

1 STATE OF NEW YORK : FIFTH JUDICIAL DISTRICT

2 SUPREME COURT : COUNTY OF ONONDAGA

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

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Plaintiffs,

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7 vs.

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

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

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Defendants.

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**JURY TRIAL**

19

20 October 4, 2013

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Onondaga County Courthouse  
401 Montgomery Street  
Syracuse, New York 13202

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1    **B E F O R E:**

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HONORABLE DEBORAH H. KARALUNAS,

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Justice of the Supreme Court and a Jury

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Direct Examination by Mr. First	1907 - 1968
Cross-Examination by Mr. Frankel	1969 - 2015
Redirect Examination by Mr. First	2015 - 2020
Cross-Examination by Mr. Stevens	2021 - 2022
Recross Examination by Mr. Frankel	2022 - 2026

**MARTIN DAVIS, DDS**

Direct Examination by Mr. Stevens	2027 - 2087
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## I N D E X      O F      E X H I B I T S

<u>Number</u>	<u>Description</u>	<u>Rec'd</u>
1135-A	Taylor/Records	1982
782	Biography	
ABK-1268	Copy/Photo	
ABK-1269	Copy/Photo	
ABK-1970	Copy/Photo	
ABK-1971	Copy/Photo	
ABK-1972	Copy/Photo	
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ABK-1981	Copy/Photo	
ABK-1982	Copy/Photo	

1 (Morning Session - October 3, 2013.)

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

4 MR. HULSLANDER: I'm the same.

5 THE COURT: The same?

6 MR. HULSLANDER: Stone is still there.

7 THE COURT: Okay.

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

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

11 MR. FIRST: Yes.

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

13 THE COURT: Morning. You may be seated.

14 BY MR. FIRST: (Cont.)

15 Q. Good morning, Dr. Cisaeros.

16 A. Morning.

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

20 A. Yes, I am.

21 Q. And what is the purpose of protective  
22 stabilization?

23 A. Well --

24 MR. FRANKEL: Excuse me, Your Honor --

25 A. -- exactly that --

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

5 MR. HULSLANDER: Speaking objection.  
6 Sorry, Judge.

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

9 (Pending Question read by the Reporter.)

10 THE COURT: Rephrase the question.

11 BY MR. FIRST: (Cont.)

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

15 A. How am I familiar?

16 Q. Yes.

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

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

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

25 Q. I'm sorry?

1           A.    All throughout my career.

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

9           A.    Yes, I can.

10          Q.    And what is your opinion?

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

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



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

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

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

16          Q.    Are they standards of care the guidelines?

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

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

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

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

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

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

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

19 A. Yes.

20 Q. All right. I want to turn you now to May 23rd,  
21 2006, the first time Jeremy went to Small Smiles. Let  
22 me first ask you generally, do you have an opinion you  
23 can state to a reasonable degree of dental certainty  
24 as to whether the care and treatment he received on  
25 that date, May 23rd, 2006, was consistent with good

1 and accepted dental practice?

2 A. Yes, I do.

3 Q. And what is your opinion?

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

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

8 A. Oh, yes.

9 Q. -- to Small Smiles?

10 A. Yes.

11 Q. What is the significance of that history  
12 specifically?

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

22 Q. What did she recognize?

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

25 Q. Go on. I interrupted you.

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

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

8           A.    I'm sorry.

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

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

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

18          A.    Yup.

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

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

1 Obviously the doctor had given her the details.

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

4 A. Yes.

5 MR. FIRST: 601, please.

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

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

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

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

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

9 Q. I'm sorry.

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

17 THE COURT: You will have to --

18 THE WITNESS: I'm sorry.

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

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

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

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

11 A. I disagree with that.

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

14 A. In particular, yeah.

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

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

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

22 A. No.

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

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

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

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

10 A. Correct.

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

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

16 Q. Sure. Go ahead.

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

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



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

3           A.    Absolutely.

4           Q.    Good and accepted practice?

5           A.    Yes.

6           Q.    On May 23rd, 2006?

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

8           Q.    Want me to ask it again?

9           A.    No.

10          Q.    What is your opinion?

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

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

17          A.    Right.

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

23          A.    Absolutely.

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

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

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

16          A. Yes.

17          Q. And what's your opinion?

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

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

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

10 A. Yes, I do.

11 Q. And what is your opinion, Doctor?

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

15 Q. Okay. Doctor, let me ask you why don't we put  
16 --

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

20 A. No, leave it down.

21 Q. You like it down?

22 A. This is the proper orientation.

23 Q. We will leave it down then.

24 A. Can't we center?

25 Q. Move it over.

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

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

12          A.   Yes, I have an opinion.

13          Q.   What is your opinion?

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

16          Q.   Yeah, sure.

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

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

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

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

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

22 A. This is the facial.

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

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

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

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

7 MR. FIRST: Take that down for one second.

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

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

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

20 A. Right.

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

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

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

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

10 A. D, E, F and G.

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

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

15 Q. Specific, what does that show?

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

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

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

22 A. Looking at the patient.

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



1       that?

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

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

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

19          Q.   How are they different from the molars?

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

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

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

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

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

19 A. Correct.

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

24 A. Yes, I have an opinion.

25 Q. What is your opinion?

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

3           Q.    Why do you feel that way?

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

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

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

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

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

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

13 THE COURT: Okay. So foundation?

14 Sustained.

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

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

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

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

25 Q. Okay. So --

1           A.    -- of what I generate.

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

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

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

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

12 THE COURT: Sustained.

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

16 A. Sorry?

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

20 A. Absolutely, yeah.

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

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

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

3                     MR. FRANKEL:   Excuse me --

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

6             A.     Yes, I am.

7             Q.     -- in this case?

8             A.     Yes.

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

11            A.     Yes, I did.

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

13            A.     \$395.

14                   MR. FIRST:   Thank you, Doctor.

15                   THE COURT:   Okay.

16                   MR. McPHILLIAMY:   No questions.

17                   MR. STEVENS:   No questions.

18                   THE COURT:   No questions.   Mr. Frankel?

19                   MR. FRANKEL:   Thank you, Your Honor.

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

22

23

24

25

1 CROSS-EXAMINATION

2 BY MR. FRANKEL:

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

5 A. No.

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

8 A. Yes.

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

11 A. Yes.

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

14 A. No.

15 Q. Call it the way you see it?

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

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

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

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

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

25 Q. Certainly you would expect he would send you



1       what you need?

2           A.    Yes.

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

5           A.    As far as I know.

6           Q.    You had a chance to look at the dental chart  
7       which is in front of you which is Plaintiff's Exhibit  
8       199?

9           A.    Yes.  I see it marked.

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

11          A.    Yes.

12          Q.    Whose depositions did you read?

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

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

16          A.    Yes.

17          Q.    Anyone else?

18          A.    The two parents and Jeremy's.

19          Q.    All right.

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

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

23          A.    Yes, I have.

24          Q.    Whose trial testimony did you read?

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

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

4           A.   Yes, sir.

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

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

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

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

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

22          A.   I think they did an appropriate job.

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

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

1 I'd say about 30 hours maybe.

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

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

5 THE COURT: Overruled.

6 THE WITNESS: That means I have to answer?

7 I mean what --

8 THE COURT: Yes.

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

11 A. Yes, I have.

12 Q. How many?

13 A. I think about approximately ten or so.

14 Q. All right.

15 A. A lot of them I think were similar.

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

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

20 Q. Go ahead.

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

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

1 A. Yes.

2 Q. You know that?

3 A. Yes.

4 Q. All right. While you were at the Montefiore  
5 between 1984 and 2001, did you tell us yesterday that  
6 you spent maybe a day and a half a week doing  
7 pediatric dental patients?

8 A. Approximately, based on my private practice  
9 three days. Half my time was doing that.

10 Q. So one and a half days a week during that  
11 period?

12 A. Uh-huh.

13 Q. Since 2001, you've been in the Department of  
14 Orthodontics at NYU; is that true?

15 A. Correct.

16 Q. Not in the pediatric dentistry department?

17 A. Not in the pediatric dental department.

18 Q. You're a professor of orthodontics, not a  
19 professor of pediatric dentistry?

20 A. I'm a professor at NYU in the Department of  
21 Orthodontics.

22 Q. Yes, sir.

23 MR. FRANKEL: Would you mark this as the  
24 next exhibit, please.

25 (Plaintiff's Exhibit No. 782 marked for

1 identification.)

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

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

5 Q. You're familiar with that, correct?

6 A. Sure.

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

9 A. Right.

10 Q. Where you teach, right?

11 A. Yes.

12 Q. Is it accurate?

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

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

17 A. That's not quite true because --

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

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

3 A. Oh, yeah.

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

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

8 Q. Relates to orthodontics?

9 A. That's true.

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

13 A. Uh-huh.

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

16 A. Yes.

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

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

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

25 A. Absolutely, categorically, no. Okay. Not

1 alone.

2 Q. Not true?

3 A. Not true. Not alone.

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

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

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

10 A. Amongst other things, yes.

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

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

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

20 A. Uh-huh.

21 THE COURT: Is that a yes?

22 THE WITNESS: Yes, I'm sorry.

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

1 be honest"?

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

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

6 A. Relative to what?

7 Q. What your experience is. Mr. --

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

10 Q. Okay.

11 A. If I did it was probably nerves.

12 Q. Nerves? Is that what you said?

13 A. Yeah.

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

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

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

17 A. Whatever you want to do.

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

22 A. Yes.

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



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

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

6           A.    Yes.

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

9           A.    Caries is.

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

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

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

16          A.    In a sense, yes.

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

19          A.    Uh-huh.  Yeah.

20          Q.    From the American Academy of Pediatric  
21          Dentistry?

22          A.    Right.

23          Q.    That covers millions of children, right?

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

25          Q.    Millions?

1           A.    Yup.  Oh, definitely.

2           Q.    And you're not saying that any child that has  
3 Early Childhood Caries can be strapped down in a  
4 papoose board and be treated, are you?

5           A.    No.

6           Q.    You're not saying that of the millions of kids  
7 that have Early Childhood Caries, it's okay to give  
8 them unnecessary dental treatment?

9           A.    Absolutely not.

10          Q.    You're not saying that of the millions of kids  
11 who have Early Childhood Caries you can drill on them  
12 without local anesthesia?

13          A.    You're qualifying it with everything -- no,  
14 that's true.

15          Q.    All right.  So Early Childhood Caries doesn't  
16 change the standard of care of what is expected of a  
17 good and reasonable dentist, does it?

18          A.    Nope.

19          Q.    You were talking this morning a little bit  
20 about the pediatrician who evaluated Jeremy a few days  
21 before he went to Small Smiles.  Do you remember that?

22          A.    Yes.

23          Q.    And you applauded her for being able to assess  
24 and in her opinion as a pediatrician what she saw,  
25 right?

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

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

6           A.   Correct.

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

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

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

17          A.   Absolutely, sure.

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

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

22          Q.   I'm sorry?

23          A.   Not really.

24          Q.   Not real?

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

1 Q. What was the level --

2 A. That statement is excessive.

3 Q. What level of swelling did Jeremy have?

4 A. It was noticed externally.

5 Q. Beyond that can you be any more specific?

6 A. No, I couldn't.

7 Q. All right. Did you review all the -- Dr.

8 Taylor's records regarding her evaluation of Jeremy's  
9 mouth?

10 A. I reviewed her -- I reviewed the records that I  
11 was given of Dr. Taylor's, Jeremy's visits to Dr.  
12 Taylor.

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

17 THE COURT: Okay.

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

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

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

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

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

1 Honor.

2 MR. FIRST: Can we approach on this?

3 THE COURT: Sure.

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

6 THE COURT: Exhibit 1135-A received over  
7 objection.

8 BY MR. FRANKEL: (Cont.)

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

13 A. I can't say if I recall.

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

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

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

20 A. Yes.

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

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

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

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

6 A. In this particular instance?

7 Q. Yes.

8 A. I guess so.

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

12 A. Do I agree with that?

13 Q. Yes, sir.

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

16 Q. I know that's what he said.

17 A. Yes.

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

20 A. Different from him?

21 Q. Yeah.

22 A. A different standard?

23 Q. Yes.

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

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

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

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

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

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

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

22          A.    That they tried other approaches?

23          Q.    Yes.  And they failed?

24          A.    Not that I can see, no.

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

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

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

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

13          A.     Say that again.

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

20          A.     Well, I mean --

21                   MR. STEVENS: Objection.

22                   Mischaracterization.

23                   THE COURT: Overruled.

24                   THE WITNESS: I'm sorry, I didn't hear.

25                   It was overruled.



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

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

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

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

15          A.    Uh-huh.

16          Q.    Are you ready to --

17          A.    That he did. Not his thinking.

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

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

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

25          A.    Correct.

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

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

6 Q. Okay.

7 A. I think it's a safe procedure.

8 Q. Pardon?

9 A. I think it's a safe procedure.

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

14 A. Yes, sir.

15 Q. Do you take their recommendations seriously?

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

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

24 MR. McPHILLIAMY: Objection. Hearsay.

25 MR. STEVENS: Objection.

1 THE COURT: Overruled.

2 A. Did I have anything to do with that?

3 Q. Yes, sir.

4 A. No, I didn't.

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

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

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

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

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

19 A. According to Cisaeros?

20 Q. Yes.

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

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

1 to restraining a child; is that true?

