the Small Smiles.

MR. STEVENS: Thank you.

RECROSS-EXAMINATION

BY MR. FRANKEL:

Q. You said it's obvious to you when you look, a kid opens their mouth, you're doing an exam, did I understand that's what you were saying?

THE COURT: Wait a second.

A. I was just going to ask you to say --

THE COURT: Wow, wow.

Q. Did I understand you right to say that any time a child comes to the dentist and the dentist says open your mouth that constitutes an examination?

A. Yes. And it's observed by the doctor, yes.

Q. That's not a clinical?

A. That's what -- why they are opening their mouth.

Q. Yes, sir. Then what you're supposedly doing you use instruments to evaluate what you feel or what you see and you record those, that's the evidence of your examination, not just look in their mouth, right?

A. No. You may not -- I may not be using anything other than a mirror or even your glove finger and putting it -- and putting it aside there is no -- you might do that in the initial -- in the initial full evaluation, but to do that in follow-up would not necessarily be indicated.

Q. Well, here you are in 2013 evaluating Dr. Aman's care, justifying it on the basis of a clinical exam without any notes of the clinical exam, right?

A. What I guess I'm justifying it on is what I know to be practical, logistically sound. That's what

you are doing when you open a patient's mouth and look at them, you're -- you see. That's the most powerful tool in your brain.

Q. Right. Just like Dr. Bonds looked at the same x-ray that you did, and said he doesn't see anything. You're assuming Dr. Aman saw and did what you would have done; is that right?

MR. STEVENS: Objection. Same question gone over earlier by the same attorney.

THE COURT: Overruled.

A. I just can't answer that question.

Q. One last topic. You said that -- did I understand you to say it was an emergency situation where Jeremy came to the Small Smiles center on May 23rd?

A. No. I think the term is emergent. It's not one in the same. It means it has a high priority because of the --

Q. It was not an emergency; is that right?

A. You know, when you -- when I think of emergency, the patient is in -- in pain and suffering and all that stuff. Okay.

Q. He wasn't, right?

A. No, he wasn't, but it was an emergent problem and it was the degree of infection that, you know,

like I said, put kids in the hospital for. And that pen-VK in and of it -- is appropriate, has its limited course, and you really need to do something about it as quickly as possible. And in the location, in the area that these types of clinics have been established, this is where these people can be treated that they can't be treated otherwise and you may never get them back again.

Q. Did you look at the notes in the record and see whether in this emergent situation as you described it, Small Smiles took the time to brush Jeremy's teeth?

MR. McPHILLIAMY: Objection. Scope.

THE COURT: Sustained.

Q. Would a dentist who thought there was an emergent situation -- would a reasonable dentist take the time to brush the patient's teeth before treating what you're describing as an emergent situation?

MR. McPHILLIAMY: Objection. Scope.

THE COURT: Overruled on that one.

A. I think that, you know, you have to understand that clinic's practices. Have a routine. And most likely that the hygienist seeing the patient, you know, this is probably part of the standard assessment, a practice that they do. It also suggests

that there may have been a lot of stuff, material, albeit plaque on the teeth, and wanted to just acclimate the kid to what is going on, and then, you know, now you have a situation where, you know, things got out of hand and needed to be -- the kid got sensitive or what not.

Q. Did you notice that they actually had restrained him before they brushed his teeth?

MR. McPHILLIAMY: Objection. Scope.

A. Yeah.

THE COURT: Overruled.

A. Yes, I noticed that.

MR. FRANKEL: That's all I have. Thank you.

THE COURT: Okay. You may step down. Thank you.

(witness excused)

MR. STEVENS: May we approach?

THE COURT: Yup.

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

THE COURT: We will take a five-minute recess. We will come back until 12:30 and take our lunch break at 12:30. Five minutes. Stand up, walk around. Do whatever you need to do.

(Proceedings in recess at 12:02 p.m..)

THE COURT: Can counsellors approach while we are waiting for Mr. Stevens.

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

THE COURT: Let's get the jury in here.

(Jury seated in the jury box at 12:12 p.m..)

THE COURT: Okay.

MR. STEVENS: Your Honor --

THE COURT: Mr. First, any additional witnesses?

MR. FIRST: No, we rest.

THE COURT: Mr. McPhilliamy?

MR. McPHILLIAMY: New FORBA rests.

THE COURT: Okay. Mr. Stevens?

MR. STEVENS: Dr. Bond, Dr. Aman and Dr. Khan call to the stand Dr. Martin Davis.

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

DIRECT EXAMINATION

BY MR. STEVENS:

Q. Good afternoon, Dr. Davis.

A. Good afternoon, Mr. Stevens.

Q. Please tell the jury whether you are a dentist licensed to practice in the State of New York?

A. Yes, I am. I've been licensed for my entire career in the State of New York. Had licenses also in New Jersey and Connecticut. Excuse me. And one time I took the Florida licensure exam. That's where I was born and grew up. I thought I might go back there, but I never did.

Q. Would you tell the jury -- by the way, have you reviewed records in this case to give testimony as an expert before this jury?

A. Yes, I have.

Q. Would you tell the jury something about your training through dental school?

A. Okay. Grew up in Florida. Went to Yale University where I received my baccalaureate degree, then went to Columbia University College of Dental Medicine, that was for my DDS, and you know did well there. So I was able to actually do a dual senior year where I could start the specialty of pediatric dentistry while I was still a senior student, which was a wonderful opportunity because they charged tuition for that in those days. So completed the training as a specialist in pediatrics there at

Columbia, and then when I finished that this -- they offered me a position on the faculty.

Q. Did you become board certified in pediatric dentistry?

A. Yes.

Q. Briefly tell the jury what that means?

A. In those days it was a very rigorous examination. You had to take an all-day written examination. Then after that you had to present a number of cases that you had completed with children from start to finish showing that you were competent in these clinical procedures. Then there was a session with five examiners where they would put slides up on the board, and you had to identify what is it, how do you treat it, what's the prognosis for that, how might it turn out. And then they came to your office and watched you treat patients, two examiners, for a half a day so it's a very rigorous process.

Q. And in addition to the certification in pediatric dentistry, did you perform a further fellowship?

A. Well, my interest in -- developed in pediatric dentistry was special needs children. What pediatric dentistry is really all about is not just doing

restorative dentistry, it's certainly about managing the child, but beyond that it's about special children. And that was sort of my area of interest, so I did a fellow with the United Cerebral Palsy which enabled me to exclusively work with those patients for a period of time. Reinforced the medicine that I learned in my training.

Q. And did you continue in your career with treating special needs children and where did you do that?

A. Uhm, for the first ten years, I was on the faculty -- I practiced in-house in the faculty practice. And at that time, perhaps half of the patients I saw came through the hospital where special needs children are -- medically complex children had complicated backgrounds. I then went from there because I really, you know, felt I still wasn't doing enough there to Blythedale Children Hospital and that's in lower Westchester, and it is all special needs children who were typically in-house for three months, and we would do all of their dental needs while they were in that hospital being rehabilitated often.

Q. And how many years were you associated with the Columbia University?

A. Oh, about 45 altogether.

Q. Okay. What position did you arise to? What was the highest position you arose to in terms of dentistry?

A. Senior associate dean for student affairs. I had also been the chair of the department for about 20 years and full professor.

Q. At Columbia University do they treat -- is there an emphasis on community outreach in the population that's underserved and at risk?

A. Yes. It's a huge emphasis. We are not in a well-to-do part of Manhattan. We are in Washington Heights. Probably three out of four children we see in either the predoctoral clinic or in our specialty clinics are on Medicaid. We have a bus that goes around to all the Head Start centers, a van really, with equipment in it to take care of those children. We have sites in seven different elementary schools, in intermediate school in the community to put our doctors to outreach. Such as the advanced general dentistry students will be out in those sites. Pediatric dentists in those sites. Students in some of them.

Q. Doctor, the jury has heard Dr. Koury Bonds testify that he took a residency at Columbia

University in something called advanced education in general dentistry primary care. Would you tell the jury are you familiar with that and what is that?

A. Yes. I'm very familiar with that program because we gave lectures to those students. These are people after they finish their DDS, they want to do another year of postdoctoral studies in general dentistry. They like to do it if possible with people who have a little more complex histories. Not routine patients, if you will. So that program sends the students to places, you know, in Harlem, to drug rehabilitation centers. There's a home for unwed mothers. So they're fairly unusual settings, plus what they do right there in the university's dental clinics.

Q. Have you -- are you a member of the AAPD?

A. Yes, I am.

Q. And what position have you held in the AAPD? What was the highest position you held?

A. Okay. I chaired a number of committees, but the highest position was as president of the academy.

Q. And what efforts did you make or what -- what did you do with respect to the underserved population when you were in the AAPD?

A. The thing I'm personally most proud of there

has always been an understanding that access to care is a problem. You know, whether it's the Surgeon General saying this is a sound epidemic and nobody is caring for these children. That the decay, 80 percent of it is in 20 percent of the kids, and we know who those people are. It's all about access. There was a sense there were not enough pediatric dentists, so we created a task force and I chaired it that looked at the work force in pediatric dentistry and it was clear after we did the numbers, looked around at the ratios, the busyness of practices, that there were nowhere near enough. There was a lot of detail in this and verification of it, but the point is that task force report was very helpful when going into some congress person's office --

MR. HIGGINS: Objection.

THE COURT: Sustain the objection.

Q. What was the outcome or the benefit of the report?

A. We had a document to go to senators and congressmen that we need to get funding to create positions and create more pediatric dentists.

Q. Did you also do some work with -- to encourage or treat or help pediatricians or other healthcare providers help with this silent epidemic?

A. Yes. Another doctor and I created a program. We went to about 15 different hospitals with a lecture series for pediatricians in those hospitals to talk about -- to recognize disease in children's mouths. I don't mean to be facetious. It is often said that pediatricians don't see what is between the lips and the tonsils. This was all about making sure they did see that.

Q. Have you -- excuse the form of the question. Have you enriched the literature with peer review journals and other writings?

A. I hope to think I have. I have about 80 publications, textbook chapters, you know, in existence now.

Q. Are some of those we've learned are called peer review journals?

A. Well, over 95 percent are peer reviews. The textbook chapters have editors. Most of those are articles in our journals.

Q. All right. I see you have a folder next to you. Did you bring up a copy of the chart -- photocopy of the chart from Small Smiles for Jeremy Bohn?

A. That's correct. That's what's in this folder.

Q. And at the request of my office have you

reviewed that chart for the purpose of giving testimony here today?

A. I have.

Q. Okay. Other than the chart, do you recall what else you reviewed?

A. I have reviewed depositions from people involved. I have read depositions from people involved. I've read testimony from here in the Court. I have looked at the radiographs. The patient record.

Q. Dr. Davis, I'd like to tell you that another physician no longer -- another dentist who is no longer in the room gave some detailed discussions about visits one and two. And I'll go a little light on those. I will still have some questions.

A. Certainly.

Q. In general, would you just tell the jury what brought Jeremy to the Small Smiles on May 23rd, 2006?

A. From what I have seen in the record --

Q. Don't tell me. Please tell them.

A. From what I have seen in the record, his mother became aware from the pediatrician, reinforced by the first dentist, Dr. Patel, she took him to subsequently that he had nine teeth in his mouth that needed to be addressed, so Dr. Patel I believe is the one that said, you go to Small Smiles, they treat children.

Q. And, Doctor, there was a lot of discussion within the last couple of hours about what we've seen on x-ray with tooth I and tooth B. Do you have an opinion -- by the way, let me stop and ask you a new question. Every time you give an opinion, will you please only give it if you hold that opinion with a reasonable degree of dental certainty. Would that be all right?

A. That's fine.

Q. Okay. When you reviewed the x-rays of tooth I and B, and the history given by the mother and whatever prior medical and dental documents you were shown, did you come to an opinion as to whether it was appropriate to treat Jeremy on the first visit with those two extractions?

A. Right. The symptoms described. The fact that the pediatrician, Dr. Taylor, had put him on penicillin. That it was observed somewhat by Dr. Patel per his record that there was infection there. The fact is that infection, trauma, pain are considered dental emergencies, so they needed to do something at that visit.

Q. What degree of destruction did you see on tooth I and B?

A. All I have to look at --

Q. Destruction?

A. Significant destruction based on the radiographs. I don't have clinical photographs.

Q. The diagnosis that was made, the diagnosis code of restorable?

A. Restorable.

Q. After the extractions, would you tell the jury what that means and whether it is significant to you?

A. There is not much point in trying to save a tooth if you cannot build it back up to sort of form and function at some point in time. So in this case, from what I saw of those radiographs, and when there is that much destruction, you are probably going to use a stainless steel crown. That is the only thing to restore all that lost tooth structure. In this case, however, the way a stainless steel crown stays on it sort of springs around the bulbous part of the primary teeth, push it down, expands a little bit and grabs hold underneath what we sort of call the height of contour where there is a bulge near the gingiva or the gums. That was pretty well gone in his teeth, so I don't think that they could have attained retention of any kind of restoration on what was left of these teeth at that point.

MR. STEVENS: Page 21. Could I have just

the odontogram.

Q. Dr. Davis, I'd like to ask you, the jury knows that on that same day there were nine other teeth that were found to have decay. What is the significance of that in a patient like Jeremy?

A. Well, given Jeremy's age, given the number of lesions or cavities that I see on that odontogram, and he is under six, I mean this is what we call Early Childhood Caries, which is a rampant form of decay. That's an infectious process. You need to stop it.

Q. Okay. And what's the significance of that entity, ECC in terms of a patient like Jeremy?

MR. HIGGINS: Objection. Cumulative.

THE COURT: Overruled.

A. We're talking about a child with a lot of cavities. A lot of these are deep cavity. This is going to affect the child's whole life. At that point, I don't think he was in nursery school. Certainly were he, he has to be in pain here because some of these were deeper lesions. Certainly was infection, which we saw the pediatrician identified. It needs to be stopped because it's going to affect his speech development, his nutrition, his growth. Frankly, I've seen in some of what I saw in the records, Jeremy is not underweight but he's not --

MR. HIGGINS: Objection.

A. -- full height.

THE COURT: Sustained.

Q. Doctor, the jury has seen this diagram, what you call odontogram. Would you tell the jury whether you have familiarity with this exact type of diagram and from where?

A. Well, yes. This is almost identical to what we use at Columbia. I think most of the 70 dental colleges use.

Q. There was some discussion in front of the jury about protective stabilization. Are you familiar with that technique?

A. Absolutely.

Q. Can you tell the jury how you are familiar with it and how much?

A. Well, it's an advanced behavior management technique. It is taught certainly in the specialty, in all programs. It is taught to predoctoral students as well in the sense that lectures and they observe it in the postdoctoral clinic. Columbia speaks to that directly, they rotate it and see it being utilized with difficult children. So I probably have stabilized, I can't imagine the number, 500 children, some of whom were -- had cerebral palsy or other

neurological disorders. Trying to help, you know, out of control movements. This helped to protect them, to stabilize them. I have also used it on children who were just having a tantrum. Don't want to have dental work done. So I've certainly taught it to residents and students as I say.

Q. Doctor, you learned that Jeremy was stabilized during the hygiene and examination and then later during the extractions with permission and consent learned that in this case?

A. That's correct.

Q. Have any opinions as to whether that was appropriate?

A. Certainly it was within the standard of care.

Q. And may I ask you, how does one of these things work, these protective stabilization devices?

A. Well, as you can see, there's a board here. It's padded, so that's to protect against bruising or anything. There's -- not on this one, if this is similar to the one they used, there is no head restraint part here.

Q. Correct.

A. This is mesh. The old models, the old days this would be a heavy material. It would be possible for the child to get very warm which is not helpful.

You don't want that. So the mesh is good. This is a more contemporary model, and these Velcro closures are simply to prevent them from being able to kick and --

THE COURT: Doctor, just a second. While you're talking and doing the Velcro, it is hard for the court reporter here.

THE WITNESS: Sorry.

THE COURT: Want to undo the Velcro, then speak.

THE WITNESS: Get rid of the noise.

THE COURT: Thank you.

A. So you can see how the Velcro opens. On some children it will just restrain their legs. I have had assistants kicked in the head by children throwing tantrums. Sometimes we might just do it on the chest, the thorax part of the arms. Sometimes we will restrain both the arms and the legs. But the idea is you're protecting this child from these sharp instruments we have in their mouth. You're protecting yourself and your staff from maybe misinjecting, hitting yourself in the thumb when you try to give an injection, and the child moves or reaches up and hits your hand so it is very much...

Q. Let me ask you this about that. When you're working on a child's mouth with your instruments, what

is the -- what danger occurs if the child is not able to cooperate and be still?

A. Well, you know, certainly there's a potential for the child to be lacerated, cut, or you can be. Or it's possible, you know, especially when you are giving injection, if you are doing one on the mandible, you have to go through maybe an inch of small tissue to get to the place where you want to give the -- express the fluid to block the nerve. And if that child is moving and you can miss that, and I've seen it happen, I even seen needles break below the surface, then you have to do a surgical procedure where you cut down going to get that and remove it. So a lot of potential when there is untoward movement of a child for someone to be hurt. That's why we call it protective stabilization.

MR. STEVENS: Your Honor, I have a demonstrative to put up on consent. Can I mark this little later on?

THE COURT: Sure.

Q. Okay. Can I have page 11. Doctor, be helpful to explain the odontogram with the aid of visual?

A. Sure.

Q. Can either stand, point to it.

A. May I come over. Okay, Your Honor if I --

THE COURT: Sure. Actually, you know what, going to a new area. It is 12:30. We are going to break right now for lunch. That's a good time. We back at 1:35.

(Luncheon recess.)

(Afternoon Session - October 4, 2013.)
(Defendant's ABK 1268 through 1282 marked for identification.)
THE COURT: I apologize for the delay. That's all on me, sorry. Okay. Ready to proceed?
MR. STEVENS: Can we have the same slide up, please.
BY MR. STEVENS: (Cont.)
Q. Dr. Davis, by the way I didn't ask you earlier, have you ever been in the courtroom before giving testimony as a dental expert?
A. No, this is the first time.
Q. Could we have the -- while that's powering up, I was just going to put the slide up on the screen and ask you to just go over the marks that are made on the odontogram at Small Smiles and what they mean and then we'll continue from there.
A. Okay. May I come down there to --
Q. When it comes up.
THE COURT: To point.
MR. HIGGINS: Judge, I object on foundation grounds.
THE COURT: What are you showing?
MR. STEVENS: A picture that they agreed to. I don't know what the objection is about.

MR. HIGGINS: I don't have an objection to the picture. Just as the witness has no foundation for testifying. If he's just testifying from the record, that's fine. I'm not clear as to what his foundation is.

MR. STEVENS: I'll ask him.

BY MR. STEVENS: (Cont.)

Q. In your review of the testimony and the medical records, have you identified what these markings mean?

A. Yes.

Q. Would you explain that to the jury, and I'll give you a laser pointer if that would be helpful. This one has a button here.

A. Maybe I will just use that.

Q. Okay.

A. We were talking about the markings on each of these teeth diagrams here.

Q. Yes, please.

A. These are the same as the representative symbols for the teeth that are on that odontogram, and each tooth I think you heard is five surfaces, and when we observe disease, we indicate it in red. There is a cavity present here that needs to be treated. Once we have done that, we then blackened it as seen here. And by the way, this is two surfaces involved

in this tooth. We will write certain things such as P is for pulpotomy. The X is you see here means we're extracting the tooth for some reason. And three vertical lines means this is plan for full coverage restoration, a stainless steel crown in the case of children.

Q. Are those the marks we see on the odontogram?

A. Yes, they are.

Q. Okay. Doctor, we've talked a little bit about the fact that the stabilization device is used to facilitate treatment. How significant -- what tolerances are there when you're using these handpieces and devices inside the child's mouth with respect to movements that are important to control?

A. How much movement of the child before you get into trouble possibly that sort of thing.

Q. Yes.

A. You know, the tolerances are very limited. I mean these are, you know, how big an adult tooth is. Children's teeth are much smaller. The enamel is thinner. The dentin is thinner. The pulps are relatively bigger inside. So that if a child -- I mean it takes a minor movement, and you can be into the pulp when there is no need to be into the pulp with the handpiece. And an handpiece is going 100,000

RPMs. It's high speed and it cuts tooth structure very quickly. And, you know, when we are using the small instruments such as spoon excavators or margin trimmers, again, it's a very delicate situation, hence the need sometimes to stabilize difficult children, special needs patients who can't hold still.

Q. Doctor --

MR. STEVENS: Can I have page 22, please.

Q. On the first day when Jeremy Bohn came to Small Smiles and was seen by Dr. Bonds can we do -- enlarge this middle portion, please. There was -- the record shows that there was a fluoride treatment and prophy. Would you tell the jury what that means?

A. A prophy that's short for prophylaxis which in essence means prevention. What it really means to us in dentistry is is that they cleaned his teeth. If they are going to do an examination, you know, even of an acute problem, emergent problem, they need the teeth to be clean enough to see it.

Q. Tell the jury why it is important to do that in order to do the examination even on a patient who comes in with the problems that Jeremy had?

A. Right. Well, a lot of young children, you know, the hygiene is not wonderful. And it's nobody's fault. It's just difficult to do. And that dental

plaque, which is a bacterial deposit we all get on our teeth, can mask where some of the disease is. In particular, a lot of early cavities start right down by the gumline where plaque first starts to form. So to take that off before the doctor comes in and looks to see if there is, you know, incipient beginning early decay is critical. Also, if you're going to put fluoride on in the case of a child with a lot of cavities, fluoride is critical. It's the one thing that will stop it. It has to be in this form applied topically. Taking the pills doesn't do any good. It goes past it. Right past the teeth so it's this topical fluoride is critical to stopping the disease. For the fluoride to work, the plaque has to be off the teeth. That's assume why they did these things.

Q. They were able to do a complete oral examination?

A. And were able to go on and do an examination, yes.

Q. During Jeremy's approximately two years of visits to Small Smiles, did you learn they had three separate hygiene visits?

A. Correct.

Q. Okay. Doctor, you told us about ECC, and you told us about the findings made in Jeremy with the

teeth that were involved?

A. Right.

Q. To what extent is there a pattern that exists in Jeremy which you see in children with ECC?

MR. HIGGINS: Objection. Relevance. Foundation.

THE COURT: Sustained.

Q. What is the -- why do -- withdrawn. What did you observe from the chart about Jeremy's mouth?

A. Well --

Q. Where was the decay? Where were his problems?

A. Jeremy's decays were classic pattern Early Childhood Caries.

MR. HIGGINS: Same objection, Judge.

THE COURT: Overruled.

Q. Would you explain why?

A. A lot of these children will get decay in their up front teeth, and a lot of the time it's in the first primary molars next to the last teeth in each of the four quadrants.

Q. Can I interrupt you for a second?

A. Yes.

Q. Why would it be that the upper fronts as opposed to the lower fronts would be more involved in a child like this?

MR. HIGGINS: Same objection, Judge.

THE COURT: I'm going to sustain that objection.

Q. What is the role of the salivary glands in terms of tooth decay?

A. Okay. Salivary glands which are located below the tongue here and the cheeks here of -- are the outlets of, those have self-protective chemistry. I won't go into the names of them. Complicated. But the teeth nearest to those ducts are the most protected.

Q. And is that -- I mean the lowers or the uppers are more protected?

A. The lowers are more protected because they are next to the ducts on the bottom. There are none on the top.

Q. And in terms of children with ECC, what does this mean in terms of the pattern that you saw in Jeremy and the pattern that you see in children with ECC in general?

MR. HIGGINS: Objection.

THE COURT: Sustained.

Q. I'd like to move for a moment to Dr. Bonds use of the protective stabilization. Can you explain to the jury why it is important to use it, true?

A. Correct.

Q. Dr. Bonds was on the stand and explained to the jury that -- first let me back up a second. Dr. Bonds told the jury that he came to Small Smiles and worked as an assistant chair side to the lead dentist for a year before he became a dentist. Started working there as a dentist and saw Jeremy, and during that year he assisted with stabilization using a papoose one or two times per week. Do you have an opinion as to whether that's a good and adequate training for the use of the device?

A. Yes, that should be adequate.

Q. And is clinical observational training accepted in your profession?

A. Absolutely. I mean that's a lot of what continuing education is.

Q. Would you tell the jury who treats children in this country in terms of pediatric dentists versus general dentists?

A. Yes, because there so few pediatric dentists, about 8,000 of us, maybe 500 of us involved in academics, leaving about 7,500 practitioners for the children out there. So 75 percent of their care is rendered by their family dentist. That's why we have it in the curriculum as predoctoral as well as

specialty.

Q. 75 percent of children all across the country?

A. Is from general practitioners.

Q. Dr. Bonds tell us that the way he learned to use protective stabilization is to follow three rules, never too tight, never too long and watching the child every second. Doctor, given the way that Dr. Bonds uses the device, do you have an opinion with a reasonable degree of dental certainty as to whether it was safe for Jeremy in a device like this outside of upset, crying, possibly some marks, that sort of thing?

MR. HIGGINS: Objection. Foundation. Leading.

MR. STEVENS: It's an opinion question, Your Honor.

THE COURT: I'm going to overrule the objection.

A. It was absolutely appropriate. The way that he is monitoring it is in keeping with the academy guidelines which do not specify any required monitoring. They don't say when you use, you know, protective stabilization you should have a pulse oximeter on. They don't say you should be monitoring heart rates. It's up to each practitioner within a

reasonable standard of care to monitor that child. We teach at Columbia look at color, not too tight, the respirations are good. The fingernails do not get blue because you cutoff circulation, it is too tight or something like that. That they are reasonably comfortable and all the parameters are in order.

Q. So the way you teach your students doesn't involve a device like a pulse oximeter at all?

A. When we do conscious sedation, we certainly have pulse oxymetry in place then, but that's kind of irrelevant to this.

Q. Okay. The jury has heard a lot about the fact that the -- there is a -- there was a pre- and a post-assessment of heart rate on the third visit.