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

4 Q. Do you agree with Dr. Bonds that it's not  
5 reasonable to restrain a child with a heart rate of  
6 204 and a oxygen saturation rate of 88 to do three  
7 fillings?

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

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

15 A. Go forward at -- any way --

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

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

20 MR. FIRST: I object. This is --

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

24 MR. STEVENS: Objection.

25 MR. FIRST: Your Honor, this is beyond the

1 scope of the direct.

2 THE COURT: Overruled.

3 MR. STEVENS: Objection to  
4 mischaracterization.

5 THE COURT: Overruled.

6 BY MR. FRANKEL: (Cont.)

7 A. So could you repeat it?

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

13 MR. STEVENS: Objection. Multiple  
14 questions and mischaracterization.

15 THE COURT: Overruled.

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

22 Q. Did you hear my question?

23 A. Yes.

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

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

5 MR. FIRST: Objection. Misstates the  
6 evidence.

7 MR. McPHILLIAMY: Objection to form.

8 MR. STEVENS: Objection.

9 THE COURT: Form objections. Overruled.

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

13 THE COURT: That's a form, right?

14 MR. STEVENS: Yes, Your Honor.

15 THE COURT: Overruled.

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

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

1 shouldn't do that?

2 A. I read that.

3 Q. You agree or disagree?

4 MR. STEVENS: Objection. Form.

5 THE COURT: Overruled.

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

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

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

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

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

22 Q. Most of the time they should?

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

1 not but --

2 Q. All right.

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

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

8 MR. STEVENS: Objection to form.

9 A. That's his statement.

10 Q. Do you agree with it?

11 THE COURT: Wait. I have to rule.

12 Overruled. You may answer.

13 A. Again, that is his statement.

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

16 A. I agree that was his statement.

17 Q. Do you agree with his opinion?

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

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

22 MR. STEVENS: Objection.

23 Mischaracterization.

24 THE COURT: Overruled.

25 A. I don't think necessarily so.



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

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

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

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

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

10 BY MR. FRANKEL: (Cont.)

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

14 A. Right.

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

20 A. No.

21 Q. No.

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

25 Q. Touching the pulp on May 23rd?

1 A. May 23rd, we're talking about I, the x-ray?

2 Q. Yes, sir.

3 A. The x-ray that just shows the crown part of the  
4 crown.

5 Q. Right.

6 MR. FRANKEL: Can we see that, Chuck.

7 Q. This version is not as good as the one that  
8 they had up. I don't know whether you can --

9 MR. FRANKEL: Can we borrow yours?

10 A. That's not very good.

11 Q. You want to look at the original?

12 A. There was -- didn't I look at one on the  
13 screen? That looks very different.

14 Q. I know it's a copy. You want to look at the  
15 original we can, or we can pull up the copy.

16 MR. FRANKEL: Why don't we look at the  
17 very one you were using before, if that's okay.  
18 Would you do that for us. I appreciate it very  
19 much.

20 MR. FIRST: 601.

21 MR. HULSLANDER: There it is.

22 MR. FRANKEL: Thank you.

23 Q. This was the x-ray you were looking at before,  
24 right, Doctor?

25 A. Yes, sir.

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

5           A.    Approximating the pulp.

6           Q.    All right.

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

10          Q.    You can see it you say, right?

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

12          Q.    Yes.

13          A.    Yes, I can.

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

16          A.    Yeah.

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

19          A.    Yes.

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

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

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

25          A.    It's not diagnostic.

1 THE COURT: You have to let him finish.

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

4 MR. STEVENS: Objection to  
5 mischaracterization.

6 THE COURT: Overruled.

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

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

18 MR. STEVENS: Objection,  
19 mischaracterization.

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

23 Q. You say you read this, right?

24 A. Yeah.

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

1 right?

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

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

11 A. Uh-huh.

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

16 MR. STEVENS: Objection.

17 THE COURT: Overruled.

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

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

21 A. Say that again?

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

23 A. A rescue expert?

24 MR. HULSLANDER: Objection.

25 Q. Yes.

1 THE COURT: Overruled.

2 MR. FIRST: Objection.

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

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

11 MR. FIRST: Objection.

12 Q. -- have you ever heard of that?

13 MR. HULSLANDER: Objection.

14 MR. STEVENS: Objection. Move to strike.

15 A. I don't even understand it.

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

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

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

3           Q.    Yes, sir.

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

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

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

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

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

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

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

18          A.    Yes.

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

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

21          Q.    Okay.

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

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

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

6 A. Yes. Well --

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

9 A. Right.

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

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

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

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

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

23 A. I don't remember that.

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



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

4 A. Any reason to wait that long?

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

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

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

15 A. Most likely if it was more extensive.

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

18 A. Uh-huh. Yes.

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

21 A. Yes.

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

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

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

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

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

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

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

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

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

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

12          Q. All right.

13          A. It does help retard, you know.

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

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

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

24          A. I can't say if --

25          Q. The condition of Jeremy's teeth after four

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

5 A. Maybe x-rays here looking at.

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

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

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

13 A. Vaguely, yes, I do.

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

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

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

23 A. Nope.

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

1 to, correct?

2 A. Correct.

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

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

15 Q. Yes, sir, I know you did.

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

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

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

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

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

9 MR. FIRST: Objection.

10 Mischaracterization. To the form.

11 THE COURT: Overruled.

12 A. Say that again.

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

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

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

24 A. I don't know what he said.

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

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

5 MR. McPHILLIAMY: Objection.

6 Argumentative. Form.

7 MR. STEVENS: Objection.

8 MR. FIRST: Objection.

9 THE COURT: Overruled.

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

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

19 MR. McPHILLIAMY: Objection.

20 MR. STEVENS: Objection.

21 THE COURT: Overruled.

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

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

1 A. No. I hope I never will.

2 Q. Mr. First didn't show you that document?

3 A. I'm sorry, what document?

4 Q. The document I believe it's Plaintiff's Exhibit  
5 70 that is an instruction to dentists at the Small  
6 Smiles clinics on how to hide their true intentions  
7 when it comes to using the term CPE for secret pulps  
8 and crowns. He didn't show you that document?

9 A. I can't recall.

10 Q. Let me ask you this, Doctor, if the clinical  
11 exam was important to you that Dr. Aman did before he  
12 performed these procedures, would you please look at  
13 the chart and show us Dr. Aman's notes as to what his  
14 clinical exam showed?

15 A. Well, I mean I see color -- color copies of  
16 this. And I've seen --

17 Q. I'll give you --

18 A. -- a change in the treatment plan that was  
19 made, you know, so that's -- so that's what the --  
20 that's how that was done.

21 Q. Just tell me what -- you got the record, you  
22 want to look at the original? I will furnish you  
23 that.

24 A. No, that's all right.

25 Q. Just let us know what clinical notes it was



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

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

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

8 A. Yes. Thank you.

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

11 A. Yes.

12 Q. And you remember that he made these notations?

13 A. Yes.

14 Q. Without indicating that it was his?

15 A. On the side, yes.

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

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

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

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

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

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

8 A. Does not appear to be, yeah.

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

11 A. Yes.

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

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

20 Q. Were you there?

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

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

24 A. Say that again.

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

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

4 A. The deposition?

5 Q. And trial.

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

7 Q. All right.

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

9 Q. Fair enough.

10 A. And Dr. Mueller.

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

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

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

18 A. I don't remember that specifically.

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

24 A. Yes. Based on the x-rays.

25 Q. I'm sorry?

1           A.    Based on the x-rays.

2           Q.    Oh, now it's the x-rays.  I thought you said it  
3 was the clinical exam and the x-rays and the x-rays  
4 really aren't that important, it's the clinical exam  
5 that is so important?

6           A.    If you're about to treat a patient, you're  
7 looking at the mouth and it's readily apparent.

8           Q.    All right.  Did you give some testimony --  
9 general testimony about keeping track of statistics or  
10 production?

11          A.    I was asked about productivity reports --

12          Q.    Yes.

13          A.    -- in general.

14          Q.    Is it improper for a nondentist to provide --  
15 to interfere with the independent judgment of a  
16 dentist?

17          A.    Independent judgment of a dentist?

18          Q.    Yes, in treating a patient?

19          A.    As that statement stands alone, a nondentist  
20 should not be involved the diagnosis and treatment of  
21 a patient.

22          Q.    Or anything that would interfere with the  
23 independent judgment of the diagnosis and treatment of  
24 a patient, correct?

25          A.    Sure.  But production reports aren't that.

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

6           A.    No.

7           Q.    Would it be proper to do that?

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

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

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

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

24          A.    Yeah. Why not.

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

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

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

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

11 THE COURT: Redirect?

12 MR. FIRST: Yes.

13

14 REDIRECT EXAMINATION

15 BY MR. FIRST:

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

20 A. I guess so, yeah.

21 Q. Okay.

22 A. I'm sorry.

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

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

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

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

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

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

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

15 A. What?

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

17 That's not uncommon. Doctor, let me ask you this, you  
18 were asked about urgency and the like. By the time of  
19 October, 2006, Jeremy had had his abscess in teeth B  
20 and I taken care of?

21 A. Correct.

22 Q. You said that was an emergent situation?

23 A. Right.

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



1           A.    Absolutely.

2           Q.    That was also another one of his major  
3 problems?

4           A.    Yes, it was.

5           Q.    So as of the time of the later visits, his --  
6 the problem teeth, if you will, had a different  
7 character, meaning less disease?

8           A.    Exactly.

9           Q.    And, Doctor, you were asked about Dr. Aman with  
10 teeth D, E, F and G. I want to ask you about  
11 something you said. I want you to explain it. You  
12 were asked about Dr. Aman's notes, and you said -- you  
13 described what notes you saw, the New Smile note, the  
14 question mark.

15          A.    New Smile, right.

16          Q.    In order to treat those teeth, would you have  
17 to see them?

18          A.    In order to treat those teeth?

19          Q.    Let me ask it differently. In order to provide  
20 any treatment, would you have to make a clinical  
21 examination of those teeth?

22          A.    Absolutely, that's what I was trying to say.

23          Q.    Okay.

24          A.    It's staring you right in the face.

25          Q.    I know it seems obvious. I want you to explain

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

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

13 Q. You just did.

14 A. Oh, okay.

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

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

21 Q. Tooth bottle?

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

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

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

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

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

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

20 Q. Okay. In the resume?

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

23 MR. FIRST: Okay. Thank you.

24 THE WITNESS: Thank you.

25 THE COURT: Well, New FORBA?

1 MR. McPHILLIAMY: No questions.

2

3 CROSS-EXAMINATION

4 BY MR. STEVENS:

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

7 A. Sorry.

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

10 A. No.

11 Q. True. Never spoken?

12 A. Nope.

13 Q. Okay. How are you today?

14 A. There's always better days.

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

19 A. Correct.

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

23 A. Not Aman's testimony.

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

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

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

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

12 A. Right.

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

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

19 MR. STEVENS: Thank you.

20

21 RE CROSS-EXAMINATION

22 BY MR. FRANKEL:

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

1 THE COURT: Wait a second.

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

3 THE COURT: Wow, wow.

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

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

8 Q. That's not a clinical?

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

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

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

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

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

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

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

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

10                  THE COURT: Overruled.

11           A.     I just can't answer that question.

12           Q.     One last topic. You said that -- did I  
13     understand you to say it was an emergency situation  
14     where Jeremy came to the Small Smiles center on May  
15     23rd?

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

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

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

23           Q.     He wasn't, right?

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

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

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

13                   MR. McPHILLIAMY: Objection. Scope.

14                   THE COURT: Sustained.

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

19                   MR. McPHILLIAMY: Objection. Scope.

20                   THE COURT: Overruled on that one.

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



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

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

9                   MR. McPHILLIAMY:  Objection.  Scope.

10          A.    Yeah.

11                   THE COURT:  Overruled.

12          A.    Yes, I noticed that.

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

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

17                   (witness excused)

18                   MR. STEVENS:  May we approach?

19                   THE COURT:  Yup.

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

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

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

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

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

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

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

8 THE COURT: Okay.

9 MR. STEVENS: Your Honor --

10 THE COURT: Mr. First, any additional  
11 witnesses?

12 MR. FIRST: No, we rest.

13 THE COURT: Mr. McPhilliamy?

14 MR. McPHILLIAMY: New FORBA rests.

15 THE COURT: Okay. Mr. Stevens?

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

18

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

22

23 DIRECT EXAMINATION

24 BY MR. STEVENS:

25 Q. Good afternoon, Dr. Davis.

1           A.    Good afternoon, Mr. Stevens.

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

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

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

13          A.    Yes, I have.

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

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

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

3 Q. Did you become board certified in pediatric  
4 dentistry?

5 A. Yes.

6 Q. Briefly tell the jury what that means?

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

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

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

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

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

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

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

1           A.    Oh, about 45 altogether.

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

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

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

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

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

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

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

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

17 A. Yes, I am.

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

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

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

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

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

16 MR. HIGGINS: Objection.

17 THE COURT: Sustain the objection.

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

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

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



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

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

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

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

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

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

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

25          Q.    And at the request of my office have you

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

3 A. I have.

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

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

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

15 A. Certainly.

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

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

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

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

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

9           A.    That's fine.

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

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

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

25          A.    All I have to look at --

1 Q. Destruction?

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

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

6 A. Restorable.

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

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

25 MR. STEVENS: Page 21. Could I have just

1           the odontogram.

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

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

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

13                   MR. HIGGINS: Objection. Cumulative.

14                   THE COURT: Overruled.

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

1 MR. HIGGINS: Objection.

2 A. -- full height.

3 THE COURT: Sustained.

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

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

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

14 A. Absolutely.

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

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

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

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

11 A. That's correct.

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

14 A. Certainly it was within the standard of care.

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

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

22 Q. Correct.

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

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

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

7 THE WITNESS: Sorry.

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

10 THE WITNESS: Get rid of the noise.

11 THE COURT: Thank you.

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

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



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

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

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

20 THE COURT: Sure.

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

23 A. Sure.

24 Q. Can either stand, point to it.

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

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

5                   (Luncheon recess.)

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1 (Afternoon Session - October 4, 2013.)

2 (Defendant's ABK 1268 through 1282 marked for  
3 identification.)

4 THE COURT: I apologize for the delay.

5 That's all on me, sorry. Okay. Ready to proceed?

6 MR. STEVENS: Can we have the same slide  
7 up, please.

8 BY MR. STEVENS: (Cont.)

9 Q. Dr. Davis, by the way I didn't ask you earlier,  
10 have you ever been in the courtroom before giving  
11 testimony as a dental expert?

12 A. No, this is the first time.

13 Q. Could we have the -- while that's powering up,  
14 I was just going to put the slide up on the screen and  
15 ask you to just go over the marks that are made on the  
16 odontogram at Small Smiles and what they mean and then  
17 we'll continue from there.

18 A. Okay. May I come down there to --

19 Q. When it comes up.

20 THE COURT: To point.

21 MR. HIGGINS: Judge, I object on  
22 foundation grounds.

23 THE COURT: What are you showing?

24 MR. STEVENS: A picture that they agreed  
25 to. I don't know what the objection is about.

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

6                   MR. STEVENS: I'll ask him.

7 BY MR. STEVENS: (Cont.)

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

10                  A. Yes.

11                  Q. Would you explain that to the jury, and I'll  
12                  give you a laser pointer if that would be helpful.

13                  This one has a button here.

14                  A. Maybe I will just use that.

15                  Q. Okay.

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

18                  Q. Yes, please.

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

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

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

8 A. Yes, they are.

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

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

17 Q. Yes.

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

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

7       Q.     Doctor --

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

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

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

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

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

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

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

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

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

23 A. Correct.

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

1 teeth that were involved?

2 A. Right.

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

5 MR. HIGGINS: Objection. Relevance.  
6 Foundation.

7 THE COURT: Sustained.

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

10 A. Well --

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

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

14 MR. HIGGINS: Same objection, Judge.

15 THE COURT: Overruled.

16 Q. Would you explain why?

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

21 Q. Can I interrupt you for a second?

22 A. Yes.

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



1 MR. HIGGINS: Same objection, Judge.

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

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

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

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

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

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

21 MR. HIGGINS: Objection.

22 THE COURT: Sustained.

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

1           A.    Correct.

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

12          A.    Yes, that should be adequate.

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

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

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

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

1 specialty.

2 Q. 75 percent of children all across the country?

3 A. Is from general practitioners.

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

13 MR. HIGGINS: Objection. Foundation.  
14 Leading.

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

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

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

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

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

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

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

15 A. Right.

16 Q. J, K, and L were filled?

17 A. Yes.

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

21 A. Correct.

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

24 A. Right.

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

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

4             MR. HIGGINS:   Form.

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

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

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

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

20            THE COURT:  Overruled.

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

23            A.   Yes.  Quite a few.

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

1       stabilization?

2                   MR. HIGGINS: Same objection.

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

6                   MR. STEVENS: Sure.

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

10                  MR. HIGGINS: Foundation.

11                  THE COURT: Sustained.

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

16                  MR. HIGGINS: Same objection.

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

20                  MR. HIGGINS: Same objection.

21                  MR. STEVENS: It's a theoretical question.

22                  THE COURT: Can you read that question  
23       back.

24                  (Pending Question read by the Reporter.)

25                  THE COURT: Can you break it down.

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

9           A.    Right.

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

15                   MR. HIGGINS:  Objection.  Form and  
16   foundation.

17                   THE COURT:  Overruled.

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

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

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

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

20 MR. HIGGINS: Thank you.

21 Q. And please assume that Dr. Bonds told this jury  
22 that in the situation of a patient's heart rate is  
23 204, he would wait for the patient to calm down before  
24 he starts to work. Do you have an opinion as to  
25 whether that's appropriate?



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

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

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

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

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

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

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

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

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

3 A. Okay.

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

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

12 MR. HIGGINS: Objection.

13 THE COURT: Sustained.

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

16 A. Passive clearly.

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

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

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

1 J, K and L --

2 A. Right.

3 Q. -- the -- before I do that one. Let me ask you  
4 the second visit to Small Smiles was August 31st,  
5 2006, correct?

6 A. Correct.

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

10 A. True.

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

13 A. True.

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

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

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

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

23 MR. HIGGINS: Same objections.

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

1 THE COURT: Uhm --

2 MR. STEVENS: They made an issue --

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

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

8 A. Yes.

9 Q. And children who go to preschool?

10 A. Correct.

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

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

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

19 A. Thank you.

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

23 A. Yes.

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

1 of that sort in a child like Jeremy?

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

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

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

23 MR. HIGGINS: Objection, Judge.

24 Narrative.

25 THE COURT: Overruled.

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

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

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

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

17          A.    Correct.

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

20          A.    Right.

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

23          A.    Right.

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

1 A. Correct. A and S.

2 Q. A and S, exactly right. I read it wrong.

3 A. Thank you.

4 Q. And, Doctor, am I reading the chart properly  
5 that from the fourth visit onward, Jeremy never needed  
6 protective stabilization again and was never again  
7 recommended even to get permission to use it?

8 A. Correct.

9 Q. Okay. In terms of child's behavior and being  
10 treated for those on the first and the third visit  
11 with protective stabilization and getting treatment  
12 and successfully, what is the significance of the  
13 child in terms of the dynamics between the child and  
14 the treatment and the dentist?

15 A. Well, the significance is very simple, Jeremy  
16 has learned that tantrum like behavior is not going to  
17 get him out of it.

18 MR. HIGGINS: Objection as to what Jeremy  
19 has learned, Judge. Foundation.

20 THE COURT: Sustained. I'm going to  
21 strike the answer.

22 Q. In general, under the circumstances, does it  
23 help a child in terms of learned behavior to be  
24 successful with treatment?

25 MR. HIGGINS: Objection. Foundation.

1           Relevance.

2                   THE COURT: Sustained.

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

6           A.    Correct.

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

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

14          Q.    With respect to J, K and L?

15          A.    Right.

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

18          A.    Right.

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

22                   MR. HIGGINS: Objection. Foundation.

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



1 the Small Smiles clinic. Very simple question.

2 THE COURT: Uhm, well --

3 MR. HIGGINS: Judge, I note.

4 THE COURT: -- it's marked on the chart.

5 I guess that's -- I think it is.

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

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

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

12 BY MR. STEVENS: (Cont.)

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

17 A. Yes, there were.

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

21 A. That it should be restored --

22 Q. Okay.

23 A. -- or filled.

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

25 A. One.

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

3           A.    Two.

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

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

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

12                   MR. HIGGINS:  Objection.  Foundation.  
13                   Relevance.

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

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

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

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

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

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

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

11 THE COURT: Sustained. Stricken.

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

14 A. Absolutely.

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

17 A. Absolutely.

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

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

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

25 A. Not in the material itself, no.

1 MR. STEVENS: Could I have number 530 up.

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

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

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

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

18 Q. Yes.

19 A. Yes.

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

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

1                   MR. STEVENS: Relevance is obvious, Your  
2                   Honor.

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

5 BY MR. STEVENS: (Cont.)

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

9           A.    Yes.

10          Q.    And why is that?

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

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

18                   MR. HIGGINS: Objection. Form and  
19                   foundation.

20                   THE COURT: Overruled.

21          A.    I see no evidence of it.

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

1 Jeremy's first appointment and his second appointment.

2 Do you agree with that proposition?

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

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

7 A. Well, the doctor providing the care.

8 Q. And in this case, Dr. Aman?

9 A. Correct.

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

14 A. No.

15 Q. Okay. Why not?

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

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

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

12 MR. HIGGINS: Objection to form.

13 A. Yes.

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

16 THE COURT: Would counsel approach.

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

19 BY MR. STEVENS: (Cont.)

20 Q. Referring to defendant's ABK-1281, 1274, and  
21 1275, which are all screen shots from plaintiff's  
22 video, Dr. Davis, my first question before I put this  
23 up is when an x-ray is taken of upper front teeth --

24 A. Right.

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

1 present, is it always visible on x-ray?

2 A. No.

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

5 A. Not always. Depends on where it is.

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

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

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

14 A. Yes.

15 Q. That's the surface towards the tongue?

16 A. Towards the tongue, the palate.

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

21 A. Yes.

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

25 A. True.



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

5           A.    May I step down?

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

8           Q.    You want to point to it?

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

21          Q.    When you say "this" you mean?

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

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

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

23 A. Sure.

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

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

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

6 A. Upside down. One way or the other.

7 Q. Us lay people that makes more sense.

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

15      Q.    Thank you.

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

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

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

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

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

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

3                   THE COURT: Sustained.

4                   MR. STEVENS: Okay.

5 MR. STEVENS: (Cont.)

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

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

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

18          A.   Correct, I saw that.

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

22          A.   Absolutely, yes.

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

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

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

1 A. Right.

2 Q. Did you see that in the chart?

3 A. Correct. Yes.

4 MR. STEVENS: Put up 835. Blowup the top,  
5 please.

6 Q. On the -- have the behavior rating scale on the  
7 third visit. Did you learn that this was the last  
8 time that Jeremy was rated as a number one on the  
9 Frankl scale?

10 A. That's correct.

11 Q. For a child who has lower jaw caries, what sort  
12 of procedure would be needed in terms of local  
13 anesthetic if you want to numb the lower jaw?

14 A. That would be that nerve block I was talking  
15 about. It's called inferior alveolar nerve block.

16 Q. And can we call that just more simply a lower  
17 jaw nerve block?

18 A. Sure. For our purposes here.

19 Q. Okay. And a lower jaw nerve block requires  
20 what kind of stability and what kind of cooperation,  
21 and how long does it take while the needle is actually  
22 inside the patient?