A. Right.

Q. J, K, and L were filled?

A. Yes.

Q. Both for heart rate and for oxygen saturation, and you recall please that the oxygen saturation pre to post went from 88 to 98?

A. Correct.

Q. And that the pre-heart rate was 204 and that at the end it was recorded as I think 153?

A. Right.

Q. First, let me ask you, would you tell the jury

what you can understand from the fact that the pre-heart rate was 204 and the pre-oxygen saturation was 88, what does this tell you about the patient?

MR. HIGGINS: Form.

THE COURT: I'm going to sustain the objection.

Q. Okay. What's the significance in a situation like the third visit when the heart rate is 204 and the oxygen saturation is 88 on the pre column?

A. Well, I would want to know why I see those sorts of measures and parameters. Normal anxiety about going to the dentist by a three-year-old wouldn't account for that. Jeremy is clearly having a tantrum here. He is physically moving about. Using up the oxygen. Elevating his heart rate. You know, that's sometimes when a child is having a tantrum to avoid things is when we will use adaptive support.

MR. HIGGINS: I object to that. Move to strike as to tantrum. No evidence in the record.

THE COURT: Overruled.

Q. What is the -- you've seen tantrums in three year olds?

A. Yes. Quite a few.

Q. And the -- is the existence of a tantrum with those parameters reason to not use protective

stabilization?

MR. HIGGINS: Same objection.

THE COURT: I'm going to sustain as to form. I'm not sure -- I don't think that was the last objection.

MR. STEVENS: Sure.

Q. Under the circumstances, where there is a tantrum going on, do you let the patient -- how do you decide how to proceed?

MR. HIGGINS: Foundation.

THE COURT: Sustained.

Q. Okay. In general, when you are treating a child with a tantrum who doesn't want to be treated, what do you weigh in terms of deciding whether to proceed --

MR. HIGGINS: Same objection.

Q. -- in a situation where the parents have already given consent because of that behavior to using protective stabilization?

MR. HIGGINS: Same objection.

MR. STEVENS: It's a theoretical question.

THE COURT: Can you read that question back.

(Pending Question read by the Reporter.)

THE COURT: Can you break it down.

Q. Doctor, would you assume -- I want to ask you about how you weigh the pros and cons of going forward with treatment. When you have a patient whose behavior is so poor and can't be reached, and you try other things, and you've gone to the parents and explained to them that you may have to use this device protective stabilization and they give you their consent, based upon the discussion, okay?

A. Right.

Q. Okay. You come back, you see the patient, the patient is still having -- let's say having a tantrum. How do you -- what do you weigh at that point in time to decide whether to proceed with the treatment or not?

MR. HIGGINS: Objection. Form and foundation.

THE COURT: Overruled.

A. Well, the child that's having a tantrum, they're having that tantrum for a reason. They learned if they manifest this behavior, if I lay down in the grocery store on my back in the aisle and start screaming and yelling, I want candy, my mother is allowed to give it to me. You have to stop it at its inception if you can. I don't know if that was possible in Jeremy's case. I think once he got to --

to the place, from what I read, he was already pretty excited and worked up. But nonetheless, one of the things we will do is to use the stabilization. Once they realize there is no point in this kicking and carrying on and flailing about, all that, it's not going to get me out of this situation and even a three-year-old understands that, they stop. I can't tell you the numbers of times we put children in stabilization and it stops the tantrum, and then the heart rate because they're not jumping around goes down. The respiratory rate goes down. The oxygen saturation goes up. Again, things that we don't often measure but when we have -- we see that. And it is just, you know, I see parents do this. I think that's more dangerous than what we're doing.

MR. HIGGINS: Objection. Move to strike the last.

THE COURT: The last sentence is going to be stricken.

MR. HIGGINS: Thank you.

Q. And please assume that Dr. Bonds told this jury that in the situation of a patient's heart rate is 204, he would wait for the patient to calm down before he starts to work. Do you have an opinion as to whether that's appropriate?

A. That's necessary. That's absolutely correct. Yeah.

Q. And do you have an opinion as to whether the pulse oxygenation going from 88 up to 98 is a good sign, a bad sign or otherwise?

A. That means he's under control or closer to it let's put it that way.

Q. By the end of the procedure the heart rate was recorded at 153, what's the significance of that?

A. He's still not happy about being where he is and what he is doing, I'm sure. He's calmed down considerably to have a 50-point drop in pulse rate.

Q. I'd like the -- you to assume, Dr. Davis, that Mrs. Varano was questioned in this courtroom, and she gave evidence from that witness chair and that my colleague, George Nowatny, questioned her, and one of the things he asked her about was whether she had -- was familiar with the -- page two of the form that she had signed which is a list of patient management techniques and during that conversation --

MR. STEVENS: Would you blowup number six and seven, please.

Q. Mr. Nowatny asked Mrs. Varano whether she would -- how she would have felt about allowing physical immobilization by the dentist or physical

immobilization by an assistant, and she told him that would have been fine with me. Okay.

A. Okay.

Q. Is there a category that hands-on immobilization as opposed to using a device like this one?

A. We differentiate between that. We call that active immobilization where human beings are involved in holding someone still versus passive where you use a device like this. It's interesting, I would only comment that there is clear --

MR. HIGGINS: Objection.

THE COURT: Sustained.

Q. In terms of active versus passive, which one actually has more safety for the child?

A. Passive clearly.

Q. Why is it that active has less safety, meaning people holding down a child and passive this device has more safety?

A. Because when people are trying to hold a child who is squirming and moving, they slip sometimes, or they're more likely to bruise the child because they're holding on tightly. Just some examples of why it is more of a problem.

Q. On the third visit when Dr. Bonds treated tooth

J, K and L --

A. Right.

Q. -- the -- before I do that one. Let me ask you the second visit to Small Smiles was August 31st, 2006, correct?

A. Correct.

Q. And there's been a point made there was three months between the first visit and the second visit, true?

A. True.

Q. Actually scheduled for September 4th, then was held on August 31st, true?

A. True.

Q. Okay. In terms of those summer months leading up to August 31st, what is the typical affect of the summer months on a dental practice?

MR. HIGGINS: Objection. Foundation. Form. Relevance.

THE COURT: I'm going to sustain the objection.

Q. Okay. When does a children's dental practice see the greatest influx of patients?

MR. HIGGINS: Same objections.

MR. STEVENS: It's significant, Your Honor.

THE COURT: Uhm --

MR. STEVENS: They made an issue --

THE COURT: No. I think it's relevant. I just don't think there is a foundation. So I think he had that as one of them.

Q. Sure. Have you worked in practices that treat children who go to school?

A. Yes.

Q. And children who go to preschool?

A. Correct.

Q. And parents -- withdrawn. And in those practices has there been -- what is the significance of the summer months in terms of scheduling?

A. Those are the bust times because the children aren't in school and the parents would like to get all their dental needs and other health needs met before school starts in September.

Q. That's all I wanted to ask you.

A. Thank you.

Q. On the third visit to Small Smiles when Jeremy was treated by Dr. Bonds and he filled he -- restored J, K and L --

A. Yes.

Q. -- would you tell the jury why it is significant or important or otherwise to treat lesions

of that sort in a child like Jeremy?

A. That goes back to what Early Childhood Caries is all about. Early Childhood Caries is --

MR. HIGGINS: Judge, was there -- I thought there was somebody saying something. I'm sorry. No. Go ahead.

A. Early Childhood Caries is a syndrome. It's a disease entity with multiple parts. It's a reflection of diet. It's a reflection of hygiene. Susceptibility of individual children is different. But the bottom line is if you don't intervene, the bacterial count in the mouth, how many bacteria are in the plaque on that child's teeth, the more plaque, the more bacteria, the more exposure to carbohydrate type foods, the more acid, the more acid the more cavities. So you try to change the diet. Give fluoride to stop the process. Make the mineralization of the teeth go back, get better. Certainly put an end to any existing cavities. If there are holes in the teeth, they are full of bacteria, you have to eliminate those or the bacteria stays there and new cavities come and the rate of progression of cavities --

MR. HIGGINS: Objection, Judge. Narrative.

THE COURT: Overruled.

A. Rate of progression of cavities it gets faster and faster and faster if you don't do those things. So it's really a virulent disease.

Q. Even treating, restoring relatively small cavities in the mouth like J, K, and L, which may go into the dentin or maybe more or less they have a -- the reason for doing it has to do with the child's ongoing health?

A. Correct. The bacterial count again reducing, I mean on microbiologically or look through a microscope level, those aren't just tiny lesions. Those are big holes in the teeth. If you're a bacteria looking for a place to hide, you make these acid, so yes, all of that has to be, you know, cured, repaired, fixed.

Q. After that third visit, Jeremy returned and now the summer is over?

A. Correct.

Q. Jeremy returned for a fourth visit to Small Smiles you recall that was on October 23, 2006?

A. Right.

Q. That just -- now the summer is over, that's just twelve days later after the October 11th, visit?

A. Right.

Q. And on the October 23rd visit, there were two surface fillings in tooth A and a surface on tooth G?

A. Correct. A and S.
Q. A and S, exactly right. I read it wrong.
A. Thank you.
Q. And, Doctor, am I reading the chart properly that from the fourth visit onward, Jeremy never needed protective stabilization again and was never again recommended even to get permission to use it?
A. Correct.
Q. Okay. In terms of child's behavior and being treated for those on the first and the third visit with protective stabilization and getting treatment and successfully, what is the significance of the child in terms of the dynamics between the child and the treatment and the dentist?
A. Well, the significance is very simple, Jeremy has learned that tantrum like behavior is not going to get him out of it.
MR. HIGGINS: Objection as to what Jeremy has learned, Judge. Foundation.
THE COURT: Sustained. I'm going to strike the answer.
Q. In general, under the circumstances, does it help a child in terms of learned behavior to be successful with treatment?
MR. HIGGINS: Objection. Foundation.

Relevance.

THE COURT: Sustained.

Q. After the fourth visit, Jeremy had some more decay and caries in his mouth that were treated in visits four to well -- four through the end, true?

A. Correct.

Q. What is the -- what is the continuing benefit of -- to Jeremy to continue to treat those lesions?

A. Well, again, it goes back to the reduction of the bacterial count and potential -- the higher caries risk to be presented with this whole process is lowering that caries risk so he is less likely to get new cavities.

Q. With respect to J, K and L?

A. Right.

Q. And this is -- the jury knows this is the odontogram.

A. Right.

Q. Where was the decay in the -- was the decay in Jeremy's mouth on J, K and L, recognized on the first day that Jeremy came to Small Smiles clinic?

MR. HIGGINS: Objection. Foundation.

MR. STEVENS: Showing the odontogram. The question was whether the decay in J, K and L was recognized to be the first day that Jeremy came to

the Small Smiles clinic. Very simple question.

THE COURT: Uhm, well --

MR. HIGGINS: Judge, I note.

THE COURT: -- it's marked on the chart. I guess that's -- I think it is.

MR. HIGGINS: No objection. It is shown in the records. But that wasn't the question.

THE COURT: I'm going to sustain the question.

MR. STEVENS: Can I have page 23, please. Would you blowup the treatment plan part.

BY MR. STEVENS: (Cont.)

Q. Dr. Davis, as of May 23, 2006, the date of this treatment plan, was there -- were there findings made when Jeremy came to see Dr. Bonds on the very first day with respect to decay in teeth J, K and L?

A. Yes, there were.

Q. Okay. And what was noted on that date on the treatment plan with respect to how that decay should be dealt with?

A. That it should be restored --

Q. Okay.

A. -- or filled.

Q. How many of those teeth had two-surface decay?

A. One.

Q. And how many of those teeth had one surface decay?

A. Two.

Q. Is the same -- were those surfaces marked on the odontogram on that same day?

A. Those are the same surfaces with the exception that L has a distal on it at some point in time there.

Q. Okay. Is it true in order to understand the diagram and the chart, you read different parts of the chart together, the odontogram, the treatment plan and the operative report?

MR. HIGGINS: Objection. Foundation. Relevance.

THE COURT: You're leading the witness. Rephrase your questions.

Q. Would you -- when Dr. Bonds treated tooth J, K and L, and told the jury that he used a technique in which the high speed drill was not used below the DEJ the dentoenamel junction, and a gentler technique is used below the DEJ, such as a spoon excavator, are you familiar with that technique?

A. That's what I was taught to do and we still teach to do.

Q. I would like to remind you or tell you that -- ask you to assume that there was a dentist who came

into court, her name was Dr. Slack, and she sat in that chair where you are sitting and when she was asked about that technique, she said, I've never heard of it. What is your comment?

A. I don't understand that response. Every -- there are 70 dental schools. They all have to be teaching how to use a spoon excavator. Sometimes it's the only way --

MR. HIGGINS: Objection as the -- to what they all have to be doing. Move to strike.

THE COURT: Sustained. Stricken.

Q. Is it taught at your dental school, Columbia University?

A. Absolutely.

Q. Did you learn it when you were a dental student?

A. Absolutely.

Q. What is the benefit of using a spoon excavator below the DEJ on decay?

A. It's a very carefully controllable way to remove the dead decay material that's in the bottom of that cavity preparation.