23 MR. HIGGINS: Objection. Leading.

24 Foundation. Form.

25 MR. STEVENS: I'll say it differently.

1 THE COURT: Sustained.

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

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

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

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

8 A. Which is a lidocaine.

9 Q. Lidocaine.

10 A. Yeah.

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

15 A. Why, certainly.

16 Q. Please tell the jury.

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



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

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

8 A. Very helpful I think.

9 MR. STEVENS: Can I have number 441.

10 THE COURT: This for demonstrative  
11 purposes?

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

14 Q. Tell the jury what you are looking at?

15 A. May I approach?

16 Q. Sure. There is the pointer right there.

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

23 Q. Yes.

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

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

4                 MR. STEVENS: 439, please.

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

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

13            Q.     Use a laser.

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

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

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

4 A. True.

5 Q. Described that as something catastrophic?

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

10 Q. Doctor --

11 MR. STEVENS: Could I have page 51.

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

17 A. Right.

18 Q. And I would like to ask you this is a -- this  
19 is an x-ray taken at Small Smiles clinic on November  
20 12, 2007, some number of months after Dr. Aman  
21 installed those four crowns and did four pulpotomies  
22 on D, E, F, G. First tell the jury what you see in  
23 general, and then I'd like to ask you a more specific  
24 question.

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

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

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

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

17 MR. HIGGINS: Objection. Misstates the  
18 testimony.

19 MR. STEVENS: Didn't she say that?

20 MR. HIGGINS: No.

21 MR. STEVENS: Well --

22 THE COURT: It's a --

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

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

1       whether the pulpotomies were performed on these four  
2       teeth?

3           A.    Yes, they were.

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

7           A.    Yes, I have.

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

13          A.    Yes, it was all appropriate and needed.

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

18               MR. HIGGINS:  Objection.  Foundation.

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

21               THE COURT:  Overruled.

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

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

25          A.    Absolutely.

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

4 A. Yes.

5 Q. And you believe those to be true?

6 A. Yes.

7 MR. STEVENS: Thank you very much.

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

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

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

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

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

18 THE COURT: Proceed.

19

20 CROSS-EXAMINATION

21 BY MR. HIGGINS:

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

24 A. Correct.

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

1 How much are you being compensated for your time?

2 A. \$350 an hour.

3 Q. How much have you billed so far?

4 A. Probably about 30 hours worth of time.

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

7 A. Probably half of that.

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

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

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

14 A. I have.

15 MR. STEVENS: Objection.

16 Q. All right. And --

17 THE COURT: Overruled.

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

20 MR. STEVENS: Objection.

21 THE COURT: Overruled.

22 A. Roughly 30 I would say.

23 Q. How many hours did that take?

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

1       that.

2           Q.    Who selected those charts?

3           A.    They were sent to me.

4           Q.    By who?

5           A.    By the law firm that retained me.

6           Q.    Which law firm was that?

7           A.    Ellis Wilson.

8           Q.    Wilson Elser?

9           A.    Wilson Elser.

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

11          A.    No, I didn't.

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

14          A.    When I was first contacted by them?

15          Q.    Yes.

16          A.    They said we would like you to become involved  
17 in something you may have heard about. It has to do  
18 with Small Smiles clinics. We want your role to be to  
19 look at the examination -- clinical examination, the  
20 radiographs, the care provided and see if they match.

21          Q.    Okay.

22          A.    Which seems reasonable.

23          Q.    So they told you what your scope of review was  
24 going to be?

25          A.    Correct.



1           Q.    And your scope of review was going to be  
2   limited to the three dentists?

3           A.    They didn't say that.  They said in any case in  
4   which involve you that's going to be your focus.

5           Q.    Okay.  So you're past president of the American  
6   Academy of Pediatric Dentistry?

7           A.    Correct.

8           Q.    And the jury heard quite a bit about that.  You  
9   ever hear anything about the Small Smiles matters  
10   before you got retained by Wilson Elser?

11                  MR. STEVENS:  Objection.

12                  MR. HIGGINS:  I'm not asking what he  
13   heard.  I'm asking whether he did --

14                  MR. STEVENS:  Objection.

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

17           Q.    Well, okay.  When you were approached by Wilson  
18   Elser, how many years ago was that?

19           A.    Probably a year and a half ago roughly.

20           Q.    Did you tell them at that time that you knew  
21   something about the Small Smiles matter?

22                  MR. STEVENS:  Objection.

23                  MR. McPHILLIAMY:  Objection.

24                  THE COURT:  Overruled.

25           A.    Yes, I did.

1 Q. Okay.

2 A. Which I had heard.

3 Q. We don't -- don't tell us what you heard. And  
4 did you -- when you were hired as an expert in this  
5 case, did you then go to Wilson Elser and say, well, I  
6 need to know everything. I need to know. I have to  
7 find out about Small Smiles and the corporate  
8 influence arguments and all of that. Did you go and  
9 ask him that?

10 MR. STEVENS: Objection.

11 MR. McPHILLIAMY: Form.

12 MR. STEVENS: Doctor explained what he was  
13 doing, Your Honor.

14 THE COURT: Overruled.

15 A. No, I did not inquire as to those things  
16 because I didn't know enough to do so.

17 Q. So as you sit here today are you assuming that  
18 the Small Smiles as part of your opinions -- are you  
19 assuming that the Small Smiles group here, the Old and  
20 New FORBA were acting appropriately in their  
21 communications and their correspondence and their  
22 dealing with the three dentists that you're testifying  
23 about?

24 MR. McPHILLIAMY: Objection.

25 THE COURT: What's the basis of -- the

1           legal basis of the objection?

2                   MR. McPHILLIAMY: Form.

3                   THE COURT: Overruled.

4           A. I really have no basis to make that judgment  
5 because I just don't know that much about that piece.

6           Q. You don't know anything about Small Smiles I  
7 mean within the context of your --

8           A. I have now read some depositions.

9           Q. You have read some depositions?

10          A. I read what's been said in here, transcription  
11 of trials. That's where I have learned subsequently.  
12 I certainly didn't know it when first approached by  
13 Wilson Elser.

14          Q. Certainly in the last year and a half you  
15 haven't done anything yourself to find out more about  
16 Small Smiles?

17          A. No.

18          Q. So what deposition transcripts were you given  
19 by Wilson Elser regarding Small Smiles and how it  
20 interacted with the three dentists that you're here to  
21 testify about today?

22          A. Okay. So I saw depositions from the three  
23 doctors.

24          Q. Bonds, Aman, Khan?

25          A. Correct.

1 Q. All right.

2 A. I saw deposition from Jeremy.

3 Q. Jeremy?

4 A. From his mother. From his father.

5 Q. Right.

6 A. Those are the ones I remember.

7 Q. Anything else?

8 A. Off the top of my head, I don't remember.

9 Q. Well, you know, you would have -- what about  
10 Dr. Mueller?

11 A. I did see his.

12 Q. You did?

13 A. I'm sorry.

14 Q. Okay. Did you -- when you read it, did you  
15 reach any opinions or findings about whether Small  
16 Smiles was influencing the dentists or directing  
17 clinical work?

18 MR. McPHILLIAMY: Objection. Form.  
19 Relevance. Form and relevance.

20 MR. STEVENS: Objection.

21 MR. FIRST: Objection.

22 MR. STEVENS: Outside scope, Your Honor.

23 THE COURT: Would counsellors approach.

24 MR. HIGGINS: I can rephrase, Judge.

25 THE COURT: Okay.

1 MR. HIGGINS: All right.

2 BY MR. HIGGINS: (Cont.)

3 Q. Uhm, is it your opinion based on any  
4 assumptions to this jury -- when you're talking to  
5 this jury giving opinions, are there any assumptions  
6 that you are -- that are embedded in your opinions?

7 A. As reflects the relationship to those  
8 corporations?

9 Q. Yeah.

10 A. No.

11 Q. Okay. So when you're sitting here talking to  
12 the jury about these three dentists, you are basically  
13 considering these dentists just as if they're in their  
14 own single practice and just doing whatever dentists  
15 do, correct?

16 A. Talking about the standard of care. The care  
17 they provided.

18 Q. Right. You haven't even considered whether any  
19 of these dentists were improperly influenced and  
20 whether there was any type of motivation for whatever  
21 was done in this chart to Jeremy Bohn; is that fair?

22 A. That's fair.

23 MR. McPHILLIAMY: Objection. Relevance.

24 MR. STEVENS: Objection.

25 THE COURT: Overruled.

1           Q.    That -- you understand that's a job for the  
2 jury, correct?

3           A.    Correct.

4           Q.    All right. So you're not here to say anything  
5 different, right? You're not here to say that these  
6 dentists weren't influenced or anything like that,  
7 that's just not part of what you're doing here; is  
8 that fair?

9           A.    I don't know those details.

10          Q.    Okay. And you never asked Wilson Elser to give  
11 you any of those details --

12                   MR. STEVENS: Objection.

13          Q.    -- is that fair?

14                   THE COURT: Overruled.

15          Q.    Is that fair?

16          A.    That's fair.

17          Q.    Thank you, Doctor. The motivation for why  
18 people do things or why they don't do things is that  
19 sometimes important in understanding what happens in a  
20 particular case?

21          A.    Of course.

22          Q.    And, Doctor, you had a very long and  
23 distinguished career, haven't you?

24          A.    Thank you.

25          Q.    I mean it's evident from your record. You

1 strike me that you're committed to pediatric  
2 dentistry, correct?

3 A. Hope so.

4 Q. Okay. Do you think it's a good idea for  
5 corporations to direct clinical care to dentists?

6 MR. McPHILLIAMY: Objection. Relevance.

7 MR. FIRST: Objection.

8 THE COURT: Overruled.

9 A. I think the dentists have to make independent  
10 decisions about care for patients.

11 Q. Okay. And that's because of patient safety,  
12 correct?

13 A. And wellness, yes.

14 Q. Okay. I this whole thing is about doctors and  
15 dentists and patient safety, correct?

16 A. Correct.

17 Q. All right. And if you have corporations  
18 telling dentists and doctors how to practice medicine  
19 that potentially can be unsafe for members of the  
20 community; is that fair?

21 MR. McPHILLIAMY: Objection.

22 MR. FIRST: Objection.

23 MR. STEVENS: Objection.

24 MR. FIRST: Beyond the scope.

25 THE COURT: I'm going to sustain the

1 objection.

2 BY MR. HIGGINS: (Cont.)

3 Q. Doctor, you as a -- the past president of the  
4 American Academy of Pediatrics, you would not want to  
5 live in a world where corporations dictate how doctors  
6 and dentists practice; is that fair?

7 MR. FIRST: Objection. Beyond the scope.

8 MR. HULSLANDER: Objection. Scope.

9 MR. STEVENS: Objection.

10 THE COURT: Overruled.

11 A. That's fair.

12 Q. That's not a safe world for people in the  
13 community, is it?

14 A. No. It has the potential for problems.

15 Q. Right. And you teach residents, you have done  
16 that for quite sometime, correct?

17 A. They -- I think too long it's why I actually  
18 retired six months ago.

19 Q. I thought you retired in 2012?

20 A. December of 2012.

21 Q. Okay.

22 A. That's nine months, isn't it?

23 Q. Yes. And did you -- did you ever teach  
24 residents about the corporate practice of medicine?

25 A. No.



1           Q.    Did you know when you were practicing that  
2 there was a state law against that?

3           A.    Yes.

4           Q.    And did you think it was there for a good  
5 reason?

6           A.    Yes.

7           Q.    And again it's a patient safety law, is it not?

8           A.    Safety, well-being, ultimately best care.

9           Q.    Okay. And, Doctor, the -- you said you had a  
10 45-year career. You must have treated tens of  
11 thousands of patients?

12          A.    A lot of patients.

13          Q.    Okay. Is that a fair estimate?

14          A.    I never put a number on them. I suppose it was  
15 well up in the thousands.

16          Q.    I mean 45 years, thousand patients, that would  
17 be like 15 or 20 a year, something like that. You  
18 have seen thousands of patients?

19          A.    Yes.

20          Q.    And you told us that you had restrained about  
21 500 in your career, correct?

22          A.    That sounds about right.

23          Q.    All right. How many of those were special  
24 needs children?

25          A.    Quarter to a third of those probably.

1 Q. Okay. So we're talking, again, math, help me  
2 on the math. We are talking --

3 A. 300 non-special needs patients.

4 Q. Over 45 years, correct?

5 A. Yes, of the active practice time.

6 Q. Right. And, Doctor, you've written on  
7 restraints before, haven't you?

8 A. Written on restraints among a few things, yes.

9 Q. And you got your medical license in 1974 --  
10 your dental license, I'm sorry?

11 A. Correct.

12 Q. And by 1979 you were publishing, correct?

13 A. Correct.

14 Q. And even in 1979 you were of the opinion that  
15 restraints should not be used for routine utilization  
16 on the average child patient; is that fair?