Q. And does that dead decayed material have any nerve endings or sensitivity?

A. Not in the material itself, no.

MR. STEVENS: Could I have number 530 up.

Q. I'm going to ask you whether this is a picture of a tool which is -- which we referred to as the spoon excavator?

A. Yes. That is one version of the spoon excavator.

Q. What is known in dentistry regarding the advantages or disadvantage of using this technique in terms of the need for a shot of local anesthesia?

A. If we anticipate this is a very shallow restoration just at the DEJ, then this is a preferred technique to remove the -- removing caries. The alternative is using a round burr slow speed handpiece which is much harder to control. Its depth going down into the dentin which is far softer material, even healthy dentin than is the hard enamel which we went through with the high speed drill.

Q. Yes.

A. Yes.

Q. And in terms of decay which is below the DEJ, what -- do you need to use local anesthesia when you use this technique to remove that dead material?

MR. HIGGINS: Objection. As to foundation and relevance, unless it is to a particular treatment.

MR. STEVENS: Relevance is obvious, Your Honor.

THE COURT: I'm going to sustain it as to form.

BY MR. STEVENS: (Cont.)

Q. Sure. In terms of using putting a stainless needle into the child's mouth, does this technique provide some alternative?

A. Yes.

Q. And why is that?

A. Because if its done carefully won't induce discomfort for that patient.

Q. Doctor, based upon everything you have seen in the record, do you have any reason to believe that Jeremy suffered any discomfort during his treatments at Small Smiles clinic by Dr. Aman, Dr. Bond, and Dr. Khan?

MR. HIGGINS: Objection. Form and foundation.

THE COURT: Overruled.

A. I see no evidence of it.

Q. I like to ask you to assume that when Dr. Slack was on the stand the other day she told the jury that she would not expect decay to progress within a period of three months, referring to the period between

Jeremy's first appointment and his second appointment. Do you agree with that proposition?

A. It's very patient dependent. In a child with active decay like this it could progress.

Q. And who would be in the best position to see that progression?

A. Well, the doctor providing the care.

Q. And in this case, Dr. Aman?

A. Correct.

Q. Dr. Slack told the jury that the absence of radiographic evidence meant to her that there were -- there was no cavities. Do you agree with that sort of statement?

A. No.

Q. Okay. Why not?

A. Because first you look at and clinically examine the patient, you often see things that you will see on a radiograph. In fact, it's that clinical examination what tells you which radiographs you need to take to augment that.

Q. Doctor, the jury has seen a video that plaintiff's attorney brought in. And this video was a video of a pulpotomy on the upper front teeth. And at the beginning of the video there was a photograph of the child's smile with the front teeth showing, and a

minute later there was a photograph looking up at the palate area showing the lingual surface of those front teeth with some big black decay. And then just 30 seconds later in the video there was a picture of the radiograph, the x-ray of those same teeth. Have I -- I've showed counsel screen shots from that video, and I'm going to show you the picture and ask you to explain to the jury whether this is an example of what can be seen of whether -- of what is shown when comparing the visual to the radiographic, may I do that?

MR. HIGGINS: Objection to form.

A. Yes.

MR. HIGGINS: Form and relevance and foundation on that.

THE COURT: Would counsel approach.

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

BY MR. STEVENS: (Cont.)

Q. Referring to defendant's ABK-1281, 1274, and 1275, which are all screen shots from plaintiff's video, Dr. Davis, my first question before I put this up is when an x-ray is taken of upper front teeth --

A. Right.

Q. -- in a young child, if there is a decay

present, is it always visible on x-ray?

A. No.

Q. Okay. When an x-ray is taken of a young child who has a cavity in the teeth, is that always visible?

A. Not always. Depends on where it is.

Q. Okay. Within the upper -- how about in the facial surface of the upper front four?

A. That's a good example of where you may not see it on the x-ray because the x-ray has to go through that entire tooth to see it as opposed to just the sides where it is much thinner. That's where you can easily see it on x-ray.

Q. Is it the same thing on the lingual surface?

A. Yes.

Q. That's the surface towards the tongue?

A. Towards the tongue, the palate.

Q. When plaintiff's attorney played a video for the jury, there were -- there was a photograph of a child's mouth, and you could see one of the upper front four teeth was partially missing?

A. Yes.

Q. And the photograph of the same mouth looking up into the palate, and then x-ray of those teeth taken straight on at a good 90-degree angle, true?

A. True.

Q. Now, would you please explain to the jury whether you're able to see in the x-rays all of the decay areas or all of the decay which is shown in the photographs?

A. May I step down?

MR. HIGGINS: Objection to referencing anything other than what is in those photographs.

Q. You want to point to it?

A. Just my finger. Okay. I think it is long enough. If you look at -- thank you. If you look at it from the facial aspect, on these two teeth in particular, you know, this is a large cavity that's easy to see. It is easy to see here and it is very visible on the radiograph over here, and again, it is because of the amount of tooth structure loss. I look at these two teeth, I certainly don't see any disease, clinically meaning directly with my vision seeing it during an examination. I do see it on the palatable aspect or lingual here. What's interesting here is as I said this is very visible on the radiograph.

Q. When you say "this" you mean?

A. This disease, the damage done to that lateral incisor in this case which is then this tooth. You know, it's very visible on the radiograph, but if I look at, for instance, for some of the areas on these

two teeth, the damages on the palatable, and I also observe clinically there is a little cavity here and a little cavity here starting, not nearly as big as these, these look pretty significant, so I look at this tooth, being this tooth, I got -- I'm not sure I see on this one. I see, you know, a spot here, and a spot here, and I say, well, that's those two areas of decay. This area of decay right here I'm not sure. I see something maybe here, and again, not to confuse it with the pulp which is this dark area here. But then I look over at this other tooth and I go, where did those two decay spots go? This is even made worse if the angulation isn't good. Like this is a very good radiograph here. The angle of the beam going through it is very much perpendicular, so it gives you a very definitive sense of the soundness of the tooth structure remaining or where -- it is not where the cavity is. This were changed, it could mask the disease more. Does that answer your question?

Q. It does. It does. These are the same two photographs. Would you orient these in the proper direction if they can be?

A. Sure.

Q. So that they -- one is above the tooth that it refers to.

A. Well, it's flipped around which is how we actually use them. But so that tooth is this tooth on the radiograph.

Q. Would you flip it so one is right above the other. In other words, coming down.

A. Upside down. One way or the other.

Q. Us lay people that makes more sense.

A. All right. So sorry. That tooth matches that radiograph. This to this. This to this. And that to this. By the way, where I said there was beginning or incipient lesions, I don't see anything on that x-ray, any little dark spots at all. Nothing there. I mean you can see the brown spot there, the little damage there. Nothing visible on the x-ray.

Q. Thank you.

MR. STEVENS: And, Your Honor, may I circulate these to the jury so they can see them close-up?

THE COURT: No. They're not in evidence, right? They're just demonstrative.

MR. STEVENS: I'd like to offer this in evidence.

MR. HIGGINS: I would object. Because our video is only demonstrative.

MR. STEVENS: I'd like to circulate as to

demonstrative items. Will not be taken into the jury room.

THE COURT: Sustained.

MR. STEVENS: Okay.

MR. STEVENS: (Cont.)

Q. How common is it for an x-ray to show no decay or on a clinical exam will show decay and in a child of Jeremy's age?

A. It's going to depend on which teeth you're looking at. Little more common on outer surfaces of teeth as opposed to in-between surfaces. Little more common in primary teeth than permanent teeth, which at the time Jeremy didn't have.

Q. Okay. When you're using local anesthetic -- by the way, did you learn from the chart that each of the three dentists used local anesthetic on at least one occasion, Dr. Bonds, Dr. Khan and Dr. Aman?

A. Correct, I saw that.

Q. And is there a difference in the efficacy or speed that the anesthetic takes effect between different parts of the mouth, upper, lower, otherwise?

A. Absolutely, yes.

Q. Tell the jury the difference between, for instance, anesthesia in the -- for the front teeth, the upper, front and a lower jaw block?

A. The difference depends on the anatomy. The bone in your upper jaw is much less dense than it is in your lower jaw, so that a lot of times we can give the local anesthetic spot right on the tooth wherever we want that tooth to go to sleep for awhile, and it soaks in rapidly, and the effects can be seen in a minute or two profoundly, so certainly three minutes. If I wanted to do the same thing with the opposite molar on the bottom arc, have to give a very different kind of injection. I can't give it local. The bone is too dense. The solution of the anesthetic won't penetrate it. So I have to go back behind it and give an injection, then go through a fair amount of soft tissue down to where the nerve comes from the top part of the head down into the jaw bone, and I have to deposit that solution right there. Then it will slowly block this, and then that's when your lip goes to sleep and your tongue on that side goes to sleep, if you had that experience. But that takes -- that can take seven, eight, ten minutes as opposed to the two or three minutes at the most for the maxillary anterior.

Q. And blowup the bottom section. Doctor, when -- on Jeremy's first visit there is a note that you have a patient who was, quote, out of control?

A. Right.
Q. Did you see that in the chart?
A. Correct. Yes.
MR. STEVENS: Put up 835. Blowup the top, please.
Q. On the -- have the behavior rating scale on the third visit. Did you learn that this was the last time that Jeremy was rated as a number one on the Frankl scale?
A. That's correct.
Q. For a child who has lower jaw caries, what sort of procedure would be needed in terms of local anesthetic if you want to numb the lower jaw?
A. That would be that nerve block I was talking about. It's called inferior alveolar nerve block.
Q. And can we call that just more simply a lower jaw nerve block?
A. Sure. For our purposes here.
Q. Okay. And a lower jaw nerve block requires what kind of stability and what kind of cooperation, and how long does it take while the needle is actually inside the patient?
MR. HIGGINS: Objection. Leading. Foundation. Form.
MR. STEVENS: I'll say it differently.

THE COURT: Sustained.

Q. Would you describe a lower jaw nerve block in terms of how it would be performed if you chose to use it?

A. Certainly. The child has to keep their mouth open. You have to visualize where you actually want the needle to enter the tissue, and it's way in the back behind your last molar, and you do it very slowly after putting topical on for two minutes, so that at first when you penetrate, they don't feel that. Then you try to go really slowly and inject a little bit ahead of the needle tip and make the tissue numb before you go through it. If you've ever had this, can be very uncomfortable if somebody rushes it. Take your time going back and eventually you have to go through maybe three-quarter -- in a three-year-old, maybe three quarters of an inch of tissue to hit the bone where that nerve is coming down from the brain to go into the jaw and be the nerve of these teeth, so that's where you have to deposit the solution. When you're there, besides the nerve, there is also the inferior alveolar, artery and vein, and you certainly don't want to be in those with the needle and inject this Xylocaine into this systemic solution of the child. You don't want to do it. So we always do

something called aspiration also, which means we back off on the syringe to make sure blood is not coming back into it at that point. So it's a rather lengthy injection compared to a simple infiltration, the upper injections.

Q. You used a word I'm not sure I heard before in this courtroom, Xylocaine?

A. Which is a lidocaine.

Q. Lidocaine.

A. Yeah.

Q. Now, should a dentist chose to do such a procedure on a child who was not cooperative or very poorly controlled, what would be the -- would there be any potential risks to the child?

A. Why, certainly.

Q. Please tell the jury.

A. Some of the risks are the ones if you had wisdom teeth taken out by a surgeon, they tell you paraesthesia, numbness, the nerve can be damaged, the artery can be damaged. You can be off the site and just be plain ineffective in where you put the solution. You miss it. Some of you may have had that experience, I certainly have, when they were doing a filling, gave me injection and it didn't get numb and they had to do it again. Don't want to do that with a

child. But the toughest part is I would decide probably, you know, if I cannot stabilize the child, I will not give that kind of injection.

Q. Are there -- by the way, would it be -- do you think it would be helpful for the jury to see an illustration of where the -- in the mouth that would be given in a situation like this?

A. Very helpful I think.

MR. STEVENS: Can I have number 441.

THE COURT: This for demonstrative purposes?

MR. STEVENS: Yes, and it has been exchanged without objection.

Q. Tell the jury what you are looking at?

A. May I approach?

Q. Sure. There is the pointer right there.

A. Thank you. As you can see, we're swinging from the midline here way over this way. You have to, you know, enter a very specific spot here because you -- you are going blindly through this soft tissue hoping to get back to that spot where the nerve emerges that I talked about. We have another view I think.

Q. Yes.

A. You will show -- you can see if this child is going to be moving around. You have to get not only

that point of entry, but this angulation, this angulation, all of those have to be correct or you are going to miss.

MR. STEVENS: 439, please.

Q. Doctor, although this is a picture of an adult male, does it depict the structures that you have to deal with in an approach when using a lower jaw block?

A. That's correct. This is simply instead of looking at it, this going in the mouth, it is just rotated forward here. So you are looking down on it. You are still coming in at this angle. This is where we are actually entering the soft tissue.