17 A. That's fair.

18 Q. That's what you wrote in 1979, correct?

19 A. Correct.

20 Q. Okay. And we talked a little bit about  
21 childhood caries. You are also a spokesperson for the  
22 American Academy of Pediatrics?

23 A. That's correct.

24 Q. October 2011, you told us or you made a  
25 statement that -- well, let me ask you this. How many

1 people -- how many kids between two and five, what is  
2 the most frequent reason now that they go to the  
3 hospital?

4 A. They go to the -- they're admitted to  
5 hospitals?

6 Q. Yeah.

7 A. I would guess asthma.

8 Q. Doctor, did you say on October 31st, 2011, that  
9 the most frequent -- children ages two to five are  
10 admitted to the hospital most frequently to have their  
11 teeth fixed?

12 A. May I?

13 Q. Please. If I misstated that, please let me  
14 know.

15 A. Okay. Children ages two to five are admitted  
16 to the hospital most frequently to have their teeth  
17 fixed.

18 Q. Is that accurate?

19 A. That's accurate, sorry. I wasn't understanding  
20 what you were asking. I apologize.

21 Q. I'm sorry, it is probably my question. The  
22 other thing, Doctor, in terms of Early Childhood  
23 Caries, just if a kid has one cavity, that's Early  
24 Childhood Caries, correct?

25 A. That's the definition, yes.

1           Q.    And what percentage of kids in the United  
2 States now under the age of five?

3                   MR. STEVENS:  Objection to "now."  We're  
4           talking 2006.

5                   MR. HIGGINS:  Okay.  I'll withdraw.

6           Q.    In 2006, what percentage of kids in the United  
7 States had one cavity?

8           A.    One cavity?

9           Q.    Yeah.

10          A.    Under the age of six?

11          Q.    Under the age of five?

12          A.    Under the age of five, trying to remember data  
13 here.

14          Q.    Sure.

15          A.    Easily 50 percent.

16          Q.    All right.  How many kids are there in the  
17 country?

18          A.    It's a country of 300 million people of which  
19 about quarter of them are under the age of 18, I  
20 guess.

21          Q.    Okay.  So we're talking millions and millions  
22 of kids would fit this definition of rampant ECC  
23 decay, right, rampant caries, correct?

24          A.    A lot, yes.

25          Q.    Okay.  Doctor, let me talk to you about

1 consent, informed consent. Is that a concept that  
2 you're familiar with?

3 A. Yes, it is.

4 Q. Have you taught that to residents?

5 A. Yes, I have.

6 Q. Would it be fair to say that consent must be  
7 full, complete and 100 percent for it to be consent at  
8 all?

9 A. The 100 percent is hard to imagine. You do  
10 your best, you know. I don't care what you put in  
11 writing on a permission form, you do your best to  
12 explain to the parent what this is about and document  
13 it with that form.

14 Q. Wherever it is, it's got to be full, complete,  
15 accurate and total if there is going to be informed  
16 consent; is that fair?

17 A. That's the standard of care is that you do your  
18 best to try to provide as much information as would be  
19 relevant to any, you know, parent who wanted to know,  
20 what would you like for your children. I mean that's  
21 what I have always used as my consent guide.

22 Q. Okay. Doctor, is it your testimony to this  
23 jury that the standard of care for informed consent is  
24 doing the best you can?

25 A. It is.

1 Q. Is that a yes or no, Doctor?

2 A. No. That's incomplete.

3 Q. So the standard of care, full, complete, total  
4 consent; is that fair?

5 A. You know, again, it's a circumstantial thing.  
6 I mean you -- I have had parents where I have  
7 explained something I swear four, five times, thinking  
8 I have really covered this 100 percent, and later on,  
9 oh, I didn't understand that. So to me standard of  
10 care about consent is making your best, honest effort  
11 to make sure a parent fully understands what you're  
12 trying to do for their child.

13 Q. That's the standard of care, best, honest  
14 effort and then you're done, that's it?

15 A. Then you ask questions.

16 Q. That's it?

17 A. Then they get to discuss it with you and they  
18 decide what you can and cannot do then.

19 Q. Is your testimony under oath to this jury that  
20 informed consent in the State of New York is best,  
21 honest effort and you're done? Is that -- yes or no?

22 A. I don't see what I'm missing there, so I'd say  
23 yes.

24 Q. Okay. And certainly we're going to hear  
25 from -- later that everybody, all the doctors and the

1 dentists have different capabilities, don't they?

2 Some are good, some are not good, somebody's best  
3 efforts might be different from somebody else's best  
4 efforts, right?

5 A. Correct.

6 Q. Right. And informed consent is another patient  
7 safety issue, isn't it?

8 A. It certainly can be, yes.

9 Q. Well, you're a mom, you're taking your kid into  
10 a doctor, as a dentist, you know, they don't know what  
11 you're talking about?

12 A. Correct.

13 Q. You got to explain it to them, right?

14 A. Correct.

15 Q. And because at the end of the day it's the  
16 mother or the dad who are caring for their children  
17 and they have to make the decision, correct?

18 A. Absolutely.

19 Q. They are the ones, not any doctor or dentist,  
20 right?

21 A. Correct.

22 Q. It's not -- at the end of the day the kids are  
23 coming home, they're not going home to the doctor or  
24 dentist office, right?

25 A. Right.

1 Q. Okay. And would you agree with me that consent  
2 obtained by fraud is no consent at all?

3 A. Well, if you're not giving honest information,  
4 you're not obtaining consent.

5 Q. Okay. And the doctor has a duty to explain  
6 consent in words that are understandable to the  
7 patient?

8 A. Correct.

9 Q. All right. The doctor has a duty to explain  
10 all of the facts that would be explained by a  
11 reasonable medical practitioner?

12 A. Correct.

13 Q. Okay. And consent can only be given when the  
14 patient has an awareness of the existing condition,  
15 fair?

16 A. Patient or guardian in this case.

17 Q. Guardian, fine.

18 A. Okay.

19 Q. That the reasonably foreseeable risks to the  
20 patient's health or life which the procedure may  
21 impose must be disclosed?

22 A. Reasonably foreseeable, correct.

23 Q. Yes?

24 A. Correct.

25 Q. And it's never the doctor's decision, is it, or



1 the dentist's decision to decide what risks should be  
2 accepted, what risks shouldn't be accepted, that's the  
3 parents or the guardian's job, correct?

4 A. That's correct, in spite of them saying,  
5 "whatever you think, doctor."

6 Q. Which some people do, right?

7 A. Yes.

8 Q. And you know and every medical practitioner  
9 knows your knowledge, you know, I mean you start  
10 talking about mesial stuff, no one is going to know  
11 what you are talking about, right?

12 A. Right.

13 Q. So you have to explain it to them, right?

14 A. Correct.

15 Q. You do that, don't you?

16 A. A lot.

17 Q. You care about your patients?

18 A. Yes.

19 Q. All right. You would never do any unnecessary  
20 treatment on a patient, would you, Doctor?

21 A. No.

22 Q. That would be reprehensible, would it not?

23 A. Yes.

24 Q. That would be a deviation of the standard of  
25 care for good and accepted dental practice, would it

1 not, Doctor?

2 A. It would be.

3 Q. That would be a violation of dental ethics,  
4 correct?

5 A. Correct.

6 Q. Now, have you reached any opinions with a  
7 reasonable degree of medical certainty as to whether  
8 Kelly Varano was provided with all the reasonably  
9 foreseeable risks on May 23rd, 2006?

10 A. With respect to --

11 Q. Restraints?

12 A. -- restraints? Okay. With respect to the  
13 protective stabilization, I see that, by the way,  
14 different than restraint. Easier terminology.

15 Q. That's fine.

16 A. From what I saw the form, and again the form is  
17 just documentation that we had the discussion.

18 Q. Yeah.

19 A. The form that they used was actually one of the  
20 better ones I have ever seen with those illustrations  
21 at the bottom. We don't have that on our form at  
22 Columbia.

23 Q. Let's just go in and look at this a little bit.

24 A. Sure.

25 Q. Can we blow -- I'm advised no known risks to

1 the immobilization procedure. So do you agree with  
2 that doctor that there are no known risks to the  
3 immobilization procedure as of May 23, 2006?

4 A. Well, you -- it steps into a huge controversy  
5 within the academy.

6 Q. How about we try since you probably want to get  
7 out of here by the end of the day, how about you just  
8 try answering the specific question.

9 A. Sure.

10 Q. Is -- do you agree or disagree that there are  
11 no known risks to the immobilization procedure?

12 A. When done correctly, other than bruising, no  
13 known risks.

14 Q. So your view as the past president of the  
15 American Academy of Pediatrics there are no known  
16 risks, except for bruising, right?

17 MR. STEVENS: Objection.

18 Mischaracterization.

19 THE COURT: Overruled.

20 Q. That's what you say?

21 A. That's what I say.

22 Q. Okay. And, of course, you know, Doctor, that  
23 the American Academy of Pediatric Dentists disagrees  
24 with you in its guidelines?

25 A. I know there are guidelines which suggest risk.

1 Q. Right. And you disagree with those?

2 A. I disagree with those and I'm not alone.

3 Q. Okay. Again, you're the only one here. If  
4 there is somebody else, I can talk to them, but you're  
5 the one who's here?

6 A. Okay.

7 Q. So can we agree that there is a -- the American  
8 Academy of Pediatric Dentistry you wouldn't be  
9 associated with it if it was some fly-by-night sham  
10 outfit?

11 A. I hope not.

12 Q. We all do. But it's a legitimate organization,  
13 isn't it?

14 A. Right.

15 Q. How many people are in it?

16 A. 8,000.

17 Q. 8,000. All pediatric dentists, right?

18 A. Yes. No, I'm sorry. About 15 percent are  
19 family practitioners.

20 Q. Okay.

21 A. We actually put the two organizations together  
22 during my presidency. One was GP that treated  
23 children and the academy. That's why they are there.

24 MR. HIGGINS: Let's go to 66, please, in  
25 evidence. I'm looking at --

1           Q.    Doctor, as of 2005, the American Academy of  
2           Pediatrics, again, the jury has seen this, has  
3           basically said their guidance documents said there  
4           were significant risks, including physical and  
5           psychological harm, right?

6           A.    I have seen that, yes.

7           Q.    When you saw that were you the president of the  
8           academy?

9           A.    No. That came after my time as president.

10          Q.    I mean you must know a lot of people in the  
11          academy, right?

12          A.    Tons, including the people that wrote that. I  
13          have discussed it with those people.

14          Q.    Right. And since we don't want to get into any  
15          hearsay objections, we are going to move on.

16          A.    Of course.

17          Q.    So certainly the people that did this or the  
18          American Academy of Pediatric Dentists probably has a  
19          process it goes back and forth, then they finally come  
20          out with this?

21          A.    This comes out with the council on dental  
22          education.

23          Q.    So it came out, and when you saw this, did you  
24          go back and try to say, this is awful, I want this  
25          out, I'm finished with this?

1           A.    I was doing that while that council was  
2           formulating this.  As a matter of fact, I mean this  
3           psychological risk --

4           Q.    Doctor, you answered the question.

5                   MR. FIRST:  Objection.

6                   MR. HULSLANDER:  Objection.

7                   MR. STEVENS:  Objection.

8                   THE COURT:  I think he answered the  
9           question.  It's cross-examination.

10          Q.    Again, I don't mean to be rude.  I'm looking at  
11   the clock.

12          A.    I know you have a purpose.

13          Q.    I'm trying.  So, Doctor, we can go back and  
14   forth about, you know, some people say it's true, some  
15   people it's not, but there is a legitimate  
16   organization out there that put this out and it says  
17   that there's psychological harm, loss of dignity,  
18   violations of patients' rights and even death, right,  
19   you may disagree with that, but isn't that something  
20   that the average mom might want to know?

21                   MR. McPHILLIAMY:  Objection to form.

22                   THE COURT:  Overruled.

23          A.    Interesting question.

24          Q.    Interesting answer.

25          A.    The "average mother" is what worries me here.

1           Q.    Can you answer that question yes or no, isn't  
2   that something --

3           A.    I can't.  It's circumstantial.  The "average  
4   mother" might be scared to death to let you use  
5   something that is critical to the care of her child.