Q. Use a laser.

A. So we are entering the soft tissue right here and going through soft tissue, some muscle. You can see this is the inferior alveolar nerve. This is the artery. This is the -- excuse me, that's the vein, the artery and the nerve that have come down from up in top of the brain. You go through all that tissue right to the jaw bone here, before you deposit it. If you put it here, if you put it here, it won't make the patient numb. Does no good. So if they are moving a lot it's obviously a problem.

Q. Okay. Cut it. I'd like you to please assume that Dr. Bonds described some of those same risks, but

he also told the jury that the child was moving during such a shot of anesthesia, there was also the risk of breaking a needle inside the child's mouth?

A. True.

Q. Described that as something catastrophic?

A. That requires what is called a cut down where you make a big incision, spread the tissue, go in there with forceps and try to find and then remove that needle tip.

Q. Doctor --

MR. STEVENS: Could I have page 51.

Q. Would you blowup the left-hand x-ray. Doctor, I'd like you to assume we have seen a picture of Jeremy as a child after his treatment with a big smile on his mouth, able to see D, E, F, and G, the New Smile white crowns that were installed by Dr. Aman.

A. Right.

Q. And I would like to ask you this is a -- this is an x-ray taken at Small Smiles clinic on November 12, 2007, some number of months after Dr. Aman installed those four crowns and did four pulpotomies on D, E, F, G. First tell the jury what you see in general, and then I'd like to ask you a more specific question.

A. Okay. It's easy enough to see there is a

stainless steel crown. You cannot tell it has a veneer. We do know they have veneers on them for aesthetic purposes, appearances if you will. What I also see in each of them I see this white radiopaque here. I see it here. I see it here. I see it here. That will tell me they have done pulpotomy in the coronal space where the pulp once was inside the crown of the tooth. I can't tell what kind of cement they used or anything else. The crowns look reasonably well-adapted certain standard of care.

Q. Here's my question to you, please assume that Dr. Cynthia Slack got on the stand under oath before this jury and she told the jury that, I believe that no pulpotomies were performed at all. Do you agree with that, Doctor?

A. No, I don't agree with that.

MR. HIGGINS: Objection. Misstates the testimony.

MR. STEVENS: Didn't she say that?

MR. HIGGINS: No.

MR. STEVENS: Well --

THE COURT: It's a --

MR. STEVENS: If she didn't say that, I withdraw the question.

Q. And I will ask the, Doctor, can you confirm

whether the pulpotomies were performed on these four teeth?

A. Yes, they were.

Q. Okay. Doctor, have you reviewed the remaining restorations of -- performed during the fourth visit onwards with Jeremy?

A. Yes, I have.

Q. Without taking too much time and going through them individually, do you have an opinion with a reasonable degree of medical certainty as to the -- as to whether those -- whether all the treatment that you saw in this case was appropriate and necessary?

A. Yes, it was all appropriate and needed.

Q. Do you have an opinion with a reasonable degree of dental certainty as to whether Dr. Bonds and Dr. Khan and Dr. Aman acted within appropriate dental judgment in their treatment of Jeremy?

MR. HIGGINS: Objection. Foundation.

MR. STEVENS: We can go through one by one if needed.

THE COURT: Overruled.

A. It's all been provided within the standards of care.

Q. And you're being compensated for your time?

A. Absolutely.

Q. And have all of your opinions been stated in this courtroom with a reasonable degree of dental certainty?

A. Yes.

Q. And you believe those to be true?

A. Yes.

MR. STEVENS: Thank you very much.

THE COURT: Okay. Go this way. Can I see counsellors real quickly.

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

THE COURT: Okay. So we can get you out of here by four, we will take our afternoon recess. It is only going to be like seven minutes. Okay.

(Proceedings in recess at 2:50 p.m..)

(Jury seated in the jury box at 3:05 p.m.)

THE COURT: Proceed.

CROSS-EXAMINATION

BY MR. HIGGINS:

Q. Dr. Davis, good afternoon. You and I have not had a chance to meet yet, correct?

A. Correct.

Q. Uhm, Doctor, just a few housekeeping matters.

How much are you being compensated for your time?

A. $350 an hour.

Q. How much have you billed so far?

A. Probably about 30 hours worth of time.

Q. How much of that has been spent in preparing for trial?

A. Probably half of that.

Q. Okay. And of those 15 hours how much of that was spent in chart review?

A. Probably half of that. A quarter of the total hours.

Q. Okay. And have you reviewed any other Small Smiles charts?

A. I have.

MR. STEVENS: Objection.

Q. All right. And --

THE COURT: Overruled.

Q. -- in reviewing those other Small Smiles charts, how many of those have you reviewed?

MR. STEVENS: Objection.

THE COURT: Overruled.

A. Roughly 30 I would say.

Q. How many hours did that take?

A. Well, that is a good bit of the other time so that was probably 15 hours, maybe. Something like

that.

Q. Who selected those charts?

A. They were sent to me.

Q. By who?

A. By the law firm that retained me.

Q. Which law firm was that?

A. Ellis Wilson.

Q. Wilson Elser?

A. Wilson Elser.

Q. No problem. Did you ask them for more charts?

A. No, I didn't.

Q. Did you -- how did you decide what you were going to review in this case?

A. When I was first contacted by them?

Q. Yes.

A. They said we would like you to become involved in something you may have heard about. It has to do with Small Smiles clinics. We want your role to be to look at the examination -- clinical examination, the radiographs, the care provided and see if they match.

Q. Okay.

A. Which seems reasonable.

Q. So they told you what your scope of review was going to be?

A. Correct.

Q. And your scope of review was going to be limited to the three dentists?

A. They didn't say that. They said in any case in which involve you that's going to be your focus.

Q. Okay. So you're past president of the American Academy of Pediatric Dentistry?

A. Correct.

Q. And the jury heard quite a bit about that. You ever hear anything about the Small Smiles matters before you got retained by Wilson Elser?

MR. STEVENS: Objection.

MR. HIGGINS: I'm not asking what he heard. I'm asking whether he did --

MR. STEVENS: Objection.

THE COURT: I'm going to sustain the objection.

Q. Well, okay. When you were approached by Wilson Elser, how many years ago was that?

A. Probably a year and a half ago roughly.

Q. Did you tell them at that time that you knew something about the Small Smiles matter?

MR. STEVENS: Objection.

MR. McPHILLIAMY: Objection.

THE COURT: Overruled.

A. Yes, I did.

Q. Okay.
A. Which I had heard.
Q. We don't -- don't tell us what you heard. And did you -- when you were hired as an expert in this case, did you then go to Wilson Elser and say, well, I need to know everything. I need to know. I have to find out about Small Smiles and the corporate influence arguments and all of that. Did you go and ask him that?
MR. STEVENS: Objection.
MR. McPHILLIAMY: Form.
MR. STEVENS: Doctor explained what he was doing, Your Honor.
THE COURT: Overruled.
A. No, I did not inquire as to those things because I didn't know enough to do so.
Q. So as you sit here today are you assuming that the Small Smiles as part of your opinions -- are you assuming that the Small Smiles group here, the Old and New FORBA were acting appropriately in their communications and their correspondence and their dealing with the three dentists that you're testifying about?
MR. McPHILLIAMY: Objection.
THE COURT: What's the basis of -- the

legal basis of the objection?

MR. McPHILLIAMY: Form.

THE COURT: Overruled.

A. I really have no basis to make that judgment because I just don't know that much about that piece.

Q. You don't know anything about Small Smiles I mean within the context of your --

A. I have now read some depositions.

Q. You have read some depositions?

A. I read what's been said in here, transcription of trials. That's where I have learned subsequently. I certainly didn't know it when first approached by Wilson Elser.

Q. Certainly in the last year and a half you haven't done anything yourself to find out more about Small Smiles?

A. No.

Q. So what deposition transcripts were you given by Wilson Elser regarding Small Smiles and how it interacted with the three dentists that you're here to testify about today?

A. Okay. So I saw depositions from the three doctors.

Q. Bonds, Aman, Khan?

A. Correct.

Q. All right.
A. I saw deposition from Jeremy.
Q. Jeremy?
A. From his mother. From his father.
Q. Right.
A. Those are the ones I remember.
Q. Anything else?
A. Off the top of my head, I don't remember.
Q. Well, you know, you would have -- what about Dr. Mueller?
A. I did see his.
Q. You did?
A. I'm sorry.
Q. Okay. Did you -- when you read it, did you reach any opinions or findings about whether Small Smiles was influencing the dentists or directing clinical work?

MR. McPHILLIAMY: Objection. Form. Relevance. Form and relevance.

MR. STEVENS: Objection.

MR. FIRST: Objection.

MR. STEVENS: Outside scope, Your Honor.

THE COURT: Would counsellors approach.

MR. HIGGINS: I can rephrase, Judge.

THE COURT: Okay.

MR. HIGGINS: All right.

BY MR. HIGGINS: (Cont.)

Q. Uhm, is it your opinion based on any assumptions to this jury -- when you're talking to this jury giving opinions, are there any assumptions that you are -- that are embedded in your opinions?

A. As reflects the relationship to those corporations?

Q. Yeah.

A. No.

Q. Okay. So when you're sitting here talking to the jury about these three dentists, you are basically considering these dentists just as if they're in their own single practice and just doing whatever dentists do, correct?

A. Talking about the standard of care. The care they provided.

Q. Right. You haven't even considered whether any of these dentists were improperly influenced and whether there was any type of motivation for whatever was done in this chart to Jeremy Bohn; is that fair?

A. That's fair.

MR. McPHILLIAMY: Objection. Relevance.

MR. STEVENS: Objection.

THE COURT: Overruled.

Q. That -- you understand that's a job for the jury, correct?

A. Correct.

Q. All right. So you're not here to say anything different, right? You're not here to say that these dentists weren't influenced or anything like that, that's just not part of what you're doing here; is that fair?

A. I don't know those details.

Q. Okay. And you never asked Wilson Elser to give you any of those details --

MR. STEVENS: Objection.

Q. -- is that fair?

THE COURT: Overruled.

Q. Is that fair?

A. That's fair.

Q. Thank you, Doctor. The motivation for why people do things or why they don't do things is that sometimes important in understanding what happens in a particular case?

A. Of course.

Q. And, Doctor, you had a very long and distinguished career, haven't you?

A. Thank you.

Q. I mean it's evident from your record. You

strike me that you're committed to pediatric dentistry, correct?

A. Hope so.

Q. Okay. Do you think it's a good idea for corporations to direct clinical care to dentists?

MR. McPHILLIAMY: Objection. Relevance.

MR. FIRST: Objection.

THE COURT: Overruled.

A. I think the dentists have to make independent decisions about care for patients.

Q. Okay. And that's because of patient safety, correct?

A. And wellness, yes.

Q. Okay. I this whole thing is about doctors and dentists and patient safety, correct?

A. Correct.

Q. All right. And if you have corporations telling dentists and doctors how to practice medicine that potentially can be unsafe for members of the community; is that fair?

MR. McPHILLIAMY: Objection.

MR. FIRST: Objection.

MR. STEVENS: Objection.

MR. FIRST: Beyond the scope.

THE COURT: I'm going to sustain the

objection.

BY MR. HIGGINS: (Cont.)

Q. Doctor, you as a -- the past president of the American Academy of Pediatrics, you would not want to live in a world where corporations dictate how doctors and dentists practice; is that fair?

MR. FIRST: Objection. Beyond the scope.

MR. HULSLANDER: Objection. Scope.

MR. STEVENS: Objection.

THE COURT: Overruled.

A. That's fair.

Q. That's not a safe world for people in the community, is it?

A. No. It has the potential for problems.

Q. Right. And you teach residents, you have done that for quite sometime, correct?

A. They -- I think too long it's why I actually retired six months ago.

Q. I thought you retired in 2012?

A. December of 2012.

Q. Okay.

A. That's nine months, isn't it?

Q. Yes. And did you -- did you ever teach residents about the corporate practice of medicine?

A. No.

Q. Did you know when you were practicing that there was a state law against that?

A. Yes.

Q. And did you think it was there for a good reason?

A. Yes.

Q. And again it's a patient safety law, is it not?

A. Safety, well-being, ultimately best care.

Q. Okay. And, Doctor, the -- you said you had a 45-year career. You must have treated tens of thousands of patients?

A. A lot of patients.

Q. Okay. Is that a fair estimate?

A. I never put a number on them. I suppose it was well up in the thousands.

Q. I mean 45 years, thousand patients, that would be like 15 or 20 a year, something like that. You have seen thousands of patients?

A. Yes.

Q. And you told us that you had restrained about 500 in your career, correct?

A. That sounds about right.

Q. All right. How many of those were special needs children?

A. Quarter to a third of those probably.

Q. Okay. So we're talking, again, math, help me on the math. We are talking --

A. 300 non-special needs patients.

Q. Over 45 years, correct?

A. Yes, of the active practice time.

Q. Right. And, Doctor, you've written on restraints before, haven't you?

A. Written on restraints among a few things, yes.

Q. And you got your medical license in 1974 -- your dental license, I'm sorry?

A. Correct.

Q. And by 1979 you were publishing, correct?

A. Correct.

Q. And even in 1979 you were of the opinion that restraints should not be used for routine utilization on the average child patient; is that fair?