6           Q.    Isn't that the mother's decision?  Who else  
7   should be making that decision, Doctor, the mother,  
8   right?

9           A.    Ultimately, the guardian's decision what  
10   happens.

11          Q.    The guardian is usually the mother, isn't it,  
12   Doctor, we all know that?

13          A.    Correct.

14          Q.    Wasn't that Kelly Varano's decision to make --  
15   to say maybe she will get scared but that's her, isn't  
16   it -- isn't it her job?  Isn't it?  Isn't she the one  
17   that should be making that decision?

18                   MR. HULSLANDER:  That's a speech!

19                   MR. STEVENS:  Objection.

20                   THE COURT:  Sustain the objection.  Next  
21   question.

22          Q.    Next question.  Isn't she the one that should  
23   make that decision?

24          A.    Informed?

25          Q.    Yes.

1 A. Yes.

2 Q. Right. And undisputed she was never told any  
3 of that, was she?

4 A. No. Those are guidelines.

5 Q. I understand, Doctor. All I'm trying to do is  
6 just get the record as she's never told that, correct?  
7 She's the mom, correct?

8 A. Correct.

9 Q. Okay. Doctor, have you reviewed the Small  
10 Smiles consent forms to see whether they were accurate  
11 as of May 23rd, 2006?

12 A. Yes, I've seen those forms.

13 Q. All right.

14 MR. HIGGINS: Can we go to the inside  
15 page, please. Can I blow up number five, please.  
16 Number four, I'm sorry. No, this is not the --  
17 here, the May 23rd one has the HOM on it. Can we  
18 blow up number five, please.

19 Q. Doctor, tell us, this is a chart, I have the  
20 original right here. This is the May 23rd, 2006,  
21 Kelly Varano comes in and on the inside there is the  
22 patient management techniques. You see that?

23 A. Correct. That's a copy here.

24 Q. I'm sorry?

25 A. Yes.



1           Q.    All right.  And as of May 23rd, 2006, Small  
2 Smiles is still using the hand-over-mouth exercise,  
3 correct?

4           A.    It's on the list.

5           Q.    All right.  That means it's still being used,  
6 correct?

7           A.    I don't know that.

8           Q.    Well, did you --

9           A.    Because that's about a period of time where  
10 there was a big transition.

11          Q.    August 18th, 2006, correct?

12          A.    About that time, yes.

13          Q.    Yup.  The American Academy of Pediatrics drops  
14 this, says no more HOM?

15          A.    Some of us disagreed a little on that because I  
16 wrote one of the main articles about that.

17          Q.    I know that, Doctor.  So hand-over-mouth is  
18 when a disruptive, screaming child is told that the  
19 hand is placed over the mouth and it is kept there  
20 until the kid stops screaming, right?

21          A.    Not that simple.

22          Q.    Okay.  That's part of it?

23          A.    That's part of it, absolutely.

24          Q.    And parents never really thought much of that,  
25 did they?

1 MR. McPHILLIAMY: Objection.

2 THE COURT: Overruled.

3 Q. Okay. Let me move on. So did you see any  
4 custom and practice or practice guidelines from Small  
5 Smiles indicating that this was not being used as of  
6 May 23rd, 2006?

7 MR. STEVENS: Objection. Relevance.

8 THE COURT: What was the objection?

9 MR. STEVENS: Beyond the scope and  
10 relevance.

11 THE COURT: Overruled.

12 A. I did not see any writing directing them to  
13 cease and desist.

14 Q. Would it be fair to say if this is still  
15 being -- she's being asked to consent to?

16 A. Consent to it, yes.

17 Q. Consent to it?

18 A. Right.

19 Q. Can we agree -- in fact, haven't you written  
20 since 1979 that hand-over-mouth is only for a child  
21 who is able to cooperate?

22 A. That's correct.

23 Q. Okay. And it's -- there is contraindication  
24 for hand-over-mouth if the child can't cooperate?

25 A. Is too young.

1 Q. Too young to cooperate?

2 A. Or has a --

3 Q. Special needs?

4 A. -- disability, yes.

5 Q. So if the child's too young to cooperate and  
6 they do hand-over-mouth, it's never going to work for  
7 him, right? Right? It's not going to work?

8 A. Correct.

9 Q. Okay. And on this form that she was asked to  
10 sign on May 23rd, 2006, there is nothing saying that a  
11 young child who is too young will not be able to do  
12 this, can't and it's contraindicated --

13 MR. McPHILLIAMY: Objection. Relevance.

14 Q. -- correct?

15 THE COURT: Overruled.

16 A. That's correct.

17 Q. Is that a deviation in the standard of care?

18 A. No, because it's actually not an aged limited  
19 thing, not when you are 2.5. Impossible.

20 Q. All right.

21 A. So it's an individual choice made by the doctor  
22 with each child.

23 Q. And isn't it an individual choice for each  
24 mother to know that if this isn't on the chart that  
25 there is a contraindication and that if your child is

1 too young he's going to get this hand over his mouth  
2 and it will never work?

3 A. Won't understand what it is.

4 Q. Right. Shouldn't the mother know that?

5 A. That's why we have stopped doing it. Not that  
6 there was any problem with the technique. It's  
7 getting the permission and stopping the treatment to  
8 go out and get it frankly.

9 Q. Right. As of May 23rd, 2006, there is no --  
10 nothing in subparagraph five that says if your child  
11 is too young it's contraindicated, is there?

12 MR. McPHILLIAMY: Objection. Relevance.

13 Q. Nothing there?

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

16 Q. Well, Doctor, this was part of the consent form  
17 that Mr. Nowatny asked about, and you were just asked  
18 about on direct?

19 A. Right.

20 Q. These forms when people walk in don't they  
21 assume they're accurate? Shouldn't they be accurate?

22 A. I would as a patient or a parent.

23 Q. That's reasonable, isn't it?

24 A. Yes.

25 Q. Okay. Did Small Smiles have any type of

1       quality care review as of 2006 to 2008 in the Syracuse  
2       office?

3           A.    I don't know that.

4           Q.    Did you do anything to find out?

5           A.    No, I didn't.

6           Q.    Would it be a deviation of the standard of care  
7       for a dental practice or a dental company not to have  
8       a quality of care function?

9                   MR. McPHILLIAMY:  Objection.

10                   THE COURT:  Uhm, overruled.

11          A.    It would be a deviation of standard of care for  
12       a large organization providing care if they were  
13       providing the care.  Nobody in private practice has  
14       somebody come in and do QA on the work they provided  
15       to patients.

16          Q.    What about Columbia, you got one at Columbia?

17          A.    We have at Columbia a big corporation, yes.

18          Q.    What about 50 dental clinics, is that a large  
19       organization nationwide?

20          A.    Aren't they independently operated?  I don't  
21       know.

22          Q.    No.

23          A.    You're asking questions.  I don't know.

24          Q.    If you don't know, that's fine.  That's fine.

25          A.    Hypothetical.

1 Q. Hypothetically, would you assume that a large  
2 50 chain dental practice, 50 offices would have a  
3 quality assurance review?

4 A. Well, my understanding the way Small Smiles was  
5 set up was that there was someone who owned the  
6 practice and was the lead dentists, and I would think  
7 it's their responsibility to conduct some sort of QA,  
8 but I don't know that.

9 Q. Okay. So you don't really know?

10 A. No, I don't.

11 Q. Okay. Doctor, I want to talk about what  
12 happened to Jeremy Bohn on May 23rd, 2006,  
13 specifically. Now, you weren't there, correct?

14 A. That's correct.

15 Q. I wasn't there?

16 A. Correct.

17 Q. Dr. Bonds doesn't remember what happened that  
18 day, correct?

19 A. I don't know what his testimony was to that  
20 effect here.

21 Q. Didn't you read?

22 A. Didn't he testify recently?

23 Q. I'm asking you, you read his testimony, right?

24 A. I read his deposition.

25 Q. And in his deposition didn't he say he didn't

1 have any memory of what happened that day?

2 A. I believe that's correct.

3 Q. And so the proof's pretty much closed, we don't  
4 have any more witnesses coming in, so we have the  
5 record, correct?

6 MR. HULSLANDER: Objection. It's a  
7 speech!

8 Q. We have the record? You reviewed the record?

9 A. Correct, and the deposition.

10 Q. And we have -- Dr. Bonds doesn't remember  
11 anything, correct? Right?

12 A. Correct.

13 Q. Okay. Jeremy doesn't remember anything really,  
14 except what the place looked like maybe. He doesn't  
15 remember anything, that's not unusual?

16 A. It's not his testimony.

17 Q. Okay. So tell me, how soon after he was  
18 separated from his mother did he start screaming?

19 MR. STEVENS: Objection. Calls for  
20 speculation and there is no evidence.

21 THE COURT: Overruled.

22 A. I don't know.

23 Q. Okay.

24 A. How soon --

25 MR. STEVENS: Objection. Assumes it was

1 after he left his mother.

2 MR. HIGGINS: Okay.

3 THE COURT: Overruled. Cross-examination  
4 and it's -- we're just doing legal objections.

5 A. I have seen children who before they're  
6 separated are hanging on their mother screaming. I  
7 have seen children go away, mom, I got this, I'm fine,  
8 and the whole range is in-between. I don't know in  
9 Jeremy's case what happened here.

10 Q. Kelly Varano testified Jeremy was fine when she  
11 was separated from him. Would you assume that for  
12 purposes of cross-examination?

13 A. Certainly.

14 Q. How soon after that did he start screaming?

15 A. I assume when he was taken in for the cleaning  
16 and fluoride and didn't want any part of it.

17 Q. Okay. Do we know how many minutes that was?

18 A. I do not think there was an indication of  
19 timing on that part.

20 Q. Okay. Do we know when -- what time the first  
21 restraint -- what were they doing to him before they  
22 finally restrained him?

23 A. Well, this is a --

24 Q. Do we know?

25 A. You're aware. No, I don't know the timing.



1           Q.    Do we know what was actually going on back  
2           there?  Is there anything in the chart that would say,  
3           you know, child separated at 8:42; 8:46 child  
4           restrained physically; 8:48 child now going out of  
5           control, anything like that?

6           A.    I don't know anybody that does that --

7           Q.    Okay.

8           A.    -- puts those kinds of things in records.

9           Q.    Okay.  Certainly not in this case, right?

10          A.    Right.  True.

11                   MR. HIGGINS:  Chuck, have the 5/23/06  
12           first restraint, please.

13          Q.    Uhm, Doctor, again, I know you weren't there.  
14           You're just reviewing the records and I understand  
15           that.  This is -- do we even know what room he was in  
16           when he was restrained the first time?

17          A.    I don't remember testimony to that effect.  
18           It's not there.

19          Q.    Okay.

20          A.    Probably the hygiene room, but I don't know  
21           that.

22          Q.    Do you know what a quiet room is, Doctor?

23          A.    Yes, we have one.

24          Q.    All right.  Do you know if the quiet room in  
25           Small Smiles was used to take kids who were screaming

1 and get them away from the other kids so they wouldn't  
2 disrupt the other kids?

3 A. Right. Very serious influence on the other  
4 kids.

5 Q. So it's really not for the kid's benefit, it's  
6 to keep the other kids calm?

7 A. Both.

8 Q. Okay. So when was he -- do you know how long  
9 he was in the hygiene room before he went into -- he  
10 was taken to the quiet room?

11 A. No, I don't know.

12 Q. Okay. Do you know whether he was screaming and  
13 kicking and flailing and crying the entire time?

14 A. In the hygiene moment, I don't know.

15 Q. Do you know who took him into the quiet room?

16 A. I assume it was the hygienist.

17 Q. We don't know, do we?

18 A. No.

19 Q. Okay. What about did anyone physically hold  
20 him down in the quiet room?

21 A. Not to my knowledge.

22 Q. Is there anything in the chart?

23 A. No.

24 Q. Is there even a reference in the chart that he  
25 went to a different room?

1           A.    No.  I got that from I think Mrs. Varano's  
2 testimony, deposition.

3           Q.    Okay.  He was restrained at some point, right,  
4 we know 5/23/06 two restraints, right?

5           A.    Correct.

6           Q.    The first one is not even recorded anywhere, is  
7 it?

8           A.    I don't remember seeing it recorded, but my  
9 understanding is that's when Dr. Bonds examined him.

10          Q.    But there is nothing in the chart that would  
11 even say how long he was restrained, who restrained  
12 him, anything, there is nothing is there?

13          A.    Wasn't that the ten-minute interval before Dr.  
14 Bonds came out and spoke to Miss Varano and said,  
15 we're going to need to restrain Jeremy?