A. That's fair.

Q. That's what you wrote in 1979, correct?

A. Correct.

Q. Okay. And we talked a little bit about childhood caries. You are also a spokesperson for the American Academy of Pediatrics?

A. That's correct.

Q. October 2011, you told us or you made a statement that -- well, let me ask you this. How many

people -- how many kids between two and five, what is the most frequent reason now that they go to the hospital?

A. They go to the -- they're admitted to hospitals?

Q. Yeah.

A. I would guess asthma.

Q. Doctor, did you say on October 31st, 2011, that the most frequent -- children ages two to five are admitted to the hospital most frequently to have their teeth fixed?

A. May I?

Q. Please. If I misstated that, please let me know.

A. Okay. Children ages two to five are admitted to the hospital most frequently to have their teeth fixed.

Q. Is that accurate?

A. That's accurate, sorry. I wasn't understanding what you were asking. I apologize.

Q. I'm sorry, it is probably my question. The other thing, Doctor, in terms of Early Childhood Caries, just if a kid has one cavity, that's Early Childhood Caries, correct?

A. That's the definition, yes.

Q. And what percentage of kids in the United States now under the age of five?

MR. STEVENS: Objection to "now." We're talking 2006.

MR. HIGGINS: Okay. I'll withdraw.

Q. In 2006, what percentage of kids in the United States had one cavity?

A. One cavity?

Q. Yeah.

A. Under the age of six?

Q. Under the age of five?

A. Under the age of five, trying to remember data here.

Q. Sure.

A. Easily 50 percent.

Q. All right. How many kids are there in the country?

A. It's a country of 300 million people of which about quarter of them are under the age of 18, I guess.

Q. Okay. So we're talking millions and millions of kids would fit this definition of rampant ECC decay, right, rampant caries, correct?

A. A lot, yes.

Q. Okay. Doctor, let me talk to you about

consent, informed consent. Is that a concept that you're familiar with?

A. Yes, it is.

Q. Have you taught that to residents?

A. Yes, I have.

Q. Would it be fair to say that consent must be full, complete and 100 percent for it to be consent at all?

A. The 100 percent is hard to imagine. You do your best, you know. I don't care what you put in writing on a permission form, you do your best to explain to the parent what this is about and document it with that form.

Q. Wherever it is, it's got to be full, complete, accurate and total if there is going to be informed consent; is that fair?

A. That's the standard of care is that you do your best to try to provide as much information as would be relevant to any, you know, parent who wanted to know, what would you like for your children. I mean that's what I have always used as my consent guide.

Q. Okay. Doctor, is it your testimony to this jury that the standard of care for informed consent is doing the best you can?

A. It is.

Q. Is that a yes or no, Doctor?
A. No. That's incomplete.
Q. So the standard of care, full, complete, total consent; is that fair?
A. You know, again, it's a circumstantial thing. I mean you -- I have had parents where I have explained something I swear four, five times, thinking I have really covered this 100 percent, and later on, oh, I didn't understand that. So to me standard of care about consent is making your best, honest effort to make sure a parent fully understands what you're trying to do for their child.
Q. That's the standard of care, best, honest effort and then you're done, that's it?
A. Then you ask questions.
Q. That's it?
A. Then they get to discuss it with you and they decide what you can and cannot do then.
Q. Is your testimony under oath to this jury that informed consent in the State of New York is best, honest effort and you're done? Is that -- yes or no?
A. I don't see what I'm missing there, so I'd say yes.
Q. Okay. And certainly we're going to hear from -- later that everybody, all the doctors and the

dentists have different capabilities, don't they? Some are good, some are not good, somebody's best efforts might be different from somebody else's best efforts, right?

A. Correct.

Q. Right. And informed consent is another patient safety issue, isn't it?

A. It certainly can be, yes.

Q. Well, you're a mom, you're taking your kid into a doctor, as a dentist, you know, they don't know what you're talking about?

A. Correct.

Q. You got to explain it to them, right?

A. Correct.

Q. And because at the end of the day it's the mother or the dad who are caring for their children and they have to make the decision, correct?

A. Absolutely.

Q. They are the ones, not any doctor or dentist, right?

A. Correct.

Q. It's not -- at the end of the day the kids are coming home, they're not going home to the doctor or dentist office, right?

A. Right.

Q. Okay. And would you agree with me that consent obtained by fraud is no consent at all?

A. Well, if you're not giving honest information, you're not obtaining consent.

Q. Okay. And the doctor has a duty to explain consent in words that are understandable to the patient?

A. Correct.

Q. All right. The doctor has a duty to explain all of the facts that would be explained by a reasonable medical practitioner?

A. Correct.

Q. Okay. And consent can only be given when the patient has an awareness of the existing condition, fair?

A. Patient or guardian in this case.

Q. Guardian, fine.

A. Okay.

Q. That the reasonably foreseeable risks to the patient's health or life which the procedure may impose must be disclosed?

A. Reasonably foreseeable, correct.

Q. Yes?

A. Correct.

Q. And it's never the doctor's decision, is it, or

the dentist's decision to decide what risks should be accepted, what risks shouldn't be accepted, that's the parents or the guardian's job, correct?

A. That's correct, in spite of them saying, "whatever you think, doctor."

Q. Which some people do, right?

A. Yes.

Q. And you know and every medical practitioner knows your knowledge, you know, I mean you start talking about mesial stuff, no one is going to know what you are talking about, right?

A. Right.

Q. So you have to explain it to them, right?

A. Correct.

Q. You do that, don't you?

A. A lot.

Q. You care about your patients?

A. Yes.

Q. All right. You would never do any unnecessary treatment on a patient, would you, Doctor?

A. No.

Q. That would be reprehensible, would it not?

A. Yes.

Q. That would be a deviation of the standard of care for good and accepted dental practice, would it

not, Doctor?

A. It would be.

Q. That would be a violation of dental ethics, correct?

A. Correct.

Q. Now, have you reached any opinions with a reasonable degree of medical certainty as to whether Kelly Varano was provided with all the reasonably foreseeable risks on May 23rd, 2006?

A. With respect to --

Q. Restraints?

A. -- restraints? Okay. With respect to the protective stabilization, I see that, by the way, different than restraint. Easier terminology.

Q. That's fine.

A. From what I saw the form, and again the form is just documentation that we had the discussion.

Q. Yeah.

A. The form that they used was actually one of the better ones I have ever seen with those illustrations at the bottom. We don't have that on our form at Columbia.

Q. Let's just go in and look at this a little bit.

A. Sure.

Q. Can we blow -- I'm advised no known risks to

the immobilization procedure. So do you agree with that doctor that there are no known risks to the immobilization procedure as of May 23, 2006?

A. Well, you -- it steps into a huge controversy within the academy.

Q. How about we try since you probably want to get out of here by the end of the day, how about you just try answering the specific question.

A. Sure.

Q. Is -- do you agree or disagree that there are no known risks to the immobilization procedure?

A. When done correctly, other than bruising, no known risks.

Q. So your view as the past president of the American Academy of Pediatrics there are no known risks, except for bruising, right?

MR. STEVENS: Objection. Mischaracterization.

THE COURT: Overruled.

Q. That's what you say?

A. That's what I say.

Q. Okay. And, of course, you know, Doctor, that the American Academy of Pediatric Dentists disagrees with you in its guidelines?

A. I know there are guidelines which suggest risk.

Q. Right. And you disagree with those?
A. I disagree with those and I'm not alone.
Q. Okay. Again, you're the only one here. If there is somebody else, I can talk to them, but you're the one who's here?
A. Okay.
Q. So can we agree that there is a -- the American Academy of Pediatric Dentistry you wouldn't be associated with it if it was some fly-by-night sham outfit?
A. I hope not.
Q. We all do. But it's a legitimate organization, isn't it?
A. Right.
Q. How many people are in it?
A. 8,000.
Q. 8,000. All pediatric dentists, right?
A. Yes. No, I'm sorry. About 15 percent are family practitioners.
Q. Okay.
A. We actually put the two organizations together during my presidency. One was GP that treated children and the academy. That's why they are there.
MR. HIGGINS: Let's go to 66, please, in evidence. I'm looking at --

Q. Doctor, as of 2005, the American Academy of Pediatrics, again, the jury has seen this, has basically said their guidance documents said there were significant risks, including physical and psychological harm, right?

A. I have seen that, yes.

Q. When you saw that were you the president of the academy?

A. No. That came after my time as president.

Q. I mean you must know a lot of people in the academy, right?

A. Tons, including the people that wrote that. I have discussed it with those people.

Q. Right. And since we don't want to get into any hearsay objections, we are going to move on.

A. Of course.

Q. So certainly the people that did this or the American Academy of Pediatric Dentists probably has a process it goes back and forth, then they finally come out with this?

A. This comes out with the council on dental education.

Q. So it came out, and when you saw this, did you go back and try to say, this is awful, I want this out, I'm finished with this?

A. I was doing that while that council was formulating this. As a matter of fact, I mean this psychological risk --

Q. Doctor, you answered the question.

MR. FIRST: Objection.

MR. HULSLANDER: Objection.

MR. STEVENS: Objection.

THE COURT: I think he answered the question. It's cross-examination.

Q. Again, I don't mean to be rude. I'm looking at the clock.

A. I know you have a purpose.

Q. I'm trying. So, Doctor, we can go back and forth about, you know, some people say it's true, some people it's not, but there is a legitimate organization out there that put this out and it says that there's psychological harm, loss of dignity, violations of patients' rights and even death, right, you may disagree with that, but isn't that something that the average mom might want to know?

MR. McPHILLIAMY: Objection to form.

THE COURT: Overruled.

A. Interesting question.

Q. Interesting answer.

A. The "average mother" is what worries me here.

Q. Can you answer that question yes or no, isn't that something --

A. I can't. It's circumstantial. The "average mother" might be scared to death to let you use something that is critical to the care of her child.

Q. Isn't that the mother's decision? Who else should be making that decision, Doctor, the mother, right?

A. Ultimately, the guardian's decision what happens.

Q. The guardian is usually the mother, isn't it, Doctor, we all know that?

A. Correct.

Q. Wasn't that Kelly Varano's decision to make -- to say maybe she will get scared but that's her, isn't it -- isn't it her job? Isn't it? Isn't she the one that should be making that decision?

MR. HULSLANDER: That's a speech!

MR. STEVENS: Objection.

THE COURT: Sustain the objection. Next question.

Q. Next question. Isn't she the one that should make that decision?

A. Informed?

Q. Yes.

A. Yes.
Q. Right. And undisputed she was never told any of that, was she?
A. No. Those are guidelines.
Q. I understand, Doctor. All I'm trying to do is just get the record as she's never told that, correct? She's the mom, correct?
A. Correct.
Q. Okay. Doctor, have you reviewed the Small Smiles consent forms to see whether they were accurate as of May 23rd, 2006?
A. Yes, I've seen those forms.
Q. All right.
MR. HIGGINS: Can we go to the inside page, please. Can I blow up number five, please. Number four, I'm sorry. No, this is not the -- here, the May 23rd one has the HOM on it. Can we blow up number five, please.
Q. Doctor, tell us, this is a chart, I have the original right here. This is the May 23rd, 2006, Kelly Varano comes in and on the inside there is the patient management techniques. You see that?
A. Correct. That's a copy here.
Q. I'm sorry?
A. Yes.

Q. All right. And as of May 23rd, 2006, Small Smiles is still using the hand-over-mouth exercise, correct?

A. It's on the list.

Q. All right. That means it's still being used, correct?

A. I don't know that.

Q. Well, did you --

A. Because that's about a period of time where there was a big transition.

Q. August 18th, 2006, correct?

A. About that time, yes.

Q. Yup. The American Academy of Pediatrics drops this, says no more HOM?

A. Some of us disagreed a little on that because I wrote one of the main articles about that.

Q. I know that, Doctor. So hand-over-mouth is when a disruptive, screaming child is told that the hand is placed over the mouth and it is kept there until the kid stops screaming, right?

A. Not that simple.

Q. Okay. That's part of it?

A. That's part of it, absolutely.

Q. And parents never really thought much of that, did they?

MR. McPHILLIAMY: Objection.

THE COURT: Overruled.

Q. Okay. Let me move on. So did you see any custom and practice or practice guidelines from Small Smiles indicating that this was not being used as of May 23rd, 2006?

MR. STEVENS: Objection. Relevance.

THE COURT: What was the objection?

MR. STEVENS: Beyond the scope and relevance.

THE COURT: Overruled.

A. I did not see any writing directing them to cease and desist.

Q. Would it be fair to say if this is still being -- she's being asked to consent to?

A. Consent to it, yes.

Q. Consent to it?

A. Right.

Q. Can we agree -- in fact, haven't you written since 1979 that hand-over-mouth is only for a child who is able to cooperate?