16          Q.    Doctor, there's nothing in the chart at all  
17 about a restrain, is there?

18          A.    During the hygiene period, no.

19          Q.    Okay.  So do we know how long he was  
20 restrained?

21          A.    Not during that activity.

22          Q.    Do we know what his heart rate was during that  
23 activity?

24          A.    That's not a routine thing any way.

25          Q.    Well, whether --

1           A.    There is no requirement.  We never have  
2           monitored kid's oxygen saturation or heart rate, you  
3           know, during stabilization.

4           Q.    So but Small Smiles did?

5           A.    I don't know why they went beyond the standard  
6           of care I know.

7           Q.    Okay.  So if you're practicing in Syracuse and  
8           somebody comes to you, you're not going to put a heart  
9           monitor on this kid when you strap him down?

10                   MR. STEVENS:  Object to "strap him down."

11                   MR. HIGGINS:  Withdrawn.

12           Q.    If you come to Syracuse and practice up here,  
13           you're not going to put a heart monitor on any kids  
14           you use protective stabilization on; is that fair?

15           A.    I am unaware of anything in the literature  
16           indicating I should do that.

17           Q.    I'm just talking about you.

18           A.    So, therefore, I have no rationale for doing an  
19           additional procedure.

20           Q.    All right.  So Small Smiles did this for no  
21           reason?

22           A.    Must have made them.

23                   MR. McPHILLIAMY:  Objection.

24                   Argumentative.

25                   THE COURT:  Overruled.

1           Q.   All right. So, Doctor, what I'm trying to  
2 figure out and maybe you can help me, is this child  
3 goes from his mother and he's not screaming, he's not  
4 crying, he's not doing anything and he's separated.  
5 He comes out at some point in time later and he's  
6 hysterical. Okay. We know from the note "patient out  
7 of control."

8           A.   Right.

9           Q.   Okay. And there's this -- the whole first  
10 restraint isn't even recorded. Is that a deviation in  
11 the custom and practice of good dental practice not  
12 even to record a restraint?

13          A.   Well, you certainly need parental permission  
14 must been obtained by then, unless I'm missing  
15 something here.

16          Q.   Doctor, is it a deviation of good and accepted  
17 dental practice not even to record a restraint?

18          A.   You should record that you used protective  
19 stabilization for a patient, absolutely.

20          Q.   Is it so that would be a deviation not to do  
21 that; is that correct?

22          A.   It would be.

23                   MR. HULSLANDER: It's in the report.

24          A.   It would be outside the standard of care.

25          Q.   When you mean outside, you mean a deviation?

1           A.    Deviation.

2           Q.    By not recording this, Small Smiles or whoever  
3 was responsible deviated from the standard of care on  
4 May 23rd, 2006; is that fair?

5           A.    No. What I don't understand, we don't know  
6 when it happened. Was it during that ten-minute  
7 interval, after they obtained permission because they  
8 tried to look in his mouth, he started having a  
9 tantrum. They said, you know, we can't examine him.  
10 He had an emergency. He was on penicillin. Some  
11 point he had been in pain, and he clearly had an  
12 infection only to be resolved by treatment.

13          Q.    All right. So, Doctor, we don't really know  
14 what happened back there, do we?

15          A.    The hygiene piece we don't know.

16          Q.    Right, we don't. And we don't know whether  
17 this child was in this thing screaming and crying and  
18 kicking and flailing during that first time, do we?

19                   MR. STEVENS: Objection.

20                   THE COURT: Overruled.

21          Q.    We don't know?

22          A.    We don't know. We have some sense of the time  
23 frame. Didn't she say seven minutes? I don't  
24 remember if that's when she went out to smoke a couple  
25 of cigarettes. I think that was the ten-minute

1 period.

2 Q. Is it really up to the mother to record a  
3 restraint?

4 A. Not suggesting that.

5 Q. Okay. All right. Doctor, do you know whether  
6 the quiet rooms are soundproof?

7 A. No, I do not.

8 Q. Okay. Doctor, how far is it from Rome, New  
9 York to Geddes Avenue in Syracuse, how many miles?

10 A. Like driving time?

11 Q. Yes, sir.

12 A. I saw from testimony from Miss Varano took her  
13 an hour.

14 Q. Okay. If I suggest 47 miles, would that seem  
15 accurate?

16 A. I don't know the roads between, but some  
17 thruway or something certainly.

18 Q. Okay. Did -- how many times did Kelly Varano  
19 and her significant other, Chuck Bohn, drive from  
20 Rome, New York to Small Smiles?

21 A. Ten times.

22 Q. Okay, 47 miles, ten times, how many hours in  
23 the car is that?

24 A. Fifty hours.

25 Q. Okay. And about how many miles did they drive?

1           A.    400, 500 miles.

2           Q.    Doctor, do you think if someone had said to  
3   them, your child needs treatment in a hospital in  
4   Rome, that they would have gone?

5                   MR. McPHILLIAMY:  Objection.

6                   MR. STEVENS:  Speculation.

7                   THE COURT:  Overruled.

8           A.    If that care was available and she was made  
9   aware of it, why wouldn't she.

10          Q.    I agree, Doctor.  Was she given the option of  
11   going to a hospital such as Strong Memorial or Albany  
12   Medical Center, right, they have to have a pediatric  
13   center there?

14          A.    Albany, I don't think so.  Certainly they do at  
15   U of R.

16          Q.    U of R is University of Rochester?

17          A.    University of Rochester, Eastman Dental.

18          Q.    Was Kelly Varano given that option on May 23rd,  
19   2006?

20          A.    I don't know.

21          Q.    Anything in the record suggesting she did?

22          A.    I did not see such.

23          Q.    What about Dr. Bonds testimony?

24          A.    I did not see that he had suggested that.

25          Q.    Okay.  What about deferral, do you know what



1 deferral is when a child becomes hysterical and  
2 uncontrollable?

3 A. Yes.

4 Q. Deferral means that you stop the treatment,  
5 correct?

6 A. Correct.

7 Q. All right. Was she ever given the option  
8 during this treatment to come back and comfort Jeremy?

9 A. Not to my knowledge.

10 Q. Okay. Would that be something you would do,  
11 Doctor, if let's say --

12 A. Make an individual decision with every parent.  
13 I mean in my lectures on behavioral management to the  
14 pediatric residents, to the students, I can give you  
15 five reasons why it is great to have a parent in the  
16 room, and five reasons why it's a horror show to have  
17 a parent in the room, so you make an individual  
18 decision in each case.

19 Q. Right. Don't you -- isn't that, again,  
20 something that the parent has to be involved with?

21 A. That's kind of a doctor's call, because if you  
22 see that, you know, a parent is, oh, poor baby, oh,  
23 sweetheart, they can exacerbate the whole thing and  
24 make it so much more difficult. On the other hand, I  
25 have had parents who are wonderful, giving me hints

1        what the child is interested in, how to better relate  
2        to them in the tell-show-do and the voice control.

3            Q.    By the way, no record here of any tell-show-do?

4            A.    Never is.

5            Q.    There isn't here?

6            A.    I never in my life did that. That's like  
7        saying I took a break and spoke to you and to do that  
8        with every child patient.

9            Q.    That's what you're suppose to do for every  
10       child patient?

11          A.    Correct. That's what every school in the  
12       country teaches. I know it is required.

13          Q.    Doctor -- okay. When Kelly -- I'm sorry. When  
14       Jeremy Bohn was restrained for the first time,  
15       whatever happened, whatever it was, at some point in  
16       time he goes to the operatory, correct?

17          A.    Correct.

18          Q.    All right. How does he get -- if he does go to  
19       the operatory, how does he get from one room to the  
20       other?

21          A.    I don't know.

22          Q.    What's going on with him during that time?

23          A.    He's having a tantrum as far as I can tell.

24          Q.    That's what you think, you don't know?

25          A.    Apparently.

1 Q. You don't know, do you, Doctor?

2 A. Why else would you put him in adaptive  
3 stabilization.

4 Q. How about to make money?

5 A. No.

6 Q. No?

7 A. It's not a valid reason.

8 Q. You're right, I agree. So, Doctor, you don't  
9 know what this child's condition was between the  
10 operatory and the hygiene or the quiet room. You  
11 don't know what was going on with him because there is  
12 nothing in the record?

13 A. I thought in his father's deposition he was  
14 present, correct?

15 Q. No, he wasn't present.

16 A. No?

17 Q. No. That's incorrect. All right.

18 A. I thought at some point he talked about hearing  
19 him screaming in the other room. Maybe it was Mrs.  
20 Varano.

21 Q. That's okay. That's after the visit.

22 A. Okay.

23 Q. So we don't know -- you can't know what was  
24 going on back there between the operatory and the  
25 hygiene, right?

1 A. No. I would be making assumptions.

2 Q. And one of the things that causes fear and  
3 anxiety in a child is being in with strangers in a  
4 dental environment; is that fair?

5 A. In any strange environment with strange people.

6 Q. You wrote that in 1979, didn't you? Yes?

7 A. Still agree with it.

8 Q. Okay. And was he kept in restraints between  
9 one room and the other?

10 A. Don't know.

11 Q. Okay. Uhm, if he had been let out was there  
12 anything that would say that Kelly Varano should not  
13 have been let back to comfort her child? Anything?

14 A. Reason why not to?

15 Q. Yeah. He's already been restrained, right?

16 A. That would be a judgment call that the doctor  
17 would make. If he starts acting up again, even though  
18 in the protective stabilization because mom is there,  
19 I wasn't there, I don't know. That's a call that they  
20 made obviously.

21 Q. Okay. So it's the call?

22 A. That's within the standard of care. It's their  
23 choice.

24 Q. It's the call the doctor made without asking  
25 Kelly, fair to say?

1 A. At that point, yes.

2 Q. Okay. You think that's okay?

3 A. I think that's okay. If she was told she can  
4 be involved with this, if she understood it, if it's a  
5 conversation, you know, this is not substantively  
6 different than those circumstances. We -- this is  
7 again a child with infection. An emergency that needs  
8 care. The mother understands there's going to be some  
9 kind of stabilization --

10 Q. Doctor --

11 A. -- to do that.

12 Q. Doctor, is it your testimony in front of this  
13 jury --

14 MR. McPHILLIAMY: Objection, Your Honor.

15 MR. HULSLANDER: He's trying to  
16 intimidate.

17 MR. STEVENS: Your Honor --

18 THE COURT: All right, Mr. Hulslander, no  
19 comments, please.

20 Q. I'm sorry, Doctor. I'm coming back over here.

21 A. That's fine.

22 Q. Is it your testimony that Kelly Varano was  
23 given the option to go back into the back room on May  
24 23rd, 2006?

25 A. I see nowhere someone -- in the record that

1       says someone went to her and said, would you like to  
2       come back.

3           Q.    And are your opinions in this case based on  
4       that presumed fact?

5           A.    Could you restate that?

6           Q.    Of course.

7           A.    I'm not sure what you're asking me.

8           Q.    Doctor, let me ask you to assume that, in fact,  
9       the record in this case is that she was told she  
10      couldn't go back on May 23rd, 2006, she couldn't go  
11      back.

12          A.    This is what that dental assistant had told  
13      her, is that what we are talking about?

14          Q.    We're talking about Kelly Varano's testimony.

15          A.    Okay.

16          Q.    And let me ask you to assume that that's right,  
17      that she did say that.

18          A.    Yes.

19          Q.    She testified to this jury. Doctor, that's not  
20      right, is it, to be told you can't go back there?

21          A.    Can't? It depends on the circumstances.

22                   MR. STEVENS: Objection. About the sixth  
23      or the seventh or eighth time he's asked the same  
24      question. Maybe the ninth time.

25                   THE COURT: Okay. So the objection is

1 asked and answered?

2 MR. STEVENS: I'm sorry. Asked and  
3 answered, Your Honor.

4 THE COURT: Sustained.

5 Q. Okay. Doctor, are your opinions in this case  
6 based upon the fact that you think she was told that  
7 she could go back there on May 23rd, 2006?

8 A. No, I have no reason to believe that either.

9 Q. Do you know one way or the another?

10 A. Don't know. She testified as you said. Just  
11 now asked me to assume that she was told she could  
12 not.

13 Q. Okay.

14 MR. HIGGINS: Chuck, let me have Exhibit  
15 781 up, please. Your Honor, for identification,  
16 this is just another screen shot of the video.