A. That's correct.

Q. Okay. And it's -- there is contraindication for hand-over-mouth if the child can't cooperate?

A. Is too young.

Q. Too young to cooperate?
A. Or has a --
Q. Special needs?
A. -- disability, yes.
Q. So if the child's too young to cooperate and they do hand-over-mouth, it's never going to work for him, right? Right? It's not going to work?
A. Correct.
Q. Okay. And on this form that she was asked to sign on May 23rd, 2006, there is nothing saying that a young child who is too young will not be able to do this, can't and it's contraindicated --
MR. McPHILLIAMY: Objection. Relevance.
Q. -- correct?
THE COURT: Overruled.
A. That's correct.
Q. Is that a deviation in the standard of care?
A. No, because it's actually not an aged limited thing, not when you are 2.5. Impossible.
Q. All right.
A. So it's an individual choice made by the doctor with each child.
Q. And isn't it an individual choice for each mother to know that if this isn't on the chart that there is a contraindication and that if your child is

too young he's going to get this hand over his mouth and it will never work?

A. Won't understand what it is.

Q. Right. Shouldn't the mother know that?

A. That's why we have stopped doing it. Not that there was any problem with the technique. It's getting the permission and stopping the treatment to go out and get it frankly.

Q. Right. As of May 23rd, 2006, there is no -- nothing in subparagraph five that says if your child is too young it's contraindicated, is there?

MR. McPHILLIAMY: Objection. Relevance.

Q. Nothing there?

THE COURT: I'm going to sustain the objection.

Q. Well, Doctor, this was part of the consent form that Mr. Nowatny asked about, and you were just asked about on direct?

A. Right.

Q. These forms when people walk in don't they assume they're accurate? Shouldn't they be accurate?

A. I would as a patient or a parent.

Q. That's reasonable, isn't it?

A. Yes.

Q. Okay. Did Small Smiles have any type of

quality care review as of 2006 to 2008 in the Syracuse office?

A. I don't know that.

Q. Did you do anything to find out?

A. No, I didn't.

Q. Would it be a deviation of the standard of care for a dental practice or a dental company not to have a quality of care function?

MR. McPHILLIAMY: Objection.

THE COURT: Uhm, overruled.

A. It would be a deviation of standard of care for a large organization providing care if they were providing the care. Nobody in private practice has somebody come in and do QA on the work they provided to patients.

Q. What about Columbia, you got one at Columbia?

A. We have at Columbia a big corporation, yes.

Q. What about 50 dental clinics, is that a large organization nationwide?

A. Aren't they independently operated? I don't know.

Q. No.

A. You're asking questions. I don't know.

Q. If you don't know, that's fine. That's fine.

A. Hypothetical.

Q. Hypothetically, would you assume that a large 50 chain dental practice, 50 offices would have a quality assurance review?

A. Well, my understanding the way Small Smiles was set up was that there was someone who owned the practice and was the lead dentists, and I would think it's their responsibility to conduct some sort of QA, but I don't know that.

Q. Okay. So you don't really know?

A. No, I don't.

Q. Okay. Doctor, I want to talk about what happened to Jeremy Bohn on May 23rd, 2006, specifically. Now, you weren't there, correct?

A. That's correct.

Q. I wasn't there?

A. Correct.

Q. Dr. Bonds doesn't remember what happened that day, correct?

A. I don't know what his testimony was to that effect here.

Q. Didn't you read?

A. Didn't he testify recently?

Q. I'm asking you, you read his testimony, right?

A. I read his deposition.

Q. And in his deposition didn't he say he didn't

have any memory of what happened that day?

A. I believe that's correct.

Q. And so the proof's pretty much closed, we don't have any more witnesses coming in, so we have the record, correct?

MR. HULSLANDER: Objection. It's a speech!

Q. We have the record? You reviewed the record?

A. Correct, and the deposition.

Q. And we have -- Dr. Bonds doesn't remember anything, correct? Right?

A. Correct.

Q. Okay. Jeremy doesn't remember anything really, except what the place looked like maybe. He doesn't remember anything, that's not unusual?

A. It's not his testimony.

Q. Okay. So tell me, how soon after he was separated from his mother did he start screaming?

MR. STEVENS: Objection. Calls for speculation and there is no evidence.

THE COURT: Overruled.

A. I don't know.

Q. Okay.

A. How soon --

MR. STEVENS: Objection. Assumes it was

after he left his mother.

MR. HIGGINS: Okay.

THE COURT: Overruled. Cross-examination and it's -- we're just doing legal objections.

A. I have seen children who before they're separated are hanging on their mother screaming. I have seen children go away, mom, I got this, I'm fine, and the whole range is in-between. I don't know in Jeremy's case what happened here.

Q. Kelly Varano testified Jeremy was fine when she was separated from him. Would you assume that for purposes of cross-examination?

A. Certainly.

Q. How soon after that did he start screaming?

A. I assume when he was taken in for the cleaning and fluoride and didn't want any part of it.

Q. Okay. Do we know how many minutes that was?

A. I do not think there was an indication of timing on that part.

Q. Okay. Do we know when -- what time the first restraint -- what were they doing to him before they finally restrained him?

A. Well, this is a --

Q. Do we know?

A. You're aware. No, I don't know the timing.

Q. Do we know what was actually going on back there? Is there anything in the chart that would say, you know, child separated at 8:42; 8:46 child restrained physically; 8:48 child now going out of control, anything like that?

A. I don't know anybody that does that --

Q. Okay.

A. -- puts those kinds of things in records.

Q. Okay. Certainly not in this case, right?

A. Right. True.

MR. HIGGINS: Chuck, have the 5/23/06 first restraint, please.

Q. Uhm, Doctor, again, I know you weren't there. You're just reviewing the records and I understand that. This is -- do we even know what room he was in when he was restrained the first time?

A. I don't remember testimony to that effect. It's not there.

Q. Okay.

A. Probably the hygiene room, but I don't know that.

Q. Do you know what a quiet room is, Doctor?

A. Yes, we have one.

Q. All right. Do you know if the quiet room in Small Smiles was used to take kids who were screaming

and get them away from the other kids so they wouldn't disrupt the other kids?

A. Right. Very serious influence on the other kids.

Q. So it's really not for the kid's benefit, it's to keep the other kids calm?

A. Both.

Q. Okay. So when was he -- do you know how long he was in the hygiene room before he went into -- he was taken to the quiet room?

A. No, I don't know.

Q. Okay. Do you know whether he was screaming and kicking and flailing and crying the entire time?

A. In the hygiene moment, I don't know.

Q. Do you know who took him into the quiet room?

A. I assume it was the hygienist.

Q. We don't know, do we?

A. No.

Q. Okay. What about did anyone physically hold him down in the quiet room?

A. Not to my knowledge.

Q. Is there anything in the chart?

A. No.

Q. Is there even a reference in the chart that he went to a different room?

A. No. I got that from I think Mrs. Varano's testimony, deposition.

Q. Okay. He was restrained at some point, right, we know 5/23/06 two restraints, right?

A. Correct.

Q. The first one is not even recorded anywhere, is it?

A. I don't remember seeing it recorded, but my understanding is that's when Dr. Bonds examined him.

Q. But there is nothing in the chart that would even say how long he was restrained, who restrained him, anything, there is nothing is there?

A. Wasn't that the ten-minute interval before Dr. Bonds came out and spoke to Miss Varano and said, we're going to need to restrain Jeremy?

Q. Doctor, there's nothing in the chart at all about a restrain, is there?

A. During the hygiene period, no.

Q. Okay. So do we know how long he was restrained?

A. Not during that activity.

Q. Do we know what his heart rate was during that activity?

A. That's not a routine thing any way.

Q. Well, whether --

A. There is no requirement. We never have monitored kid's oxygen saturation or heart rate, you know, during stabilization.

Q. So but Small Smiles did?

A. I don't know why they went beyond the standard of care I know.

Q. Okay. So if you're practicing in Syracuse and somebody comes to you, you're not going to put a heart monitor on this kid when you strap him down?

MR. STEVENS: Object to "strap him down."

MR. HIGGINS: Withdrawn.

Q. If you come to Syracuse and practice up here, you're not going to put a heart monitor on any kids you use protective stabilization on; is that fair?

A. I am unaware of anything in the literature indicating I should do that.

Q. I'm just talking about you.

A. So, therefore, I have no rationale for doing an additional procedure.

Q. All right. So Small Smiles did this for no reason?

A. Must have made them.

MR. McPHILLIAMY: Objection. Argumentative.

THE COURT: Overruled.

Q. All right. So, Doctor, what I'm trying to figure out and maybe you can help me, is this child goes from his mother and he's not screaming, he's not crying, he's not doing anything and he's separated. He comes out at some point in time later and he's hysterical. Okay. We know from the note "patient out of control."

A. Right.

Q. Okay. And there's this -- the whole first restraint isn't even recorded. Is that a deviation in the custom and practice of good dental practice not even to record a restraint?

A. Well, you certainly need parental permission must been obtained by then, unless I'm missing something here.

Q. Doctor, is it a deviation of good and accepted dental practice not even to record a restraint?

A. You should record that you used protective stabilization for a patient, absolutely.

Q. Is it so that would be a deviation not to do that; is that correct?

A. It would be.

MR. HULSLANDER: It's in the report.

A. It would be outside the standard of care.

Q. When you mean outside, you mean a deviation?

A. Deviation.

Q. By not recording this, Small Smiles or whoever was responsible deviated from the standard of care on May 23rd, 2006; is that fair?

A. No. What I don't understand, we don't know when it happened. Was it during that ten-minute interval, after they obtained permission because they tried to look in his mouth, he started having a tantrum. They said, you know, we can't examine him. He had an emergency. He was on penicillin. Some point he had been in pain, and he clearly had an infection only to be resolved by treatment.

Q. All right. So, Doctor, we don't really know what happened back there, do we?

A. The hygiene piece we don't know.

Q. Right, we don't. And we don't know whether this child was in this thing screaming and crying and kicking and flailing during that first time, do we?

MR. STEVENS: Objection.

THE COURT: Overruled.

Q. We don't know?

A. We don't know. We have some sense of the time frame. Didn't she say seven minutes? I don't remember if that's when she went out to smoke a couple of cigarettes. I think that was the ten-minute

period.

Q. Is it really up to the mother to record a restraint?

A. Not suggesting that.

Q. Okay. All right. Doctor, do you know whether the quiet rooms are soundproof?

A. No, I do not.

Q. Okay. Doctor, how far is it from Rome, New York to Geddes Avenue in Syracuse, how many miles?

A. Like driving time?

Q. Yes, sir.

A. I saw from testimony from Miss Varano took her an hour.

Q. Okay. If I suggest 47 miles, would that seem accurate?

A. I don't know the roads between, but some thruway or something certainly.

Q. Okay. Did -- how many times did Kelly Varano and her significant other, Chuck Bohn, drive from Rome, New York to Small Smiles?

A. Ten times.

Q. Okay, 47 miles, ten times, how many hours in the car is that?

A. Fifty hours.

Q. Okay. And about how many miles did they drive?

A. 400, 500 miles.
Q. Doctor, do you think if someone had said to them, your child needs treatment in a hospital in Rome, that they would have gone?
MR. McPHILLIAMY: Objection.
MR. STEVENS: Speculation.
THE COURT: Overruled.
A. If that care was available and she was made aware of it, why wouldn't she.
Q. I agree, Doctor. Was she given the option of going to a hospital such as Strong Memorial or Albany Medical Center, right, they have to have a pediatric center there?
A. Albany, I don't think so. Certainly they do at U of R.
Q. U of R is University of Rochester?
A. University of Rochester, Eastman Dental.
Q. Was Kelly Varano given that option on May 23rd, 2006?
A. I don't know.
Q. Anything in the record suggesting she did?
A. I did not see such.
Q. What about Dr. Bonds testimony?
A. I did not see that he had suggested that.
Q. Okay. What about deferral, do you know what

deferral is when a child becomes hysterical and uncontrollable?

A. Yes.

Q. Deferral means that you stop the treatment, correct?

A. Correct.

Q. All right. Was she ever given the option during this treatment to come back and comfort Jeremy?

A. Not to my knowledge.

Q. Okay. Would that be something you would do, Doctor, if let's say --

A. Make an individual decision with every parent. I mean in my lectures on behavioral management to the pediatric residents, to the students, I can give you five reasons why it is great to have a parent in the room, and five reasons why it's a horror show to have a parent in the room, so you make an individual decision in each case.

Q. Right. Don't you -- isn't that, again, something that the parent has to be involved with?

A. That's kind of a doctor's call, because if you see that, you know, a parent is, oh, poor baby, oh, sweetheart, they can exacerbate the whole thing and make it so much more difficult. On the other hand, I have had parents who are wonderful, giving me hints

what the child is interested in, how to better relate to them in the tell-show-do and the voice control.

Q. By the way, no record here of any tell-show-do?

A. Never is.

Q. There isn't here?

A. I never in my life did that. That's like saying I took a break and spoke to you and to do that with every child patient.

Q. That's what you're suppose to do for every child patient?

A. Correct. That's what every school in the country teaches. I know it is required.

Q. Doctor -- okay. When Kelly -- I'm sorry. When Jeremy Bohn was restrained for the first time, whatever happened, whatever it was, at some point in time he goes to the operatory, correct?