17 Q. I'm sorry, Doctor, can you see this?

18 THE COURT: You can get down.

19 THE WITNESS: I can see it. This is fine.

20 Q. Doctor, this is just another screen capture of  
21 the video the jury's seen.

22 A. Those are two of the three that we had looked  
23 at earlier.

24 Q. Exactly. I think we just flipped this one up.

25 A. Yes. That's 180 degrees flipped.

1 Q. Doctor, would you agree that you can see decay  
2 here and here and that it matches here in some  
3 respects?

4 A. Looks pretty close.

5 Q. That you can also see decay here and here and  
6 it is matching in some respect there?

7 A. If I saw anything, it was lower down than that  
8 where you were pointing. I guess what concerns me is  
9 on the lateral incisor -- you want me to point to it  
10 so we know what we are talking about. It is obviously  
11 some decay or caries in here. This is pitted. It's  
12 brown. And I don't see a thing over here. So it's  
13 variable.

14 Q. Okay.

15 A. You see it.

16 Q. We can definitely see here and here, these two?

17 A. Yes. This one is tough, but I think I can see  
18 something there on that.

19 Q. Doctor, if you can just take your seat back. I  
20 thank you and appreciate it.

21 A. No problem.

22 Q. Doctor, is there -- as to the restraints, is  
23 there any part of that that you agree with the  
24 American Academy of Pediatric guidelines, is there any  
25 part of that you agree with their guidance on



1 restraints?

2 A. No. Again, the big -- I'll stop there. Stop  
3 right there.

4 Q. Okay. And what about the hand-over-mouth,  
5 would -- if you still were practicing, would you be  
6 using hand-over-mouth?

7 MR. McPHILLIAMY: Objection. Relevance.

8 THE COURT: Sustained.

9 Q. Doctor, if this child was being restrained and  
10 he was screaming to get out and screaming for his  
11 mother and screaming to go home, they wouldn't let him  
12 up, would they?

13 MR. STEVENS: Objection.

14 MR. McPHILLIAMY: Objection. Speculative.

15 Q. That's how they are trained, right?

16 MR. STEVENS: Objection.

17 THE COURT: Sustained. Sustained.

18 Q. Doctor, would you agree with me that as to the  
19 dental family relationship that the parents being  
20 involved and being given accurate information is  
21 crucially important for the safety of a child?

22 A. To their safety, well-being and the care you  
23 provide.

24 MR. HIGGINS: All right. Thank you,

25 Doctor.

1 THE WITNESS: You're welcome.

2 MR. HIGGINS: That's all I have, Judge.

3

4 CROSS-EXAMINATION

5 BY MR. FIRST:

6 Q. Doctor, I will ask you about one limited issue.

7 A. Please.

8 Q. You had an exhibit shown as Exhibit 66 that  
9 contained -- you didn't really testify much from it,  
10 but it contained where it had a copy of the guidelines  
11 attached to it. I'm going to show you Exhibit 67,  
12 which is dated August 18, 2006, came from Rich Lane,  
13 somebody with FORBA, and went to all the lead dentists  
14 and office managers at various Small Smiles clinics.  
15 And I'm going to ask you relative to this  
16 hand-over-mouth issue, to read out loud the last  
17 paragraph where it says note?

18 A. Note: Important to note that hand-over-mouth  
19 (HOM) is no longer included as an acceptable technique  
20 per the revised guideline on behavior guidance for the  
21 pediatric dental patient. Please ensure that all  
22 health history forms on the back page are the new  
23 forms that no longer contain hand-over-mouth as a  
24 dentistry patient management technique.

25 Q. Thank you. So that indicates that clinic wide

1 notice went out about that technique no longer being  
2 part of the guidelines; isn't that correct?

3 A. I don't know who that was sent to, but the  
4 guidelines clearly states it.

5 MR. FIRST: Thank you.

6

7 CROSS-EXAMINATION

8 BY MR. McPHILLIAMY:

9 Q. Afternoon, Dr. Davis.

10 A. Afternoon.

11 MR. McPHILLIAMY: Can I have 22, please.

12 Q. Doctor, you were asked a number of questions  
13 about the documentation of restraint in the hygiene  
14 room. Do you remember Mr. Higgins asked you about  
15 those questions?

16 A. Yes.

17 Q. Can you read --

18 MR. McPHILLIAMY: Actually, can I have  
19 that blown up that bottom part, Craig.

20 A. Patient out of control, protective  
21 immobilization used. Consent secured. And I'm not  
22 sure whose signatures those are. It includes the RDH,  
23 which is the registered dental hygienist, whoever that  
24 was.

25 Q. Patient out of control, protective

1 immobilization used, consent secured?

2 A. Right.

3 Q. In your opinion, is that documentation that  
4 protective immobilization was used in the hygiene  
5 room?

6 A. Well, can we go back to the chart so I know in  
7 the context in which this note was made?

8 Q. Hygiene procedures.

9 A. Okay. It's on the hygiene procedures page, so  
10 I assume that means it was in the hygiene room or  
11 wherever they were doing the hygiene activity.

12 MR. McPHILLIAMY: Can I have 27, please,  
13 blown up a little bit.

14 Q. Doctor, this is the operative procedure --

15 A. Correct.

16 Q. -- page?

17 A. Yes.

18 Q. When teeth B and I were extracted on May 23rd?

19 A. Yes.

20 Q. Same day as the hygiene visit, is that your  
21 understanding?

22 A. Yes.

23 Q. And is it noted that protective immobilization  
24 was used in the treatment room also, is that  
25 documented?

1           A.    That's very clearly documented for twenty  
2 minutes as it says.

3           Q.    Okay.  Now, Mr. Higgins asked you a lot of  
4 questions about hand-over-mouth.  Let's talk about  
5 that for a second.

6           A.    Sure.

7           Q.    When a dentist uses hand-over-mouth, is the  
8 nose covered also?

9           A.    No.

10          Q.    Why is that?

11          A.    Because you're restricting the airway and you  
12 scare the daylights out of the child.

13          Q.    Beyond safe for the patient?

14          A.    Would not be safe for the patient.  No one  
15 wants their air cutoff.

16          Q.    Based on the hours and hours that you reviewed  
17 in this matter, did you see any indication of the  
18 hand-over-mouth was used with regard to Jeremy?

19          A.    No.  None.

20          Q.    Now, Doctor, going back to your credentials.

21          A.    Yes.

22          Q.    The AAPD is a nationwide organization and  
23 consists of all 50 states; is that correct?

24          A.    That's correct and six provinces in Canada.

25          Q.    Okay.  Any of the islands surrounding?

1           A.    No.   Well, Manhattan.   That's a foreign  
2 country.

3           Q.    And you were the past president of that,  
4 correct?

5           A.    Yes, sir.

6           Q.    And are you familiar with an organization known  
7 as the American Society of Dentistry for Children?

8           A.    Indeed.

9           Q.    Tell us about that, that society?

10          A.    To make a long story short, back in the  
11 twenties, the dentists have signs in the offices that  
12 said "children not welcome."   A few gentlemen, and  
13 they were all men at that time, decided this was  
14 wrong, children need care.   They suffered pain,  
15 infection, loose teeth, get orthodontic problems,  
16 all of which I'm sure you heard a ton of here, and  
17 they started the American Society of Prevention in  
18 Dentistry for Children, which later became just ASDC.  
19 It was about a 105 years old when I became president  
20 of that organization after I had been AAPD president,  
21 and, you know, did the committees and the chairs and  
22 usual things, and we brought them together as one  
23 organization.   So that the general practitioners who  
24 provide 75 percent of the care in this country would  
25 learn from the specialists who went on for additional

1 training to ensure that what was being done for  
2 children in either setting was as good as it could  
3 possibly be, so that's the importance of it.

4 Q. I believe you told us that you were president  
5 of that organization as well as the AAPD?

6 A. That's correct.

7 MR. McPHILLIAMY: Nothing further.

8 THE COURT: Thank you.

9 MR. STEVENS: One I will ask from here.

10

11 REDIRECT EXAMINATION

12 BY MR. STEVENS:

13 Q. Dr. Davis, does standard of care require  
14 dentists to advise a parent of the risks identified in  
15 the AAPD guidelines for protective immobilization?

16 A. Standard of care does not require that. Those  
17 are guidelines from an important organization. They  
18 are kind of intended, especially when we are using  
19 them in training often to say, you know, it's nice,  
20 you know, you really need to talk to the parent here  
21 people, but, you know, it's not a standard of care.

22 Q. Why is it that you said that the manner in  
23 which Dr. Koury Bonds used protective stabilization is  
24 safe?

25 A. Because he considered in the way he monitored

1 the patient. All the important things. It's not too  
2 tight. They can breathe. The circulation is good.  
3 And, you know, the critical things are monitored.

4 Q. Not too tight, watch even every second, not too  
5 long?

6 MR. HIGGINS: Objection. Beyond the  
7 scope.

8 A. Not too long.

9 MR. STEVENS: I'm done, Your Honor.

10 MR. HIGGINS: One final question.

11 THE WITNESS: Please.

12

13 RECROSS-EXAMINATION

14 MR. HIGGINS:

15 Q. Doctor, under your view of this risk issue, you  
16 wouldn't be telling the parents about the risks that  
17 the American pediatric guidelines set forth; is that  
18 fair?

19 MR. McPHILLIAMY: Objection. Scope.

20 THE COURT: Overruled.

21 A. I don't see the necessity for it.

22 MR. HIGGINS: Thank you.

23 THE COURT: Okay. Doctor, you may step  
24 down. Can I see counsellors up here for a minute  
25 before I let the jury go.



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

3 THE COURT: I will hold you up for a  
4 minute so I can tell you what is in store for next  
5 week.

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

8 THE COURT: All right. Uhm, Mr. Stevens.

9 MR. STEVENS: That's me.

10 THE COURT: Do you have any additional  
11 witnesses?

12 MR. STEVENS: I do not.

13 THE COURT: So do you rest?

14 MR. STEVENS: On behalf of the three  
15 dentists we rest, Your Honor.

16 THE COURT: Okay. And do you have any  
17 rebuttal witnesses?

18 MR. FRANKEL: We don't, Your Honor.

19 THE COURT: Okay. So the proof is closed  
20 in this case. What that means is I need to meet  
21 with the lawyers and work on the jury charge and  
22 verdict sheet and that would be something that  
23 will not be ready Monday morning.

24 So we're going to be off on Monday. Well,  
25 actually let me -- come up here again.

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

3           THE COURT: All right. I'm sorry. We're  
4           just trying to figure out what's the best  
5           utilization of your time and our time. So what we  
6           have decided is that Monday will be a day off.  
7           We'll start Tuesday morning at nine o'clock.

8           We will start at quarter of nine if that's  
9           okay. Is that a problem for anyone to get here  
10          then? Who is calling him? And we'll have closing  
11          arguments, my jury charge, and then you will begin  
12          your deliberations.

13          And your deliberations may go into the  
14          Wednesday. We don't know what will happen. But  
15          we'll do that on Tuesday, and Monday is a day off.  
16          Okay. Have a great weekend. Don't talk about the  
17          case. Don't do any independent research.

18          TRIAL JUROR: Yes, dear.

19          THE COURT: Behave.

20          (Jury excused for the day at 4:18 p.m..)

21          THE COURT: Okay. We have to go upstairs  
22          so everybody can leave. Just the lawyers to talk  
23          about Sunday.

24          (Proceedings in recess at 4:19 p.m..)

25

## 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.

\$	1974 <sup>[1]</sup> - 2099:9 1979 <sup>[5]</sup> - 2099:12, 2099:14, 2099:18, 2115:20, 2133:6 1982 <sup>[1]</sup> - 1942:3 1984 <sup>[1]</sup> - 1973:5 199 <sup>[2]</sup> - 1970:8, 1984:13 1:35 <sup>[1]</sup> - 2043:4	1947:25, 1950:11, 1954:6, 1954:13, 1955:12, 1994:13, 1994:25, 1995:1, 2001:4, 2024:15, 2035:17, 2063:24, 2107:9, 2113:11, 2113:17, 2113:20, 2114:1, 2115:6, 2116:10, 2117:9, 2119:12, 2127:4, 2129:18, 2134:24, 2135:10, 2136:7, 2141:18 250 <sup>[1]</sup> - 1939:19 27 <sup>[1]</sup> - 2141:12 2:50 <sup>[1]</sup> - 2087:16	5	8:46 <sup>[1]</sup> - 2122:3 8:48 <sup>[1]</sup> - 2122:4
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