A. Correct.

Q. All right. How does he get -- if he does go to the operatory, how does he get from one room to the other?

A. I don't know.

Q. What's going on with him during that time?

A. He's having a tantrum as far as I can tell.

Q. That's what you think, you don't know?

A. Apparently.

Q. You don't know, do you, Doctor?
A. Why else would you put him in adaptive stabilization.
Q. How about to make money?
A. No.
Q. No?
A. It's not a valid reason.
Q. You're right, I agree. So, Doctor, you don't know what this child's condition was between the operatory and the hygiene or the quiet room. You don't know what was going on with him because there is nothing in the record?
A. I thought in his father's deposition he was present, correct?
Q. No, he wasn't present.
A. No?
Q. No. That's incorrect. All right.
A. I thought at some point he talked about hearing him screaming in the other room. Maybe it was Mrs. Varano.
Q. That's okay. That's after the visit.
A. Okay.
Q. So we don't know -- you can't know what was going on back there between the operatory and the hygiene, right?

A. No. I would be making assumptions.
Q. And one of the things that causes fear and anxiety in a child is being in with strangers in a dental environment; is that fair?
A. In any strange environment with strange people.
Q. You wrote that in 1979, didn't you? Yes?
A. Still agree with it.
Q. Okay. And was he kept in restraints between one room and the other?
A. Don't know.
Q. Okay. Uhm, if he had been let out was there anything that would say that Kelly Varano should not have been let back to comfort her child? Anything?
A. Reason why not to?
Q. Yeah. He's already been restrained, right?
A. That would be a judgment call that the doctor would make. If he starts acting up again, even though in the protective stabilization because mom is there, I wasn't there, I don't know. That's a call that they made obviously.
Q. Okay. So it's the call?
A. That's within the standard of care. It's their choice.
Q. It's the call the doctor made without asking Kelly, fair to say?

A. At that point, yes.
Q. Okay. You think that's okay?
A. I think that's okay. If she was told she can be involved with this, if she understood it, if it's a conversation, you know, this is not substantively different than those circumstances. We -- this is again a child with infection. An emergency that needs care. The mother understands there's going to be some kind of stabilization --
Q. Doctor --
A. -- to do that.
Q. Doctor, is it your testimony in front of this jury --
MR. McPHILLIAMY: Objection, Your Honor.
MR. HULSLANDER: He's trying to intimidate.
MR. STEVENS: Your Honor --
THE COURT: All right, Mr. Hulslander, no comments, please.
Q. I'm sorry, Doctor. I'm coming back over here.
A. That's fine.
Q. Is it your testimony that Kelly Varano was given the option to go back into the back room on May 23rd, 2006?
A. I see nowhere someone -- in the record that

says someone went to her and said, would you like to come back.

Q. And are your opinions in this case based on that presumed fact?

A. Could you restate that?

Q. Of course.

A. I'm not sure what you're asking me.

Q. Doctor, let me ask you to assume that, in fact, the record in this case is that she was told she couldn't go back on May 23rd, 2006, she couldn't go back.

A. This is what that dental assistant had told her, is that what we are talking about?

Q. We're talking about Kelly Varano's testimony.

A. Okay.

Q. And let me ask you to assume that that's right, that she did say that.

A. Yes.

Q. She testified to this jury. Doctor, that's not right, is it, to be told you can't go back there?

A. Can't? It depends on the circumstances.

MR. STEVENS: Objection. About the sixth or the seventh or eighth time he's asked the same question. Maybe the ninth time.

THE COURT: Okay. So the objection is

asked and answered?

MR. STEVENS: I'm sorry. Asked and answered, Your Honor.

THE COURT: Sustained.

Q. Okay. Doctor, are your opinions in this case based upon the fact that you think she was told that she could go back there on May 23rd, 2006?

A. No, I have no reason to believe that either.

Q. Do you know one way or the another?

A. Don't know. She testified as you said. Just now asked me to assume that she was told she could not.

Q. Okay.

MR. HIGGINS: Chuck, let me have Exhibit 781 up, please. Your Honor, for identification, this is just another screen shot of the video.

Q. I'm sorry, Doctor, can you see this?

THE COURT: You can get down.

THE WITNESS: I can see it. This is fine.

Q. Doctor, this is just another screen capture of the video the jury's seen.

A. Those are two of the three that we had looked at earlier.

Q. Exactly. I think we just flipped this one up.

A. Yes. That's 180 degrees flipped.

Q. Doctor, would you agree that you can see decay here and here and that it matches here in some respects?

A. Looks pretty close.

Q. That you can also see decay here and here and it is matching in some respect there?

A. If I saw anything, it was lower down than that where you were pointing. I guess what concerns me is on the lateral incisor -- you want me to point to it so we know what we are talking about. It is obviously some decay or caries in here. This is pitted. It's brown. And I don't see a thing over here. So it's variable.

Q. Okay.

A. You see it.

Q. We can definitely see here and here, these two?

A. Yes. This one is tough, but I think I can see something there on that.

Q. Doctor, if you can just take your seat back. I thank you and appreciate it.

A. No problem.

Q. Doctor, is there -- as to the restraints, is there any part of that that you agree with the American Academy of Pediatric guidelines, is there any part of that you agree with their guidance on

restraints?

A. No. Again, the big -- I'll stop there. Stop right there.

Q. Okay. And what about the hand-over-mouth, would -- if you still were practicing, would you be using hand-over-mouth?

MR. McPHILLIAMY: Objection. Relevance.

THE COURT: Sustained.

Q. Doctor, if this child was being restrained and he was screaming to get out and screaming for his mother and screaming to go home, they wouldn't let him up, would they?

MR. STEVENS: Objection.

MR. McPHILLIAMY: Objection. Speculative.

Q. That's how they are trained, right?

MR. STEVENS: Objection.

THE COURT: Sustained. Sustained.

Q. Doctor, would you agree with me that as to the dental family relationship that the parents being involved and being given accurate information is crucially important for the safety of a child?

A. To their safety, well-being and the care you provide.

MR. HIGGINS: All right. Thank you, Doctor.

THE WITNESS: You're welcome.

MR. HIGGINS: That's all I have, Judge.

CROSS-EXAMINATION

BY MR. FIRST:

Q. Doctor, I will ask you about one limited issue.

A. Please.

Q. You had an exhibit shown as Exhibit 66 that contained -- you didn't really testify much from it, but it contained where it had a copy of the guidelines attached to it. I'm going to show you Exhibit 67, which is dated August 18, 2006, came from Rich Lane, somebody with FORBA, and went to all the lead dentists and office managers at various Small Smiles clinics. And I'm going to ask you relative to this hand-over-mouth issue, to read out loud the last paragraph where it says note?

A. Note: Important to note that hand-over-mouth (HOM) is no longer included as an acceptable technique per the revised guideline on behavior guidance for the pediatric dental patient. Please ensure that all health history forms on the back page are the new forms that no longer contain hand-over-mouth as a dentistry patient management technique.

Q. Thank you. So that indicates that clinic wide

notice went out about that technique no longer being part of the guidelines; isn't that correct?

A. I don't know who that was sent to, but the guidelines clearly states it.

MR. FIRST: Thank you.

CROSS-EXAMINATION

BY MR. McPHILLIAMY:

Q. Afternoon, Dr. Davis.

A. Afternoon.

MR. McPHILLIAMY: Can I have 22, please.

Q. Doctor, you were asked a number of questions about the documentation of restraint in the hygiene room. Do you remember Mr. Higgins asked you about those questions?

A. Yes.

Q. Can you read --

MR. McPHILLIAMY: Actually, can I have that blown up that bottom part, Craig.

A. Patient out of control, protective immobilization used. Consent secured. And I'm not sure whose signatures those are. It includes the RDH, which is the registered dental hygienist, whoever that was.

Q. Patient out of control, protective

immobilization used, consent secured?

A. Right.

Q. In your opinion, is that documentation that protective immobilization was used in the hygiene room?

A. Well, can we go back to the chart so I know in the context in which this note was made?

Q. Hygiene procedures.

A. Okay. It's on the hygiene procedures page, so I assume that means it was in the hygiene room or wherever they were doing the hygiene activity.

MR. McPHILLIAMY: Can I have 27, please, blown up a little bit.

Q. Doctor, this is the operative procedure --

A. Correct.

Q. -- page?

A. Yes.

Q. When teeth B and I were extracted on May 23rd?

A. Yes.

Q. Same day as the hygiene visit, is that your understanding?

A. Yes.

Q. And is it noted that protective immobilization was used in the treatment room also, is that documented?

A. That's very clearly documented for twenty minutes as it says.

Q. Okay. Now, Mr. Higgins asked you a lot of questions about hand-over-mouth. Let's talk about that for a second.

A. Sure.

Q. When a dentist uses hand-over-mouth, is the nose covered also?

A. No.

Q. Why is that?

A. Because you're restricting the airway and you scare the daylights out of the child.

Q. Beyond safe for the patient?

A. Would not be safe for the patient. No one wants their air cutoff.

Q. Based on the hours and hours that you reviewed in this matter, did you see any indication of the hand-over-mouth was used with regard to Jeremy?

A. No. None.

Q. Now, Doctor, going back to your credentials.

A. Yes.

Q. The AAPD is a nationwide organization and consists of all 50 states; is that correct?

A. That's correct and six provinces in Canada.

Q. Okay. Any of the islands surrounding?

A. No. Well, Manhattan. That's a foreign country.

Q. And you were the past president of that, correct?

A. Yes, sir.

Q. And are you familiar with an organization known as the American Society of Dentistry for Children?

A. Indeed.

Q. Tell us about that, that society?

A. To make a long story short, back in the twenties, the dentists have signs in the offices that said "children not welcome." A few gentlemen, and they were all men at that time, decided this was wrong, children need care. They suffered pain, infection, loose teeth, get orthodontic problems, all of which I'm sure you heard a ton of here, and they started the American Society of Prevention in Dentistry for Children, which later became just ASDC. It was about a 105 years old when I became president of that organization after I had been AAPD president, and, you know, did the committees and the chairs and usual things, and we brought them together as one organization. So that the general practitioners who provide 75 percent of the care in this country would learn from the specialists who went on for additional

training to ensure that what was being done for children in either setting was as good as it could possibly be, so that's the importance of it.

Q. I believe you told us that you were president of that organization as well as the AAPD?

A. That's correct.

MR. McPHILLIAMY: Nothing further.

THE COURT: Thank you.

MR. STEVENS: One I will ask from here.

REDIRECT EXAMINATION

BY MR. STEVENS:

Q. Dr. Davis, does standard of care require dentists to advise a parent of the risks identified in the AAPD guidelines for protective immobilization?

A. Standard of care does not require that. Those are guidelines from an important organization. They are kind of intended, especially when we are using them in training often to say, you know, it's nice, you know, you really need to talk to the parent here people, but, you know, it's not a standard of care.

Q. Why is it that you said that the manner in which Dr. Koury Bonds used protective stabilization is safe?

A. Because he considered in the way he monitored

the patient. All the important things. It's not too tight. They can breathe. The circulation is good. And, you know, the critical things are monitored.

Q. Not too tight, watch even every second, not too long?

MR. HIGGINS: Objection. Beyond the scope.

A. Not too long.

MR. STEVENS: I'm done, Your Honor.

MR. HIGGINS: One final question.

THE WITNESS: Please.

RECROSS-EXAMINATION

MR. HIGGINS:

Q. Doctor, under your view of this risk issue, you wouldn't be telling the parents about the risks that the American pediatric guidelines set forth; is that fair?

MR. McPHILLIAMY: Objection. Scope.

THE COURT: Overruled.

A. I don't see the necessity for it.

MR. HIGGINS: Thank you.

THE COURT: Okay. Doctor, you may step down. Can I see counsellors up here for a minute before I let the jury go.

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

THE COURT: I will hold you up for a minute so I can tell you what is in store for next week.

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

THE COURT: All right. Uhm, Mr. Stevens.

MR. STEVENS: That's me.

THE COURT: Do you have any additional witnesses?

MR. STEVENS: I do not.

THE COURT: So do you rest?

MR. STEVENS: On behalf of the three dentists we rest, Your Honor.

THE COURT: Okay. And do you have any rebuttal witnesses?

MR. FRANKEL: We don't, Your Honor.

THE COURT: Okay. So the proof is closed in this case. What that means is I need to meet with the lawyers and work on the jury charge and verdict sheet and that would be something that will not be ready Monday morning.

So we're going to be off on Monday. Well, actually let me -- come up here again.

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

THE COURT: All right. I'm sorry. We're just trying to figure out what's the best utilization of your time and our time. So what we have decided is that Monday will be a day off. We'll start Tuesday morning at nine o'clock.

We will start at quarter of nine if that's okay. Is that a problem for anyone to get here then? Who is calling him? And we'll have closing arguments, my jury charge, and then you will begin your deliberations.

And your deliberations may go into the Wednesday. We don't know what will happen. But we'll do that on Tuesday, and Monday is a day off. Okay. Have a great weekend. Don't talk about the case. Don't do any independent research.

TRIAL JUROR: Yes, dear.

THE COURT: Behave.

(Jury excused for the day at 4:18 p.m..)

THE COURT: Okay. We have to go upstairs so everybody can leave. Just the lawyers to talk about Sunday.

(Proceedings in recess at 4:19 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 4, 2013.

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